The Health Advocate
Your voice in healthcare

Mental health

Mental health—are we relieving pressure on our hospitals?

Creating a supportive culture around mental health

Mental health care in the Australian acute health system: Emergency!

The continuity of support question

+MORE INSIDE

The official magazine of the Australian Healthcare and Hospitals Association

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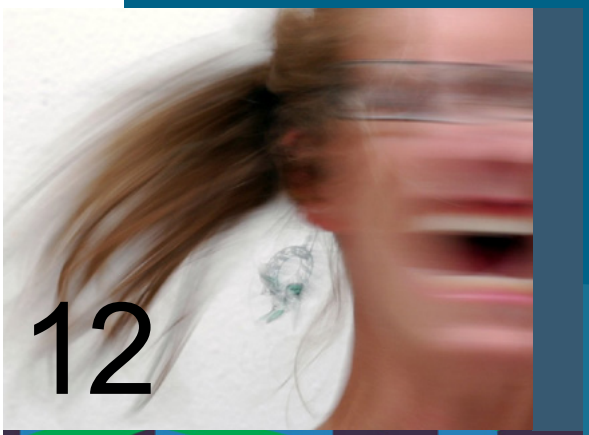

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DEBORAH COLE
Board Chair, Australian Healthcare and Hospitals Association (AHHA)

Mental ill-health: What do we do when someone's not ok?

He was enjoying knock-off drinks at his local country pub when Matt* got a distressing text message from Dave*, a divorced father-of-two. The text was sent to four of Dave's mates and simply read, 'Goodbye'.

Matt immediately hopped into the car and raced over to Dave's place to find him in a distressed state ranting about his hardships with his family and declaring that he no longer wanted to be alive. Scared but unsure what to say or do, Matt just waited until Dave calmed down and fell asleep. The next day, another recipient of the text message called in to see if Dave was ok. Dave laughed off the incident saying he'd had too much to drink and meant to text 'Goodnight'. While all four friends knew that Dave was battling with his mental health, none of them knew what to do or how to help.

That was two weeks ago. Since then all four men feel a jolt of nerves whenever their phone buzzes late at night: *Please don't let it be Dave.*

Despite the ongoing focus on mental health, too many of us feel ill-equipped to help when someone is suffering—we don't know how to start the conversation, we're scared we'll say the wrong thing and make matters worse. At the same time, the person who is suffering is worried that if they open up to their employer, family member, friend or healthcare professional that they will be judged, or seen as weak or 'less than'. And so they stay silent, try to get on with it, too often with devastating consequences.

Around 45% of Australians aged 16 to 85 will experience a mental illness such as depression, anxiety or a substance abuse disorder. Despite ongoing prevention efforts, suicide rates also continue to rise with men over the age of 85 at the highest risk.

With these stats it came as welcome news that in the 2018-19 Budget the Government has allocated an increase of $338.1 million in mental health funding with a focus on suicide prevention, research and older Australians.

Expenditure on mental health is an investment in a productive community and economy, but we need more than funding if we are going to tackle the devastating burden of mental ill-health on Australia. It's not enough to throw money at it. It's not enough to talk about it. We need to tackle the pervading stigma and use the funds to create a health system that supports the whole person—a system where health professionals are empowered to respond promptly and with compassion, an integrated system where mental health services and expertise are part of a holistic approach to person-centred care.

> "Around 45% of Australians aged 16 to 85 will experience a mental illness such as depression, anxiety or a substance abuse disorder. Despite ongoing prevention efforts, suicide rates also continue to rise with men over the age of 85 at the highest risk."

We also need to tackle the paralysis that so many people feel in the face of mental ill-health by going beyond simply asking, 'Are you ok?' We need to look out for everyone, know the signs, and re-learn the art of putting down our phones and having meaningful conversations.

I was recently scrolling through Instagram and came across a meme that said, 'Check on your strong friend'. It got me thinking about the people in my life and their own experiences with mental health. Sometimes it is the person who looks the most in control that is battling the most behind closed doors. These people are the least likely to ask for help. As friends, partners, brothers, sisters, parents and health leaders, we need to develop the skills to reach out in a way that makes people feel safe and respected rather than cornered and judged. An integrated health system, informed conversations and eradicating mental health stigma will help Australians live to their full potential. It'll save lives. ha

ALISON VERHOEVEN
Chief Executive
AHHA

Mental health—many facets, many factors

Welcome to this August issue of *The Health Advocate* where the theme is 'Mental health'.

We have been fortunate enough to attract many worthwhile and interesting articles from a great range of contributors for this issue. This reinforced to me that for good mental health and excellent mental healthcare so many things have to be 'working right' and 'done right', both within ourselves and the environment and community in which we live—which includes governments and the caring professions. And all of these facets and factors can vary so much depending on other aspects of our health and our own particular situations in life.

Frank Quinlan from Mental Health Australia, for example, has contributed an opinion piece on creating a supportive mental health culture in the workplace. He has also taken fingers to keyboard to write about the 'healing circle' used in some Indigenous cultures to help, support and guide those in the community who are straying from life's pathway where meaning, achievement, purpose, and identity are valued.

Headspace Board member Katina Law has written on mental health support for young Aboriginal and Torres Strait Islander people, while Community Mental Health Australia CEO Amanda Bresnan has set out her organisation's position on what should happen with continuity of support for people on Australian Government mental health support programs that are being wound back with the advent of the National Disability Insurance Scheme (NDIS). Some are finding that they are not eligible for NDIS support.

The Australasian College for Emergency Medicine Australia has written on dealing with mental health conditions in the emergency setting, and the problems associated with 'access block' to the hospital.

Pain Australia, and Chronic Pain Australia, have both written on different aspects of mental health and chronic pain, while Paul Martin from the Brisbane North Primary Health Network has provided an article on 'The Way Back', a new support service for suicide prevention in the Redcliffe area of Brisbane.

Paul has also kindly provided an account of how Brisbane North PHN has commissioned an array of low intensity mental health services—these are structured, evidence-based psychological therapies suitable for people who might be going through difficult life events or experiencing mild depression or anxiety.

Meanwhile, Sydney North PHN has written about mental health services reform in their region, involving a stepped care approach in primary care and 13 new programs.

Also in the mental health services reform 'space' is Sebastian Rosenberg, from the Centre for Mental Health Research at the Australian National University. He has given his thoughts on whether current reform directions are, or will, relieve the pressure on hospitals.

Stepping out for mental health is Exercise and Sports Science Australia, who with partner organisations have published a new International Consensus Statement aimed at increasing access to appropriate exercise programs for people with mental illness—with the ultimate aim of closing the life expectancy gap between people with mental illness and the rest of the population.

We also have, from the Australian College of Nursing, an account of a conversation with nurse leader Professor Lorna Moxham on mental health nursing.

If those articles don't entice you into the pages of this issue of *The Health Advocate*, maybe our article from Nutrition Australia (Vic.) on promoting healthy eating through your health service will.

Finally I must mention our 2018 World Hospital Congress pages in this issue, where Aparnaa Somanathan previews a session the World Bank will give on building integrated service delivery and where we have been able to publish the Congress program in full!

If you haven't registered for the Congress as yet, hopefully this will act as your incentive to make sure you get to Brisbane in October. It's shaping up to be a world-class Congress in every sense. And remember, it only happens here once every 20 years! ha

AHHA in the news

4 JUNE 2018

Safer care, reduced hospital waiting times: research points a way ahead

'Research published in the latest issue of *Australian Health Review* (AHR) points the way to some interesting opportunities to improve various aspects of hospital activity—and make them more efficient', according to the *AHR's* chief editor, Professor Gary Day.

"A study from a Monash University team looked into Mortality and Morbidity Reviews."

'They are not necessarily complicated ideas. One study, from a combined US-Australia author team, including from private health insurer HCF, found that telephone support given by registered nurses to patients recently discharged from Australian private hospitals reduced 28-day readmission incidence by 29%.'

A study from a Monash University team looked into Mortality and Morbidity Reviews (MMRs). The research team found that while MMRs undoubtedly contributed to reduced mortality and improved patient care, formal evidence on outcomes was sparse, and there was little consistency in the way MMRs were conducted. The team found that MMRs could be improved if conducted by multidisciplinary review teams that included those with most contact with the patient in question. MMRs would also be improved if focused on education and quality improvement rather than the actions of individuals, and if they followed a hospital-wide standard format.

A Queensland-based research team investigated all aspects of outpatient waiting times. Rationalising referrals, triaging of patients and wait list audits were found to have most effect on waiting times.

6 JULY 2018

Come a long way, long way to go—cardiac care for Aboriginal and Torres Strait Islander people

'Today's report on Aboriginal and Torres Strait Islander cardiac care released by the Australian Institute of Health and Welfare shows encouraging progress while also showing there is still some way to go to bridge gaps in treatment and mortality,' Australian Healthcare and Hospitals Association (AHHA) Acting Chief Executive Dr Linc Thurecht said today.

'On the plus side, the report shows access to care for Aboriginal and Torres Strait Islander people with heart conditions has improved markedly in recent years, while mortality rates have fallen.

'On the minus side, Indigenous Australians continue to be much more likely than non-Indigenous Australians to be hospitalised for cardiac conditions, are less likely to use specialist services and in-hospital services, and are much more likely to die from a cardiac condition, either while in hospital or in the community.

'And Indigenous Australians continue to suffer from rheumatic heart disease at disproportionate rates—it's a condition rarely seen in non-Indigenous Australians.

HAVE YOUR SAY...

We would like to hear your opinion on these or any other healthcare issues. Send your comments and article pitches to our media inbox: communications@ahha.asn.au

11 JULY 2018

Nine Australian finalists out of 27 in International Hospital Federation awards

Three Australian organisations are among the finalists for the Grand Award:

- Dental Health Services Victoria for 'Value-based healthcare: A new approach to improve oral health outcomes
- Metro South Hospital and Health Service, Queensland Health for 'Our Transformation to Australia's First Digital Health Service'
- Wide Bay Hospital and Health Service for 'Wide Bay Amazing Sustainable Turnaround'.

There are four Australian finalists in the award for Quality and Safety and Patient-Centred Care:

- Australian Red Cross Blood Service, Canberra Hospital and Health Service—Women's and Children's Hospital, and Darling Downs Hospital and Health Service, for 'IRONing out Maternity Blood Management: Improving identification and management of iron deficiency and anaemia'
- Queensland Health, and Children's Health Queensland Hospital and Health Service, for 'Lady Cilento Children's Hospital Gender Clinic & Statewide Service, Children's Health Queensland Hospital & Health Service'
- Queensland Health Metro South Hospital and Health Service for 'Gestational Diabetes Mellitus App and Interactive Clinician Portal (Internet Based)'
- Redcliffe Hospital, Queensland Health, for 'A Pharmacist-led Hospital-based Opioid Stewardship Service'.

The two Australian finalists in the Corporate Social Responsibility category are:

- Western Health (Vic.), for 'Western Health Healthcare Environmental Sustainability (HES) Program'
- Metro South Hospital and Health Service (Qld), for 'Improving access to oral health with a patient-centred focus to a vulnerable community'.

16 JULY 2018

AHHA launches a new podcast series

AHHA has hit the airwaves with the launch of The Health Advocate Podcast series. Each episode will feature interviews with researchers, previews of AHHA events, and insights into our advocacy and professional development work and activities. It's interesting, entertaining and time efficient at around 10 minutes an episode.

The first episodes are now live. Episode two features upcoming World Hospital Congress speaker Chris Pointon talking about the #hellomynameis campaign and compassionate care, while episode three features Deeble Institute summer scholar Elizabeth McCourt discussing the latest Deeble Institute for Health Policy Research Issues Brief, Improving Pharmacist Involvement in Pandemic Influenza Planning and Response in Australia and her experiences of being a pharmacist at the recent Gold Coast Commonwealth Games.

You can find the podcast episodes on the AHHA website at http://ahha.asn.au/health-advocate-podcast or subscribe via iTunes or in your podcast app of choice.

16 JULY 2018

End-of-life care in GP settings—to improve care, more information needed

Information on end-of-life care in the primary care setting is difficult to obtain—which makes it difficult to support primary health practitioners in providing optimal care for patients and their families, says the Australian Healthcare and Hospitals Association (AHHA).

The Association has released an Issues Brief through its Deeble Institute for Health Policy Research—*Integrated information networks to support end-of-life care in general practice.*

The paper was written by Prof. Claire Johnson (Monash University), Prof. Geoffrey Mitchell (University of Queensland), Prof. Angus Cook (University of Western Australia). Mr Jinfeng Ding (University of Western Australia) and Ms Laura Deckx (University of Queensland).

'Australia's population is ageing. As a consequence we are faced with an increasing number of people with physical and age related illnesses and disability, and an increasing demand for appropriate and supportive end of life care', Vivian Bullwinkle Chair of Palliative Care Nursing, Prof. Claire Johnson said.

'At the moment end-of-life care tends to be happen in silos according to diagnosis or the bodily system most affected.

'Specialist palliative care has evolved primarily for people with acute clinical needs—most often for those with a cancer diagnosis.

'But the reality is that most end-of-life care is provided in the community by general practitioners, community nurses and associated health professionals, whether they recognise it as end-of-life care or not', Prof. Johnson said.

AHHA in the news

20 JULY 2018

Australian Healthcare Ethical Framework focuses on 'doing the right thing'

'A consensus framework for ethical practices in healthcare launched in Tokyo today with the support of Health Minister Greg Hunt is all about doing the right thing by patients and healthcare as a whole', said Australian Healthcare and Hospitals Association Chief Executive, Alison Verhoeven.

The AHHA is one of five organisations that led the development of the Australian Consensus Framework for Ethical Collaboration, along with the Australian Orthopaedic Association, the Medical Technology Association of Australia, Medicines Australia, and the Royal Australasian College of Surgeons.

Since then 50 other bodies have signed on, including professional associations and colleges, industry organisations, hospital and health services organisations, regulators, and patient and advocacy groups.

The Framework has been endorsed by Australian and state and territory health ministers and was presented to APEC (Asia Pacific Economic Cooperation) in Tokyo at its 2018 Business Ethics for Small and Medium Enterprises Forum.

20 JULY 2018

Australian Consensus Statement on Ethics in Healthcare wins international award

Australian health leaders presenting a Consensus Statement on Ethics in Healthcare in Tokyo today have won the 2018 APEC (Asia-Pacific Economic Cooperation) Business Ethics Lighthouse Award.

