Leadership needed to tackle mental health stigma at work
Perinatal depression support
Embracing change in Australia’s mental health care system
Helping refugees overcome trauma

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Finding compassion when the tank has run dry

A few years ago, in my capacity as CEO of Dental Health Services Victoria, I asked a member of my team to hit the road and interview public dental patients across Victoria. I wanted to give them a voice and use their stories to advocate for the introduction of universal dental care in Australia.

One of the patients we interviewed was a man named Ivan. Ivan had lived with undiagnosed bipolar disorder for 20 years, suffering from manic depressive episodes, anger management problems, insomnia and suicidal thoughts. Ivan wouldn’t sleep for four or five days at a time, and struggled to cope with irrational thoughts and a tendency to become suddenly violent.

After migrating to Australia from his native Croatia with his wife and son, things got progressively worse until he attacked a mechanic with a hammer during an altercation. Ivan sought psychiatric help, but after being misdiagnosed, he lost faith in the system. Soon after, he snapped again. He hit his son, causing his wife to file for divorce.

Ivan found himself living on the streets. He became suicidal and admitted himself into hospital where he was again misdiagnosed, this time with Obsessive Compulsive Disorder. A few years later and at rock bottom, Ivan reached out again and found a psychiatrist and a psychologist who correctly diagnosed him with bipolar disorder. With proper treatment and medication he started putting the pieces of his life back together and began pursuing his career as a public speaker educating people on mental ill-health.

A lot of people will read that story and think Ivan is a monster. He attacked his mechanic with a hammer. He hit his son, who does that? The thing is, Ivan was a man in crisis. He knew he was a man in crisis. He reached out for help several times and several times, the system failed him. Is what he did ok? Absolutely not. Is the fact that he was not properly diagnosed and treated for over 20 years ok? Absolutely not.

People working on the frontline in hospitals and medical clinics will know men like Ivan all too well, and their compassion tanks will have run dry after constantly coping abuse that makes them feel rattled and unsafe. Their feelings are completely valid. No one wants to go to work every day and be verbally or physically abused by out-of-control or irate patients. It’s debilitating, it’s exhausting and it wears you down. So what do we do?

Before judging, I want you to imagine what it must be like to feel completely out of control—to live in fear of yourself, to reach out and feel like nobody understands, to wake up every day wanting to end your own life and hate yourself for not being able to go through with it.

Is every person who is abusive or violent suffering from mental ill-health? No, some of them are just not nice people. For others, being in the world feels like a burden and their behaviour is the manifestation of daily suffering.

Each year, more than 3.6 million Australian adults and 60,000 children experience mental ill-health. Those who live with mental health issues are often faced with a health system that doesn’t prioritise their needs and is too fragmented to provide holistic care.

We need mental health services that focus on prevention, intervention and support for recovery. A system that addresses the social determinants of mental ill-health and supports families and communities to implement preventive measures. We need a system that shows compassion even when the compassion tank has run dry. A system that puts the ‘heart’ back in health.

People living with mental ill-health can recover and live a meaningful and contributing life if they are able to access an integrated system that provides responsive and effective care. The development of the Fifth National Mental Health Plan will take steps to establish a collaborative approach to tackling mental ill-health in Australia, with key priority areas including integrated planning and service delivery, coordinated treatment, suicide prevention and Aboriginal mental health, as well as tackling stigma and discrimination, and improving safety and quality. The consultation draft was released in October last year, with release of the final plan imminent.

We need all parts of the health system to work together to improve the health outcomes of people experiencing mental ill-health. Only then will we be able to improve the experience of our valued health workers who face high-risk situations every day. While we’re working on that, let’s fill our compassion tanks and challenge our tendency to judge. Or at least, try.
HHA recently held its 2017 Annual General Meeting and Sidney Sax Medal dinner in Sydney, as well as the launch of its inaugural Reconciliation Action Plan.

AHHA ANNUAL REPORT AND FINANCIAL STATEMENTS

AHHA’s 2016–17 annual report and the 2016–17 audited financial statements were tabled and accepted. Both are available on our website.

We made great strides in finalising our governance arrangements during the past year to achieve ISO 9001 accreditation. This was in line with commitments set out in our 2016–2020 Strategic Plan and 2016–17 Business Plan to undertake all of our work in a culture mindful of membership interests, investments, and trust.

Financially we continue to perform well, with strong membership retention supplemented with commissioned project work that aligns with the organisation’s values and allows us to invest in our advocacy, policy, membership and event programs, which continued to be very successful during the year. We attracted funding for additional new projects, as well as continued and renewed funding for projects that we were already leading, which enabled us to bring added expertise and value to our core work. We had a small surplus for the year slightly in excess of budget, and our fundamentals in terms of revenue and outgoings are very sound.

Membership of AHHA is split almost evenly across the acute and primary care sectors, and continued to expand during 2016–17, particularly to include more organisations providing services to, or on behalf of, public sector health organisations. Membership fees have been maintained at a constant or discounted level for the past five years, as we have built more sustainable revenue sources for our work.

Every staff member in AHHA contributes to the success of the organisation, and I am very grateful to have the opportunity to work with a very dedicated, committed and highly professional team, supported by a very strong and engaged Board. The coming year will be extremely busy and active as we take on the extra responsibilities of hosting the 2018 World Hospitals Congress. But, as a team with our partners Queensland Health, we are confident of doing Australia and AHHA members proud.

RECONCILIATION ACTION PLAN

AHHA is proud to have officially launched its Reconciliation Action Plan, which sets out positive and measurable actions and activities to support Aboriginal and Torres Strait Islander peoples through public health policy. The plan is available on the AHHA website.

SIDNEY SAX MEDAL

The 2017 Sidney Sax Medal was proudly presented to the late Jeff Cheverton, accepted on his behalf by his partner, Rod Goodburn. Jeff demonstrated vigour and commitment to equity, human rights, and economic empowerment that benefited not only clients, but the organisations he worked for, the teams he led, and the many boards he sat on, including the Board of AHHA.

JEFF CHEVERTON MEMORIAL SCHOLARSHIP

In partnership with Brisbane North Primary Health Network and the North Western Melbourne Primary Health Network, AHHA announced the two winners of the inaugural Jeff Cheverton Memorial Scholarship:

- Dr Mikaela Jorgensen, from Macquarie University
- Miss Madelaine Thorpe, from Brisbane South Primary Health Network.

10-YEAR HEALTH AGREEMENT BLUEPRINT

Preceding the annual general meeting AHHA facilitated a roundtable discussion to work through various key issues and ideas to be incorporated into AHHA’s 10-year health agreement blueprint. Both the Government and the Opposition have asked AHHA to provide input to their national health policy platforms as they plan for the next Healthcare Agreement between the Commonwealth, and the states and territories. The agreement may run for 10 years this time rather 5 years as for current and past agreements.

The AHHA team will now synthesise and consolidate stakeholder input with a view to finalising the blueprint over the next few months.

-presentations given at the Blueprint Roundtable are available on the AHHA website. The AHHA discussion paper, Volume to value: Strategies for outcomes-focused and value-based healthcare: a blueprint for a post-2020 national health agreement is also available on the website.

HEALTH CONSUMER GROUPS APPEAL FOR PRIVATE INSURANCE TO BENEFIT ALL

In late September we joined the Consumers Health Forum, CHOICE, the Public Health Association of Australia and the National Rural Health Alliance in calling on the Government to ensure that any proposed reforms to health insurance benefit ALL Australians.

All options put forward by the government at the time of writing reduce the level of funding available to public hospitals in favour of private health insurers, as well as reducing choices available to patients with private health insurance.

We support the need for substantial reform to health insurance, given the trend toward continually rising premiums and rapidly diminishing value of many health insurance policies.

However, moves to make PHI more affordable should not be without close attention to the impact on, and potential damage to, the public health and hospital system relied on (and voted on) by the majority of Australians.
Value of health data highlighted in August 2017 Australian Health Review

Behind much of the work being undertaken in Australia to improve the efficiency of our health services, and the quality of care they provide, is better use of linked data. This was highlighted in the August 2017 edition of Australian Health Review (AHR) in an open access article on the growth of linked hospital data use in Australia.

‘When done well, with appropriate privacy and confidentiality safeguards, linked hospital datasets can yield information that is very useful for health policy formulation, without the need, for example, to conduct new data collection activities or run surveys based on patient recall’, AHR’s editor-in-chief, Professor Gary Day said.

‘According to the article, from a University of Melbourne author team, Western Australia and New South Wales have easily outperformed the other states and territories over the last 20 years—over 80% of publications using linked hospital data were from these two states. The investment made by these states in developing data linkage capability to support health systems research is behind this.

The August edition of AHR also included an article on improving the accuracy of clinical costing for admitted sub-acute (in this case rehabilitation) patients. This was achieved through an ‘action research’ approach involving identifying current activity, finding gaps, revising the costing methodology, implementing changes and evaluating the effects of those changes.

Data issues and analysis were also at the centre of articles on the lack of data on periodontal disease in Indigenous adults, and using an outpatient scheduling database in investigating geographic clustering in chronic liver disease presentations within a health service district in Brisbane.

An open access article from Griffith University looked into what matters when operational decisions are made about emergency surgery queues. There are tensions surrounding such decisions, especially between surgeons and operating theatre managers, but also involving anaesthetists and nurses. Clinical precedence and logistical challenges are both important, and need to be appreciated and understood by all parties.

Also data-related, social participation as an indicator of successful ageing was considered in an article by a team of authors from Macquarie University. This study went further than most in looking at three different concepts of social participation, and how they are measured. The authors suggested that a measure of social participation segmented into each of the three concepts predicts variances in health outcomes more accurately than any of the measures on their own.

AHHA is proud to support research through AHR that contributes to the delivery of high quality, efficient and effective health services for all Australians.
Western NSW PHN shows what works in delivering effective Aboriginal health services

The AHHA has released a Deeble Institute Evidence Brief on ‘What works’ in partnering to deliver effective Aboriginal health services: the Western New South Wales Primary Health Network experience.

The partnership between the Western New South Wales Primary Health Network and Aboriginal primary healthcare services in the region is proving to be very effective—especially in terms of increased trust and support for a stronger network of services for local Aboriginal communities.

