2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name
Reclink Australia

Name
Mr Jason Harris

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"Reclink Australia strongly suggests the revisiting of recommendations from the attached 2010 Victorian Government's Ministerial Advisory Committee on Mental Health report, 'Improving the physical health of people with severe mental illness'. We draw the Commission's attention in particular to the subtitle for this report - 'No mental health without physical health', which underpins the benefits of Reclink Australia's structured programs for people experiencing mental illness. Participants in these programs in particular note a significantly reduced experience of stigma and discrimination, due to working with others - often with similar mental health issues - in team environments that feature high levels of encouragement in a positive setting."

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
"Reclink Australia notes the Victorian Government's willingness to work in partnership with organisations like Reclink. Our structured programs are proven to have preventative and alleviating effects on mental health issues, with respondents in a recent study by La Trobe University noting less need to access mental health services, among other positive outcomes. A copy of this report is attached for the Commission's reference. The 2010 Ministerial Advisory Committee's on Mental Health's report also specifically recommends (p.25) that service models like Reclink Australia's be expanded to people with severe mental illness."

What is already working well and what can be done better to prevent suicide?
"Reclink Australia is a firm believer in social prescribing to assist with suicide prevention, and notes the shift to this method in countries like the United Kingdom and Canada. Reclink's programs are specifically designed to alleviate forms of disadvantage that includes key suicide risk factors, such as social isolation and depression, and recommends the Victorian Government consider increased levels of engagement with our service model."

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
"Lack of cohesive services and linking these with each other is a big factor. Reclink Australia works in partnership with over a hundred agencies in Victoria alone to make connections and maximise/activate resources across support services, which might otherwise go unused. Our structured programs serve as a soft entry point to people finding out about and accessing further treatment where needed, and this has been a feature of Reclink's work since inception almost thirty years ago. "

What are the drivers behind some communities in Victoria experiencing poorer mental

health outcomes and what needs to be done to address this?
"Multiple factors such as job insecurity, social isolation, family and intimate partner/domestic violence, drug and alcohol abuse, and social discrimination can all be significant factors in poorer mental health outcomes. Reclink Australia believes that revisiting the recommendations from Victorian Government's 2010 Ministerial Advisory Committee on Mental Health report, 'Improving the physical health of people with severe mental illness', will have a positive effect on this cohort of Victorians."

What are the needs of family members and carers and what can be done better to support them?
"Reclink Australia operates AAA Play in partnership with the Victorian Government; a valuable service for family members and carers for Victorians with disability who wish to engage in sport and recreation. The service provides an easy, ""one stop shop"" for these people to locate opportunities for their family member or client via a dedicated website and telephone line. The concurrent mental health benefits for participants is noted, and Reclink Australia hopes to continue and grow this partnership with the Victorian Government."

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
"Fair pay, along with ongoing training and support for these workers."

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
"The Reclink Australia model provides excellent opportunities for Victorians living with mental illness to participate in social activity, with the attached studies from La Trobe University showing both the positive effects of our structured programs on mental health outcomes, along with a significant social return on investment from these - last evaluated at around $8.94 for every $1 of investment. We encourage further investment and engagement from the Victorian Government to maximise the availability of these programs for Victorians living with mental illness."

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
"Increased access to service must be the priority, and funding organisations which produce sound, demonstrable results in this area."

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
"Investment in structured programs with proven results, with funding guaranteed for appropriate periods of time to ensure organisations are not left wondering whether their service delivery to Victorians experiencing mental illness will be affected."

Is there anything else you would like to share with the Royal Commission?
Please examine the attached reports closely; we believe our structured programs results speak for themselves and will only improve with further investment.

Centre for Sport and Social Impact

LA TROBE UNIVERSITY

The social value of a Reclink Australia structured sport program –

'Reclink Australia Victorian Football League'

reclink australia

Final report

Acknowledgements

We wish to thank the participants and stakeholders from the Reclink Australia Victorian Football League teams who were involved in this study. Their generosity in sharing their experiences and opinions was very much appreciated and extremely valuable in completing this research. We would particularly like to acknowledge and thank Reclink Australia representatives, Peter Cullen (OAM) (Founder & National Development), John Ballis (Chief Executive Officer) and Chris Lacey (State Manager—Victoria) for their guidance throughout the study. Their constructive feedback and involvement enhanced both the research process and its outcomes.

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February 2017

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THE SALVATION ARMY

1. Introduction

Reclink Australia's mission is to provide sporting, social and arts activities to enhance the lives of people experiencing disadvantage. Targeting some of the community's most vulnerable and isolated people—those who experience mental illness, disability, homelessness, substance abuse issues, addictions, and social and economic hardship—Reclink Australia has facilitated cooperative partnerships with a network of over 200 member agencies that are also committed to encouraging participation in sport, recreation and arts programs by a population group under-represented. Through a range of structured and informal programs and activities, Reclink Australia promotes and delivers the health, social and economic benefits of physical activity to an otherwise largely inactive population group.

Participation in sport has often been linked to improved health and well-being. However, it is not clear what the outcomes of participation are for specific population cohorts, such as people experiencing disadvantage. Anecdotal information collected by Reclink Australia indicates that participation in Reclink Australia programs has a range of benefits for participants. However, it is unclear what the exact nature of the benefits is across the population of Reclink Australia participants.

In 2016, Reclink Australia commissioned the Centre for Sport and Social Impact (CSSI) at La Trobe University to determine the social value of the Reclink Australia Victorian Football League. The aim of the project was to identify the ways in which the Reclink Australia Victorian Football League contributes to the physical, mental and social health of people experiencing disadvantage. A secondary aim was to identify the benefits of the Reclink Australia Victorian Football League to participating agencies and volunteers. This report presents: an outline of the methodology used; a description of the Reclink Australia Victorian Football League; the themes identified in the data relating to the resources, activities, benefits and outcomes of the Reclink Australia Victorian Football League; the challenges and opportunities identified from the study; and finally a calculation of the social return on investment (SROI) for the Reclink Australia Victorian Football League.

2. Social Return on Investment methodology

An SROI methodology (Cupitt, Sally, ed. A Guide to Social Return on Investment. Cabinet Office, Office of the Third Sector, 2009) was used to identify the resources, activities, outputs, benefits and social value of the Reclink Australia Victorian Football League. The four phases of this process are listed below.

Phase one: Establishing scope and identifying stakeholders

The first phase was to identify the scope of the research. This was negotiated with the Chief Executive Officer of Reclink Australia and further refined in response to challenges experienced during the data collection process. The initial scope of this research was to include people who had participated in the Reclink Australia Victorian Football League during the 2015 season. However, the difficulty in recruiting past participants (i.e. those no longer actively involved with a football team) led to the scope of the project being adjusted to those participants directly involved in activities of the 13 Reclink Australia Victorian Football teams during the 2016 season.

Internal and external stakeholders for each of the 13 teams were initially identified by Reclink Australia. Additional internal and external stakeholders for each team, and the Reclink Australia Victorian Football League overall, were identified through interviews with agency representatives from each participating team.