The award recognises the significant international leadership demonstrated by the Australian health sector in developing a model for ethical collaboration across all parts of the health system, including:

- patients;
- clinicians;
- professional colleges;
- hospitals and health services;
- Commonwealth and state/territory governments; and
- medical technology and biopharmaceutical companies.

23 JULY 2018

'Hello, my name is...' should be the starting point of all healthcare

'Today is *#hellomynameis* day, which recognises, above all, that healthcare is an interaction between two human beings', says Dr Linc Thurecht, Acting Chief Executive of the Australian Healthcare and Hospitals Association (AHHA).

AHHA has released a Perspectives Brief, The *#hellomynameis* story: 'Through adversity comes legacy' through the Association's Deeble Institute for Health Policy Research.

The paper has been written by Chris Pointon, co-founder of the *#hellomynameis* movement with his late wife Dr Katherine Granger MBE.

'The message of the *#hellomynameis* campaign is about reminding healthcare staff to introduce themselves to patients, and use the opportunity of introducing themselves to help build a relationship with their patients', Dr Thurecht said.

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- end-of-life conversations
- pain management
- assessment skills
- self-care and building resilience
- recognising deteriorating patients.

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www.pallcaretraining.com.au

The Palliative Care Online Training Portal is funded by the Australian Government.

FRANK QUINLAN
Chief Executive Officer
Mental Health Australia

Healing isn't about fixing what's broken...

On 12 July 2018 Mental Health Australia staff took part in a traditional 'healing circle', a NAIDOC Week event exploring Aboriginal cultural beliefs around healing or 'recovery' and its links to country and community.

Aunty Matilda spoke about how, in her own culture, the emphasis is not on the illness, problem or dysfunctional behaviour that needs to be fixed. Instead, there is this idea of a pathway that a person follows over the journey of their lifetime. Staying on this pathway delivers a sense of meaning and achievement, and an ever-developing sense of purpose and identity. 'Healing', in the Aboriginal sense of the word, is required when a person strays from this pathway.

In Indigenous cultures, it is the shared responsibility of those who take part in the healing circle—community members, family, friends and Elders—to ensure that a person finds their way back to their pathway and stays the course. The idea that communities bear responsibility to solve one another's problems and assist each other's healing is a powerful one.

We have much to learn from this traditional wisdom that has enabled Indigenous cultures to survive and thrive in Australia, without many of the social ills that afflict their communities today, for thousands of years prior to colonisation.

In March last year, during a visit to the Ngalkanbuy Clinic on Elcho Island, I was fortunate enough to accompany a local mental health worker on her morning rounds to visit clients and other local community health facilities. As she shared her views with me, it couldn't have been clearer that so much of what we impose on our Indigenous communities, with the very best of intentions, often makes no sense and serves to perpetuate systemic oppression.

After decades of lamenting social, political and health inequalities between white Australians and our First Nations' Peoples, only in recent years have we begun to understand the value of traditional knowledge and healing practices to overall health and wellbeing.

In mental health, Indigenous concepts of wellbeing, illness and healing can teach us a lot. Learnings about our interrelationships with other people, our communities, our past experiences, and our environment can help us to develop systems and strategies to better support the needs of all Australians—regardless of ethnic, linguistic or cultural background—who experience mental health issues.

That is why it is so important to embrace events like NAIDOC Week and to make the most of opportunities that expose us to

"We know that Indigenous adults are 4 to 7 times more likely to experience mental health issues than non-Indigenous Australians. We know that Indigenous adults are still 7 times as likely to experience substance abuse disorders, and that risk of suicide among Indigenous Australians is 6 times as great as for non-Indigenous Australians."

It's about restoring connections and sharing responsibility.

views and concepts usually viewed through a more mainstream cultural lens. This is so important if we are to solve the riddle of how to tackle mental illness and adequately support people across the cultural divide.

We know that Indigenous adults are 4 to 7 times more likely to experience mental health issues than non-Indigenous Australians. We know that Indigenous adults are still 7 times as likely to experience substance abuse disorders, and that risk of suicide among Indigenous Australians is 6 times as great as for non-Indigenous Australians.

NAIDOC Week reminds us of the importance of sharing wisdom and knowledge across cultures, of learning from the past, and of connecting and celebrating the cultural diversity that exists in Australia.

This year's theme 'Because of her we can' was also an opportunity to celebrate the contributions that Indigenous women have made and continue to make to our understanding and awareness of contemporary Indigenous issues.

First Nations women were the carriers of the dreaming stories, songs, languages and knowledge that kept their culture strong for 65 million years prior to colonisation. And although Indigenous women continue to play active and significant roles at all levels of Australian society today, their roles are too often invisible, unsung or diminished (notwithstanding the fact that the representation of Indigenous women on the Boards of Indigenous corporations is significantly higher than the representation of women on ASX listed companies!).

The reminder of the strength, contribution and resilience of First Nations women is aptly timed to join the growing chorus of voices calling on men to do more to grow a culture of respect around women and girls on the back of the #MeToo movement.

And it is aptly timed to rally all of us in mental health to seek out and embrace Indigenous ideas of healing to enrich our knowledge base, improve our practice approaches, and develop the kinds of relationships and services that will be taken up and deliver outcomes in Indigenous communities.

But the most important thing we can take away from traditional Aboriginal healing practices and beliefs in NAIDOC Week 2018 is a sense of community responsibility towards our First Nations' Peoples for the wounds inflicted by past policies and events. And an understanding of the role that healing on a national level plays in Closing the Gap between Indigenous and non-Indigenous health outcomes. ha

CAROL BENNETT
Chief Executive Officer
Painaustralia

Mental health and chronic pain

The chicken or the egg?

IMPACTS OF PAIN

Unmanaged, ongoing chronic pain can cause severe emotional and psychological devastation—from major depression and anxiety to suicide. However, what is less well known is how better management of chronic pain can prevent mental health problems altogether.

Chronic pain affects one in five Australians including adolescents and children, and one in three over the age of 65. According to the Australian Institute of Health and Welfare, 6.9 million Australians are living with musculoskeletal conditions alone.

There are wide-reaching impacts of pain, including forced early retirement, financial stress, pressure on relationships, and inability to socialise or participate in previously enjoyable activities. Uncertainty about ever being pain-free or the possibility of worsening pain can be accompanied by feelings of anxiety, sadness, grief and anger. Sometimes patients struggle to be believed and can feel stigmatised. These burdens can be very difficult to manage.

According to the Australian Bureau of Statistics, one in five Australian adults with severe or very severe pain also suffer from depression or other mood disorders. In patients with chronic pain presenting for treatment, the prevalence of major depression is around 40%. There are also high rates of anxiety, including generalised anxiety disorder and post-traumatic stress disorder.

For 24-year-old Ellyn, the fibromyalgia she experienced as a child meant that a simple hug could cause rib displacement, causing intense nerve pain and requiring weeks of physiotherapy and rehabilitation. Not knowing whether her actions were helping or hindering her created a lot of anxiety.

SUICIDAL BEHAVIOUR

The presence of chronic pain is also an important risk factor for suicidal behaviour, which has been found to be two to three times as high as for the general population. A 2006 Australian study by the Department of Health and Ageing found that 21% of people who died by suicide experienced physical health problems that may have contributed to their death.

Painaustralia hears many stories. One was about a woman who had taken her life after two years of relentless chronic pain. Sam had contracted pneumonia, which led to other conditions, as well as a severe form of chronic neuropathic pain. No longer able to work, she was in and out of hospital, unable to live the life she once knew, and on a daily mix of opioids and other painkillers. She saw no other way out.

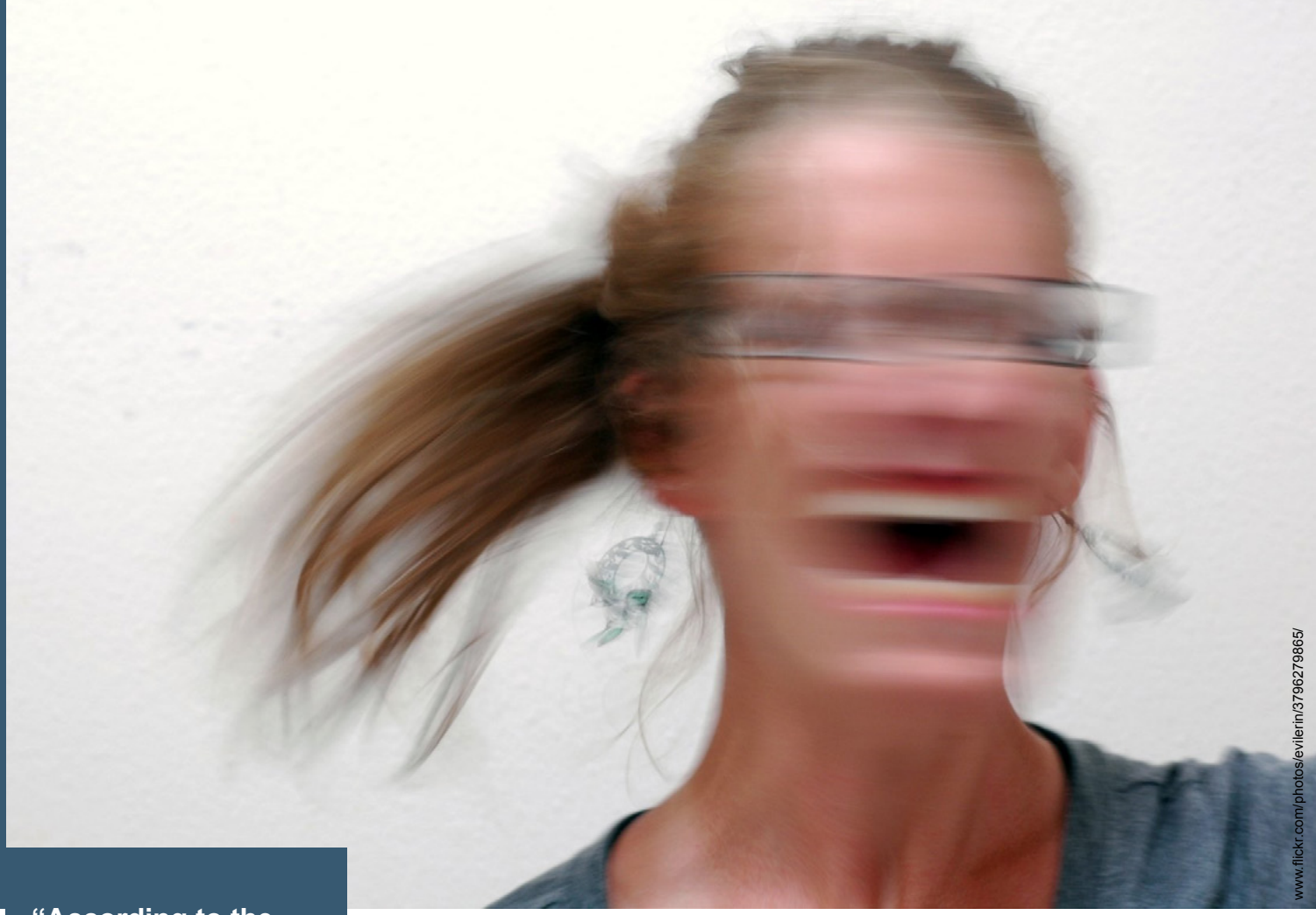
OPIOID USE

A recent study by the Australian Institute of Health and Welfare found that the use of opioids is on the rise in Australia, up 24% between 2010-11 and 2014-15, from 369 to 456 prescriptions per 1,000 population. Pain management is one of the main reasons opioids are prescribed. This is despite the limitations of regular opioid use in managing chronic pain, and side effects related to dependence, cognitive functioning and mood.

Peter was 34 when 100 kilograms of steel hit him in the back while working at a metal recycling factory. For several years he was prescribed opioids, which he says made him depressed and anxious. He calls this state 'zombie-like' and says finding an alternative pain management approach and getting off opioids was difficult, but learning to better manage his pain was a 'God-send'.

A DIFFERENT APPROACH

The approach Peter and many others have found is known as multidisciplinary (or interdisciplinary) pain management. It is holistic and person-centred care that



www.flickr.com/photos/evilerin/3796279865/

"According to the Australian Bureau of Statistics, one in five Australian adults with severe or very severe pain also suffer from depression or other mood disorders."

embraces a combination of medical, physical and psychological therapies, while minimising use of pain medication (particularly opioids). Also known as a bio-psycho-social approach, it aims to address all the factors that influence the pain experience. At Painaustralia we now have enough evidence to say that this is the best way to improve function, quality of life, and mood for many people in chronic pain.

The latest statistics from the electronic Persistent Pain Outcomes Collaboration—collecting data from 60 participating multidisciplinary pain clinics and 21,433 patients across Australia and New Zealand—reveal many clinically important gains following treatment, including: a 26% reduction in pain; a 54% reduction in depression; a 54% reduction in stress; a 58% reduction in pain interference; and a 42% reduction in anxiety.

At the core of this approach is self-management—empowering patients with the skills and knowledge to take control of their pain management strategy on a daily basis. When people understand how they can live with pain, they are often able to take control of their lives, and feel less overwhelmed.

Using Cognitive Behavioural Therapy (CBT) to influence a change in perception of pain (and therefore its ability to impact life) is another fundamental aspect of multidisciplinary pain management. Studies of CBT-based pain programs have shown significant improvements in disability, anxiety, depression and pain.

The problem is that not everyone can access a multidisciplinary pain clinic. An Australian Pain Society report from 2010 revealed wait times for public pain clinics across Australia are frequently more than a year, and eight years later this is largely unchanged. There is also a need for better education for GPs and consumers, more affordable allied health care, and focused research.

THE CHARGE FOR CHANGE

Painaustralia is leading the charge for change. Formed in 2011 to implement the recommendations of the National Pain Strategy and ensure pain is on the national agenda, we are starting to see progress.

The Federal Government is funding a national action plan for chronic pain management—a step towards Australia-wide reform—while the Opposition included chronic pain in its National Policy Platform (for the first time). Both the Minister for Health and Shadow Minister for Health gave presentations at the Painaustralia 2018 Annual General Meeting, showing bipartisan support.