In particular, the number of Aboriginal people using integrated care services for chronic conditions more than doubled in the space of only 4 months.

Western NSW PHN CEO Andrew Harvey said ‘The structure and governance of Aboriginal health services in this PHN region are unique in Australia, and could possibly provide lessons for other PHNs and Aboriginal health programs generally’.

‘There have been many keys to success. We started at ground level, when we set up the PHN, by having an Aboriginal Health Council as an integral part of our governance structure. We also made sure we had strong Aboriginal representation on our Board.’

‘Then, when we went to commissioning services we truly placed “Aboriginal health in Aboriginal hands” at all levels by contracting a consortium of two leading Aboriginal health organisations in the region, Maari Ma Health Aboriginal Corporation and Bila Muuji Health Services, to deliver the program, which they named “Marrabinya”, meaning “hand outstretched”.’

The model for Marrabinya was born out of the thinking and design work undertaken by the two organisations, based on their understanding of community and general practice needs. Among many things, they increased the proportion of funding devoted to services by being innovative in keeping administration costs down.

A Cultural Safety Framework released at the same time is part of an ongoing effort in the PHN region to provide services that improve Aboriginal health.

AHHA Chief Executive Alison Verhoeven said ‘Although the Marrabinya scheme is in its infancy, the governance and on-the-ground structures put in place, the shared commitment to success, and the determination to “see it through” in both the short and long terms, are exemplars for PHNs and similar organisations.’

Chair of the Western NSW PHN Aboriginal Health Council, William ‘Smiley’ Johnstone, said ‘We want to show the rest of Australia how to do the business with Aboriginal health.’

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
Growth of private patients in public hospitals—wrong question, wrong problem, weak data

‘The Australian Government is asking the wrong question in seeking to reduce pressure on private health insurance premiums by addressing the growth of private patients using their health insurance in public hospitals’. So said Alison Verhoeven, AHHA Chief Executive in September.

The Association has provided its submission to the Australian Government’s public consultation on its paper, Options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals.

‘While we are all concerned about the runaway costs and shrinking benefits offered by private health insurance, we’re not convinced that patients using private health insurance in public hospitals is the real problem’, Ms Verhoeven said.

‘In short, the forest will not be fixed by barking up this one particular tree.’

‘The real problem is that health costs are rising faster than inflation or population growth, and we have a situation that is essentially the result of “vertical fiscal imbalance”—under our federal system, the states and territories have to deliver public hospital and healthcare services, but lack the capacity to raise all of the required funds.

‘When a patient elects to use their private health insurance in a public hospital, that service has to be provided, and has to be paid for. It makes sense for the states and territories to send private health insurance funds the bill, just as a private hospital would do if the patient was treated there.

‘And it makes sense for private patients to use their insurance in these situations when it means they get their choice of doctor, or, if in a rural area, choosing a doctor in private practice at the local hospital rather than travel hundreds of kilometres to the nearest private hospital.

‘The Department of Health has set out five proposed options for reform of the private-patients-in-public-hospitals “problem”. But they will all result in limiting the benefits paid to patients, reducing choice, reducing the money paid to public hospitals, and reducing the value of a patient’s health insurance.

‘For most of the options there is a real danger that individuals will drop their health insurance—and it will be the healthier younger people first, meaning that remaining clients will on average be of higher risk, which will ramp up pressure on premiums again.

‘The only winners in the short term will be the private health insurance funds, who are doing very well in terms of profitability and return on equity, including an 18% increase in net profit over the 12 months to March 2017. They could see a saving on the $1 billion they currently pay out to public hospitals, adding to around $6.4 billion they already receive through the Private Health Insurance Rebate.

‘What’s really needed is an overall review of health system funding in Australia, involving all affected parties—a shared problem needs a shared solution.

‘We’ve set out some steps in our submission—including better data on health insurance use, ensuring health workforce retention in rural areas, cost transparency, a public interest test on the Private Health Insurance Rebate, determining appropriate levels of profitability in the private health insurance industry, and moving away from funding based on service volume to funding that rewards better health results’, said Ms Verhoeven.
NSW Minister for Mental Health Tanya Davies addresses stigma and mental health care reform.

Embracing change in Australia’s mental health care system
Living with mental illness or distress is not something that should sideline people from the community. Instead, mental illness is something that the entire community, and health care sector, should endeavour to understand and accept as part of many people’s journey through life.

We need to start putting people, not process, at the heart of the mental health care system. That is why NSW is in the midst of a decade-long period of reform to ensure our system is responsive to the needs of people who depend on our mental health services.

This means transforming the old ways of thinking about mental health care. It means embracing a system that provides support for people to stay out of hospitals and remain in their community, promotes the active participation of people with mental illness in their own treatment, and most importantly—it means embracing a system that ensures everyone can lead meaningful and fulfilling lives.

“We have to challenge our own preconceived ideas about mental illness. As Mental Health Month begins in NSW, it is the perfect time to embrace this year’s theme ‘Share the Journey’.”

We need to make it easier for people to navigate between different services and providers, and ensure a better balance between hospital and community care. These people are our friends, our families, our next door neighbours and they deserve nothing less.

I have a strong personal commitment to ensuring every person living with a mental illness has the opportunity to live a better life and reach their full potential. Underpinning this commitment to improving mental health services across NSW is a record $1.9 billion investment in mental health in the 2017-18 NSW Budget.

This is an increase of $87 million from last year’s budget, with $23 million of this additional funding budgeted to increase mental health services provided in the community.

This reform concentrates on making our services and system work for the people it is designed to help, which means it’s vital we take time to reflect on what changes are needed in NSW.

Much of this change is driven by an improved understanding of what works in mental health care. Our commitment to this change in perception and in practice means that we are not afraid of being challenged by new ideas. We are going through a seismic shift which means we have had to bring some of our best minds on board to have a look at where we might be able to do things better.

In this vein I have initiated a broad-ranging review into the practice of seclusion, restraint and observation in NSW mental health facilities. It’s time that we stopped and looked at our practices in mental health units, and how this affects the people who arrive in these inpatient units at times of great distress.

This review is being led by the NSW Chief Psychiatrist, Dr Murray Wright, in conjunction with the NSW Principal Official Visitor, Karen Lenihan, and Jackie Crowe from the National Mental Health Commission, who brings lived experience to the review panel.

I want to ensure that every measure possible is put in place to protect people at a vulnerable time in their lives when they need care, compassion and respect. The public have been invited to make submissions to this review, with many submissions being received from patients, carers, family members and mental health staff. I look forward to receiving a report from the review panel at the end of the year.

The other major review underway at the moment relates to the NSW Mental Health Commission, and is a statutory review, required under the Mental Health Commissioner Act. The Mental Health Commission of NSW has been instrumental in the continuing reform of mental health services and systems across the state.

The review will look at the Act itself and whether the objectives remain valid in directing and focusing the work of the Commission. It’s an exciting opportunity to reflect on the significant achievements of the Commission and ramp up for the next five years of mental health reform, under the new Commissioner, Catherine Lourey.

The Commission’s Living Well strategy gave the Government unique insights into how we could change the way consumers access mental services, and the way the health system and the community treat people living with a mental illness.

It has been instrumental in informing our reform agenda, which focuses on respect, dignity, and wellbeing for every person who comes into contact with health services. I encourage all community members to embrace this time of change and to use the opportunity to help build a better mental health system. Many of us will, after all, be touched by mental health issues at some point in our lives, either through personal experience, or through knowing or caring for someone with a mental illness.

If you wish to ‘Share the Journey’ with those living in the community with mental illness, and participate in Mental Health Month this October, you can find all the information and resources you’ll need by visiting www.mentalhealthmonth.org.au.
Mental health needs community-driven, whole-of-government responses

“When a history of colonisation, intergenerational trauma, high rates of suicide, and high rates of chronic disease are a part of your everyday life, it means that unless these factors are addressed and confronted, the ‘solutions’ offered by government will just be a patching up of problems.”
WE HAVE PEOPLE WHO HAVE LOST THEIR SOUL.

Those are the words of a community-managed mental health provider in Tennant Creek in the Northern Territory, talking about Aboriginal children in their community. It’s not a comment anyone should hear about any community, let alone children.

I recently had the opportunity to visit Tennant Creek to attend a roundtable run by the NT Mental Health Coalition, Community Mental Health Australia’s member peak in the NT, for the Primary Health Network (PHN) NT. The roundtable sought to examine the development of a model of stepped mental health care in the NT.

Almost the entire mental health workforce for Tennant Creek was at the roundtable—a relatively small group of highly dedicated and skilled workers. Hearing from them about their experiences and frustrations—most particularly being expressed for the Aboriginal community of Tennant Creek and the surrounding region—was heartbreaking and at times horrific.

NATIONAL INITIATIVES, LOCAL CONSEQUENCES

The roundtable was a stark reminder that what gets done at a national level will trickle down and affect what happens on the ground. In these remote and regional Aboriginal communities, federal decisions impact on those already struggling to meet capacity and deal with highly complex, traumatised people.

What was most apparent from listening to the people delivering the services and support, is that we cannot take one approach developed at the national level and then try and force it to fit into communities that are dealing with a range of different circumstances, including isolation, limited to no access to technologies (such as mobile phones and the internet), and fly-in fly-out and ever-changing workforces.

ADAPTING TO THE NDIS

The Barkly region, of which Tennant Creek is the major town, was a trial site for the roll-out of the NDIS, and workers at the roundtable reported high rates of ineligibility for the scheme. Federal Government programs such as Personal Helpers and Mentors (PHaMs) have been a significant source of assistance and help for individuals, families, and sometimes neighbours of people being impacted by persistent mental health issues.

PHaMs is a flexible, low-barrier-to-entry program that has delivered significant support, particularly in communities where a range of people are impacted by another person’s mental health issues. Funding for PHaMs is moving into the NDIS, but potentially not all (or not even most) of those now receiving assistance from PHaMs are likely to be eligible for support through the NDIS.

As many of the workers stated, the people who need PHaMs just keep coming, but the funding is not, and their workload is not getting any less.