All stakeholders identified by Reclink Australia were contacted via email or telephone in August 2016 and invited to participate in the study. In total, twenty-six stakeholders participated in an interview between August and November 2016. Of the 13 Reclink teams (the Collingwood Knights fielded two teams in the Reclink Australia Victorian Football League in 2016), one was represented by three interviewees, five were represented by two interviewees, five were represented by one interviewee and one team was not represented. In-depth semi-structured interviews were then conducted with participating stakeholders to elicit data pertaining to the:

- Resources required to sustain the team;
- Football, social and community activities of the team; and
- Individual participant and agency benefits generated by being involved with the team;

Twenty-three interviews were conducted over the telephone and three were conducted face-to-face.

Table 1 lists the categories of stakeholders interviewed and the number of interviewees in each category.

Table 1

Stakeholders	
Lead agency representatives	8
Supporting agency representatives	6
Volunteers	8
Reclink Australia representatives	2
Community club representatives	2
Total	**26**

Note: Interviewees may have crossed over several categories. For example, team representatives were also support agency representatives or Reclink Australia representatives, and therefore were able to provide multiple perspectives on the Reclink Football program. Table 1 represents each individual's current primary role in relation to the Reclink football team they were associated with.

In addition to 26 interviews with stakeholders in the Reclink Australia Victorian Football League, telephone interviews were conducted with 30 participants from 11 of the 13 teams in the Reclink Australia Victorian Football League. This cohort of active players was recruited primarily from players who attended the 2016 Peter Cullen Medal lunch in September 2016 and agreed to be interviewed about their experience of participating in the Reclink Australia Victorian Football League. Twenty-nine of the 30 participant interviewees had been active Reclink football players in 2016 while one was a sports-trainer for a team. Six players reported having dual roles with their respective teams in 2016 including as umpire, coach, vice president, water runner and spectator. Twenty-five interviewees were male and five were female, while the interviewees ranged in age from 18 to 66 years with most being in the 18–30 (16 interviewees) and 31–40 (8 interviewees) age ranges.

Phase two: Map outcomes

Phase two consisted of identifying the resources, activities and outcomes of the Reclink Australia Victorian Football League within the research scope period. This was done by analysing the interview data and additional information provided by Reclink Australia and the lead agency representatives for some teams, then developing an initial map or logic model (Table 1). This logic model was the crucial step to establishing that the outcomes identified during the interviews can be logically attributed to the activities of the Reclink Australia Victorian Football League teams, and not the result of some other source or activity. Upon completion of this map, the SROI analysis commenced.

Phase three: Calculating the SROI

The SROI calculation table was built through three stages (this appears in a commercial in confidence document, available by negotiation with Reclink Australia – reference to the 'columns' in this document are made below).

Stage 1: Stakeholders: All stakeholders of the Reclink Australia Victorian Football League identified are listed in the first column.

Stage 2: Input Map: The next two columns of the SROI table list the type and value of all inputs or resources that each stakeholder/s contributed to the activities of the Reclink Australia Victorian Football League. The total value of this column is used as the final "input" value in the SROI calculation.

Stage 3: Outcome values: Stage 3 of the table contains six columns. The first column describes the outcomes attributed to the teams' activities; the second column lists an "indicator of change" for each outcome, which is the actual change that has occurred. The third column provides the evidence that supports the assumption that the outcome listed can be satisfactorily attributed to the Reclink Australia Victorian Football League teams' activities. For example, an outcome of the teams' activity was that participants had improved mental health, which is clearly evidenced by the presence of the mental health agencies and the support available to players through the football teams, and the multiple positive mental health outcomes reported by football participants, non-participating members of the teams, and of lead and supporting agency representatives involved with teams. The indicator of change is the estimated number of team members per team with improved mental wellbeing due to their involvement in the activities of a Reclink Australia Victorian Football League team.

The next three columns explicitly state the "quantity or extent of change", the actual impact that the team activities have had on the football participants, the "financial proxy used" as the value for that impact, and the "total value" attributed to that outcome.

The total value of the outcomes in the SROI analysis table are then divided by the total inputs, to calculate the SROI ratio.

Phase four: Reporting the findings

The reporting of findings is an important phase in ensuring the SROI calculation and the associated research is communicated effectively. In this case particularly, communicating to stakeholders and the wider community the types of benefits the Reclink Australia Victorian Football League provides is potentially more valuable than focusing on the SROI ratio. The CSSI team therefore encourages Reclink Australia to present this information back to stakeholders in the Reclink Australia Victorian Football League and to the wider community in 2017.

3. Key findings

The Reclink Football League targets a population in the community who are less likely to join a 'typical' community sporting club. They are the sub-populations in the community who are experiencing hardship, such as homelessness, unemployment, physical or mental health issues, drug or alcohol addiction or in prison, and in this way the Reclink Australia Victorian Football League is able to deliver social value to people in the community who may not otherwise be able to reach the benefits of sport and recreation through traditional activities. Peter Cullen describes the league as a 'social league dealing with social issues'.

By focusing on disadvantaged and vulnerable people within the community, the Reclink Australia Victorian Football League is not just about playing footy, but a support mechanism and pathway that connects them to the community, support services and other networks as they continue their journey to life improvement. A participant's journey with Reclink toward a more positive and healthy lifestyle can be long, indirect and go through several stages of development and transition. These can be illustrated as an upward spiral which begins at the point they connect with someone who can facilitate their engagement with the Reclink Australia Victorian Football League and leads to the point at which they reach independence and can become a supporter for other participants as illustrated in Figure 1.

The key findings from this report are:

1. The Reclink Australia hub and spoke model provides a unique way to develop multi-agency collaborative partnerships and activate latent community resources and infrastructure (such as ovals, buses, second hand football equipment) to achieve positive outcomes for disadvantaged and disengaged individuals, community service agencies and the broader community;
2. The most important 'value add' of the Reclink Australia Victorian Football League is that it provides community service agencies with an avenue to work collaboratively, in order to reach and engage with disadvantaged members of the community with an interest in Australian football. This is particularly valuable for agencies with a remit or mandate to work with hard to reach individuals and sub populations;
3. The Reclink Australia Victorian Football League provides a unique opportunity for individuals who are already engaged in support, treatment or programs to improve their recovery and life circumstances. For participants who are not already engaged with formal support services, the Reclink Australia Victorian Football League provides a pathway to access treatment and/or support services;
4. The nature of Australian football as an activity (a team game, a contact sport, part of the Victorian culture), means that it has the potential to attract a hard to reach population who can receive a range of benefits that would perhaps not be available through other sport or physical activity-based programs;
5. The Reclink Australia Victorian Football League provides ongoing, flexible levels of support for disadvantaged, disengaged and disconnected participants (Figure 1);
6. Our calculation, based on the social value received by the participants and the wider Victorian community, is a $1 input for a $8.94 social return.