But there is still a long way to go. Along with our members, Painaustralia will continue to work to develop practical and strategic solutions to this problem. If we can tackle pain more effectively, the evidence strongly suggests we will reduce suicides and the prevalence of mental health problems—a win for everyone. ha

Painaustralia is the national peak body working to improve the quality of life of people living with pain, their families and carers, and to minimise the social and economic burden of pain. For more information please visit www.painaustralia.org.au

Mental Health reform

One of the biggest issues facing mental health now is the pressure on hospital services—which makes it all the more curious that the term 'hospital avoidance' does not appear at all in the 5th National Mental Health Plan.

The pressure on hospital services and the lack of alternatives is manifesting in a couple of ways. The first is that there have been calls, particularly from some psychiatrists, for more beds. To me this is an understandable response to unrelenting workplace pressure. But it would surely represent a deeply disappointing re-assertion of an expensive and often-traumatic, 20th century-based model of care.

At the same time, the desperate voices of consumers and carers who struggle to find the care they need in a timely fashion are as loud as ever. National surveys of managers of acute general hospital mental health wards suggest just under one-half of their beds are occupied by people who would be better off in other settings. However, there is nowhere to send people. Housing is scarce. Temporary supported accommodation in the community is practically non-existent. The fabled step-up/step-down services can be counted in dozens of beds nationally, not hundreds. Home-based services have been largely withdrawn in favour of outpatient clinics providing telephone contacts or requiring patients to come to the hospital campus for care.

So can we move past this to ease the squeeze on hospital mental health services and deliver a more effective contemporary mental health system? Current reforms paint a confusing picture. If hospital avoidance and earlier intervention were the goals, it could fire a suite of clear-eyed reforms designed to stimulate the primary and community-based care necessary to provide genuine alternatives to hospitalisation. However, and as illustrated by the 5th Plan, these matters do not appear central to current reform efforts, which instead seem split between different policies and paradigms.

Responsibility for Federally-funded mental health services has been shifted to the 31 Primary Health Networks. Each of these bodies has a surprisingly small amount of funding to plan and arrange local mental health and suicide prevention services. Using tools like the mysterious National Mental Health Service Planning Framework, this is essentially a more or less familiar, population-based planning approach.

Different altogether is the National Disability Insurance Scheme, with its powerful neo-liberal rhetoric of personalised budgets, individual fund-holding and choice. I live in the ACT, the jurisdiction with the longest experience operating under the NDIS. Stories of problems fitting mental health into the NDIS paradigm used to happen weekly, but are now becoming daily. The psycho-social sector in Australia was always a peripheral element in the overall service landscape. Even in Victoria, it never represented more than around 15% of total mental health spending, about half what the sector currently receives in New Zealand. In most other Australian jurisdictions, the sector was much smaller. The NDIS's bolshy, autonomous philosophy struggles to fit into a mental health sector characterised by poor access to typically fragmented care.

Are we relieving the pressure on our hospitals?

SEBASTIAN ROSENBERG
Fellow, Centre for Mental Health Research, Australian National University

pixabay

"National surveys of managers of acute general hospital mental health wards suggest just under one-half of their beds are occupied by people who would be better off in other settings. However, there is nowhere to send people."

The advent of the NDIS has seen services like Personal Helpers and Mentors (PHaMS) and Partners in Recovery (PIR) largely disappear. The list of mental health services between the GP/psychologist and the front door of the local public hospital was thin already, but is becoming thinner.

The 5th National Mental Health Plan indicated that PHNs were supposed to work with their local, state-funded health districts (LHDs) to drive its reforms, though the precise goal of these reforms is not easy to pinpoint. The PHN-LHD relationship has proven a patchy experience, made more complex because some health districts need to work with multiple PHNs and vice versa. It is unclear what, if any, theory of change has been promulgated by the Federal Government and the Department of Health as the best way for reform to be achieved. This has rather left locals to make it up themselves, with inevitably mixed results.

Perhaps because of this, the state and territory governments have now been invited by their federal counterparts to play a more central role in helping PHNs manage their primary mental health care planning. This could be a good thing, helping to overcome traditional federal/state barriers. But it could also be a recipe for confusion and even centralised control over a reform which seemed designed to foster a more localised approach.

At the same time, funding for primary mental health care, provided by GPs and psychologists, continues to grow and is now at around $28m per week. Psychologists are also able to provide services to help NDIS clients address issues of 'functional impairment' under the NDIS. However, and more broadly, there are significant shortages and morale issues across much of the mental health workforce. People would like to work somewhere they feel they are really helping.

One of the lesser-spotted recent mental health reforms was the commitment made by the Federal Government to give the National Mental Health Commission a greater role in monitoring. This kind of accountability has been at the centre of mental health plans and policies for 25 years but never quite materialised, leaving our system open to accusations of being 'outcome blind'. The Commission developed two national mental health report cards, in 2012 and 2013, under the 'Contributing Life' banner. It was then distracted by the national review which was eventually published in November of 2014. The Commission is yet to specify how it intends to fulfil its new expanded monitoring role.

The mental health policy situation is confused, with multiple and competing paradigms uninformed by regular and reliable outcome information. Without a clear effort around hospital avoidance, pressure on Australian hospital mental health services is likely to remain dangerously high. ha

Mental health care in the Australian acute health system: Emergency!

Accessing specialist inpatient mental health care from Australia's emergency departments has never been so difficult for people with acute mental and behavioural needs than it appears to be now.

When people who are seriously unwell attempt to get treatment through the acute health system, they experience unacceptably long waiting times to see a mental health specialist for psychiatric care. People with serious mental illness are among the most vulnerable populations presenting to emergency departments. If these waits were widely experienced by patients with other emergency medical conditions, the way the health system works would surely have been reformed by now.

At the Australasian College for Emergency Medicine we have a special interest in understanding how the acute health system works to advance emergency medicine training, education and professional standards of care. We know from our members—specialist emergency physicians—that the capacity of the Australian health system has not kept pace with population demand, which continues to increase year-on-year against a backdrop of underfunding.

Accessing and navigating a system that is working below optimum levels is not only frustrating and distressing for patients, but also a significant source of stress for clinicians who work in it.

'ACCESS BLOCK'

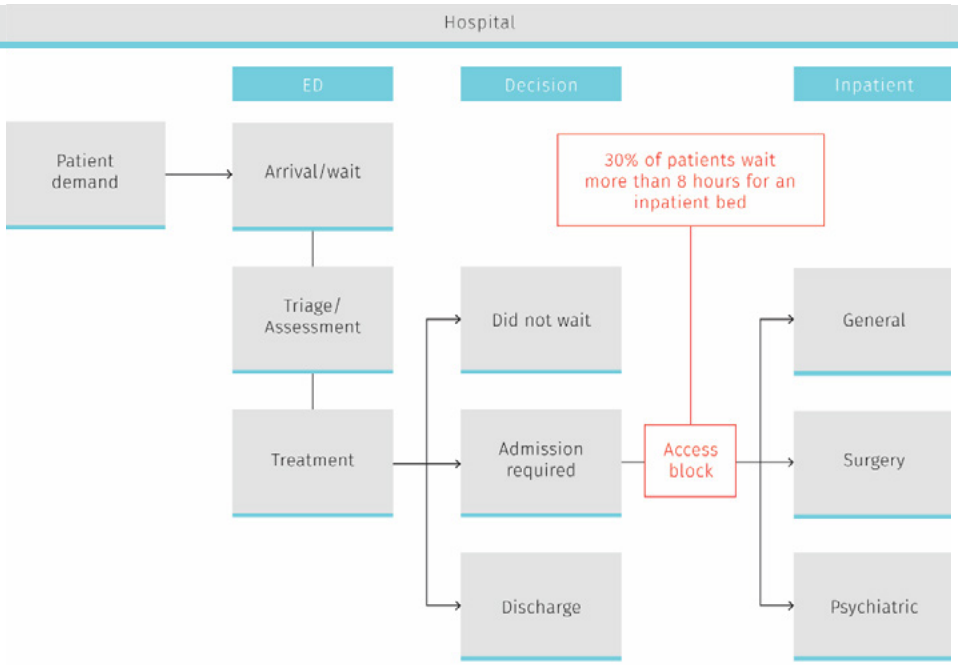
One indicator that tells us the system is not working is a phenomenon called 'access block'. Access block describes the situation when patients who have been admitted to hospital and require an inpatient bed are delayed from leaving the emergency department for eight hours or more due to lack of capacity and resourcing. People most affected by access block are patients who require unplanned hospital admissions because of their medical condition.

Twice-yearly research by the College shows that managing admitted patients experiencing access block in the emergency department represents about one-third of an emergency clinician's workload. We know that access block leads to emergency department overcrowding, poor patient experiences and poor patient health outcomes.

Even though long waits for inpatient care and access block manifest in emergency departments, these issues signify whole-of-hospital and health service bottlenecks and dysfunction that require macro reform.

For the majority of patients, emergency departments act as the 'front door' to the health system. Our members consistently report that access block is worse for people presenting to hospital emergency departments with serious mental illnesses, including those with self-harm and alcohol and drug issues.

This led the College to do some further research exploring access block among patients waiting for specialist inpatient mental health care in emergency



ACCESS BLOCK: THE DELAY IN INPATIENT ADMISSION FROM THE ED IS A WHOLE-OF-HOSPITAL ISSUE

SHELLEY COGGER
Policy Officer
Australasian College for Emergency Medicine

departments. We found that while people with mental health presentations make up only 4% of emergency department patients, they make up one-fifth of patients waiting for specialist inpatient treatment and almost one-third experiencing access block.

In this survey, there was an instance reported where a patient needing specialist inpatient mental health care spent six days waiting in an emergency department. When people present to emergency departments with mental health crises, emergency physicians need to be confident that hospitals have sufficient expertise and capacity to provide them with timely care, combined with adequate specialist mental health services and programs in the community.

Prolonged delays for people with mental illnesses are not only inequitable, but discriminatory. Emergency departments operate 24 hours a day, with high levels of ambient noise and activity, and minimal natural light. People staying for several days can't sleep, with particular impacts for mental health, given sleep cycles are so important for therapeutic management.

In addition, for these patients, prolonged waits lead to a higher likelihood of psychological distress, which often results in serious behavioural disturbances that require physical and chemical restraint in emergency departments and containment in safe assessment rooms.

INTERVENTIONS TARGETING ACCESS BLOCK NEEDED FOR PATIENTS WITH MENTAL AND BEHAVIOURAL CONDITIONS

We know that emergency physicians genuinely want to be able to provide the best possible emergency medical care for the communities they work in, but oftentimes the system works against them.

We think that restrictive practices in emergency departments could be substantially reduced by health system interventions that target access block for patients with mental and behavioural conditions in public hospitals and increase access to inpatient mental health services, as well as wraparound services in the community.

The College is currently advocating for greater transparency around prolonged delays in access to specialist inpatient mental health treatment from emergency departments. We believe greater transparency around delays can be an important lever for improving the safety and quality of acute mental health care. ha

"Access block describes the situation when patients who have been admitted to hospital and require an inpatient bed are delayed from leaving the emergency department for eight hours or more due to lack of capacity and resourcing."

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Civil and Environmental Engineer

Tim Longhurst
Professional Futurist

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The Institute of Healthcare Engineering, Australia (IHEA) invites you to register for the 25th Congress of the International Federation of Hospital Engineering (IFHE) to be held on **6-11 October 2018 at Brisbane Convention & Exhibition Centre** with the theme: ***'Healthcare Engineering – Building on Sustainable Foundations'.***

PARTNERSHIP OPPORTUNITIES

Partnering or exhibiting at the congress will provide an excellent opportunity to promote your organisation. To view the partnership opportunities visit **www.ifhe2018.com** or contact the event organisers: Krysty Monks from Iceberg Events on **+61 7 3876 4988** or **krysty@icebergevents.com.au**

Visit **www.ifhe2018.com** to register, read more about the keynote speakers and to receive email updates.

Re-imagining the aged care workforce of tomorrow

Almost a quarter of HESTA members work in aged care. As partners in their future, we want to help drive meaningful change for the sector and the millions of Australians who will one day depend on it.

Over the last two years, we've been researching aged care to find out how rapid change in the sector is impacting the people caring for Australia's seniors.

Our data and research, drawn from more than 200,000 HESTA members working in aged care, aim to help the sector build, train and retain its future workforce.

We surveyed thousands of people working in aged care to learn about their career plans.

Here's what they told us.

POTENTIAL SHORTFALL OF AGED CARE WORKERS

Our research showed that as many as 80,000 employees currently working in aged care may leave the sector over the next five years.

This potential future shortfall is a big challenge, as the sector needs to attract significantly more employees to keep up with growing demand. In fact, the Productivity Commission forecasts Australia may need as many as one million aged care workers by 2050 to meet the expected demand from baby boomers*.

FINDING SOLUTIONS

So, what could be done to attract more people to work in aged care and retain experienced, valuable employees?

While our research highlighted the issues, there were lots of positive solution-led suggestions from employers and employees.

Off the back of this report, we're looking forward to partnering with the sector to explore ideas for practical solutions to some of aged care's greatest challenges. Not only will this impact our members' working experience, but also the quality of life in retirement for millions of Australians.

top reasons aged care workers intend leaving their jobs for other parts of HACS*

49%	wanted to develop new skills
38%	wanted to try something different
22%#	were not being paid enough

* Note: Respondents were able to give multiple reasons. So, results do not sum to 100%.
# Almost a quarter of the aged care workers who said they intended to move to jobs elsewhere in HACS cited 'other' reasons, including finishing studies, unhappiness with the aged care sector or unhappiness with how care workers and clients are treated.

top reasons for wanting to remain in aged care but change employers*

30%	I'm not happy with my manager
30%	I'm not getting the training I need^
29%	I'm not happy with the organisation I work for
25%	I want to develop new skills

aged care

366,000
estimated workforce[1]

23%
intending to leave aged care within five years

84,000
estimated outflow

non-aged care

985,000
estimated workforce[2]

4%
intending to leave job but stay in HACS

9%
intending to move to aged care

4000
estimated inflow to aged care from HACS

* Productivity Commission (2011) Caring for Older Australian Final Report.
Source: 1. The Aged Care Workforce 2016, Australian Government Department of Health, March 2017. This is an estimate of all PAYG aged care workers, including those in residential facilities, home care and home support outlets. 2 2016 Census, Australian Bureau of Statistics. This is an estimate of Health Care and Social Assistance sector, minus the Aged Care workforce.