SILOED ‘SOLUTIONS’

A point that was made and was highly evident in Tennant Creek, is that people often experience not just ‘mental health problems’ but a whole range of factors that contribute to the issues in their community. A National Mental Health and Suicide Prevention Plan that is a ‘health ministers’ plan and not a plan that looks at mental health and wellbeing, and all the factors that impact a person’s mental health—such as housing, employment, education, transport—will not help any community and definitely not an Aboriginal community.

Understanding the person as a whole, and the factors contributing to what they are going through, is not a simple task. People and communities are complex. When a history of colonisation, intergenerational trauma, high rates of suicide, and high rates of chronic disease are a part of your everyday life, it means that unless these factors are addressed and confronted, the ‘solutions’ offered by government will just be a patching up of problems.

COMMUNITY-LED APPROACHES

The ‘problems’ of places like Tennant Creek aren’t new and have been the subject of headlines and subsequent punitive approaches to address them—interventions, welfare management and constantly changing policies have seen decisions that are made nationally and then imposed on communities. Years of these approaches does not appear to have made any significant difference.

The key message that came through from the workers in Tennant Creek was that the community must be able to develop their own approaches. As the Redfern Statement made clear, Aboriginal communities have the solutions. Communities like Tennant Creek and their surrounds literally need their capacity, confidence, sense of purpose, hope and soul built up from the ground and this must be developed by them. The foundations of the social determinants of health are crucial, and without stabilising all those other factors, mental health cannot be properly addressed.

A HUMAN RESPONSE

The other clear point from the roundtable was that it takes time to develop trust and relationships. The existing community-managed services have done this over a long time. What is needed is to build their capacity and to listen to what they and the community are saying they need.

The words that stuck with me were from a worker talking about what they do every day—services do more than what is required. They feed people, provide clothes, whatever is needed. It is a human response.

This must form the basis of any policy or approach that is developed in mental health. We have to work with communities to develop approaches that suit them, otherwise we will keep repeating what has happened before and it will fail. The people of Tennant Creek are entitled to far, far better than that.

Amanda Bresnan is the Executive Director of Community Mental Health Australia (CMHA), a coalition of the eight state and territory peak community mental health organisations. CMHA, through its state and territory bodies, has a direct link and contact to mental health organisations delivering services at the community level. On Twitter @CMHA2016.

This article was originally published in Croakey on 10 July 2017: see www.croakey.org/mental-health-needs-community-driven-whole-of-government-responses/
New mental health treatment services are being delivered across regional WA to support GPs and their patients.

Regional Western Australians on low incomes are now able to access better, more targeted primary mental health treatment after the roll-out of Mental Health Portals.

The new services came into effect on 1 July with WA Primary Health Alliance (WAPHA) commissioning Mental Health Portals across regional WA.

The new approach involves a fundamental shift towards a stepped care model for mental health, enabling GPs to access early intervention for some of the most vulnerable Australians who experience mental ill-health.

Traditionally, access to mental health support has been uneven. Some areas have good access to a range of services while others, particularly in outer suburban, regional or rural areas, have had fewer options for treatment.

WA Primary Health Alliance general manager Linda Richardson said the Mental Health Portals would provide GPs with a greater range of options to connect eligible patients in regional WA to a more integrated system of care within their local areas.

‘The new model is designed to ensure vulnerable people can more easily access mental health support at the right level and at the right time, wherever they are in WA.

‘There are two key elements in the new approach:
1. Each region’s Mental Health Portal acts as a single point of contact for GPs and other regional and rural practitioners seeking primary mental health support for people.
2. It ensures people receive the most appropriate mental health support services for their needs, referred to as stepped care.

‘Under the stepped care approach, people are matched with the appropriate care for their level of need at any point in time. As needs change, the care changes too’, Ms Richardson said.

In the same way that physical ailments are treated differently depending on their severity, mental illnesses can require different treatments, and people need varying levels of support, depending on their circumstances.

The seven regions—Kimberley, Pilbara, Midwest, Wheatbelt, Great Southern, Goldfields and the South West—each have a local service provider that delivers the local Mental Health Portal that GPs can refer eligible patients to.

People eligible to receive mental health services under the scheme are those who are financially disadvantaged or considered to be at risk of suicide or self-harm, children and young people, and/or any person living in an area where no other services are available.

Once a GP connects a person to the Mental Health Portal, they will receive a phone call from a mental health professional who will coordinate a comprehensive assessment to determine the right care services. Over the course of treatment, their GP will receive regular updates on
 Thankfully, there is now a substantial body of evidence pointing to the fact that prevention can represent good ‘value for money’ and much of this evidence originates in Australia.

The move to a stepped care model comes after a review in 2014 by the National Mental Health Commission that looked at every aspect of Australia’s mental health response. The review found the system was poorly planned and badly integrated.

‘While one in five Australians experience mental ill health at some time, most with mild to moderate severity, fewer than one-half of people with common mental health conditions such as anxiety or depression get treated at all’, Ms Richardson said.

Ms Richardson said services provided through the Mental Health Portal can treat mild to moderate mental illness as well as assist GPs to manage people experiencing more severe and complex conditions.

Treatment options can include face-to-face counselling, telephone counselling, online therapy supported by phone sessions, and other forms of care, including group and community support.

For those with mild to moderate conditions a Practitioner Online Referral Treatment Service (PORTS) is one of the options, and includes expert assessments, telephone and online treatments, consultations with GPs, a strong evaluation framework, and commitment to timely service for both patients and GPs. PORTS can be particularly suitable for regional residents, where access to mental health services is poor.

‘Care management may also be available for people with severe and complex conditions where the Mental Health Portal service provider will work very closely with the referring GP or psychiatrist’, Ms Richardson said.

This new approach signals a significant change for people in Country WA. Improved access is a step toward improved health.

WA Primary Health Alliance is supported by funding from the Australian Government under the PHN Program.
GOALS IN STEPPED CARE, PERSON-CENTRED CARE AND SERVICE INTEGRATION

PHNs have a critical role in the Australian Government’s reform of the mental health system. We have been funded to commission innovative, cost-effective primary mental health services for mild to severe presentations that are regionally appropriate, evidence-based and outcomes-driven.

Stepped care is a central element of the mental health reforms announced by the Commonwealth, which recognised the need to provide the community with a greater and more effective array of primary mental health care options targeted to meet individual needs.

Stepped care is a central element of the mental health reforms announced by the Commonwealth, which recognised the need to provide the community with a greater and more effective array of primary mental health care options targeted to meet individual needs.

PHNs have also been funded to develop a regional mental health and suicide prevention plan that seeks to improve service integration, reflects a stepped care approach and promotes person-centred care. The plan needs to align primary, secondary and tertiary mental health services while recognising the social, physical and economic environments that influence mental health and wellbeing.

In order to achieve these goals, Capital Health Network (CHN) has been considering the current national policy and context. Does it work in practice and could it be applied in the ACT? What is the current state of the ACT mental health system and where do we want to be in the future?

WHERE ARE WE NOW?

Baseline Needs Assessment

To assess our current state, Capital Health Network conducted a Baseline Needs Assessment (BNA) which helped us to determine where there were service gaps, and to develop strategies to meet these needs. During this process we consulted broadly with consumers, carers, ACT Health, GPs, mental health professionals, service provider organisations and other stakeholders.

Our BNA highlighted the following:

- a fragmented system with many services that were not well integrated
- lack of psychological intervention services for individuals with moderate to severe presentations
- a need for early intervention services (in life, illness and episode)
- the need for a ‘no wrong door’ approach to services
- poor geographical distribution of services
- lack of psychological interventions and support services for young people with, or at risk of developing, a severe mental illness.

Integrated Mental Health Atlas

Another important part of the process was the commissioning of an Integrated Mental Health Atlas which provides a detailed understanding of available service types in the ACT. This will allow CHN to understand where the Territory is relatively well-resourced and where there are gaps, as well as helping to avoid service duplication. CHN will also use the Atlas to compare itself to other geographical areas, and to map available service types against evidence-based best-practice.
WHERE DO WE NEED TO BE?

What’s needed and what’s required
To determine our desired future state, Capital Health Network has asked itself ‘What does the community need?’ and ‘What is required to get there?’

To help answer these questions we have sought the views of stakeholders, consumers and carers through our commissioning processes. We will extend our understanding through seeking information from individual consumers about their experiences of the mental health care system in the ACT.

How to approach reform

CHN has also engaged with stakeholders to better understand how to approach reform in our region, based on the needs and gaps identified in our BNA, and our priority areas. Stakeholders identified the importance of accountability, ongoing planning, and building the capacity of existing services that work well rather than ‘reinventing the wheel’.

Another important factor was to provide integrated primary care services so that a client can step up and down the levels of care without having to go back to their GP or navigate the system themselves.

THE WAY FORWARD

Getting the right model of care

Based on feedback from our stakeholders and the findings of the BNA, CHN commissioned a scoping study to look at various stepped care models, including the strengths and weaknesses of each.

Public consultations indicated that stepped care could play a useful role in diversifying the ACT’s primary mental health services.

Earlier this year the CHN introduced a ground-breaking integrated primary mental health stepped care model for the ACT. The model, based on the UK’s Improving Access to Psychological Therapies (IAPT) model, has two parts: low intensity and high intensity interventions.

The CHN’s program has been named Next Step and is a ‘first’ in Australia, providing greater flexibility for people experiencing mental ill health to access services that meet changing needs.

The program has recently been expanded to include services for young people—a gap highlighted in our Business Needs Assessment.

Future planning

Planning is a key to going forward. Future needs assessments and enhancements to the Integrated Mental Health Atlas will continue to inform our future planning for primary mental health care services in the ACT.
Perinatal depression support more accessible than ever

“From October, parents in Melbourne’s east and north-east will benefit from an innovative Perinatal Depression Support initiative aimed at helping busy mums and dads to access mental health treatment more easily.”

ROBIN WHYTE
Chief Executive Officer, Eastern Melbourne Primary Health Network
PERINATAL DEPRESSION
New parents are naturally very focused on doing what is best for their new baby or young child, and these busy mothers and fathers can often be neglecting their own mental health and physical wellbeing. Research tells us that 10% of Australian mothers with children under two are diagnosed with perinatal depression\(^1\) and up to 1 in 10 new dads struggle with depression following the birth of their baby\(^2\).