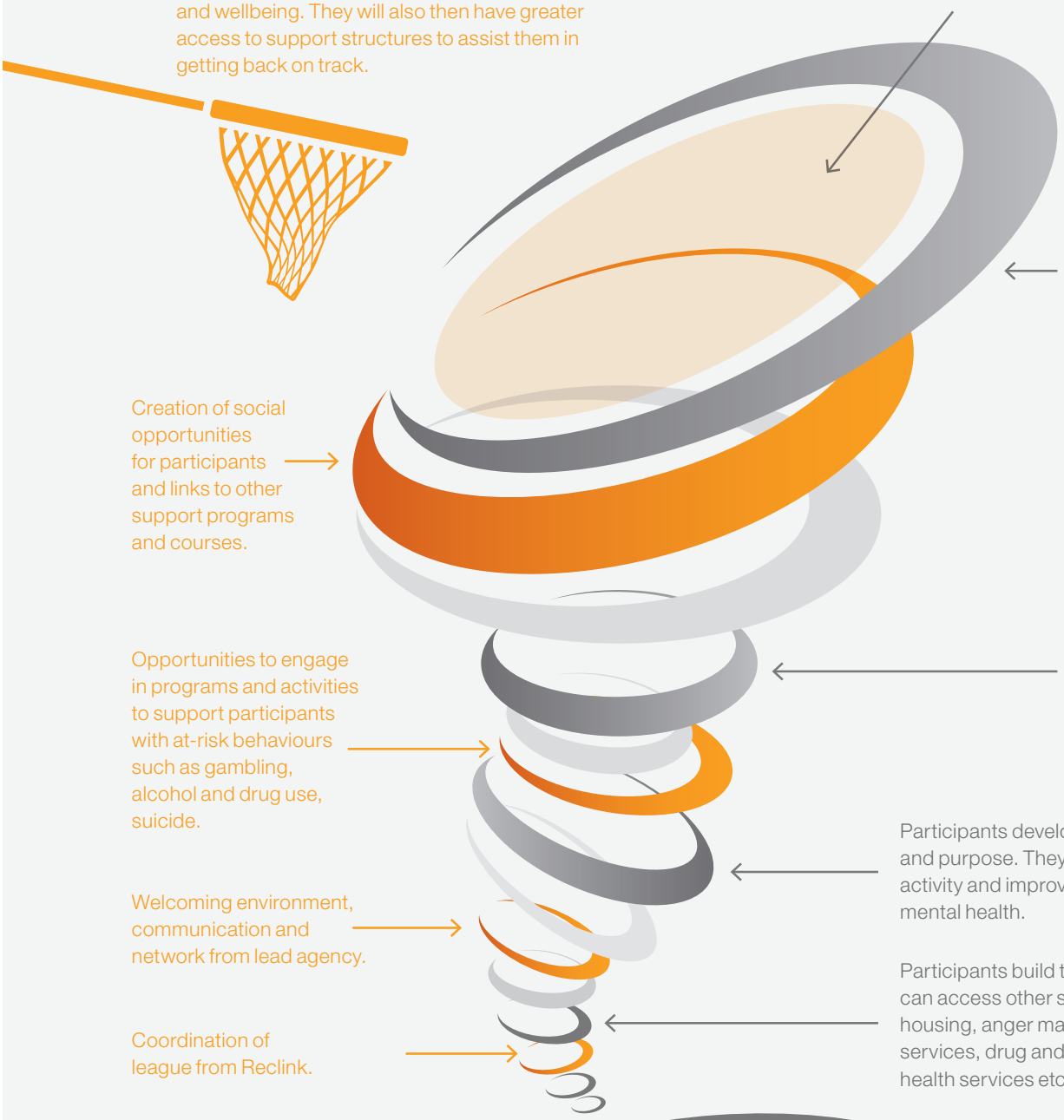
Figure 1: Pathway to life improvement

Agency inputs

One of the crucial outcomes from the Reclink Football League is that participants within a club environment are more likely to have a support network, which can **'catch'** them if they begin to fall backward in their path to health and wellbeing. They will also then have greater access to support structures to assist them in getting back on track.

Participant inputs

Participants remain in the Reclink League and are able to support and mentor other participants. Those participants who participate while incarcerated or in drug treatment programs are able to better transition to community and continue playing in other teams.



Participants have access to job opportunities and receive support to enter the workforce such as references access other vocational courses. References can be used to secure other needs such as housing and court appearances.

Creation of social opportunities for participants and links to other support programs and courses.

Participants build interpersonal skills, confidence, leadership skills, and vocational skills such as reliability, time management and teamwork.

Opportunities to engage in programs and activities to support participants with at-risk behaviours such as gambling, alcohol and drug use, suicide.

Participants develop a sense of belonging and purpose. They engage in physical activity and improve their physical and mental health.

Welcoming environment, communication and network from lead agency.

Participants build trust with agencies and can access other support programs for housing, anger management, mental health services, drug and alcohol treatment, health services etc.

Coordination of league from Reclink.

Participants can enter the league as an introduction to support and social programs available, or while they are engaged with support or services (such as prison or drug and alcohol).

4. Reclink Australia and the Reclink Australia Victorian Football League

Reclink Australia is well placed to engage some of the most isolated and disadvantaged people in our community. By bringing many parts of the community together to create participation opportunities and pool collective resources to deliver an activity, Reclink Australia has the potential to break the downward spiral of self-destructive behaviours by including the participants who are currently excluded and disengaged from their community.

The Reclink Australia Victorian Football League

The genesis of the Reclink Australia Victorian Football League was Peter Cullen's street outreach work in St Kilda in the late 1980s. He recognised the need to respond to people living destructive lives in a way that assisted these people to have purpose and structure in their daily activities. What started as an irregular, unstructured 'kick-to-kick' session and social games of Australian football organised by Peter in 1989, quickly grew to four teams playing in an organised football competition in 1991. Through the 1990s the Reclink Australia 'hub and spoke network' model, facilitating cooperative partnerships with local partners to deliver programs specifically targeted at the needs of local communities, was promoted across Australia.

The Reclink model, as it applies to the Reclink Australia Victorian Football League, is based on facilitating partnerships between multiple community services providers in a bid to unlock the potential for each organisation to collaborate and combine efforts. Football is used as a vehicle to create pathways for those most disadvantaged to be re-engaged into their local communities.

In 2003, Reclink Australia partnered with the Victorian Government, employed its first staff member and recruited South Yarra Football Club as the first community football club to accept Reclink Australia participants. In 2004, 10 teams competed in the Reclink Australia Victorian Football League.

In 2016, the year in which this study was conducted, the Reclink Australia Victorian Football League had grown to 13 teams competing in 60 games of football over an 18-week season. This culminated in participants and supporters celebrating 25 years of community football at the Reclink Grand Final at Peanut Farm, St Kilda on September 7th and 8th, 2016.