TRANSFORMING THE AGED CARE SECTOR

Read the report at www.hesta.com.au/campaigns/transforming-aged-care

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WGEA Employer of Choice for Gender Equality

Chant West Specialist Fund of Year 2016 Winner

Specialist Fund of Year 2017 Winner

Mental health nursing

Prof. Lorna Moxham FACN

A conversation with nurse leader Professor Lorna Moxham FACN. **Australian College of Nursing**

When one thinks about nursing as a career choice, 'glamorous' is not always the first word that comes into mind. But that is exactly what Lorna thought when she decided to become a nurse—along with the opportunities to work and travel to different countries, the promise of quality career opportunities and the reputation that the profession allowed you to 'do good'. What's not glamorous about that?!

Today, nurse leader Professor Lorna Moxham FACN holds many current and former titles, roles, and achievements, including: Professor of Mental Health Nursing and Leader of Living Well Longer in the Global Challenges program at the University of Wollongong; active Fellowships at the Australian Colleges of Nursing and Mental Health Nurses; over 80 journal articles published; and is a former editorial board member of the *International Journal of Mental Health Nursing*.

For someone reading about the Professor's career achievements, being a nurse IS a fairly glamorous career—similar to what she at first believed it to be—and far from the general preconceived view of nurses practising mainly in hospitals.

"There is a lack of mental health training in Australian Bachelor of Nursing curricula—graduates get comprehensively trained in nursing, but they need specialist training."

Lorna is now best known for her work in mental health nursing, with her proudest career achievement being Recovery Camp—an initiative that she spent almost five years developing through the University of Wollongong.

The start of her mental health nursing journey came when a spare shift opened in the psychiatric ward of the hospital where Lorna was working as a student nurse—a 'chance opportunity' is how she recalls the experience.

'I was petrified and thought of every stereotype that you possibly could about people with mental illness. But after the shift I reflected (as a nurse does after a shift) and thought about why I wasn't at all scared.'

It was this experience that she credits for her decision to enrol in specialist psychiatric training to become a Registered Psychiatric Nurse and to 'understand why she had held these fears'.

As an established nurse leader with over 30 years in the field, and as a current university academic, Professor Moxham has influenced policy development, service delivery and curriculum.

In 2011 she contributed to the Australian Mental Health Nurse Education Taskforce and is keenly aware of the challenges that the nursing profession faces in mental health care: 'There is a lack of mental health training in Australian Bachelor of Nursing curricula—graduates get comprehensively trained in nursing, but they need specialist training. People with mental illness deserve specialist nurses, just like other health service users get.'

This echoes a similar outlook that Lorna had previously voiced in the *Nursing Australia* journal in 2012: 'Mental health nursing needs specialist mental health nurses. It is the responsibility of the industry to ensure those employed in mental health are specialists. In a midwifery unit, you would only ever be looked after by a midwife.'

Prof. Moxham has also found that inexperienced nurses and those not specialist-trained can be scared and fear aggression in the workplace: 'They can subscribe to the stigma and this can lead to them avoiding spending time with consumers. They stay in the nurses station and given they don't have enough training or experience, they can't be blamed.'

This is an area where Lorna wants to see changes in approach with mental health care: 'It is pleasing to see that mental health is being talked about more openly, but we have more to do to change the stigma that still surrounds people who live with mental illness. I'd love to see change and help improve and increase psychiatric nursing skills content in undergraduate curricula. After all, these skills are useful everywhere.'

Since 2013, Lorna has held the role of Global Challenges leader for *Living Well, Longer* at the University of Wollongong. This has allowed her experience and research to shape how clinical placements are provided to health students to aid mental health recovery and promote healthy ageing in people living with mental illness.

This project—Recovery Camp—is her proudest career achievement, as mentioned above. It is described on the Recovery Camp website as 'a person-centred, recovery-focused initiative which invites individuals with a lived experience of mental illness to participate in a five-day therapeutic recreation camp in the Australian bush'.

The initiative has been nationally and internationally recognised through many awards for its impact on people living with mental illnesses, and on the education of health professionals. The project itself has brought a number of interdisciplinary health students, researchers and academics from nursing, psychology, dietetics and exercise physiology to deliver a holistic approach to recovery from mental illness.

When asked about where she would most like to see mental health in the next 20 years, Professor Moxham notes that there should be 'more resources in the community and to have specialist trained mental health nurses 24/7 in every aspect', in settings such as emergency departments and drug and alcohol rehabilitation services.

Lorna is just as passionate about nursing now as when she first started her career as is evident from her career path, and in her advocacy work in mental and general health education, community services and aged care.

Lorna Moxham is still 'doing good' as a nurse. ha

For more information about Recovery Camps, please visit http://recoverycamp.com.au/.

All three days will feature practical examples, real solutions and in depth discussions. This is your chance to hear from the world without the cost of an international airfare. The program is out now—don't miss this once-in-20-year opportunity!

World Hospital Congress Program out now!

Join health leaders from around the world to examine how healthcare needs to evolve to meet 21st century demands.

Around the globe health systems are in transition. Impacts of new technology, changing demographics and disease profiles, funding pressures, new models of care and more are driving transformation. So how at this critical point do we harness the benefits and overcome the obstacles?

The World Hospital Congress will bring over 160 speakers from more than 30 countries together for three days of illuminating presentations. Healthcare leaders from around the world will gather to discuss how healthcare needs to evolve to meet the demands of the 21st century against three sub-themes:

DAY 1
FROM VOLUME TO VALUE

A global movement is underway to change the focus of hospitals and health organisations from volume of services and activities to the value of the outcomes achieved. Join discussions on value-focused care, patient reported outcome and experience measures, transparency in reporting, preparing for transformational change and achieving funding value.

DAY 2
FROM FOUR WALLS TO THE NEIGHBOURHOOD

Hospitals don't exist in a vacuum, so how can they be good citizens in the medical neighbourhood where the acute, primary and community care sectors all have a role to play? Discussions will focus on how integrated care can be supported at funding, structural and clinical levels to provide sustainable, appropriate health services and how an integrated approach can provide better health outcomes and sustainable universal health care.

DAY 3
FROM INFORMATION TO INTELLIGENCE

The information revolution has provided us with greater capacity than ever before to collect data—from detailed clinical information to patient flows, we have more information than ever at our fingertips. Transforming that information into intelligence will allow us to deliver more reliable and patient-centred care, plan for and deliver services efficiently and effectively, and provide new opportunities for collaboration. But how do we achieve this and how are security, privacy, workforce training and other concerns being addressed?

DAY 1: WEDNESDAY 10 OCTOBER

FROM VOLUME TO VALUE

Time	Session
8:30am to 9:30am	**Joint Plenary Session with the 25th Congress of the International Federation of Hospital Engineering (IFHE)** **Disease, disaster and destruction: providing health services in times of catastrophe, epidemic and conflict** Glenn Keys, Executive Chairman, Aspen Medical Pty Ltd, Australia Bronte Martin, Nursing Director, Trauma & Disaster, National Critical Care Trauma Response Centre (NCCTRC), Australia Berna Marcelina, Provincial Director, Standardization, BC Clinical and Support Services, Canada
	Morning tea, exhibition and poster displays
10:00am to 12:00pm	**Opening Ceremony** The opening ceremony will feature a traditional Aboriginal Australian Welcome to Country, a cultural experience that is not to be missed. It will be followed by keynote addresses. Dr Francisco Balestrin, President, International Hospital Federation Dr Deborah Cole, Chair, Australian Healthcare and Hospitals Association Francesca Colombo, Head of Health Division, OECD Professor Elizabeth Teisberg, Executive Director, Value Institute for Health and Care, Dell Medical School in Austin, Texas, United States of America
	Lunch, exhibition and poster displays
12:45pm to 1:45pm	**Plenary Session 1** **Moving beyond Quality to Value** Dr Daphne Khoo, Deputy Director Medical Services (Healthcare Performance Group) Ministry of Health, Singapore **The #hellomynameis story – 'through adversity comes legacy'** Chris Pointon, Co-founder, #hellomynameis, United Kingdom
1:45pm to 2:45pm	**Panel Session 1** **What does the 21st century patient demand from healthcare?** What do patients want from healthcare, how have those expectations changed and how are they likely to continue to change?
	Afternoon tea, exhibition and poster displays
3:15pm to 4:00pm	**International Hospital Federation Awards Ceremony** The 2018 International Awards of the International Hospital Federation (IHF) recognise and honour hospitals and healthcare organisations for innovation, excellence, outstanding achievements and best practices in areas that are worthy of international recognition.
4:15pm to 5:45pm	**Concurrent Sessions:** 1.1: International Hospital Federation Award Winners 1.2: Platforms for value: data and analytics 1.3: Paying for value, achieving outcomes 1.4: Lightning Talks 1.5: Patients, process and tools: Looking for the right combination to move from volume to value 1.6: Welcome to our backyard – a look at research and innovation in Queensland 1.7: IHF Special Interest Group – Investor Owned Healthcare Organizations: Aligning planets for a better flow of capital towards healthcare practice
6:30pm to late	**Gala Dinner** Join us for a spectacular evening celebrating Australian culture, food and wine in the Plaza Ballroom, Brisbane Convention & Exhibition Centre.

DAY 2: THURSDAY 11 OCTOBER

FROM FOUR WALLS TO THE NEIGHBOURHOOD

Time	Session
8:30am to 9:30am	Plenary Session 2 **Health Care Integration - why is it so hard to deliver and sustain?** Professor Claire Jackson, Professor in General Practice and Primary Care Research, Director, Centre for Health System Reform and Integration, University of Queensland, Australia **Patients and Consumers as a Dynamic Force for Change** Melissa Thomason, Patient Advocate, United States of America
9:30am to 10:30am	Panel Session 2 **How can we rethink the role of the hospital in the medical neighbourhood?** How do hospitals engage with the broader health system and how can this be improved or changed?
	Morning tea, exhibition and poster displays
11:00am to 12:30pm	Concurrent Sessions: 2.1: It takes a community… collaboration for better outcomes 2.2: World Bank: Building Integrated Service Delivery to meet 21st century health needs – lessons learnt from World Bank operations 2.3: Health workforce as a driver to integrated care 2.4: Lightning Talks 2.5: From projects to scalable solutions: sustainability in integrated care 2.6: Transforming the delivery of care so that it's integrated and delivered at the right time and place 2.7: IHF Special Interest Group – Healthcare Management: A competency-based approach to enhance healthcare management, how to make best use of it
	Lunch, exhibition and poster displays
1:30pm to 2:30pm	Plenary Session 3 Nigel Edwards, Chief Executive, Nuffield Trust, United Kingdom **Patient Engagement in Egypt** Nagwa Metwally, Member of Supreme Council, Egyptian Red Crescent, Egypt
2:30pm to 3:30pm	Panel Session 3 **Patient centred care – integrating health services around the patient** What is patient centred care? And what are the practical ways that integrating health services around the patient can work and have impact?
	Afternoon tea, exhibition and poster displays
4:00pm to 5:30pm	Concurrent Sessions: 3.1: Coordinating coordination: what funding, structural, technological and clinical models do we need to support integrated care 3.2: Shared goals, shared gains 3.3: Addressing inequality and cultural disadvantage: perspectives on improving the health of Indigenous people 3.4: World Health Organization: Hospital transformations on the path to Universal Health 3.5: Disruptive forces: turning traditional services models on their head 3.6: Partnering and leading in our communities: hospitals as change agents – Lessons from the USA 3.7: IHF Special Interest Group – University Hospitals: Management of innovation; development and dissemination by University Hospitals. Implications of disruptive innovation
5:30pm to 7:30pm	IHF General Assembly Annual meeting of the IHF General Assembly, the formal decision-making body of the International Hospital Federation. All IHF Members are invited to participate.
6:00pm to 9:00pm	Optional Lone Pine Koala Sanctuary Dinner Join us for the unique experience of a dinner surrounded by a forest of koalas at Lone Pine Koala Sanctuary.

DAY 3: FRIDAY 12 OCTOBER

FROM INFORMATION TO INTELLIGENCE

Time	Session
9:00am to 10:00am	**Plenary Session 4** Charles Alessi, Chief Clinical Officer, Healthcare Information and Management Systems Society (HIMSS), United Kingdom **The Hospital Experience of People who are Blind or have Low Vision: How You Can Help** Karen Knight, General Manager Advocacy and Engagement / QLD, NSW & NT Client Services, Vision Australia, Australia
10:00am to 11:00am	**Panel Session 4** **Can value be achieved in high-tech, high-cost systems?** How do we judge the balance between cost and value? With increasingly expensive technology, how do we measure value? And what low cost solutions still offer the best outcomes?
	Morning tea, exhibition and poster displays
11:30am to 1:00pm	**Concurrent Sessions:** 4.1: Bright sparks: the cutting edge of innovation 4.2: Innovation: a building block for quality and value 4.3: The power of data: building understanding through better use of data 4.4: Lightning Talks 4.5: Making numbers count: getting the most out of big data and artificial intelligence 4.6: Visions of the Hospital of the Future 4.7: IHF CEO Circle: The IHF CEO Circle Mentorship Program
	Lunch, exhibition and poster displays
1:45pm to 2:15pm	**Plenary Session 5** **Healthcare Systems: Future Predictions for Global Care. Towards progress, avoiding pitfalls and achieving sustainability** Professor Jeffrey Braithwaite, Foundation Director, Australian Institute of Health Innovation, Macquarie University, Australia
2:15pm to 3:00pm	**Panel Session 5** **The bright future for healthcare** The challenges can seem overwhelming but never before have so many options and possibilities been available to us. Just what will the future offer for healthcare?
3:00pm to 3:30pm	**Closing Ceremony** The closing ceremony will feature a taste of what is to come in 2019 when the World Hospital Congress moves to Oman as well as a recap on the experiences shared over the last three days.
3:30pm to 5:00pm	**The Aussie Sundowner** Join the Australian tradition of finishing a Friday with a drink and some great food. This is your opportunity to experience an authentic Australian BBQ, taste some Australian native foods and meet some real, live Australian animals!

All speakers and program times are correct at time of publication and are subject to change.

APARNAA SOMANATHAN
Program Leader for Human Development, World Bank

Strengthening integrated care in the European Union

Confronted with the dual challenges of population ageing and a rising non-communicable disease (NCD) burden, countries in the European Union (EU) have acknowledged the need to reorganise their health systems and promote greater integration of care.

In particular, in many Central and Eastern EU member states, current models of service delivery are inadequately suited to meeting the health and social care needs of a population vulnerable to NCDs and increasingly frail.