From October, parents in Melbourne’s east and north-east will benefit from an innovative Perinatal Depression Support initiative aimed at helping busy mums and dads to access mental health treatment more easily.

Eastern Melbourne Primary Health Network (EMPHN) has provided funding to a consortia of community health organisations, led by Carrington Health, to provide mental health support for those experiencing or at risk of mild to moderate perinatal depression.

SUPPORT THROUGH TECHNOLOGY
This initiative is innovative in its use of technology, including SMS, and phone and video conferencing, to make the service more accessible to busy parents.

The SMS platform will be delivered by the SMS4Families program, developed by the University of Newcastle. Parents will receive 14 SMS messages a month following registration. Parents can register anytime from 20 weeks gestation until 12 weeks post-birth, and will receive messages for up to 40 weeks. At registration, the baby’s expected date of delivery or date of birth is entered so that the messages can be linked to the baby’s development from pregnancy through the first year.

The texts link common stressors such as ‘getting ready for the birth’, ‘infant crying’ or ‘lack of sleep’ with self-assessment of how the parent is managing. The brief interactive replies allow parents to declare that they ‘are not coping’ without declaring that they are mentally ill. When parents respond to the Mood Tracker query by opting for the ‘OK’ button, they are then asked ‘Are you really OK?’ or ‘OK but struggling?’.

If they select the latter option they are offered a further query to identify distress (‘not coping’) and escalated to phone contact. Escalated support will also be available through more traditional face-to-face counselling in community health centres.

A STRONG EVIDENCE BASE
The SMS4Families program has been developed by the University of Newcastle, and builds on the success of the SMS4Dads program, which was developed over four years, guided by an Advisory Committee comprising leading researchers in psychiatry, epidemiology, psychology and parenting.

More than 90% of fathers taking part in the SMS4Dads program reported it helped them in becoming fathers and improved their relationship with their partner. Mothers said the messages created conversations and built capacity for when times were difficult.

THE BENEFITS OF EARLY INTERVENTION
This perinatal depression support initiative aims to help parents manage symptoms of perinatal depression and reduce the prevalence of more severe perinatal mental health issues in our community. By addressing those at risk of or with mild to moderate symptoms, this initiative aims to step in before problems become more severe. In turn, this will improve outcomes for family health and wellbeing while ensuring our children have the best opportunity for a great start in life.

CUSTOMISED HELP FOR DIFFERENT RISK LEVELS
To make sure the right care is delivered to the right clients, different approaches have been built into the initiative for people at different levels of risk and need. Low-risk clients will be supported to access effective online cognitive behaviour therapy programs, such as MumMoodBooster and Mood Gym. Clients at possible risk following assessment will be offered time limited (to six sessions) cognitive behaviour therapy (face-to-face, Skype or phone), or an online program, which is clinician-moderated.

THE CONSORTIUM
The Perinatal Depression Support initiative consortium is led by Carrington Health and includes Link Health, EACH (Eastern Access Community Health), Access Health and Community, Inspiro, healthAbility, and Nexus Primary Health.

This consortium covers the breadth of EMPHN’s catchment, comprising 1.5 million people, meaning face-to-face treatment is close to as many parents in our community as possible.

References

For further information about the service, or to make a referral, please phone Carrington Health on 03 9890 2220. This initiative is supported by funding from the Australian Government under the PHN Program.
Nepean Blue Mountains PHN gives frontline mental health workers a head start
A new best practice reference guide presented at the recent 18th International Mental Health Conference will support Partners in Recovery Support Facilitators and other frontline mental health workers in their roles, including the transition to the National Disability Insurance Scheme (NDIS).

The guide, which features checklists, flowcharts, templates and fact sheets, was developed by Nepean Blue Mountains PHN (NBMPHN) as the Lead Organisation in the Partners in Recovery (PIR) program, in collaboration with PIR Support Facilitators. Many of the resources were co-designed with carers and consumers. The Guide aligns with the Department of Health’s PIR Guidance Pack, and with National Disability Insurance Agency (NDIA) resources.

NDIS TRANSITION
The PIR program is currently transitioning to the NDIS. Psychosocial disability prevents people becoming involved in day-to-day life and is recognised as a significant barrier to keeping a home, getting a job and staying physically healthy.

The Guide builds on the assistance that NBMPHN, as one of the first areas to commence the NDIS program, has been providing to other PIR organisations.

It includes an NDIS Application Checklist setting out the steps workers need to take when preparing and submitting an NDIS application. It also specifies what happens after submitting an application and how to review an NDIS decision. In summary, it provides the foundation for preparing good quality psychosocial NDIS applications.

SHARING THE LEARNING
NBMPHN CEO, Lizz Reay, said ‘The key focus of the guide is to share our learning and the tools we developed to avoid “reinventing the wheel”.’

‘We believe the NDIS is a positive reform, but how the scheme works in practice and how it works alongside the health system is confusing—not only for mental health workers across the social sector but also within clinical services’, Ms Reay said.

‘The Support Facilitators Best Practice Guide gives other Partners in Recovery organisations the best chance of transitioning effectively to the NDIS by using a successful “tried and tested” approach.’

The Guide will become part of the Australian-Government-funded Transition Support Project (for PIR and Day to Day Living (D2DL) programs to the NDIS) (www.transitionsupport.com.au). The Project is being delivered by Flinders University. The Guide is also available to download from the NBMPHN website (www.nbmphn.com.au).

Partners in Recovery (PIR) is a community-based program aimed at supporting people living with severe and persistent mental health concerns to develop their own plans for sustained recovery, and by getting local services and supports from multiple sectors to work in a more collaborative, coordinated and integrated way.

Individuals who are eligible for PIR are linked in with a local PIR Support Facilitator who will work together with the individual to develop their own plans based on their needs.

PIR commenced in the Nepean Blue Mountains region in 2013. Since then, the team has developed many resources covering Support Facilitation and NDIS Support Coordination.

The PIR program has been extended until June 2019 to support transition to the NDIS. The NDIS is scheduled for roll out by 30 June 2019.
Connecting practitioners to improve mental health care

Interdisciplinary practitioner networks and an online professional development webinar program prove popular with thousands of mental health practitioners.

THE MHPN APPROACH
The Mental Health Professionals’ Network (MHPN) promotes a collaborative approach to primary mental health care in Australia using two main platforms:

• local practitioner networks; and
• an online professional development program delivered via webinars.

GPs, psychiatrists, psychologists, mental health nurses, social workers, counsellors, nurses (registered and enrolled) and occupational therapists, as well as community-based mental health workers, are active participants in these activities.

All MHPN-supported activities are voluntary for practitioners while also meeting self-reporting requirements for continuing professional development [CPD] across the key participating professional associations.

NETWORKS
MHPN networks are based on the premise that consumer outcomes will be enhanced if practitioners from different disciplines connect on a regular basis. They will be better informed about each other’s fields of expertise, which will result in faster and more informed referrals.

MHPN supports over 360 practitioner networks in communities across Australia, 40% of which are located in regional, rural and remote areas. The networks are self-directed so that each can adapt to meet the unique needs and challenges of local practitioners and their communities. Over 9,000 practitioners per year have participated in MHPN networks over the past five years.

WEBINARS
Since December 2010 MHPN has produced and delivered over 65 webinars, including several for other organisations. Webinars have covered a wide range of mental health topics and all are recorded and available for viewing or downloading from MHPN’s website.

MHPN’s Department-of-Health-funded webinar program has attracted over 25,000 participants to live webinars, while recorded sessions have been viewed or downloaded more than 100,000 times.

Each webinar features an interdisciplinary panel of experts engaging in a facilitated case study discussion—thereby providing easy access to national expertise for busy practitioners and those in rural and remote locations.

WHERE WE HAVE MADE A DIFFERENCE—TWO EXAMPLES

1. Service delivery in the Kimberley region

Networks can have a direct impact on service delivery in communities. For example, in the remote town of Kununurra, MHPN’s network and webinar platforms connect practitioners from around the Kimberley region. Psychologist Nicole Jeffery-Dawes leads the network, which uses Telehealth, an online platform that allows practitioners from Kalumburu to Balgo and everywhere in between to participate in the network online.

A challenging aspect of working in the Kimberley, which has an area the size of Victoria, is a lack of coordination of services. MHPN network meetings provide one way of overcoming this hurdle. ‘Being able to have links and collaborations with other practitioners definitely helps my work in communities. We make our connections while we learn together’, Nicole says.

Practitioners also watch MHPN webinars together and discuss them: ‘The webinars are fantastic. Professional development is so expensive in the Kimberley when it takes two days to get anywhere. Making high quality professional development easily accessible makes a real difference to us’, Nicole says.

2. Professional development in partnership with the Australian Borderline Personality Disorder Foundation

MHPN has partnered with a number of organisations to deliver professional development on a variety of topics.
One example is a partnership that started this year with the Australian Borderline Personality Disorder (BPD) Foundation and Spectrum (personality disorder service for Victoria). This initiative uses both the network and online national webinar platforms to improve practitioner capacity to recognise, respond to and treat people living with BPD, and to better support their families and carers.

“We have been overwhelmed with the numbers wishing to attend MHPN BPD network meetings”, says Janne McMahon OAM, Patron of the Australian BPD Foundation.

“Up to 70 practitioners attend, and meetings usually book out within 24 hours. They provide an excellent opportunity for practitioners to meet, share information and provide mutual support. We are looking forward to continuing the partnership with MHPN through these networks and an upcoming webinar series.”

ABOUT MHPN
MHPN was established in 2008 and is funded by the Commonwealth Department of Health.
MHPN works with member and partner organisations to improve mental health care for all Australians.
Member organisations are the Royal Australian College of General Practitioners; the Australian Psychological Society, the Royal Australian and New Zealand College of Psychiatrists and the Australian College of Mental Health Nurses.
Key stakeholder organisations are the Australian Association of Social Workers, Occupational Therapy Australia and the Royal Australasian College of Physicians.
We also work collaboratively with the Australian College of Rural and Remote Medicine, and Primary Health Networks around Australia.
Learn more: www.mhpn.org.au.
Navigating mental health reform collaboratively

A new co-funded role is supporting inter-agency collaboration on state and federal mental health reform in Tasmania.
In Australia, we often hear that mental health policy and service provision are on the cusp of a brave new world.