The Reclink football teams

The 13 teams participating in the Reclink Australia Victorian Football League in 2016 and therefore included in the scope of this study were the:

- Bendigo Victory
- Collingwood Knights A
- Collingwood Knights B
- Kardinia Cats
- Malmsbury Tigers
- Casey Cobras
- Sacred Heart Mission
- Salvo Hawks
- Southern Peninsula Swans
- Cohealth Kangaroos
- Wynbay Bulldogs
- Frankston Dolphins
- Sunbury Phoenix

Eleven of these teams had a designated 'lead agency' responsible for managing and organising the team. Each lead agency generally appointed a staff member to manage the day-to-day operations of the team. Additional staff members from each lead agency frequently

assisted by performing a range of duties—including on-field playing mentors, client management and support, food preparation, bus driving—on match days and at practice/training sessions. The day-to-day management and operation of Sunbury Phoenix and the Frankston Dolphin teams were coordinated by 'coaches' with considerable experience within the Reclink Australia Victorian Football League, appointed and funded directly by Reclink Australia.

Most teams were supported to varying degrees by various other 'supporting agencies' that provided staff to assist with range of duties on match days and at practice/training sessions. Teams were also generally supported at games and training by numerous community volunteers, including non-playing vulnerable and isolated people.

Every team was open to participants from all sectors of the community including males, females and people with a disability. However, some teams were established to meet the needs of specific 'sub-populations' within their communities including: unemployed youth; people tackling alcohol and other drug issues; people experiencing homelessness or mental illness; and youth engaged with the criminal justice system.

Although different for each team, the typical 2016 season for a Reclink Australia Victorian Football League football team involved:

- Some form of pre-season training, incorporating physical preparation and team building activities, beginning in March;
- Round 1 of the Reclink Football League on Wednesday April 6;
- Football training every second Wednesday (for approximately 90 mins) between March and September;
- A game of football every second Wednesday between April and August, with total of 9 games alternating between 'home' and 'away' games. Each team had one 'bye' round in which they did not have a game;
- Participating in a Grand Final at the Peanut Farm, St Kilda on September 7 or 8;
- A team presentation event to wrap up the season in September 2016; and
- Several members of the team attending the Peter Cullen Medal count to recognise the league's best and fairest player, at the Mooney Valley Legends Bistro on September 20.

Scope of this research

This report provides a snapshot of the activities of the 13 Reclink Australia Victorian Football League teams and the social value they have delivered during the 2016 football season. Activities included in the research were limited to those that the teams reported they were directly involved with. The social impact of the activities of the teams are considered primarily from the perspective of their direct impact on the participants (both playing and non-playing) in the football team. The impact on the agency representatives and individual volunteers involved in running the team, the impact on the agencies supporting the team, and the impact on the wider community is also considered.

Through the research, the core components of a football team that participates in the Reclink Australia Victorian Football League were identified. Although each Reclink football team is unique and has its own variation of each component, the reported outcomes are based on a general 'average' for a typical team. For example, all teams reported providing food and beverages at the end of all home games for members of both participating teams. For some teams, this was done by a voluntary supporting agency (e.g. Rotary or Lions Clubs) supplying a barbeque as well as providing and cooking all the food (sausage, bread, onions, condiments etc.) and drinks. Other teams relied on the catering arm of their lead agency to purchase and prepare the food and drinks, or accessed food from food rescue and redistribution agencies (e.g. FareShare and Foodbank Victoria).

5. Resources

Resources for the football program provided by Reclink Australia

Reclink Australia, primarily through their Victorian State Manager and the Founder & National Development Manager, are the central body responsible for coordinating and administering the Reclink Australia Victorian Football League. Reclink Australia allocates an annual budget for the Reclink Australia Victorian Football League. This is made up of direct funding provided by the Victorian State Government, funds raised through activities conducted by Reclink Australia (e.g. Charity games etc.), and donations from individuals and organisations. In 2016, the Reclink Australia budget for the Reclink Australia Victorian Football League, was $63,227.00.

Resources from team Lead Agencies

Through the application of its unique hub and spoke model of collaborative partnerships with service providers and key stakeholders, Reclink Australia has used football as a vehicle to draw together numerous agencies and individuals focused on supporting and engaging with people experiencing disadvantage in the community. As a result, 11 of the 13 Reclink Australia Victorian Football League teams have a designated lead agency with major responsibility for organising and managing the team. These agencies included not-for-profit charitable social welfare organisations (e.g. the Salvation Army, St Lawrence and Sacred Heart Mission), community health organisations (e.g. Ermha Ltd, CoHealth and Mental Illness Fellowship Australia), a youth homelessness support agency (Latitude Directions for Young People), the Victorian Police, and Parkville College/ Malmsbury Youth Justice Centre. The other two teams in the Reclink Australia Victorian Football League were managed by individuals who were appointed and funded directly by Reclink Australia.

DIRECT FUNDING FOR FOOTBALL TEAMS

Several lead agency representatives reported that their organisation directly funded the activities of the Reclink football team that they were involved in. For example, agency representatives for two teams indicated that a budget of approximately $8,000 (excluding any staff salaries) was required each year to cover the full cost of running a team in the Reclink Australia Victorian Football League. Another agency representative reported that they had calculated a cost of $650 per participant per season when applying for funding for the football team they support.

HUMAN RESOURCES

As a generalisation, each lead agency had a dedicated person who was responsible for managing the football team. This person usually spent about one day per week (8–10 hours) for approximately 6 months, managing the team.

In addition to the lead agency staff member who coordinated the team, four to eight agency (either lead agency or supporting agency) staff were usually involved in supporting each team every game-day. This was reported to be for approximately four hours including pre-game preparation, game time and post-game activities, but varied according to whether the game was played at 'home' or 'away'. Two to four agency staff usually attended training for about two hours per training session.

Each team also reported having the support of a varying number (between four and eleven) of volunteers to help manage the team and perform football-specific tasks each week. Volunteers were identified as contributing four to six hours each per week in roles including coaching, team management, on and off field mentoring, goal and boundary umpiring, bus driving, and food preparation.

OPERATIONAL AND ADMINISTRATIVE RESOURCES AND INFRASTRUCTURE

Lead and support agency representatives reported that any operational and administrative resources and infrastructure required to effectively manage the football team (cars, computers, office space and equipment, telephones etc) were provided by their agency as a matter of course. No agency representatives reported that managing the football team required any additional operational and administrative resources or infrastructure above and beyond what is usually provided by their agency to someone in their position.

FOOTBALL EQUIPMENT

Every team reported that they provided every participant with a full set of playing equipment—including playing jumper, shorts, socks and boots—at no cost to individual participants. In addition, teams also provided all the other equipment necessary for football matches and training (footballs, training cones, first aid equipment, water bottles, coaching whiteboards, etc.). Teams obtained these resources either directly from Reclink Australia, as donations from a supporting agency (e.g. AFL or VFL club) or purchased them directly. Every team also had access to either a storage facility at the club room that they used, or a trailer that they used to both store and transport the football equipment.

FACILITIES

All teams used football grounds and facilities (changes rooms, toilets, etc.) provided free of charge by a local council. Games and training were held mid-week so these facilities were not used by other sporting groups at the time that the Reclink Australia Victorian Football League teams used them. The grounds varied in standard and quality from very high standard facilities used by VFL clubs (e.g. Victoria Park used by Collingwood Knights and the Collingwood VFL team) to suburban football ovals used by community football clubs on weekends (e.g. Victoria Road Oval in Hawthorn used by the Salvo Hawks). These grounds were maintained by council and there was generally no additional work or maintenance provided for Reclink Australia Victorian Football League games or training. The Reclink teams often have a relationship with the local community football club that also used the ground; this enabled the Reclink teams to use equipment that belonged to the community football club such as goal post padding and coach benches. Again, these resources were not otherwise being used mid-week.