These systems are often hospital-centric, with ineffective, poor quality primary care services and limited continuity of care. As demand for health services grows in the face of ageing and NCDs, such low-value high-cost health service delivery systems do little to mitigate the fiscal impact associated with these trends. Strengthening integrated care involves redesigning health and care services around people's needs and achieving alignment and cooperation between the various parts of the health and care systems to better address the current health needs of the population.

Below I have provided some guidance on the design and implementation of service delivery models that promote integration of care. Given the particular context and nature of the health reform challenges in the Central and East-European member states of the EU, there is a particular emphasis on those countries.

In designing such models one should: (i) systematically review the main reform levers of integrated care; (ii) identify processes needed to create an enabling environment for the implementation of integrated care; and (iii) provide guidance on sequencing the different levers and support strategies.

Six reform levers and associated core actions are identified in the Table 1 that represent the 'what' of integrated care: reorganising care around the People-Centered Integrated Care (PCIC) model's principles (see www.jointlearningnetwork.org/people-centered-integrated-care); introducing information and communication technology (ICT) infrastructure and solutions for service delivery; establishing performance monitoring and feedback mechanisms; empowering and engaging patients; aligning financing and incentives; and strengthening the health workforce.

Two types of support processes are also listed in Table 1 that address the challenge of how to ensure successful implementation of the reform levers: creating an enabling macro environment with the appropriate policy and legislative support and leadership; and creating an enabling environment for effective implementation and learning.

The correct sequencing of reforms is critical for successful implementation. Ideally, an incubation or preparation phase is required when the overall policy, legislative and governance frameworks are established and the reform is developed through a consultative process. The roll-out of the reforms would follow, with key elements being piloted and scaled up.

Appropriate sequencing of reforms is critical for two reasons. One reason is that relevant policy and legislative frameworks need to be put in place before reforms are implemented. The other is that so many of the reforms are inter-linked and cannot be approached in isolation from each other. The report includes a roadmap for reform which provides broad guidance on the sequencing of reforms and considers the inter-linkages between the levers.

There is a strong case to be made for integrated care reforms in the EU. With the right policies to ensure that health and social care systems provide a continuum

Design and implementation of appropriate service delivery models.

of services based on need throughout the life course, people can live longer, more productive lives. Moreover, health system reforms including better integration of care are needed to ensure better value for money and mitigate the impacts of ageing and NCDs on healthcare costs, thereby promoting fiscal resilience.

Integrated care reform is a disruptive reform process that requires both long-term planning before the reform and sustained implementation support during the reform. Integrated care reform is disruptive because it implies changes to healthcare structures, organisation workflows and the creation of new roles, processes and working practices. It also implies a significant cultural shift in emphasis, from providers to the patient. For the new models to work well, objectives and incentives must be aligned across diverse organisations and processes. ha

Aparnaa Somanathan and her World Bank colleagues will be speaking at the 2018 World Hospital Congress in Brisbane on Building Integrated Service Delivery to meet 21st century health needs. For more information on the World Hospital Congress program visit www.hospitalcongress2018.com.

TABLE 1:
SUMMARY OF CORE ACTION AREAS FOR INTEGRATED CARE REFORM

CORE REFORM ACTIONS
LEVER 1: Re-organising health care delivery around the core principles of PCIC
(a) Establish primary health care as the first point of contact
(b) Introduce multi-disciplinary teams
(c) Promote organizational change through vertical and horizontal integration
(d) Build integrated clinical pathways and dual referral systems
LEVER 2: Establishing performance monitoring and feedback mechanisms
(a) Establish continuous performance monitoring and evaluation
(b) Create continuous feedback loops linked to action plans
LEVER 3: Empowering and engaging patients
(a) Empower patients
(b) Engage patients in decision making
LEVER 4: Strengthen ICT infrastructure and solutions for service delivery
(a) Establish e-health
(b) Enhance security and confidentiality of e-health data.
(c) Introduce new functions to tap the full potential of e-Health
LEVER 5: Aligning financing and incentives
(a) Ensure appropriate resources are available for the reform
(b) Align financing and incentives with stakeholder objectives
(c) Strengthen strategic purchasing capacity
LEVER 6: Strengthening the health workforce
(a) Develop a primary health care workforce to implement PCIC
(b) Improve workforce composition and competency
INTERVENTIONS AND PROCESSES FOR EFFECTIVE IMPLEMENTATION OF INTEGRATED CARE
Creating an enabling macro environment with appropriate policy and legislative support and leadership
(a) Make PCIC a policy priority with sustained political support
(b) Institute strong governance mechanisms at the very beginning
(c) Ensure that a supportive legislative framework is in place
(d) Ensure effective leadership
Creative an enabling environment for effective implementation and learning
(a) Promote high degree of stakeholder engagement
(b) Address communication barriers
(c) Provide dedicated support for implementation

PAUL MARTIN
Executive Manager, Mental Health Alcohol and Other Drugs, Brisbane North Primary Health Network

The way back after a suicide attempt

New support service is helping people in Redcliffe most at risk of suicide.

A new community-based suicide prevention service operating in the Brisbane North PHN catchment has seen a doubling of referrals since it began in October 2017.

The Way Back Support Service provides personalised support to people discharged from Redcliffe Hospital following a suicide attempt or who are experiencing a suicidal crisis.

This program is a national initiative designed by Beyondblue and delivered locally by Mental Illness Fellowship Queensland (MIFQ).

Since January this year the service has been averaging 14 referrals per month, the highest proportion of which have been for people aged 36–45.

Clients typically engage in 5–15 sessions during their time with the service and to date (as at June 2018) the service has received 76 referrals—29 males and 47 females.

This result validates the PHN's focus on The Way Back Support Service in the Redcliffe peninsula—an area that has in recent years experienced a suicide rate far higher than most other parts of the catchment.

According to the Australian Bureau of Statistics, the suicide rate in Redcliffe was 17.6 per 100,000 between 2012 and 2016, 1.5 times the national average of 11.74.

ACTING ON THE EVIDENCE

We decided to support a trial of The Way Back in our region following a comprehensive needs analysis and commissioning process.

Federal Member for Petrie, Luke Howarth MP, launched the service at Redcliffe Hospital in February this year.

Speaking at the launch, Mr Howarth said he was surprised to learn that up to one-quarter of those who attempt suicide will try again within three months of leaving hospital.

'This is obviously not acceptable and we must intervene to do what we can to stop this cycle', he said.

'It's critical that we provide support within the three month period immediately after people leave hospital', Mr Howarth added.

It is also worth noting that nationally, more than half those discharged from hospital receive no support or follow-up treatment.

HOW THE SERVICE WORKS

To bridge this gap, The Way Back provides one-on-one care to guide people safely through this critical risk period, and ordinarily this is non-clinical.

But, as part of our local implementation, MIFQ is also providing clinical support to meet an identified service gap in the Redcliffe area.

When someone is referred from Redcliffe Hospital to The Way Back, a specialised team works together with the individual and their support people to identify their needs, develop a personalised safety plan, and connect them to health and community services and clinical care, if needed.

Support is provided for up to three months.

TESTIMONIALS

Also at the launch was Tina Pentland, whose son Hamish died in 2009 with a history of mental health issues and several suicide attempts.

Ms Pentland is a member of the committee responsible for establishing The Way Back Support Service in Redcliffe and she had some incredibly moving things to say at the launch.

'My son Hamish was 20 when he first attempted suicide', Ms Pentland said.

'If the Way Back existed as a support for him then, I believe he could have had the early support he desperately needed to help him take control of his mental health and give him hope for life and he might still be alive today', she said.

'The impact of suicide on families is devastating, so it's important to provide them with a source of hope and support during an incredibly difficult and frightening time.

'The Way Back Support Service offers real hope for recovery for people after a suicide attempt.

'The service offers short-term support to meet the individual's needs and opens paths towards long-term strategies for living and further options for ongoing care.

'The Way Back's Support Coordinators involve carers and families throughout a person's recovery process', she said.

At Brisbane North PHN we have received some very positive feedback from people who have accessed this service.

One client recounted how the 'easy-going atmosphere' helped keep them at ease and made it 'a little easier to discuss uncomfortable topics'.

'Overall my experience has been excellent with The Way Back service and I feel that I am able to see a brighter future for myself because I've had such a good experience with someone who is kind and compassionate', the client added.

Heaping more praise on The Way Back staff, the client said they had been 'working with me to find the tools I need to give myself the best chance at a stable and comfortable life in the future'. ha

For more information on The Way Back Support Service, or to download Brisbane North PHN's suicide prevention services guide, visit https://goo.gl/nUL2ar.

Community representative Tina Pentland served on the committee responsible for establishing The Way Back Support Service in Redcliffe.

At the launch of The Way Back Support Service, February 2018 (L–R): *beyondblue* CEO Georgie Harman, community representative Tina Pentland, Brisbane North PHN Executive Manager Paul Martin, Support Coordinator Judith BheBhe, Federal Member for Petrie Luke Howarth MP, MIFQ CEO Jennifer Pouwer, and Senior Elder for the Gubbi Gubbi people Dr Eve Fesl.

PAUL MARTIN
Executive Manager, Mental Health Alcohol and Other Drugs, Brisbane North Primary Health Network

Low intensity mental health services in Brisbane North

Seven new services commissioned to help people cope with difficult life events.

Over the past year, Brisbane North PHN has progressively commissioned a number of 'low intensity' mental health services to meet local needs in North Brisbane, the Moreton Bay Region and Kilcoy.

Transferring this commissioning responsibility to Primary Health Networks was a key part of the Federal Government's response to the National Mental Health Commission's review of mental health programs and services.

Low intensity services are structured, evidence-based psychological therapies that are suitable for people who might be going through difficult life events or experiencing mild depression or anxiety.

A diagnosis is not needed to access low intensity services.

beyondblue NewAccess

The *beyondblue* NewAccess program is perhaps the highest profile low intensity service available in the Brisbane North PHN region.

Delivered locally by Mental Illness Fellowship Queensland (MIFQ), NewAccess has also been rolled out across numerous other PHN regions in Queensland, New South Wales and the ACT.

This program supports people who are experiencing early signs of anxiety and depression, and aims to overcome key issues that often prevent people from seeking mental health support, such as cost, lack of accessible support services and stigma.

Participants can choose to access the program in person, via a video app such as Skype or Facetime, or by phone. They can access six private sessions with their own qualified coach, who will tailor a recovery plan that suits their individual needs.

CARING FOR RESIDENTS OF AGED CARE PROGRAM

Among the other low intensity services available, the Caring for Residents of Aged Care Program is delivered by the provisional psychologists at Change Futures.

This program provides supportive counselling or structured intervention focusing on resolving the past and improving quality of life.

It examines the impacts of grievances and other life events on quality of life and reframes these experiences to improve functioning and wellbeing for people living in aged care.

DAYBREAK PROGRAM

Another of the commissioned providers is Hello Sunday Morning. It delivers the Daybreak Program, which supports people to reduce their alcohol consumption and create healthier habits.

Daybreak is a 16-week program, accessible via a mobile app, providing peer support, daily messages and activities, along with access to trained health coaches and referral as needed. Complex cases can be escalated to clinical psychologists.

Federal Member for Brisbane, Trevor Evans MP, launches the NewAccess program.

beyondblue CEO Georgie Harman (L) and NewAccess coach Tabitha Ring (R) at 2017 program launch.

"Low intensity services are structured, evidence-based psychological therapies that are suitable for people who might be going through difficult life events or experiencing mild depression or anxiety."

OPTIMAL HEALTH

Optimal Health is an eight-week self-development program delivered by Neami National in a group, face-to-face setting, designed to build self-efficacy.

The program supports people to achieve key principles of personal recovery, acknowledging that optimal health is self-defined and self-directed.

The program helps participants to understand stress, vulnerability, strengths and strategies, identify collaborative partners and support networks and the tools they need to manage effective change.

PEACH TREE SUNSHINE PARENTING PROGRAM

The Peach Tree Sunshine Parenting Program runs for six weeks and aims to reveal if a peer-led group model could deliver improved health outcomes for mothers experiencing mild postnatal depression or anxiety.

It includes a 4-week parenting workshop that will help to build maternal resilience, supported by perinatal peer workers and a pre and post-workshop session with a psychologist.

Workshop content explores issues focused on building maternal resilience, understanding postnatal depression and anxiety, looking after mum and baby, managing relationship changes, parenting skills and confidence, self-esteem and identity, bonding with baby, mindfulness and affirmations, and diet and nutrition. An additional session is included for partners.

PROBLEM MANAGEMENT PLUS

Problem Management Plus (PM+) is a structured, low intensity, brief therapeutic intervention for adults from culturally and linguistically diverse backgrounds who are experiencing mood or anxiety disorders, stress and a range of psychological stressors, particularly in situations of adversity.

PM+ is delivered by World Wellness Group and helps people to develop coping strategies for managing stress and problems. Participants learn how to get going and keep doing, strengthen social supports and stay well.

INSTITUTE FOR URBAN INDIGENOUS HEALTH

The Institute for Urban Indigenous Health (IUIH) has also been engaged to deliver integrated social healthcare services. This is a specialised service for Aboriginal and Torres Strait Islander people of all ages.

IUIH provides an integrated social healthcare model that includes low intensity psychological services within a broader primary mental healthcare model. ha

For referral and contact details regarding these programs, visit https://goo.gl/SWFpnc. Information about other evidence-based low intensity services is available from www.mymentalhealth.org.au.

CRAIG PARSONS
Mental Health Drug & Alcohol Commissioning Manager, Sydney North Primary Health Network

Mental health services reform in Sydney North

Supporting a stepped care approach in primary care.

"A range of capacity-building activities for general practice have been rolled out, including extensive in-practice education sessions delivered by a specially recruited clinical liaison team. "

NEED FOR REFORM

Approximately 45% of Australians aged 16–85 will experience a common mental health disorder (such as depression, anxiety or substance misuse) in their lifetime.[1] The majority of Australians who seek care for a mental health concern will receive their care in the primary care sector with GPs being at the frontline of service delivery.[2] Mental health concerns vary from low level issues to complex mental illnesses.

Despite this, until recently, the services available to those receiving their support in the primary care setting were limited—that is, access to psychological therapies via the Better Access and Access to Allied Psychological Services [ATAPS] programs, and mental health nursing services.

Mental health reform efforts, informed by the work of the Australian Mental Health Commission, have focused on increasing the range of services available to consumers and improving integration and accessibility.