Nationally, the mental health sector is adjusting to the channelling of Commonwealth mental health funds through Primary Health Networks (PHNs) for the commissioning of mental health services in local jurisdictions.

Simultaneously, the roll-out of the National Disability Insurance Scheme (NDIS) continues apace, signifying a whole new model of service delivery for individuals with severe and complex mental health conditions.

At the same time, the release of the Fifth National Mental Health Plan is imminent, promising to furnish states with a national framework against which to plan and measure reform progress for the five years ahead.

For the mental health sector in Tasmania, concurrent national reform platforms are the tip of the iceberg. In 2015, after broad consultation, the Tasmanian State Government released its own strategy for reform, Rethink mental health: better mental health and wellbeing—a long-term plan for mental health in Tasmania 2015–2025. This was followed in 2016 by the release of the Tasmanian suicide prevention strategy 2016–2020 and accompanying plans for youth suicide prevention and workforce development and training.

When you consider, as a whole, the cascade of mental health reform strategies, priorities, directives, consultations, actions, timelines, measures and outcomes—give or take a handful of bureaucratic buzz words—it can become more than a little overwhelming.

The agencies responsible for the implementation of mental health reform in Tasmania are primarily the Tasmanian State Government’s Mental Health, Alcohol and Drug Directorate and the state’s single PHN, Primary Health Tasmania. To their credit, they have acknowledged the complexities faced by a sector navigating multiple reform streams. Furthermore, they support the reform ideals of collaboration and integration with more than just lip service.

In April this year I was appointed to the new role of Sector Reform Officer, a position within the Mental Health Council of Tasmania, and co-funded by the Mental Health, Alcohol and Drug Directorate and Primary Health Tasmania.

The explicit objective of the role is to facilitate inter-agency collaboration on state and federal mental health reforms, and to provide a mechanism for identifying emerging issues and opportunities as shifts in mental health policy and practice occur.

As far as we are aware, Tasmania is the only state in Australia to have bridged the state-federal mental health reform divide with a jointly funded resource dedicated to this purpose.

So, from this positive vantage point of collective goodwill, what can be achieved in practical terms? The possibilities abound and so do the challenges.

If a joint approach to mental health reform can work anywhere it ought to be in Tasmania, where we boast the relatively straightforward structure of a single PHN working alongside a single state government agency to implement reform.

A number of other factors work in our favour—in particular, the existence of shared priorities across state and federal reform platforms. These priorities include:

- the principles of person-centred and recovery-oriented care;
- prevention and early intervention;
- developing a stepped model of mental health supports delivered in community settings, and
- using innovative models of service planning and delivery in the Tasmanian context.

Of course opportunities also bring forth equal and opposite challenges. For example:

- Each reform platform has its own timeline that exists independently of other reform processes.
- The mental health service system intersects with multiple other service streams, including welfare, housing, alcohol and drugs, emergency services and justice.
- Cultural change is gradual, and shifting long-held beliefs about the appropriate parameters between primary, clinical and community mental health care takes time. And yet the impetus to surmount these challenges is strong. If we don’t, we risk perpetuating the problem of a further fragmented mental health service system.

We risk an uneven, unwieldy spread of services with duplication in some areas and deficit in others. Critically, we risk consumers and carers missing out on—or experiencing adverse outcomes from—the intended benefits of reform.

Will a collaborative approach to mental health reform succeed in Tasmania? Provided each stakeholder brings to the table an ongoing commitment to action over words, I think our chances are better than most.
Helping refugees overcome trauma

Australian Refugee and Migrant Care Services Limited (ARMCare) wins primary health care award.

EMPOWERING REFUGEES TO BUILD A NEW LIFE IN AUSTRALIA

Helping refugees overcome the trauma they have experienced and access health care and other services to start building a new life in Australia has won Dr Claire Jones the Individual Distinction Award at the 2017 HESTA Primary Health Care Awards.

Based in Brisbane, Dr Jones was recognised for establishing Australian Refugee and Migrant Care Services Limited (ARMCare). ARMCare walks alongside refugees, offering understanding and compassion, and providing healthcare coordination, advocacy and social support. Through the work of the organisation she founded, Dr Jones is helping hundreds of refugees achieve health equality and equipping them with the knowledge to reach their health goals.

Refugees come to Australia with the hope of a better future. But when trying to build a new life they face huge obstacles with language and cultural barriers exacerbating often complex physical and mental health needs.

UNDERSTANDING, COMPASSION AND CARE

Dr Jones works tirelessly volunteering for ARMCare as a liaison person between refugees and health professionals. A key part of her work is obtaining comprehensive patient histories from refugees to assist doctors and other health professionals.

The refugees she supports come from diverse backgrounds, sometimes fleeing brutal conflicts. Dr Jones says witnessing the difference her work makes in their lives is inspiring.

‘Seeing the first smile as someone begins to emerge from the devastating mental health effects of trauma, which can take years, is greatly rewarding’, Dr Jones says.

‘I’ve also watched people regain their dignity and confidence in response to affirmations and care, after the degradation caused by human rights abuses. And when clients become healthy and able to manage their own healthcare, it’s wonderful to see them helping others who are unwell.’

OVERCOMING MENTAL HEALTH TRAUMA

Of the hundreds of refugees Claire has helped, Eh Paw’s courageous story—of overcoming significant trauma and losing family members in the wars in Burma/Myanmar—stands out.

When she arrived at ARMCare, Eh Paw was 55 years old, but looked tired and frail. To escape the war, she fled into the jungle with her newborn, husband and young children, where they had to survive for weeks without food, shelter, or medical care. They reached the Thai-Burma border, where they endured 12 years of hardship and near-starvation in a refugee camp, before arriving in Australia.

Starting a new life in Australia posed a different set of challenges. Suffering post-traumatic stress disorder from her experiences, Eh Paw had not been able to sleep for more than an hour a night for over 10 years, and suffered nightmares, flashbacks, panic and terror. Claire took Eh Paw to Emergency at the local hospital to access immediate care for her disorder.

Over the following weeks and months, Claire worked with Eh Paw to address her physical and mental health challenges, taking her to a GP, psychologist, dietitian, podiatrist, dentist, optometrist, and audiologist. Claire also helped Eh Paw to apply for and obtain a disability pension, and her husband to obtain a carer’s payment, so he could look after her.

Eighteen months later and Eh Paw is almost unrecognisable. She looks younger than her 55 years, smiles, laughs, enjoys her grandchildren, grows vegetables for the family, visits friends, and attends church and community events. Living in Australia has given Eh Paw a quality of life that otherwise wouldn’t have been possible and she is grateful for the new life she has been able to build.

POSITIVE HEALTH IMPACT ON OVER 200 REFUGEES SO FAR

Dr Jones has helped more than 200 refugees improve their health outcomes. Her work has also positively impacted the community, reducing mental health stigma, improving health literacy among her clients, and increasing refugees’ use of community health services.

Claire said the $10,000 prize money from her HESTA award win was both a motivation and a means to continue her work to further develop ARMCare’s life-changing services.

‘The award encourages me to keep developing services and methods which achieve better health outcomes for refugees in Australia’, she says.
“The refugees she supports come from diverse backgrounds, sometimes fleeing brutal conflicts. Dr Jones says witnessing the difference her work makes in their lives is inspiring.”
Leadership needed to tackle mental health stigma at work

Frank Quinlan
Chief Executive Officer
Mental Health Australia

Mental Health in Organisational Culture
Over the last decade or more, the conversation around mental health and mental illness has shifted considerably. In Australia alone, the persistence, professionalism and profile of many individuals and organisations working to improve the mental health of our community continues to grow. So many are doing great work, too many to mention, and while this work is penetrating many areas of society, we all know we still have a lot more work to do... especially in the workplace.

How many organisations in Australia have hosted a morning tea for R U OK? Day, or raised money for Beyond Blue, or Lifeline, or Reachout, or more...and then failed to transfer that intent and support for mental health into their organisational culture? How many have failed to establish a culture where employers feel safe to talk about their mental health? A culture where they feel supported? And what does a culture of care and support look like in a multinational company employing thousands, or a building site, or a school staff room, or a hospital? We know the prevalence of burnt-out, anxiety and stress in groups like young doctors, and we know they are reluctant to take time off for mental health. Why?

An Example that ‘Went Viral’
Earlier this year when an American CEO’s surprising reply to an employee’s sick day email went viral, it reminded me of just how much stigma we’re facing in the workplace. The email was titled ‘Where’s Madalyn’, and in the body Madalyn Parker wrote to her boss: ‘I’m taking today and tomorrow off to focus on my mental health. Hopefully I’ll be back next week refreshed and back to 100%.’

Her CEO, Ben Congleton, showed support and leadership in his reply. ‘I just wanted to personally thank you for sending emails like this’, he wrote. ‘Every time you do, I use it as a reminder of the importance of using sick days for mental health—I can’t believe this is not standard practice at all organisations. You are an example to us all, and help cut through the stigma so we can bring our whole selves to work.’

Screen shots of the email exchange were shared tens of thousands of times on social media and the story was well reported throughout mainstream media in Australia, New Zealand, the UK and the US.

Why did an email exchange between an employee and employer from a smallish company in the US receive so much traction? Because the CEO’s response went against expected norms.

Changing the Culture
Ben Congleton is not the only progressive leader out there—there are many promoting a culture of care and acceptance around mental health in the workplace, and many encouraging people to bring their ‘whole selves’ to work.

Our own Prime Minister The Hon Malcolm Turnbull regularly talks about helping to secure the mental wealth of our nation, but the organic and prolific sharing of the ‘Where’s Madalyn’ email, and the comments...
“How many organisations in Australia have hosted a morning tea for R U OK? Day, or raised money for Beyond Blue, or Lifeline, or Reachout, or more…and then failed to transfer that intent and support for mental health into their organisational culture?”

that followed, suggest the positive response is not yet the norm in the modern workplace.

To change the culture will be a challenge, but more progressive leadership in this area is a start. We need leaders who realise that an open, honest, and caring culture around mental health in the workplace will support the individual, but in turn support the bottom line.