TRANSPORT

All Reclink teams accessed some form of transport, usually a bus, to transport players to away games once every four weeks (i.e. 5 or 6 times a season). This was usually done through one of three different arrangements:

1. used a bus that belonged to one of the agencies supporting the team;
2. hired a bus from a commercial bus hire company, usually at discount rates;
3. used a private vehicle.

FOOD AND BEVERAGES

All teams provided food and drinks for members of their own team, visiting teams, game officials (umpires), volunteers and spectators at each home game (5 or 6 times a season). This usually involved a barbeque with the associated consumables (sausages, onions, bread, fruit, condiments). This was a very tangible and practical example of the Reclink Australia model in action, as all teams reported that these resources were either donated by a partner agency (e.g. Rotary and Lions), obtained from a local not-for profit organisation (e.g. FareShare and Foodbank Victoria) or supplied by the lead agency.

In addition to providing food and drinks, all Reclink teams had access to equipment to store and prepare food and beverages (i.e. BBQs, cooking implements and gas, fridges, kitchens at venues). This was usually provided at no cost by one of the supporting agencies (e.g. Rotary Club) or the kitchen facilities at the venue were used (e.g. Malmsbury and Victoria Park).

OTHER SUPPORT

In addition to a lead agency, most Reclink Australia Victorian Football League teams had several other agencies that supported and assisted them in a variety of ways to run the team. This included staff to manage, support and provide services to participants or to act as playing and non-playing mentors. Supporting agency staff also performed various tasks on game days and at training—umpiring, providing first aid, driving buses, preparing and cooking food etc.—to ensure the smooth operation of the team. Examples of support provided to individual teams by supporting agencies reported during the interviews conducted for this project included:

- Organisations such as Kangan Institute, Holmesglen TAFE and SEDA provided people who were undertaking sports-related courses and required a certain number of hours of practical experience to fulfil their course requirements;
- Victoria Police provided police officers to drive buses and supervise teams using police buses;
- AFL Victoria provided coach training courses and development days for Reclink Australia Victorian Football League coaches and participants. An AFL Victoria trainee also acted as team manager/coach for one team;
- AFL and VFL clubs provided resources to Reclink Australia for distribution to individual teams (this included boots, jumpers and auction items for fundraising);
- AFL and VFL clubs supported individual teams with football equipment and jumpers, use of facilities, personnel to attend training and talk to players, and community development officers to work with the teams;
- Past and current AFL players and media personalities volunteered their time to attend and participate in Reclink Australia (e.g. attend Grand Final Day) and individual team activities (e.g. run training sessions for teams);
- Local football clubs supported Reclink Australia Victorian Football League teams by allowing them to use their facilities (club rooms and change rooms) and equipment (coaching benches, goal post padding, etc.), encouraging their players to attend or lead Reclink team training, and supporting Reclink players to play within local football club teams; and
- Corporate organisations provided volunteers for Reclink Australia organised events (e.g. Reclink Grand Final) and sponsored individual teams.

6. Activities

The following section lists and describes the activities undertaken by Reclink Australia and the 13 individual Reclink Australia Victorian Football League teams during the 2016 season.

Reclink Australia activity

As identified earlier in this report, Reclink Australia, primarily through their Victorian State Manager and the Founder & National Development Manager, coordinate and administer the Reclink Australia Victorian Football League. The activities undertaken by Reclink Australia to facilitate the operation of the 2016 Reclink Australia Victorian Football League season included:

- Directly employing an administrator/coach for each of two Reclink football teams—the Sunbury Phoenix and the Frankston Dolphins;
- Organising and conducting one pre-season and one post-season meeting of representatives of all Reclink Australia Victorian Football League teams;
- Coordinating and covering the costs associated with two field umpires officiating in 60 Reclink Australia Victorian Football League football games;
- Developing and administering the fixture for 10 rounds of 6 football games per round between April and August;
- Organising and running three Development days, incorporating sessions on addiction issues and anger management and violence, each with approximately 40 participants;
- Coordinating the Reclink Grand Final (a two-day event in which 12 of the 13 teams participate in 6 games);
- Coordinating (collecting votes and organising the presentation event) the Peter Cullen Medal for the Reclink Australia Victorian Football League best and fairest award, attended by 150 people;
- Organising and running a Level one coach training course for 20 participants;
- Generating media publicity for the Reclink Australia Victorian Football League and supporting individual teams to generate local media publicity—6 local newspaper articles and one Herald Sun newspaper article in 2016;
- Providing managerial and administrative support for the Reclink Australia Victorian Football League (e.g. dispute resolution, tribunal, etc.);
- Providing policies and guidelines on issues including player registration, codes of conduct etc.; and
- Providing public liability insurance for the Reclink Australia Victorian Football League.

RECLINK AUSTRALIA VICTORIAN FOOTBALL LEAGUE GRAND FINAL

The Reclink Australia Victorian Football League Grand Final—a two-day event involving 6 games between 12 of the 13 Reclink teams—was coordinated and managed by Reclink Australia. This event involved significant activity, including:

- Promotion and media;
- Medal and trophy presentations;
- Personal trainers conducting a warm-up boot camp for spectators;
- National anthem signing;
- Live music from a bagpipe band;
- Community radio broadcasting (by Casey Radio);
- Past AFL player and celebrity visits;
- Food and beverage provision;
- Boots for All distribution;
- School volunteers performing a range of tasks including boundary umpiring and litter collection; and
- Coordinating two field umpires for each game.

PETER CULLEN MEDAL

The other major event that Reclink Australia organise in their role as coordinators and administrators of the Reclink Australia Victorian Football League, is the Peter Cullen Medal. This is an annual activity in which the field umpires at each game vote for the league's 'best and fairest' players. The final official Reclink Australia event for the season is a formal sit-down lunch attended by approximately 150 players, agency representatives, corporate sponsors and support staff. A presentation is compiled each year of the videos and photos from the preceding season.

Football-specific activities

LEAD AGENCY TEAM MANAGEMENT

The lead agency representatives who participated in interviews for this project reported that they undertook a wide range of administrative and team management activities to facilitate the efficient running of their team. The range of activities they reported included:

- Recruiting and registering players;
- Recording who plays each game;
- Organising social and educational events;
- Managing and reporting incidents;
- Managing client and agency-based risks;
- Managing finances and payments to umpires and other providers;
- Managing relationships and communicating with Reclink Australia;
- Identifying and applying for grants—a considerable workload for some lead agencies that relied on external funding to operate their team;
- Identifying, securing and managing sponsorship opportunities and relationships;
- Using social media, mainly Facebook, to communicate with players about the football activities and to share football experiences and stories;
- Communicating with facility managers (local councils, etc.);
- Generating local media, mainly in local newspapers, to promote the team and recruit players;
- Producing videos for team sharing and promotion—one team had a volunteer who videoed three games per season for promotion and team coaching purposes; and
- Organising and conducting fund raising activities such as cleaning up at the Melbourne Show, raffles, barbeques, Bunnings Sausage Sizzles and a Dinner Dance.