Primary Health Networks are central to the Australian Government's mental health reform efforts. PHNs have responsibility for commissioning evidence-based primary mental health programs and services to meet the spectrum of mental health needs in their local communities.

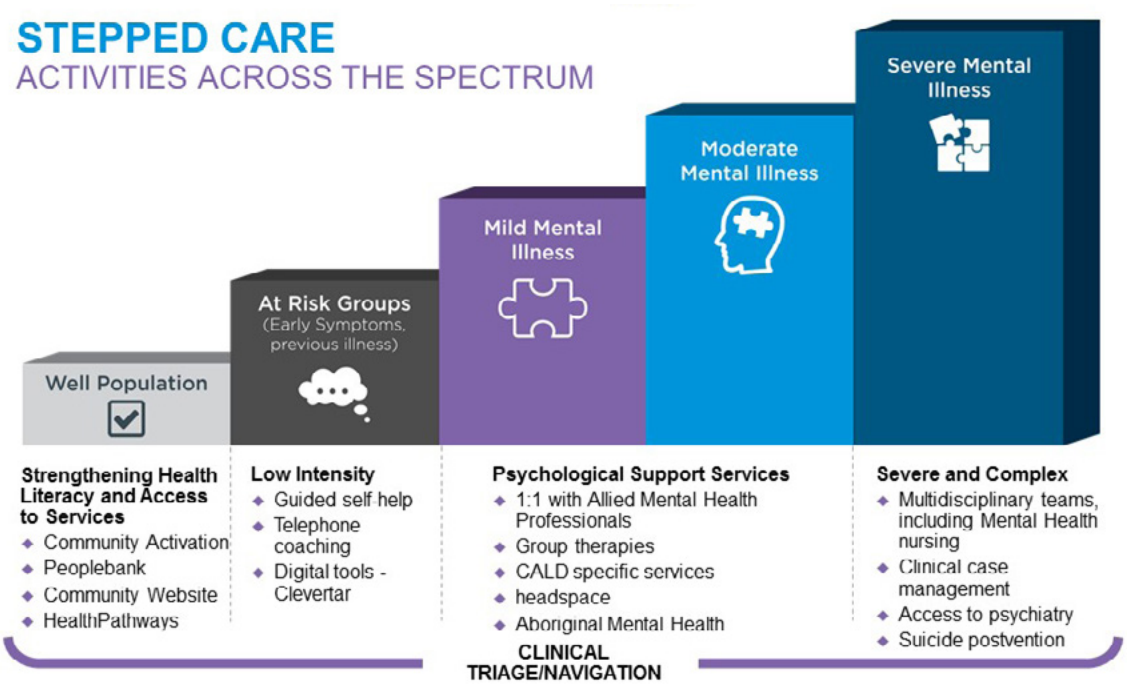
THE SYDNEY NORTH PHN APPROACH

Over the past 2 years, Sydney North PHN has worked closely with local GPs, consumers, service providers and other key stakeholders to identify the types of mental health services required for the region to meet the breadth of mental health needs experiences by the local community and agree the vision for mental health reform within the region.

This has led to the funding and establishment of 13 new mental health and drug and alcohol programs in the region, offering tailored support. Local innovations include:

- development of low intensity psychological services providing guided self-help and coaching support
- a more flexible approach to the delivery of psychological therapies for underserviced populations—including group programs, CALD specific services, outreach, telephone support and care coordination
- expansion of headspace services using a 'hub and spoke' model to incorporate outreach, care coordination and extended use of digital therapies
- support for adults and young people experiencing severe mental illness and complex needs through provision of clinical team-based care, expanding on the Mental Health Nurse Incentive Program
- expanded suicide prevention services providing rapid access to care coordination and psychosocial support
- culturally appropriate services offering care coordination, advocacy and wellbeing groups for Aboriginal and Torres Strait Islander people in the region
- specialist drug and alcohol services providing counselling, case management and care coordination for adults and young people experiencing co-occurring substance misuse and mental health issues.

To facilitate access to and integration of these services, SNPHN has established a new



SNPHN's Stepped Care Approach—Activities Across the Spectrum

clinical triage hub to support GPs to navigate the new programs and match patients to the right level of care.

A range of capacity-building activities for general practice have been rolled out, including extensive in-practice education sessions delivered by a specially recruited clinical liaison team. New resources including referral forms, secure messaging processes, and websites, have been developed.

Stepped Care education events have been delivered and community events and expos have been organised across the region. Recent community events have highlighted the need for access by underserviced populations, including people of Chinese background and Aboriginal and Torres Strait Islander communities.

FUTURE ACTIVITIES

With services now into their second year of service delivery, SNPHN's proactive approach to commissioning management will continue to support providers to innovate, respond to emerging needs within the community, and work collaboratively with other services within the region.

The key focus for SNPHN's clinical triage team will be continuing to support stepped care and integration through:

- refinement of decision support tools
- use of intelligent information technology to support communication between services
- expansion of mental health and drug and alcohol shared care initiatives, linking general practice, public health and community-managed organisations
- care navigation programs to be delivered in general practice.

This work will be informed by a newly formed GP Stepped Care working group, consumer and carer focus groups, and the existing SNPHN Mental Health, Drug and Alcohol Advisory Committee.

Work has commenced on a regional mental health and suicide prevention plan, in partnership with Northern Sydney Local Health District, to be delivered in 2020. This plan will require ongoing engagement and collaboration with local consumers, GPs and regional service providers to ensure that the local service sector effectively delivers upon the vision of providing the right care, at the right time, in the right place. ha

SNPHN Mental Health Clinical Triage Hub

References

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2. Department of Health and Ageing 2013. National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993–2011. Commonwealth of Australia: Canberra.

SYDNEY NORTH Primary Health Network

FRANK QUINLAN
Chief Executive Officer
Mental Health Australia

Creating a supportive culture around mental health

Workplaces have a pivotal role.

Earlier in June (2018), a journalist at the *West Australian* newspaper responded to our report on the economics of investment in mental health: *Investing to Save*. He said increased investment and better support services can only be effective when accompanied by a 'supportive workplace and community culture' around mental health. And he's right.

Regardless of how good and easily accessible mental health services are, stigma—unless addressed—will continue to prevent people from talking about their struggles and accessing support.

And nowhere is mental health stigma more prevalent and pernicious than in the workplace. We know that mental health conditions cost Australian workplaces approximately $12.6 billion per year in lost productivity. We also know that workplaces can either foster an environment that promotes help-seeking, or they can discourage it.

Much needs to be done in our workplaces to break down stigma and create the supportive culture that makes recovery possible. And it's not just about improving the bottom line. It's about improving the mental health of individuals and restoring their capacity to lead full and contributing lives: not just as employees, but as parents, family members, carers, friends and fellow community members.

Late last year the Victorian Police Chief Commissioner Graham Ashton took leave to focus on his mental health. This sent a powerful and supportive message to members of the forces that will hopefully empower others to recognise when they are struggling, and to talk openly and authentically about their own experiences in what is a very stressful and demanding line of work.

Ashton's example demonstrates the critical role that leaders within organisations play in influencing workplace culture. Not only that, it shows that if unhealthy attitudes to mental illness can be turned on their head in an institution like Victoria Police—an institution built on the physical and emotional endurance of its members, on the denial of vulnerability—surely these attitudes can be turned on their head in any workplace.

Our own workplaces—organisations working in mental health—are by no means immune from these challenges. We are often trying to do so much with so little, against resistance that is so strong, and with expectation that is so high. We must find ways of leading by example, of 'being the change that we seek'. We will surely make mistakes, but we must find ways of overcoming barriers that perpetuate unhelpful behaviours and attitudes.

Recently I attended a meeting of the Mentally Healthy Workplace Alliance, which brings together mental health advocates and representatives from business and government to drive change in workplace culture. This was an opportunity to explore further the implications for Australian workplaces of the broader societal shift we are seeing towards a more positive and supportive view of mental illness.

Workers want psychological safety, freedom from stigma and discrimination, and access to help when they need it. Employers want practical tools to gauge the health of their workplaces, practical assistance to implement change, and help to separate quality evidence-based interventions from the snake oil.

"We know that mental health conditions cost Australian workplaces approximately $12.6 billion per year in lost productivity. We also know that workplaces can either foster an environment that promotes help-seeking, or they can discourage it."

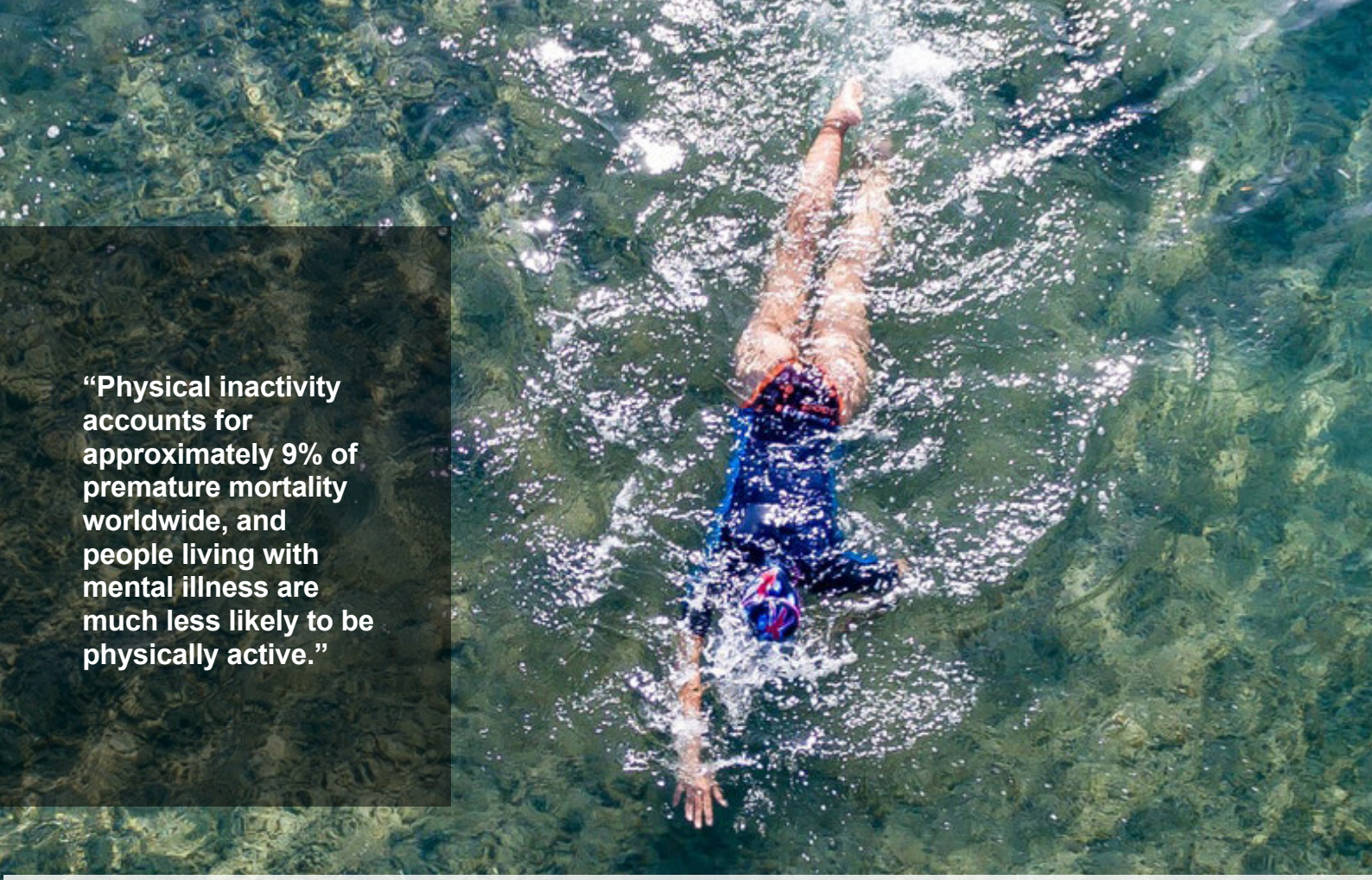
As the *Investing to Save* report demonstrates, it is in the financial interests of both workplaces and the broader economy to protect and preserve employee mental health. Simple strategies such as increased job control and formal therapeutic training would produce a collective $4.6 billion in savings for Australian workplaces.

As the blurred boundary between work life and private life becomes ever more obscured (I am writing this update on my day of), and as many of us spend up to half our waking hours at work, the focus on workplaces to implement strategies to protect and improve the mental health of Australians will amplify. ha

Marten Bjork

CAMELLA BRIGHTMAN
Marketing Member Communications Officer, Exercise & Sports Science Australia

The role of physical activity in closing the life expectancy gap in mental illness



"Physical inactivity accounts for approximately 9% of premature mortality worldwide, and people living with mental illness are much less likely to be physically active."

People living with a mental illness die much earlier than the rest of the population, mostly due to preventable cardiovascular disease. Dying 15 to 20 years earlier means that life expectancy for people with mental illness is similar to that seen in the population at large in the 1950s.

Physical inactivity accounts for approximately 9% of premature mortality worldwide, and people living with mental illness are much less likely to be physically active.

The role of exercise interventions is a key component of closing the life expectancy gap for people experiencing mental illness, according to a new International Consensus Statement.

'People experiencing mental illness engage in significantly lower levels of moderate to vigorous physical activity and spend significantly more time engaging in sedentary behaviour. A growing number of clinical trials demonstrate efficacy of lifestyle interventions, including exercise, for both physical and mental health in people with mental illness. However, large-scale translation into routine clinical care has not occurred.'—*International Consensus Statement*

Officially released in the *Translational Journal of the America College of Sports Medicine*, 'The role of sport, exercise, and physical activity in closing the life expectancy gap for people with mental illness' is the first joint International Consensus Statement by Exercise & Sports Science Australia, the American College of Sports Medicine, the British Association of Sport and Exercise Science, and Sport and Exercise Science New Zealand.

The Statement aims to delineate the key factors that must be addressed by key decision-makers to increase access to appropriate exercise programs for people with mental illness and subsequently contribute to closing this life expectancy gap.

'This statement represents a significant piece of work between like-minded organisations after two years' worth of collaboration' says Anita Hobson-Powell, ESSA Chief Executive Officer and co-author.