We need leaders like Professor Allan Fels, the outgoing Chair of the National Mental Health Commission, who has continually urged the federal government to embrace mental health as its next big reform agenda, warning it is costing the economy more than $60 billion each year and 12 million lost working days in reduced productivity.

Professor Fels and the team at the NMHC highlighted the importance of workplace mental health in NMHC in Contributing Lives, Thriving Communities—Report of the National Review of Mental Health Programmes and Services. Some of the key ‘take home’ points were:

• For every $1 invested in mental health initiatives there’s an average return on investment of $2.30. The opportunity cost of not promoting good mental health at work and not supporting people who have mental illness is very high.
• The greatest barrier to full-time workforce participation, by workers with mental ill-health, is not lack of treatment options, but lack of workplace support.
• Mentally healthy workplaces have a positive culture conducive to mental wellbeing and support people who experience mental health difficulties. Mentally healthy workplaces are found to be more productive, innovative and likely to recruit and retain the best and brightest people.
• Action on workplace mental health represents a significant opportunity to reduce human wastage and productivity leaks, build stronger and more resilient organisations, and promote thriving communities.
• Supporting people’s recovery and promoting good mental health at work is good for people and good for business.
• Businesses can and are doing something about this to better support people and create mentally healthy work places, but more needs to be done.

At the very minimum the equation is simple—invest $1 and receive more than $2 back. That’s an investment that few CEOs or Boards would argue with.

The flow-on effects are infinite, as the report suggests. Invest in a culture of care and support for employees and the outcome will be increased productivity, innovation and the ability to recruit and retain the best and the brightest people—people like Madalyn and Ben perhaps, leaders in promoting and de-stigmatising workplace mental health.

People in leadership and management positions should constantly ask themselves: ‘Do I model the culture and behaviour that I hope to see in others?’ Workplace mental health is a good place for us to start.

Contributing Lives, Thriving Communities—Report of the National Review of Mental Health Programmes and Services can be downloaded at: www.mentalhealthcommission.gov.au.
Increased recognition of mental health conditions in the community has heightened the focus on the role community pharmacies play in helping patients manage these issues.

Research shows mental health issues will affect one in every five Australians, and are the third leading cause of disability burden in Australia, accounting for an estimated 27% of total years lost due to disability.

Approximately 14% of Australians will be affected by an anxiety disorder in any 12-month period and about 3% of Australians are affected by a psychotic illness, such as schizophrenia.

While community pharmacies help manage patients experiencing mental illness across the broad spectrum, depression is the most common presentation, affecting about one in five women and one in eight men at some stage during their lives.

Depression is a lot more than just being in a low mood. According to Beyondblue, a person may be depressed if, for example, for more than two weeks, they have felt sad, down or miserable most of the time, or have lost interest or pleasure in some of
A role for community pharmacists.

their usual everyday activities—to name but a few symptoms.
Depression is a serious illness and one that affects a person’s physical and mental health. But, importantly, in the vast majority of cases it can be treated and the first step is seeking help from a health professional.

As the most accessible health professionals, community pharmacists are a good place to begin when seeking initial assistance for depression. Some community pharmacists have undertaken special courses in mental health first aid.

Seeking help in this way is supported by Lifeline Research Foundation Executive Director Alan Woodward, who is also a board director for Suicide Prevention Australia and a member of the New South Wales Mental Health Commission’s Community Advisory Council.

Mr Woodward says pharmacists have a very important role in managing people’s health and wellbeing.

“They are a trusted point of contact and through this incidental contact they are well-placed to pick up something that someone has said which may indicate there is a problem”, he said.

‘They can then try to find out more about the situation or be a point of reference to another healthcare professional.

‘It’s one of those informal roles. Pharmacists may be seen as shopkeepers providing goods that you pay for, but that is really selling the role of pharmacy way short.”

Dr Luke Martin, Beyondblue’s Families Project Manager, said less than one-half of the people who have a mental health condition seek professional help.

‘Pharmacists have a role to play. Clearly pharmacists have a relationship with their patients, and they get to know them over time’, he said.

‘In addition, a pharmacy is a non-stigmatising environment where a pharmacist and patient can have a very important conversation, particularly in the context of talking about your health.

‘Pharmacists who have a good relationship with their patients are better able to notice over time any changes in patient behaviour, and recognise potential early signs or symptoms of depression, anxiety or other mental health disorders.’

With more than 80% of people in Australia using the same pharmacy regularly, the importance of the easy accessibility of community pharmacies for mental health patients cannot be over-stressed. Being able to walk in off the street and speak to a health professional who a person feels comfortable with, and who understands the issues and can provide assistance can be crucial.

“Research shows mental health issues will affect one in every five Australians, and are the third leading cause of disability burden in Australia, accounting for an estimated 27% of total years lost due to disability.”
Top mental health service award to Mental Health First Aid Australia

Not-for-profit organisation honoured for ‘extraordinary and world-leading influence’

Mental Health First Aid (MHFA) Australia has won the ‘TheMHS’ Medal for 2017. The medal is the top annual award in the Mental Health Service Awards of Australia and New Zealand program. It honours ‘a unique and inspiring contribution to mental health by an individual or organisation’.

The medal was presented by the Minister for Health, Greg Hunt MP, to MHFA co-founder Betty Kitchener AM, and CEO Nataly Bovopoulos, at the annual TheMHS Conference in Sydney.

MHFA Australia is a national not-for-profit charity providing evidence-based ‘mental health first aid’ training for communities and the workplace. The organisation was founded in 2000 by Betty Kitchener AM and her husband Professor Tony Jorm.

MHFA courses give participants the necessary knowledge and skills to provide a ‘first line of response’ to people either developing a mental health problem, experiencing a worsening problem or in a mental health crisis. ‘Mental health first aid’ is administered until professional help is provided or the problem is resolved.

MHFA offerings differ from other mental health training programs in that they focus on building skills rather than mental health awareness alone.

The aim is NOT to teach people how to be counsellors or mental health professionals. Like traditional first aiders, the training is about how to use skills to keep others safe in crisis situations until professional help arrives or the crisis resolves.

MHFA Australia courses are of two main types:
• Evidence-based courses that teach mental health first aid strategies to members of the public (communities and workplaces).
• Instructor Training Courses that train and accredit suitable individuals to deliver MHFA courses to communities and workplaces across Australia.

Over 500,000 Australians and more than 2 million people worldwide have been trained through MHFA. MHFA programs are licensed to organisations in 22 countries.

Recently, Clinical Documentation Improvement (CDI) has gained more visibility as a way for hospitals to deliver improved operational and financial outcomes. CDI is a process where clarity is sought from clinicians to ensure the documentation in the medical record reflects patient complexity and is written in a format that is fit for producing clinically coded data. This contributes to overall improvements in patient care and reimbursement.

Best-practice CDI programs aim to seek complete, accurate and specific clinical documentation in the medical record during the patient’s admission rather than after the fact. Successful CDI programs appoint a CDI Specialist (CDS) to ensure the documentation fully reflects the patient episode of care. This process enhances patient outcomes and in turn enables complete and accurate coding and the allocation of an appropriate diagnosis related group (DRG).

Quality CDS training therefore must be specific and closely aligned with the ever-changing ICD-10-AM/ACHI coding and AR-DRG grouping environment.

If not, there is no assurance that CDI efforts will actually result in delivering quality data for performance measurement and reimbursement.

The 3M™ DRG Assurance™ CDI training meets these requirements. Our multidisciplinary team of expert clinicians and HIM/coders has trained 36 CDSs representing 29 Australian hospitals.

Our training is fully aligned with Australian Coding Standards and AR-DRG grouper-specific content and has been modified for the clinical environment so that ‘clinical truth’ is ethically upheld in the quest for appropriate DRG changes.

3M™ DRG Assurance™ Trained Participants will:
- gain the skills to improve the quality of the documentation in the medical record to deliver quality patient care, facilitate the coding process and benefit the primary and secondary uses of the data
- receive detailed manuals containing clinical and coding content for the Major Diagnostic Categories (MDC), along with supporting reference material to help capture specificity and improve the documentation to produce more valuable hospital data for reporting and reimbursement
- understand the relationship between documentation, codes and diagnosis related groups (DRGs)
- understand the critical success factors for performing concurrent CDI reviews
- network with industry professionals.

The importance of aligning Clinical Documentation Improvement with clinical coding

The 3M™ DRG Assurance™ 4-day CDI Intensive Training Course is designed for CDI Specialists, HIM/Coders, Clinicians or Medical Officers who have been nominated to participate in CDI initiatives.

Course content & materials will be in ICD-10-AM/ACHI Tenth Edition, AR-DRG v8 (the AR-DRG version for the Private Hospital course will be made in consultation with the participants) and cover the following areas:

- Pre-MDC
- Circulatory System
- Digestive System
- Musculoskeletal System & Connective Tissue
- Respiratory System
- Male Reproductive System
- Female Reproductive System

3M™ DRG Assurance™ Trained Participants will:
- gain the skills to improve the quality of the documentation in the medical record to deliver quality patient care, facilitate the coding process and benefit the primary and secondary uses of the data
- receive detailed manuals containing clinical and coding content for the Major Diagnostic Categories (MDC), along with supporting reference material to help capture specificity and improve the documentation to produce more valuable hospital data for reporting and reimbursement
- understand the relationship between documentation, codes and diagnosis related groups (DRGs)
- understand the critical success factors for performing concurrent CDI reviews
- network with industry professionals.

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- Circulatory System
- Digestive System
- Musculoskeletal System & Connective Tissue
- Respiratory System
- Male Reproductive System
- Female Reproductive System

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BRIEFING

Where have all my friends gone?

Ageing well and targeting loneliness and isolation.

One of the biggest challenges facing the delivery of quality community aged care services is dealing with social isolation (lack of a relationships with others) and loneliness (feelings of lack, or loss of companionship) among older people.

Australian Census figures show that over one in three women and one in five men aged 65 or older live alone. Aged and Community Services Australia reviewed a wide body of research and found up to 10% of older Australians suffer from loneliness. People experiencing social isolation and loneliness are more likely to have poorer mental and physical health, and are at greater risk of dementia and mortality.