LEADERSHIP GROUP

Most teams reported having some form of leadership group of 4–6 representatives. This group was usually made up of players (often the captain and vice-captain), the coach, a lead agency representative, and a supporting agency representative (such as Rotary Clubs). These leadership groups often met both formally and informally to plan activities, allocate key tasks to individuals to ensure the efficient and smooth running of the team, and to manage and discuss specific incidents and issues as they arose during the season.

EQUIPMENT AND UNIFORM MANAGEMENT

All team administrators reported undertaking numerous activities related to obtaining and maintaining the equipment and uniforms necessary for the team to train for, and participate in, the Reclink Australia Victorian Football League. The range of activities they reported related to managing equipment and uniforms included:

- Securing equipment and uniforms from sponsors, community organisations, and the AFL, VFL or community football clubs;
- Distributing uniforms to, and retrieving uniforms back from, team participants;
- Transporting equipment to and from training and games; and

- Maintaining and storing the equipment (e.g. laundering uniforms and pumping up footballs);

GAME DAY ACTIVITIES

All teams were scheduled to participate in nine games during the 2016 Reclink Australia Victorian Football League home-and-away season and one Reclink Grand Final Day game. Some games were cancelled or abandoned during the 2016 season, usually due to one of the competing teams not having enough players to field a team, or incidents of on-field aggression. Based on the information gathered during this project, it is estimated that a 'typical' home game for a Reclink football team involved approximately 25 players while an away game involved 18–20 players.

Most lead agency representatives indicated that a Reclink football game day required a full day of their time including pre-game preparation, travel to and returning from away games, and post-game activities.

Through the course of the interviews with the team administrators, it became apparent that a 'typical' Reclink Australia Victorian Football League game-day involved a wide range of activities and roles including:

- Team management—setting up the oval (coaching benches, goal post padding, etc.), communicating with players, organising and distributing equipment and uniforms, accessing facilities, arranging transport, completing match-related paperwork, liaising with field umpires, identifying and supporting volunteers to perform a range of duties (first aid, scoreboard, goal and boundary umpiring) etc.;
- Coaching (often done by more than one person)—organising team positions, communicating with players, running pre-game warm up, inter-changing players during the game, etc.;
- Off-field mentoring—particularly if participants have specific issues that need to be addressed or incidents occurred during the course of the game;
- Goal and boundary umpiring;
- Providing first aid;
- Running water and messages to players;
- On-field mentoring—to support players to participate or manage on-field incidents;
- Maintaining the score board and time-keeping;
- Transporting players to and from the game venue—some participants also require transport to home games or to get to the meeting point to be then able to travel on the bus to away games; and
- Obtaining and preparing food and drinks for pre- and post-match consumption by participants, volunteers, spectators and officials.

TRAINING DAY ACTIVITIES

Each team indicated they organised a training session every alternate Wednesday during the season and pre-season. One team reported organising two training sessions on non-game weeks and one training session on game weeks. Each training session lasted between 1 to 1.5 hours. During this time, players received coaching instruction and participated in physical activity. This also provided an opportunity to connect with players and identify support needs. For some teams, food was provided before and after training, and some participants were transported to and from training.

PRE-SEASON ACTIVITIES

Most teams reported organising some form of training prior to the start of the Reclink Australia Victorian Football League season. This may not have been football focused but based on general fitness, individual capacity building, and team building such as bushwalking or running.

END OF YEAR PRESENTATIONS AND CELEBRATIONS

All teams reported holding a celebration at the end of the football season, usually involving awarding trophies and awards to participants who had made a significant contribution or achievement during the season.

Social support and personal development for players

Most teams reported organising and undertaking a range of activities to support and encourage group and individual personal development with a focus on developing skills to enhance and improve their daily lives. Although football was the primary activity of interest to participants, it also provided a platform to raise and discuss a wider range of social, physical and mental wellness topics. Examples these types of activities undertaken by teams included:

- Speakers from supporting and external agencies talking at football training about issues such as anger management, smoking, gambling and addictions;
- An external agency conducting a 'mental health check-up' with participants before the start of a football game;
- Taking players to a supermarket to educate them about healthy eating options.

"We did responsible gambling, we did the drink drive program, the good sport program….we deliver them in the context of football. So they're not sitting in a classroom or something like that. They're sitting in the training room…... They have some amazing insight and knowledge that gets shared amongst themselves. It's a great learning environment that they will actively engage in." (013A, Lead agency representative, Team manager).

"I've taken kids to the supermarket and bought them food for what they need to eat because they don't know. One kid didn't know what tuna was you know? You just try and re-educate them in other areas of their lives. Mentoring, domestic violence." (019A, Reclink representative, Coach).

"We've done a mental health check-up day before a game once. We had a mob come …. They are a sort of footy orientated mental health sort of awareness which is really good." (019A, Reclink representative, Coach).

LINKING TO SERVICES AND AGENCIES

Many agency representatives spoke about working closely with football participants to identify health and social needs, and to link them to services and agencies that could appropriately support them. In addition to supporting participants to access services, several agency representatives directly supported participants in their interactions with other aspects of the social welfare and justice systems.

"We always try to hide the vegies under the meat. Our 'more than just football' motto, is just that. You know, football brings them. The services that we have, all the ones that we've mentioned, are all called upon to bring their expertise. Their expertise isn't football. You know, that's just to get them there. Loosely, some of them are footballers and so on, which is great, but it's what they can offer through their service. You know, Headspace and YSAS are based at the Vic Park where we are, so it takes out that whole, oh, 'here's a card, and you've got to go three blocks, and take two trains and a bus to get there'. It's here. You're turning up on Wednesday, you've been dragged off the track and going up to that service. It works best potentially." (014A, Lead agency representative, Coach).

SOCIAL ACTIVITIES

In addition to organising football-specific and educational or personal development activities for participants, most teams provided a safe environment for players to socialise in. Lead agencies organised social and teambuilding activities such as boxing, horse riding, ten pin bowling, film nights, and museum trips, etc.