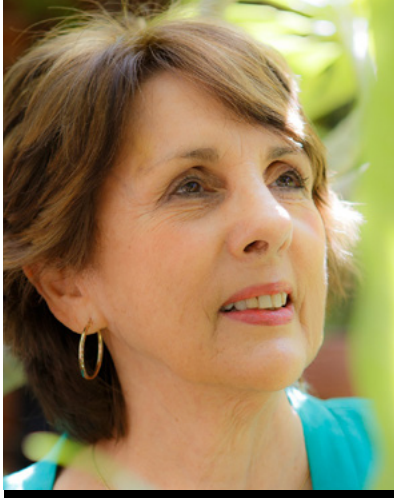
The statement identifies that exercise practitioners (such as accredited exercise physiologists), as members of a multidisciplinary team, play a core role as advocates for positive lifestyle change, with the ability to address major modifiable risk factors contributing to premature mortality.

'Although not a magic bullet, physical inactivity is a key, modifiable risk factor that we overwhelmingly know how to address. Helping people experiencing mental illness to live active lives is not a gap in knowledge, rather a lack of implementation', explains Dr Simon Rosenbaum, lead author and researcher with the School of Psychiatry, University of Sydney, and the Black Dog Institute.

Professor Philip Ward, co-author and director of the Schizophrenia Research Unit, South Western Sydney Local Health District, and the Ingham Institute for Applied Medical Research, states, 'This is a great step towards increasing awareness of the critical role that enhancing physical activity can play in improving the lives of people living with mental illness. Enhancing the role of exercise and sports science professionals working with people with mental illness will provide a huge boost to the quality of care they receive.'

The organisations that endorse this consensus statement commit to promoting the role of exercise interventions as a key component of a global strategy toward achieving a 50% reduction in the life expectancy gap of people experiencing mental illness by 2032.

'We believe that enhanced training of our members, facilitating culture change within mental health services, and advocating for the provision of required infrastructure are the cornerstones of achieving this goal', says Dr Rosenbaum. ha



DR CORALIE WALES
President, Chronic Pain Australia

Living with chronic pain

Recognising and dealing with its effects on mental health.

YES, IT'S OFTEN DETRIMENTAL

Living with chronic pain is often detrimental to a person's mental health and wellness. While chronic pain will not go away entirely, the good news is that through various forms of management, a person living with chronic pain can still live the life they want to physically and mentally.

Chronic Pain Australia, the national grassroots voice of people living with chronic pain, defines chronic pain as persistent pain that lasts longer than six months in a person's body. Often the pain can be so bad that people living with it are stopped from doing everyday activities. The pain can even make sleeping impossible and its persistence means that, for many people, working is not possible—which in turn significantly effects their income and quality of life.

Living with chronic pain can completely alter your sense of self, and make you less confident and more socially isolated. These are some of the reasons why in many cases people living with chronic pain report lower levels of mental health and wellness. It is important to note, however, that every person living with pain has a different journey and experience of pain, and not all have poor mental health.

FEEDBACK FROM THE NATIONAL PAIN SURVEY

Recently Chronic Pain Australia conducted its annual National Pain Survey, asking Australians living with chronic pain what they needed from their GP, pharmacist, other health providers, parliamentarians and the general community to help them manage their pain. What came up repeatedly as part of the survey was the need for medical professionals to understand that mental health and chronic pain go hand-in-hand.

Another key requirement from people living in pain was that that they wanted to stop being judged for having their health condition. People reported instances where they were told by their health professionals that they were exaggerating how bad the pain was, something only the person living with chronic pain knows.

The survey also demonstrated that people living with pain wanted to be listened to when they were meeting with any health professional. They wanted to be validated and wanted the health professional to have greater empathy for them. In short, they wanted to be treated like a human. Respondents to the survey said how terrible they were made to feel about themselves and how their mental health suffered when their interaction with a health professional was not up to scratch.

Another key finding from the survey was the desire for governments to provide practical help to people living with chronic pain in order for them to better manage their mental health, and to understand that mental health challenges and living with chronic pain go together.

'Increase the number of appointments available under a mental health plan to help me keep on top of the mental health issues associated with chronic pain, social isolation, and family breakdown' [Respondent #450]

STIGMA AND DISCRIMINATION

Stigma and discrimination play a familiar role in the lives of people living with chronic pain. Because pain is an invisible illness, it can be very hard for people who don't live with chronic pain to relate to a person who lives with chronic pain. It is common to hear stories of people living with chronic pain being told to 'take better care of themselves' or spoken to like they are children who are not experts on their pain and their bodies. Often people are told to their face that they are simply faking their pain. These

interactions are incredibly hurtful and embarrassing to the person in pain, further damaging their sense of self.

STAYING CONNECTED IS CRUCIAL

For people living with chronic pain and poor mental health and wellness staying connected is crucial. Chronic Pain Australia runs a free 24/7 forum for people living with chronic pain. Here people in pain are welcomed with values of compassion, non-judgment and understanding. Many forum participants have indicated that they have avoided suicide because of the friendship and support they find on the forum.

The Forum can be accessed from the homepage of the Chronic Pain Australia website—www.chronicpainaustralia.org.au.

The website also has some top tips on free resources available that people in pain find helpful—see http://chronicpainaustralia.org.au/documents-2/top-hits. ha

For more information about National Pain Survey 2018 results please visit the National Pain Week website—www.nationalpainweek.org.au.

Ian Espinosa

AMANDA BRESNAN
Chief Executive Officer
Community Mental Health Australia

The 'Continuity of support' question

This article articulates the community-managed mental health sector's position on what constitutes 'continuity of support' for people receiving assistance from three Australian Government mental health programs—Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMs) and Day to Day Living (D2DL)—and who are not eligible for the National Disability Insurance Scheme (NDIS).

HOW IS CONTINUITY OF SUPPORT BEING DESCRIBED?

The Department of Social Services (DSS) has stated the following:

For existing Commonwealth clients who are assessed as not meeting the NDIS access criteria, the Commonwealth has committed to providing continuity of support. This will include assistance for PHaMs clients who are aged 65 or over when the NDIS begins in their areas, and/or clients who do not meet the residence requirements of the NDIS.

'Continuity of support' means that clients who are found to not meet the access requirements of the NDIS will be supported to achieve similar outcomes, even if the arrangements for doing that change over time.[1]

Funding was allocated in the 2018-19 Federal Budget for continuity of support—however there is as yet no clear articulation by any government department or the National Disability Insurance Agency (NDIA) on how continuity of support will actually work in practice, or what the 'provider of last resort' would look like and who the provider/s would be. (See 'Provider of last resort' section below for more information.)

THE LOSS OF SERVICES

A range of highly successful community-managed mental health services will no longer be funded in various jurisdictions as the NDIS moves to full implementation. These services are primarily focused on community-based rehabilitation, and their disappearance means that people will no longer have access to these services that support them to reduce the disabling impacts of their mental condition.

The further significant issue is the gap in service provision that will be created with the transferring of funds for federally-funded mental health programs from the Department of Health (DoH) and DSS for PIR, D2DL, PhaMs and the Mental Health Respite: Carer Support (MHR:CS) service to the NDIS while many of the people currently receiving assistance from that funding will be ineligible for the NDIS.

PROVIDER OF LAST RESORT

For people both eligible and ineligible for the NDIS, the provision of support relies on a healthy marketplace. Where a market does not exist in a particular area to provide needed services, both the NDIS and the states and territories have foreshadowed that there should be a 'provider of last resort' who will meet the service needs.

CMHA believes that clarity around the arrangements for 'provider of last resort' is a high priority for the Australian Government and state and territory governments. This is directly linked to the continuity of support provision as services are withdrawn or transferred to the NDIS.

CMHA supports the point made by the Productivity Commission in the NDIS Costs Inquiry that the NDIS is not expected to fill all service gaps. There should also not be a situation where some people with, for example, a particular mental health condition receive a high level of support while others with a similar condition do not. People living with a mental health condition

"A range of highly successful community-managed mental health services will no longer be funded in various jurisdictions as the NDIS moves to full implementation."

must have their psychosocial needs met regardless of whether they are eligible for the NDIS or not.

In addition, the Australian Government has said that if Commonwealth mental health program clients 'choose' not to make an NDIS access request there will be no continuity of support and these people's needs will be the responsibility of state and territory governments. Where a person's ability to express their 'choice' is affected by their psychosocial disability (i.e. cognitive behavioural impairments), this cost-shifting stance is of great concern and not consistent with Australia's obligations under the UN Convention on the Rights of Persons with Disability.

WHAT SHOULD CONTINUITY OF SUPPORT LOOK LIKE?

The CMHA's position is that continuity of support must directly align with the Australian Government's statement that clients found ineligible for the NDIS will be supported to achieve the same outcomes, even if arrangements change over time. This support could be provided through the NDIS; through a low-barrier-to-entry flexible program funded by the Australian Government; and through state and territory governments continuing to fund community mental health services.

The following aspects should be incorporated:

- Links between the NDIS and all parts of the mental health system recognising that people will need assistance from different parts of the system at different times, even if they have an NDIS package.
- People accessing Australian Government funded mental health programs—PhaMs, PIR and D2DL—will be assisted to test their eligibility for the NDIS where they elect to test their eligibility. This assistance will be funded through the NDIS and be provided by the PHaMs, PIR or D2DL service provider.
- People assessed as ineligible for the NDIS, or who do not test their eligibility, will receive a service plan for assistance funded by the NDIS and provided for by either the PHaMs, PIR or D2DL service provider or by the NDIS Local Area Coordinator (LAC) such that they do not receive a lesser amount of service than previously. The service provider or LAC will action the plan, and the person/client will be able to determine who assists them. Part of the package of services available to these people must include access to supported decision-making. The peer workforce can be important in this context.
- If the person requires a period of support to coordinate their plan, this will be provided for through a federally funded low-barrier-to-entry flexible support program. This assistance may be short or longer term, depending on the person's needs as determined in the planning process by either the service provider or the LAC.
- As funding decreases for PHaMs, PIR and D2DL and is transferred to the NDIS, people found not eligible for the NDIS will be referred to the flexible, low-barrier-to-entry program if they require ongoing support to coordinate services and in determining services they want and need. People must be able to enter and exit the program based on their need to access coordination support—that is they do not need to seek access to the program through the NDIS if they have already been through the NDIS access process and were given assistance via this process. This program needs to be funded by the Federal Government on an ongoing/recurrent basis and have the appropriate capacity to meet the needs of people ineligible for the NDIS.
- For individuals living with a mental health condition who are ineligible for the NDIS and are required to navigate Information, Linkages and Capacity Building (ILC) services either through an LAC or a service provider, it is vital that the system does not create a 'second class' of clients where the timeframes and referral processes for non-NDIS services and care coordination are not as good. An oversight mechanism should be built into the referral process that includes quality and safeguard measures around referral and access timeframes that are comparable to people with an NDIS package.
- For continuity of support for families and carers there is a need for direct and indirect supports, including building supports into ILC and service provider processes. ha

Reference

1. Information for providers, Personal Helpers and Mentors Service, July 2016, Department of Social Services, Australian Government

Addressing the mental health and wellbeing of the Aboriginal and Torres Strait Islander Community

The NAIDOC Week 2018 theme of 'Because of her, we can' celebrates the enormous contributions made by Aboriginal and Torres Strait Islander women to our immediate and wider communities.

Over the years, Aboriginal and Torres Strait Islander women have been at the forefront of campaigns to secure improvements to the health and wellbeing of our community.

Aboriginal and Torres Strait Islander women are the first line of response in the event of trauma. If a violent or distressing incident occurs, such as a suicide, it is often the women who respond first, particularly in regional and remote communities.

Indigenous people in Australia suffer from intergenerational trauma left over from past policies and events. We are all wounded in our hearts from the past. There is constant death in our communities, people going to jail and alcohol and drug issues. By the time many Aboriginal and Torres Strait Islander children are 12 years old, they will have experienced more trauma than a non-Indigenous child in their lifetime.

And yet, Aboriginal and Torres Strait Islander young people's access to mental health services is considerably lower than that of non-Indigenous youth. Twenty per cent of Aboriginal and Torres Strait Islander people live in rural areas, with 49% of that figure living in the Northern Territory. And it is in these areas crucially where there is also a lack of counselling, medical and psychiatric services. People have to travel a long way from their homes to access the services they need, and many simply do not have transport options.

Language is also a huge barrier. In many remote communities in Western Australia and the Northern Territory, English is a second language. More than one-half (60%) of Aboriginal and Torres Strait Islander people in the Northern Territory speak an Australian Indigenous language, followed by 13% of those living in Western Australia.

There can also be a sense of shame in seeking support and a deep-seated suspicion of medicalised services.

Clearly, there is huge demand for bespoke mental health support to meet the unique needs of Aboriginal and Torres Strait Islander young people. The one-size-fits-all policy does not work.

I don't profess to have all the answers, but I believe it has to start with authentic community engagement and liaison. My belief in this is what brought me to the Headspace Board—to advocate for better mental health services for all young people.

Headspace has successfully attracted young people from marginalised and at-risk groups.

In 2016-17, 6,351 young people who identified as Aboriginal and Torres Strait Islander visited a Headspace centre. This figure is testament to the unique culturally appropriate service delivered by Headspace. In addition, Headspace runs a targeted Yarn Safe campaign to encourage help-seeking from Aboriginal and Torres Strait Islander young people.

We need flexible approaches to ensure Aboriginal and Torres Strait Islander young people can access mental health support. An example of this includes a collaborative Headspace outreach service we're trialling in the remote Pilbara, with a strong component tailored to Aboriginal and Torres Strait Islander young people. Instead of young people coming to us, Headspace workers operate across the region—they are embedded in high schools and youth centres, and they can make home visits to families and elders to help their young relatives.