A high level of social participation and engagement has been found to contribute to lower levels of psychological distress, higher self-rated health, better physical function, and lower risk of future dependence for activities of daily living (ADLs) in community-dwelling older adults. Those at particular risk of isolation and loneliness include older people living with a disability, with low socioeconomic status, living in rural areas, or with low levels of literacy limiting their access to information and services.

While there are some research studies that demonstrate the existence of social isolation and loneliness in the community, systematic approaches to identifying older people in the community who may desire and benefit from greater social participation are rare. Targeting social participation and engagement presents opportunities to improve older adults’ quality of life (QoL) by keeping them connected to their community and the activities they enjoy. The burden on healthcare may also be reduced, as social participation helps to maintain the physical and psychological health of older adults and in turn can reduce their need to access healthcare services, such as support to complete ADLs or treatment for depression due to social isolation.

In an innovative new project, the Centre for Health Systems and Safety Research, Australian Institute of Health Innovation at Macquarie University, has partnered with Uniting to consider new ways for gaining insights into the social lives and experiences of their clients. The aim of this project is to support clients in gaining greater access to social participation activities which can enhance their lives and allow them to continue to engage with their communities.

The project involves discussions with clients about their social participation using a validated survey, the Australian Community Participation Questionnaire (ACPQ), as well as assessing their quality of life using and the ICEpop CAPability Measure for Older Adults (ICECAP-O), as part of regular community aged care assessments.

A pilot study among 289 clients and 12 case workers in Northern Sydney found the survey questions can help to initiate conversations between clients and their case workers about ways to enhance social participation. The project therefore seeks to measure how these conversations and assessment tools might drive greater uptake of social participation activities, and, as a consequence, improve individuals’ QoL by reducing social isolation and loneliness. The project has been funded through a Dementia and Aged Care Services Fund grant from the Commonwealth Department of Health.

From a client perspective, they will be helped to identify what brings purpose, meaning and value to their lives. They can then use appropriate services to increase social participation and reduce loneliness.

For care providers, case workers, and community care planners, the integration of the ACPQ and ICECAP-O into routine community aged care assessments provides valuable insights into essential aspects of their clients’ health that may not have been previously assessed. The tools allow staff to quantify changes in social participation and QoL over time. By linking client responses to these tools with Uniting service use data we will be able to examine associations between service use and client outcomes.

The project may also benefit the wider community through increased social participation and engagement bringing extra resources into the community. Using community services such as transport and companion support can help older people to develop and maintain connections with
“People experiencing social isolation and loneliness are more likely to have poorer mental and physical health, and are at greater risk of dementia and mortality.”

families and friends. Additional benefits include uptake and maintenance of membership of groups such as neighbourhood associations, and religious and service organisations.

In summary, the novel tools selected for this project can easily be incorporated into routine assessments, and have the potential to substantially improve QoL for older adults living in the community, as well as improving community aged care services provision, and benefiting the community as a whole. 

References

Authors top to bottom:

LINDSEY BRETT, Post Doc Research Fellow, Centre for Health Systems and Safety Research, Australian Institute of Health Innovation, Macquarie University

ANDREW GEORGIU, Professor, Centre for Health Systems and Safety Research, Australian Institute of Health Innovation, Macquarie University

MIKAELA JORGENSEN, Research Fellow, Centre for Health Systems and Safety Research, Australian Institute of Health Innovation, Macquarie University

JOYCE SIETTE, Research Fellow, Centre for Health Systems and Safety Research, Australian Institute of Health Innovation, Macquarie University

GRACE SCOTT, Research Assistant, Centre for Health Systems and Safety Research, Australian Institute of Health Innovation, Macquarie University

JOHANNA WESTBROOK, Professor, Centre for Health Systems and Safety Research, Australian Institute of Health Innovation, Macquarie University
Long-acting reversible contraceptive methods can reduce unintended pregnancies

Increased access needed in Australia.

A HHA has released a Consensus Statement on Reducing Unintended Pregnancy for Australian women through Increased Access to Long-Acting Reversible Contraceptive Methods. The statement reflects the views of consumers and leading health professionals and experts who attended an AHHA workshop on this topic earlier this year. (LARCs are progestogen-only implant and hormonal and copper intrauterine devices [IUDs]).

The uptake of LARCs is low in Australia—yet clinical and other experts, both in Australia and internationally, recommend them as the most effective reversible contraceptive, within the context of informed choice.

The release of the contraceptive pill in 1961 led to huge changes in women’s lives as they assumed control over their reproductive future.

The pill continues to be used widely—estimates for primary contraceptive method for Australian women are that 33% use oral contraceptives, 30% condoms, and 19% sterilisation.

Despite this, however, unintended pregnancy remains a significant health issue. Around 60% of Australian women who have had an unintended pregnancy were using contraception—most notably the pill (43%) and condoms (22%). The problem with the pill was usually a missed dose.

‘Although they will not suit everyone, LARCs are a more effective less user-dependent method of contraception’, AHHA Chief Executive Alison Verhoeven said.

There is international evidence that LARC methods are more cost effective (to the health system) than oral contraceptives and male condoms, as typically used—and this is not sensitive to modest changes in discontinuation rates, failure rates, duration and frequency of follow-up consultations, and/or ingredient costs.

Nevertheless, LARCs still have some way to go in terms of being used as a genuine contraception alternative in Australia. There are several barriers to best-practice contraceptive management for women in Australia, ranging from lack of knowledge and support systems among consumers and professionals to financial barriers. For example, one financial barrier is that Medicare and Practice Nurse Incentive
Programme payments are inadequate to cover the costs of insertion of LARC devices (in particular for IUDs); consequently there may be ‘gap’ fees to pay. The need for patients to contribute high fees upfront, relative to less effective forms of contraception, impacts on equitable access.

Services may also introduce models of practice that require a multiple number of patient consultations (e.g. three visits), which are not always evidence-based, to offset the overall costs of insertion provision. However, this also shifts costs to the patient (both financial and time).

Further, MBS items associated with insertion and removal of LARC devices are restricted to GPs, whereas trained registered nurses, midwives and nurse practitioners can also competently perform these procedures. While services provided by eligible nurse practitioners and eligible midwives (particularly those in private practice) are able to prescribe and can attract a Medicare benefit, the majority of nurses and midwives are not currently able to work to their full scope of practice, impacting the efficiency with which services can be offered and potentially the availability of these services, particularly in rural and remote locations.

Participants at the AHHA workshop felt that all levels of government across the health, social and education sectors, as well as consumers, health professionals, and professional colleges and associations, had roles and responsibilities in reducing unintended pregnancies.

As a first step, women in Australia should be supported in making informed choices about contraception. This can start from secondary school age onwards, through mechanisms such as education programs in schools and national clinical guidelines.

Changes to financing and models of care will also be needed, to ensure equitable access to LARCs. This includes MBS items for insertions and removals that adequately reflect the cost of providing the service, as well as taking into account the public health benefit.

Training programs for health professionals in implant and IUD insertion and removal should be made easily available. In particular, nurses, midwives and nurse practitioners can and should have increased involvement in LARC procedures.

Finally, there is a need to develop better national data sources on contraceptive use and pregnancy outcomes. This will help ensure that policy development and needs assessments are evidence-based.

The Consensus Statement is available on the AHHA website at www.ahha.asn.au/node/96.

The development of the consensus statement and associated communication was supported by funding from Merck Sharp & Dohme (MSD).
Few diseases are as isolating as dementia. Losing a sense of your life story and, finally, yourself, can make health, happiness and connection seem out of reach.

HESTA has invested $19 million through our Social Impact Investment Trust to finance Korongee, a cutting edge Australia-first village designed to maintain a sense of self, home and community for people living with dementia.

As the second leading cause of death in Australia today1, dementia is a growing public health challenge. Unless a medical breakthrough is made, by 2056 more than 1.1 million Australians, and those who care for them, are expected to face it.2

‘The demand for dementia care across Australia is outstripping the available supply of services and facilities’, HESTA CEO Debby Blakey says. ‘This investment will help provide a world-class facility for the local community and benefits our members by earning a return, while also piloting a model for investing in aged care that could attract other large investors to this space.’

Korongee is a partnership between HESTA, not-for-profit aged care provider Glenview, Social Ventures Australia (SVA) who manage our Social Impact Investment Trust, and the Commonwealth Government.

It’s the single biggest investment to date by the Trust, which is Australia’s largest social impact investment fund.

FEELING TRULY AT HOME
Taking its cues from the Netherlands’ successful De Hogeweyk village model, the village in Glenorchy, Tasmania will set 15 homes within a small town complete with streets, a supermarket, cinema, café, beauty salon and gardens.

Each household will match residents with similar interests and life experiences, so they can feel truly at home. That sense of continuity will flow through to the village’s design, based on a typical Tasmanian streetscape that allows residents to wander freely and safely with support from health professionals acting as ‘home makers’.

The project is the latest addition to HESTA’s impact investing program, which aims to deliver both a return for our members and a measurable positive impact in the community. The program invests in areas of urgent need such as social and affordable housing and now, person-centred aged care.

PARTNERS IN AGED CARE’S EVOLUTION
Ms Blakey says the HESTA investment in Korongee is a fantastic example of collaboration between HESTA and the health and community sector.

‘We heard about the great work Glenview was doing and, because HESTA has a specific focus on identifying investment opportunities in our sector, we were able to explore how we could support this fantastic project’, she confirms.

The collaboration has been welcomed warmly by Glenview CEO Lucy O’Flaherty, who shares our vision for healthier, happier ageing. ‘Korongee’s design will make it possible for residents living with dementia to walk around the village and participate in everyday life decisions, which are presently not available to those in dementia care’, Lucy explains.

‘It has been shown that residents at the De Hogeweyk dementia village live longer, eat better and take fewer medications, so we hope to see similar transformative health benefits at Korongee.’

References
1. Dementia Australia, 2017
2. Alzheimer’s South Australia, 2017

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Korongee services hub

Korongee aerial view
Introducing
Fruit in Jelly

NEW DESSERT RANGE

Easy open packaging
Portion controlled dessert with Australian fruit
2 delicious flavours for menu variety

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The Health Advocate

SPC ProVital is a registered trade mark of SPC Ardmona.