7. Outputs

Based on the data collected during the Reclink Australia and individual team stakeholder interviews conducted during this study, it is estimated that, by undertaking the activity outlined in Section 6 above, a 'typical' Reclink Australia Victorian Football League team produced the following outputs:

- 4 weeks of pre-season training consisting of one training or team building session of approximately 90 minutes per week;
- 19 weeks (6 April–10 August) of regular season football activity involving:
  - one 90-minute training session each fortnight and one training session during the 'bye' week in which they did not have a game;
  - one game each fortnight, alternating between 'home' and 'away' matches with one bye week;
- 4 weeks of preparation for the Reclink Grand Final involving one training session of approximately 90 minutes per week;

Based on the data collected during the interviews and subsequent data provided by lead agency representatives from each team, it is estimated that a 'typical' Reclink Australia Victorian Football League team had:

- 45 players participate in the season;
- 23 players participate in 5 or more games in the season;
- 45 players participate in the team's Grand Final game;
- 12 players attend each training session;
- 3 participants attend each of 3 Reclink Development Days;
- 1 participant attend a Reclink Level One coaching course;
- 12 participants attend the Reclink Peter Cullen Medal event;
- 1 lead agency representative who worked for 8 hours per week, each week for 26 weeks to coordinate and manage team activity;
- 2 lead or supporting agency staff who attended each of 9 games for 4 hours per game;
- 2 lead agency or supporting agency staff who attend each of 16 training sessions for 2 hours per session;
- 2 lead agency or supporting agency staff who attended Grand Final day for 8 hours;
- 3 volunteers attend each of 9 games for 4 hours per game;
- 2 volunteers attend each of 16 training sessions for 2 hours per session; and
- 3 volunteers attend Grand Final day for 8 hours
- 6 spectators (family, friends, members of the community) attend each of 9 games for 2 hours per game
- 3 spectators (family, friends, members of the community) attend each of 16 training session for 1.5 hours per session.

8. Why football?

The data from the interviews with 26 stakeholders and 30 Reclink Australia Victorian Football League participants suggests that there is something unique about football as an activity, such that it provides opportunities and outcomes not possible through other activities. Football, in the context of the Reclink Australia Victorian Football League, is like an incubator or microcosm of real life. It focuses on developing and displaying life skills such as being part of a team, commitment, and controlling aggression. All of this is concentrated in a controlled and supported environment.

> *"You're not there to just talk about your problem, you're there to play footy ostensibly but what happens by osmosis is the guys see "oh hang on, he's done something, he's moved on". And the thing is, if you're playing footy you've got a reason to band together. It's like going to war together in a way and you come out and there's a bond that you just can't artificially create in a therapeutic environment except with a long period of time. So football does it very quickly." (016A, Agency representative, Coach/team manager).*

> *"The football stuff is really powerful…… I mean it really changes lives. There's a spiritual component to us, to it for us and I think the guys get that and I've seen some remarkable stuff happen to participants. And if it wasn't for the football maybe it might've happened somewhere down the track, but what I can say is I saw them come in to an environment as damaged people and I've seen them leave as members of the community, happy, healthy." (016A, Lead agency representative, Coach/team manager)*

> *"Football is the platform for the interaction. There's no need for them to communicate over anything except for what's happening in terms of around the football. If that's how they relate, then that's a great way to relate because there's no challenge to be anything other than yourself. Yet if you're an introverted person that breaks down so many barriers just to allow the conversation around the football." (018P, Reclink player/ coach, Male 48 years old).*

Football as an activity, and the Reclink Australia Victorian Football League specifically, provides two types of opportunities which are perhaps not available from other activities or through football as it is organised in other contexts. First, clients who were already engaged in support programs (e.g. drug and alcohol rehabilitation programs, mental health programs) could be directed into an appropriate team participating in the Reclink Australia Victorian Football League. This provided a positive and supportive environment with the potential to 'amplify' the therapeutic outcomes of the programs they were already engaged with.

> *"The footy has provided a fantastic add-on to the program that I think we underestimated. We underestimated the therapeutic dimension of it. We thought it would just be good for activity but it's been equal to all the other therapeutic components of the program." (022A, Supporting agency representative, Counsellor).*

> *"I ended up saying to myself, "I want to overcome the fear." Because I was in defence, so I said to myself, "I'm going to tackle the ball like I'm going to tackle my recovery." Just put my body on the line. I ended up with (laughs) a few bumps and bruises. I actually looked at it like, "Okay, when I was using, I got my own bumps, bruises, scars. But they were from using." Whereas this time, it was a positive one. It was overcoming my fears. I sort of relate it to life. If I'm going to go for something, take the risk. Sometimes it works out, sometimes it doesn't. Sometimes I'll get hurt but it's okay. I'm doing something positive.....At least I actually gave it a go." (005P, Reclink player, Male, 44 years old).*

Second, some Reclink Australia Victorian Football League participants, having been initially attracted to join a team because of their interest in playing football, developed a trusting relationship with agency workers and were subsequently more likely to become aware of, and access, support services to address their social and health needs.

> *"I didn't realise myself, and so many people I've seen go through ups and downs, they had no idea that kind of support was out there until they got involved with Reclink and spoke with the coaches and other players and learned what was actually available for them in their problems. How Reclink could actually help them." (019P, Reclink player, Female, 46 years old).*

> *"We're more than just footy, we're not just a footy club. We're there to help people throughout their problems, to help people like with housing and stuff like that. They help people get off drugs, help people with alcohol problems, help people with accommodation for homeless people and stuff like that. So it's a lot more than people think it actually is." (013P, Reclink player, Male, 23 years old).*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9. Outcomes (Benefits)

Benefits to participants in the Reclink Australia Victorian Football League

"If it hadn't been for Reclink I probably would have been still sleeping in the streets today mate, that's serious. They are actually one of my life savers, gave me purpose, reason, something to do and develop me as a person." (005A, Volunteer, Assistant coach).

SOCIAL HEALTH BENEFITS

For many of the Reclink Australia Victorian Football League participants who were experiencing disadvantage, mental illness, disability, homelessness, substance abuse issues, addictions, and social and economic hardship, participating in a Reclink football team was one of very few opportunities in their lives to build and access social networks within the community. It helped reduced social isolation and provided opportunities for social interaction in a supportive and welcoming environment. For others it was more simply an opportunity to have fun in an otherwise chaotic and stressful life.

"And social health—well to be honest mate, before this I wasn't a very social person and I got into this and I've basically made another family other than my own." (013P, Reclink player, Male, 23 years old).

"The social so that's probably more beneficial to me...It just means social connection." (016P, Reclink player, Male, 34 years old).

"They've given us the opportunity for people that haven't really had that much opportunity in their life, to actually go out for the day and have fun." (08P, Reclink player, Male, 24 years old).

Participants in the interviews conducted during this study identified clear and powerful social benefits for participants in the Reclink Australia Victorian Football League by:

- Providing a meaningful connection to their community;
- Building a family environment where participants felt that they were not only welcome but that they belonged and were needed;

  "Because it gives…for me it also gives a sense of belonging somewhere." (027P, Reclink player, Male, 35 years old).

- Creating an opportunity to connect or re-connect with family members and friends;
- Providing an opportunity to meet peers facing similar challenges and grow a friendship group to socialise with at the football and beyond;
- Providing roles models, real life examples and networks of people in a supportive environment who may have been in a similar situation and have improved their lives, offering motivation and understanding;

  "As I said, it's all networking, you know. Someone might have a drug addiction and someone may have had one, and they can talk to each other and they can go "okay, this is what I did… this is how I got through it" and that might give them that avenue that they've been looking for, to help them recover." (028P, Player/umpire, Male, 36 years old).