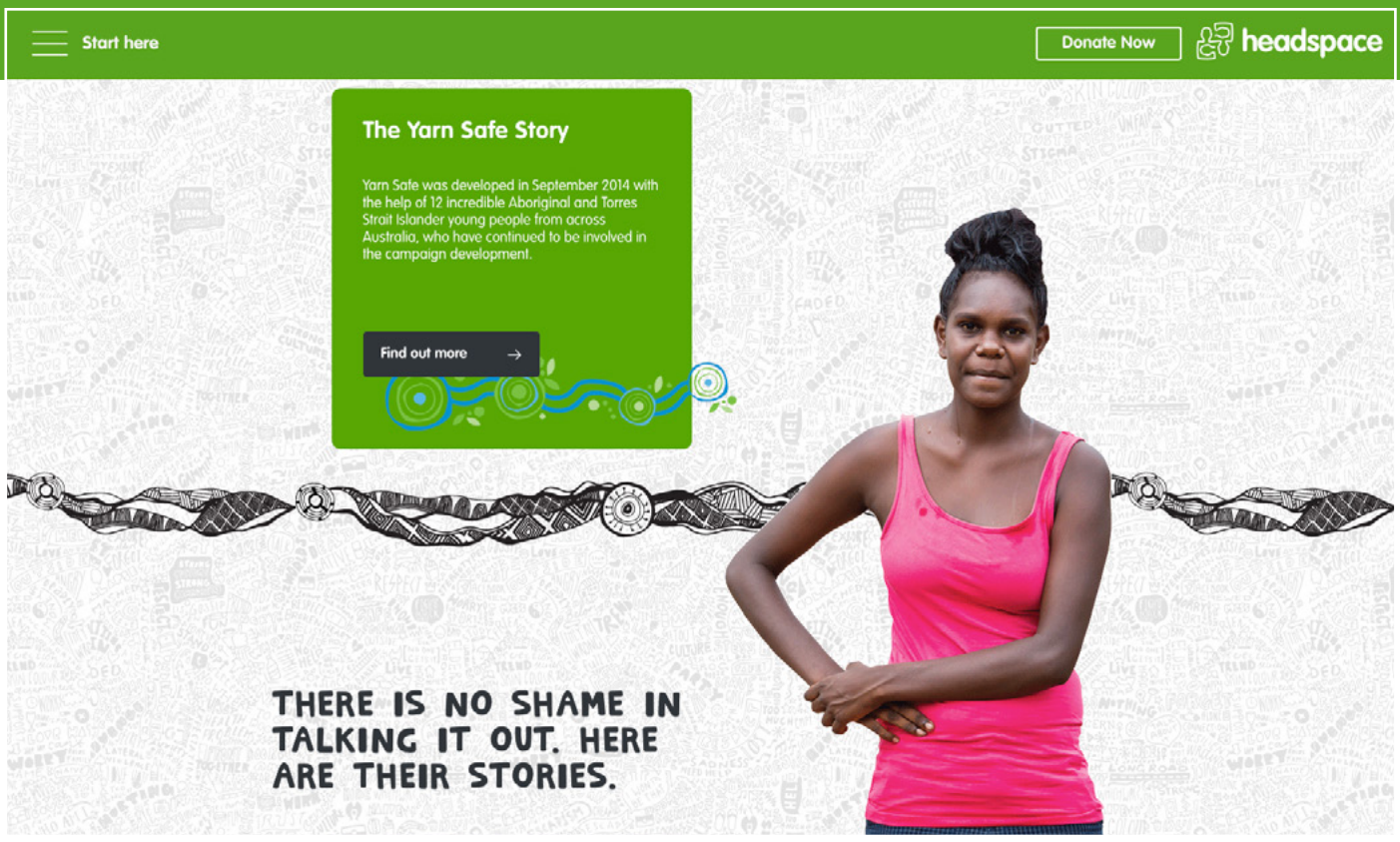
This kind of innovative and collaborative approach is an excellent model and in my view what we want to see more of.

Headspace has also had success establishing an Aboriginal and Torres Strait Islander Youth Mental Health Traineeship Program that provides our young people with education and employment opportunities. Among its many positive outcomes, the program has expanded the Aboriginal and Torres Strait Islander mental health workforce in remote areas and is continuing the conversation around mental health within the Aboriginal and Torres Strait Islander community.

We can always do more, and the key moving forward is continued and improved community collaboration. We need to talk more with each other and work together. This is the best course to achieving optimum mental health outcomes for Aboriginal and Torres Strait Islander young people. ha

NAIDOC Week 2018: The importance of bespoke mental health support for young Aboriginal and Torres Strait Islander people.

KATINA LAW
National Board Member, Headspace



headspace.org.au/yarn-safe/

THE BURDEN WE CARRY IS UNDERSCORED BY DISTURBING NATIONAL STATISTICS:

- Our life expectancy is almost 10 (9.5) years less than other Australian women, and two-thirds of these deaths are due to heart disease, kidney disease and diabetes.
- The suicide rate among our women is highest in the 20-24 age group (21.8 deaths per 100,000)—making it five times that of non-Indigenous women.
- In 2014-15, we were 32 times as likely to be hospitalised due to family violence as non-Indigenous women.

The statistics and anecdotal evidence for the health and wellbeing of our young Aboriginal and Torres Strait Islander people are equally startling:

- From 2012 to 2016, suicide was the leading cause of death for Aboriginal and Torres Strait Islander young people aged 15-34, and was the second leading cause for those aged 35-44.
- Between 2012 and 2016, Aboriginal and Torres Strait Islander children and young people aged 5-17 years accounted for more than one-quarter of all suicide deaths in this age group (90 of the 337 deaths, or 26.7%).

How to promote healthy eating for a healthier community

pixabay

Health services play an important role in enabling staff and visitors to make healthier choices.
Healthy Eating Advisory Service, Nutrition Australia (Victoria Division)

Picture the entrance to your hospital or health service. What do you see?

On the outside there are plenty of 'No Smoking' signs, and statements about your health facility's commitment to being a health-promoting environment.

But when you step inside, there's a café or vending machine full of soft drinks, chocolate bars, salty snacks and sugary cakes.

Poor nutrition is a major public health issue in Australia, with nearly two-thirds of adults and one-quarter of Australian children considered overweight or obese.

In fact, less than 4% of Australians eat enough vegetables each day, and around one-third of our daily energy intake comes from unhealthy foods and drinks high in added fats, sugar and salt—the types of foods and drinks being sold in health facilities across the country!

Hospitals and health services can play an important role in helping staff and visitors make healthy lifestyle choices which help prevent the onset of chronic disease and alleviate strain on our health care system.

Supplying healthier foods and drinks in your retail outlets, vending machines and catering is a simple, yet effective way to support preventive health initiatives, and meet community expectations about your role in promoting healthy lifestyles.

Every Australian state and territory (except Tasmania) has guidelines for supplying healthy foods and drinks in hospital and health services' commercial food services (not patient meals). And the most successful way to implement these guidelines is by getting everyone from the CEO to the café staff on board, to support a whole-of-organisation approach to promoting healthy eating.

If you want to improve the foods and drinks being supplied in your hospital or health service, here's how to get started:

ENLIST MANAGEMENT SUPPORT

Getting the go-ahead from the board or executive team will place healthy eating firmly on your health service's agenda.

Make the case for change by outlining your organisation's duty of care to staff, patients, and the community, and identifying existing commitments to population health in policies, strategies or funding arrangements.

If there are no such commitments to hand, or if promoting good nutrition is not included, see if you can make it happen. Use local statistics on dietary intake, chronic disease, or overweight or obesity hospitalisations to highlight a need for local action.

ENGAGE STAKEHOLDERS AND SUPPORTERS

This includes anyone responsible for providing foods and drinks (such as contract managers, retail outlet managers, and vending suppliers) to develop a working relationship and understand if there are any existing commercial arrangements to be aware of.

And get support from others who are involved in health and wellbeing activities, such as human resources staff, occupational health and safety reps, and nutrition and health promotion staff.

You might form a committee, or simply ask these groups to provide input on key parts of your action plan.

ENGAGE FOOD SERVICE PROVIDERS

This is obviously one of the most important steps in improving the food and drinks provided in your health service's retail outlets, and catering and vending machines.

Talk with suppliers/providers about the organisation's plans for promoting healthy eating, and how your state or territory's guidelines apply to them, then set realistic expectations and timelines for action.

Work with them to elicit initial steps they're willing to take, such as swapping ingredients, healthier cooking methods, sourcing healthier packaged products, relative pricing of healthy and unhealthy options, and promoting healthier options to customers.

And remember, changes don't need to happen all at once! You may wish to make simple changes first, and plan for more complex changes in the future.

ASSESS YOUR MENU

After making some simple charges, you could review retail outlet and catering menus, and products available at vending machines, to get an indication of how they align against your state or territory's guidelines. Then assist suppliers /providers in working towards offering a better balance of healthy foods and drinks overall.

DON'T GO IT ALONE!

There's lots of support available from people who've embarked on this journey before you. Get in touch with another hospital that has already implemented the healthy food and drink guidelines, or contact health promotion staff in your local council, state/territory government, or community health service. ha

In Victoria, the Healthy Eating Advisory Service provides free assistance on providing healthier food and drink options in hospitals, according to the Healthy Choices guidelines.
Visit www.heas.health.vic.gov.au for information, training, online menu and vending assessments, and even case studies.
HEAS is delivered by Nutrition Australia (Vic Division), with support from the Victorian Government.
Or contact your local Nutrition Australia office for assistance to promote healthy eating in your hospital or health service www.nutritionaustralia.org.

Become an AHHA member

Help make a difference to health policy, share innovative ideas and get support on issues that matter to you – **join the AHHA**.

The Australian Healthcare and Hospitals Association (AHHA) is an independent national peak body advocating for universal and equitable access to high quality healthcare in Australia.

With 70 years of engagement and experience with the acute, primary and community health sectors, the AHHA is an authoritative voice providing: strong advocacy before Ministers and senior officials; an independent, respected and knowledgeable voice in the media; and a valued voice in inquiries and committees.

By becoming a member of the AHHA, you will gain access to AHHA's knowledge and expertise through a range of research and business services.

The Deeble Institute for Health Policy Research was established by the AHHA to bring together policy makers, practitioners and researchers to inform the development of health policy. In joint collaboration with our university partners and health service members, the Institute: undertakes rigorous, independent research on important national health policy issues; publishes health policy Evidence Briefs and Issue Briefs; conducts conferences, seminars, policy think-tanks and workshops; and helps policymakers, researchers and practitioners connect when they need expert advice.

The AHHA's JustHealth Consultants is a consultancy service exclusively dedicated to supporting Australian healthcare organisations. Drawing on the AHHA's comprehensive knowledge of the health sector, JustHealth Consultants provides expert skills and knowledge in areas including: corporate and clinical governance training; strategy and business planning advice; organisation design and improvement; health services planning and program evaluation; and board induction training.

In partnership with the LEI Group, the AHHA also provides training in "Lean" healthcare which delivers direct savings to service provider and better outcomes for customers and patients.

To help share important developments across these various health research, policy and training spheres, the AHHA publishes its own peer-reviewed academic journal (*Australian Health Review*), as well as this health services magazine (*The Health Advocate*). ha

To learn more about these and other benefits of membership, visit www.ahha.asn.au/membership

More about the AHHA

Who we are, what we do, and where you can go to find out more information.

AHHA Board

The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The 2016–2017 Board is:

Dr Deborah Cole (*Chair*)
Dental Health Services Victoria

Dr Michael Brydon
Sydney Children's Hospital Network

Dr Paul Burgess
NT Health

Ms Gaylene Coulton
Capital Health Network

Dr Paul Dugdale
ACT Health

Mr Nigel Fidgeon
Merri Community Services, Vic

Mr Walter Kmet
WentWest, NSW

Mr Adrian Pennington
Wide Bay Health and Hospital Service, Qld

AHHA National Council

The AHHA National Council oversees our policy development program. It includes the AHHA Board as well as a range of members. The full list of Council members can be found at: **ahha.asn.au/governance**

Secretariat

Ms Alison Verhoeven
Chief Executive

Mr Murray Mansell
Chief Operating Officer

Dr Linc Thurecht
Research Director, Acting Deeble Institute Director

Susan Killion
Senior Advisor

Mr Krister Partel
Advocacy Director

Ms Lisa Robey
Engagement and Business Director

Ms Kylie Woolcock
Policy Director

Dr Chris Bourke
Strategic Programs Director

Dr Rebecca Haddock
Deeble Institute Manager

Mr Nigel Harding
Public Affairs Manager

Ms Kate Silk
Integration and Innovation Manager

Ms Sue Wright
Office Manager

Mr Daniel Holloway
Web/Project Officer

Ms Freda Lu
Assistant Accountant

Ms Malahat Rastar
Events Officer

Mr Matthew Tabur
Executive Officer

Ms Odette Fuller
Administration Officer

Australian Health Review

Australian Health Review is the journal of the AHHA. It explores healthcare delivery, financing and policy. Those involved in the publication of the AHR are:

Prof Gary Day
Editor in Chief

Dr Simon Barraclough
Associate Editor, Policy

Prof Christian Gericke
Associate Editor, Models of Care

Prof Sonj Hall
Associate Editor, Health Systems

Dr Linc Thurecht
Associate Editor, Financing and Utilisation

Ms Danielle Zigomanis
Production Editor (CSIRO Publishing)

AHHA Sponsors

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- Novartis Australia

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2018 IHF BRISBANE
42nd World Hospital Congress
10–12 OCTOBER 2018 BRISBANE AUSTRALIA

INNOVATE | INTEGRATE | INSPIRE
How can healthcare evolve to meet 21st century demands?

Health leaders from around the world are heading to Brisbane to discuss how healthcare needs to evolve to meet 21st century demands – will you be joining them?

Here are a just a few reasons why the World Hospital Congress should be on the very top of your must attend list.

Interested in value based healthcare?
If you are interested in value based healthcare you will have read "Redefining Health Care: Creating Value-Based Competition on Results". Author and innovation expert Professor Elizabeth Teisberg will provide her insights into the evolution that needs to take place in healthcare and she will be joined by health leaders who are implementing value based healthcare in Brazil, Malaysia, Singapore, Denmark and Australia.

Interested in health system integration?
You can learn from the Nigel Edwards, Chief Executive of the Nuffield Trust on the UK experiences in his keynote address, but you can also hear how Tanzania is developing an innovative and integrated health system from primary care up, how Taiwan is integrating home medical care services or how Iran is developing integrated and people-centred palliative care.

Interested in the impact of technology on healthcare delivery?
The information revolution has provided us with greater capacity than ever before to collect data - from detailed clinical information, to patient flows, we have more information than ever at our fingertips. So how is this being utilised around the world? Learn what Spain is achieving with health apps, how Zambia is using technological innovations to provide better quality of care in low resource settings and how the Mayo Clinic in the USA has used technology to review and improve opioid prescribing.

These are just a few of the many fascinating presentations and amazing experiences that will take place at the World Hospital Congress. The program is available now, so don't delay, register for your opportunity to be a part of this momentous event.

www.hospitalcongress2018.com

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