Easy open packaging
Portion controlled dessert
with Australian fruit
2 delicious flavours
for menu variety

Fruit in Jelly Range
NEW

For more information, contact your local food service distributor
spc.com.au

### Texture C Puree Range

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‘This sounds good’

THE EXPERIENCE
Thirty-four-year-old Ken Farmer has embraced the community, played local football and says he has seen things that most Australians will never see.

Ken was sent to Central Australia after registering with the Remote Area Health Corps (RAHC), which offers short-term paid placements to urban-based health professionals to support the permanent health workforce in remote Indigenous communities across the Northern Territory.

He had spent some of his childhood in New Guinea and his father worked in developing countries. Ken followed these footsteps and worked on an aid project in East Timor.

‘I sort of figured I didn’t know enough about my own back yard as I would like, and went up to Darwin for a bit of a change’, he said.

‘I worked in private practice for a year, got fed up with that, heard about RAHC and thought this sounds good.’

After completing his placement, Ken went to work for the Northern Territory Department of Health and began recruiting through RAHC himself.

‘It’s hard to convince people to come up and work in the Territory, especially people with good experience, energy, and a sense of humour and adventure’, he said.

‘I love this place so much. I’ve never been one to wear suits and ties. I have to wear shoes to work but I go barefoot around the streets and no-one cares or looks at you.

‘There’s no rushing, it’s free of the rat race.

‘You’ve only got to go 20 km in any direction and you’re in the wilderness. There are beautiful waterholes and great 4WD opportunities.’

THE WORK
Ken said the dental work was diverse and challenging.

‘Some of the health outcomes we come across are as bad as you see anywhere else in the world’, he said.

‘Most Australians have no idea what’s going on in this country.

‘It’s definitely enlightening. It gives perspective on things you might be complaining about and problems in your own life.

‘We can design the best dental programs that we want, but we’re losing the battle to the global soft drink giants every day of the week.

‘Things are slowly improving with what’s happening in shops and schools in communities. If we can change the diet
Victorian dentist Ken Farmer went to Alice Springs on a three-week placement and three years later he’s still there.

we’ve got a better chance of saving ourselves thousands of fillings and extractions.
‘Prevention is always better than treatment. ‘Smoking is a problem too and we see a lot of gum disease as a result.’
Ken believes the loss of traditional culture has contributed to poor oral hygiene.
‘I’ve come across a couple of old guys who had their first dental visit in their 60s and they’ve got perfect teeth and they’ve never brushed them in their lives’, he said.
‘These are the guys who still live off bush tucker and kangaroo, still hunt and know the old ways.
‘We can give out as many toothbrushes as we want, but in my opinion unless you change what you’re eating it won’t make any difference.’
Ken said the work was more satisfying than private practice.
‘I get to see trauma and cancer cases, medical cases. There are no resident specialists in Central Australia or Arnhem Land.
‘If you’re back in private practice you tend to be doing a lot of teeth whitening, check-ups and cleans; we get to do healthcare still, which is why I did dentistry, not to sell whitening products as a businessman.
‘It’s a lot more interesting to be involved with healthcare, and makes it easier to get up and go to work in the morning.’

THE OPPORTUNITIES
Ken said there’s plenty of work for people who want to make a difference. He said RAHC relieved the pressure on permanent dentists in Alice Springs and helped build relationships in remote communities.
‘RAHC is really fantastic, it increases the options and resources for the NT Department of Health’, he said.
‘There are some excellent dental nurses and therapists as well, who have been doing it for a long time. They’re incredibly gifted and passionate about what they do.
‘If someone is semi-retired they can do several stints in a year. It’s great if they go back to the same community and build relationships.’
Ken said potential recruits needed to be prepared for difficulties, harsh conditions and administrative tasks.
‘People have got to be flexible because things do go wrong’, he said.
‘You need to have a good sense of humour and be a people person, have a passion for adventure and a commitment to doing healthcare and helping people.
‘We’re not out there to make money or brag about the work we do.
‘People have to be aware they won’t be staying in a five-star resort in a remote Aboriginal community. There might be the odd spider or bug around.
‘You’ll have a mattress to sleep on and usually there’s air-con, but there are no coffee shops.’
Ken said the rewards included meeting some wonderful people and seeing special places.
‘Sometimes the community might allow access to a beautiful site that tourists don’t normally get to see’, he said.
‘I’ve seen some amazing places.
‘Working in a remote community is a chance to provide necessary healthcare and experience things you would never get to do anywhere else.’

The Remote Area Health Corps (RAHC) was established in 2008, and is funded by the Australian Government Department of Health under The Indigenous Australians’ Health Programme: Stronger Futures Northern Territory to ‘address persistent challenges to accessing primary healthcare services for Aboriginal and Torres Strait people in the Northern Territory’.
RAHC recruits, culturally orientates and deploys health professionals to enable the provision of increased primary healthcare services to assist in addressing the shortfall in health service delivery in remote Indigenous NT communities. RAHC’s focus is on recruiting urban-based health professionals.
YOU CAN SUPPORT INDIGENOUS HEALTH EQUALITY

We all deserve the chance to be healthy; and you can help make this happen.

Ten years into the campaign for Indigenous health equality, Aboriginal and Torres Strait Islander health outcomes are improving. The support of people like you is helping make that difference. But we still have a long way to go to close the gap entirely by 2030.

National Close the Gap Day is your opportunity to keep the pressure on government and ensure we achieve health equality within a generation.

Find out more and register your activity in support of health equality for all Australians.

oxfam.org.au/closethegapday
As Australia continues to navigate the implications of an ageing population, experts agree there needs to be a greater focus on the nutrition of older Australians.

As people get older, their lifestyle, appetite and activity levels change—and especially so if they are a patient in a hospital or a resident in an aged care facility. This can affect the types and amount of foods they eat. Therefore it’s so important that every meal occasion is treated as an opportunity to maximise nutrition.

Fibre is essential in maintaining healthy ageing. This often-undervalued dietary component allows for a functional digestive system while also contributing to other major body processes such as the stabilisation of glucose and cholesterol levels.

Although dietary fibre can often be found in cereals, fruits and vegetables, the unfortunate reality is that many older Australians are still not getting enough fibre in their diet.

“Individuals need 25-30g of fibre in their diet a day, and it’s concerning to see just how many people are not getting their recommended daily dose of fibre,” said Denise Burbidge, Accredited Practising Dietitian & Nutritionist, The Food Clinic.

“I see so many people who are struggling to eat their core foods—like fruits, vegetables and wholegrains. If people aren’t eating the right fibre rich foods, their body will experience a range of health complications.” Cheri Hugo, Director of My Nutritional Clinic and founder of The Lantern Project said food enjoyment, as well as nutritional status, also impacts the quality of life of older Australians.

“We know that food variety, adequate choice, ease of access to foods, portion size, independence as well as foods that engage the five senses affect mealtime enjoyment. These factors are also hard to achieve for people on texture modified diets,” said Ms Hugo.

With a commitment to healthy ageing, Australian food manufacturer SPC Ardmona has developed SPC ProVital to provide Australians with a range of nutritious and expertly formulated fruit-based products designed to address specific health requirements.

SPC ProVital Fibre Right Apple & Prune Puree offers a way for people to get essential amount of nutrients into their diet without compromising the taste of delicious food. It can be consumed as meal accompaniment or snack and is specifically formulated to provide a good source of fibre, with at least 5g in each serve.

SPC ProVital Fibre Right is also a ‘Texture C Puree’ which means it has been developed and rigorously tested to meet the strict guidelines of ‘Australian Standardised Terminology and Definitions for Modified Texture Foods and Fluids’ to deliver a product suitable for people on Texture C diets. Their easy-open portion controlled packaging also allows easy accessibility for those with mobility issues such as arthritis.

Dijana Dragicevich, Senior Speech Pathologist at the Royal North Shore Hospital said, “It’s so important that modifications to textures and flavours are made to products, especially for those with eating, speaking and mobility issues like dysphagia.”

A recent study of 400 patients conducted at Royal North Shore Hospital in Sydney revealed 7 out of 10 patients stated that the SPC ProVital fibre right fruit range taste and texture was either very good or excellent.

SPC believes that positive nutritional food choices support the health and longevity of all Australians. As the next evolution of the easy-open portion control fruit range, SPC ProVital Fibre Right makes it simple and delicious for people to meet their daily fibre intake. SPC ProVital is determined to give Australia’s ageing population choice, taste and nutrition every day, every meal occasion.

Key features of SPC’s ProVital Fibre Right range include:

- Delicious apple & prune smooth fruit puree
- Suitable for Texture C Diets
- Available in portion control 120g cup and bulk 2.95kg can
- Easy-open portion control packaging
- Made in Australia
- At least 5g of fibre per serve


Developed by Health Haus

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“Fibre Right” is a trademark of SPC Ardmona.
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).

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

Ms Jill Davidson
CEO SHine South Australia

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: aah.aasn.au/governance

Secretariat
Ms Alison Verhoeven
Chief Executive

Mr Murray Mansell
Chief Operating Officer

Dr Linc Thurecht
Research Director, Acting Deeble Institute Director

Mr Krister Partel
Advocacy Director

Ms Lisa Robey
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Ms Freda Lu
Assistant Accountant

Ms Suhil Sudhakar
Administration 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)

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Contact details
AHHA Office
Unit 8, 2 Phipps Close
Deakin ACT 2600

Postal address
PO Box 78
Deakin West ACT 2600

Membership enquiries
T: 02 6162 0780
F: 02 6162 0779
E: admin@ahha.asn.au
W: www.ahha.asn.au

Editorial enquiries
Nigel Harding
T: 02 6180 2808
E: nharding@ahha.asn.au

Advertising enquiries
Lisa Robey
T: 02 6180 2802
E: lrobey@ahha.asn.au

General media enquiries
E: communications@ahha.asn.au

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FROM THE AHHA DESK
We know that for many Australian adults, consuming the recommended 25-30g Fibre per day can be a challenge. Fibre is essential for gut function, promotes stable blood sugar levels and is related to a reduced risk of certain chronic diseases. It is especially important for older Australians; as the digestive system slows down with age.

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For more information or samples, please contact Jelica Vrkic at Jelica.Vrkic@spc.com.au


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