- Generating opportunities for participants to support others, giving them a sense of empowerment and being needed.
- Providing an opportunity for participants to be part of a team.

  "I felt like I was needed for the team...we have like a good connection with that you know? It makes us, like, sort stuff out too with each other." (020P, Reclink player, Male, 20 years old).

"I feel like it's just the team support. On the field, you can't do it on your own. Life in general. You need supports and same as in recovery. You really need that support and that connection." (002P, Reclink player, Male, 32 years old).

- Creating connections and opportunities to engage with the community

  "In the community, addicts are pretty frowned upon because we steal, most of us don't work, we're always taking. We're not part of the community. So being in Reclink, it's like that first initial step. Afterwards people can go off and do other things. So that's actually a stepping stone to get us back into the community. If you want people to be in the community more and help out, be community-minded, well this is one good way to do it. Because you're introducing people that, really, they don't have a lot of community-minded experience." (005P, Reclink player, Male, 44 years old)

PHYSICAL HEALTH BENEFITS

The Reclink Australia Victorian Football League created opportunities for participants to take part in football training, play regular games of football and participate in a range of other physical activities (e.g. boxing, horse riding, bush walking and triathlons). For many participants, it may have been their only physical activity for the week, and without they may not have participated in any physical activity at all.

"Absolutely, absolutely it certainly does. Especially the ones where they come to training, you see that in their capacity for endurance throughout the game…. (without Reclink footy) the majority of them would just drop out (of physical activity)." (004A, Lead agency representative, Team manager).

"..with physical health it actually got me to go out and exercise and do things. Like I never really did and I should've because I was always self …. like you know about my body and stuff. So getting out there and having that fitness and even when we're not training, we still go and do boxing and stuff like that so the fitness is definitely in there. So that's good for the physical". (015P, Reclink player, Female, 25 years old).

For some participants, the opportunity to play in the Reclink Australia Victorian Football League football provided a motivation to get fitter and do more physical activity.

"….because when I heard I'd be playing, started going to the gym, and I'm like, oh, I got to get fit again. I've got a game coming up. After that, it was like, well, why did I only do it for now? Why can't I just keep doing it? Yeah, since the footy started, that's when my motivation got up, and then even after it, I kept going to the gym regularly." (008P, Reclink player/water runner, Male, 24 years old).

"That's what it's done for me. I think it kept me engaged in physical activity. So like I'd go down, I live in St Kilda, I use the Sea Baths every day. When I finished my football games, I'd go down and do stretches and cool downs in the steam room and sauna. So for me, that's maintained a healthy lifestyle activity" (026P, Reclink player, Male, 36 years old).

In addition to the direct benefits associated with being more physically active, analysis of the interview data collected in this study identified a range of other physical health benefits for participants in the Reclink Australia Victorian Football League including:

- Increased interest in healthy eating and access to a regular and secure source of food.

  "So it's interesting that the ones that are doing the football and then going to the food security program, engage a lot more because it's based around nutrition, and they link the nutrition to, "Oh, wow, I might actually be able to play better footy"." (013P, Lead agency representative, Team manager).

  "I just went up to him and said "you've had three pies that's enough", and he just said "I haven't had anything to eat for four days".

That sort of brought me down to earth, and I've watched him since and we make sure he's involved, and if he doesn't feel well he runs water instead of playing. So as long as he comes and we make sure he has a feed for sure." (012P, Volunteer, Team manage/ secretary/treasurer).

- Motivation to change unhealthy or social undesirable behaviours to healthier or more socially acceptable alternatives including reduced drug and alcohol use, addressing problem gambling and providing an alternative to being involved in criminal activity.

  "Okay, if I weren't with Reclink I'd still be on heroin now. I stopped the speed because of Reclink, so the using it anyway. I stopped gambling. I had a good eight years there where I spent $400 bucks every bloody fortnight mate and I tell you, every ad I've ever seen is true. You come out feeling like a dickhead, you beat yourself up all week and then you go out and you do it again. Well Reclink stopped that." (001P, Reclink player, Male, 54 years old).

  "I was just in and out of jail…..and like I was constantly getting charged with one thing or another and the time that I've been playing footy, three years, I haven't been charged once." (016P, Reclink player, Male, 34 years old).

  "I saw it as a way of using sport as a way to engage young people, to try and steer them away from coming under the attention of the Police or getting into trouble as well as reducing their drug and alcohol use." (015A, Supporting agency representative, Coach).

Importantly, several of the Reclink Australia Victorian Football League participants interviewed in this study highlighted that it provided an important avenue for people with drug and alcohol problems to participate in sport in an environment that is free of alcohol and drugs.

"Just having general fun without drugs involved… it's no alcohol involved. When I was growing up, a lot of my mates played footy and if I wanted to watch a game there'd be people drinking everywhere. That's not the culture I want to be a part of anymore, because it's not going to be safe for me to be around that environment. I've found everyone in the Reclink organisation to be very supportive of what we're doing. I've found it something that I'm interested in just because I know I'm safe doing it. It's an organisation I can be a part of, meet people, make friends, without having to worry about drugs and alcohol around me." (004, Reclink player, Male 28 years old).

"… if I'm to start playing footy again, it won't be for a district league or anything like that. I'd probably end up hooking up with a Reclink just to avoid... Because in football, for me, there was a lot of alcohol, and alcohol come with the drugs, and I just want to be able to actually go and play for a team, that don't... They can sit around and talk without a can in their hand." (008P, Reclink player/water runner, Male, 24 years old),

MENTAL HEALTH BENEFITS

It was clear from nearly every interview conducted with agency representatives and individual participants that everyone involved in the Reclink Australia Victorian Football League experiences a positive impact on their mental wellbeing that they strongly associate with what they described as 'Reclink football'. This benefit was sometimes associated with addressing a specific mental illness but also often interpreted as participants being generally happy, less stressed, more self-confident and more socially engaged.

"For us, it's people recovering from you know, mental illness from that and we have seen that people are connected to community, they're volunteering, they're getting work and they're just, in general, they're happier and healthier people." (029P, Reclink player/coach, Male, 36 years old).

"In terms of just their sense of self, their mental health, their wellbeing in that way, it does improve greatly during the course of the season." (013A, Lead agency representative, Team manager).

In addition to, and inseparable from, the social and physical health benefits, team stakeholders and individual participants who were interviewed for this study identified a broad range of mental health benefits from involvement in the Reclink Australia Victorian Football League including:

- Providing a positive experience and a break from everyday concerns.

  "I get away from everything else. Like when it comes to Collingwood Knights like that's basically where I go to forget about everything else and just focus on the footy because that's the kind of environment that they bring….Yeah it gets me away from just everything in general because once I'm on that football field, that's all I think about, is football." (009P, Reclink player, Male, 22 years old).

- Reducing symptoms of depression and assisting in management of mental health.

  "I've had feedback from some of the players who suffer from depression or mental health issues…. they said they can definitely feel the difference about coming down to training and running around. It sort of helps them with that depression." (015A, Supporting agency representative, Coach).

  "Absolutely 100%, it keeps me from having depression through the winter. If it weren't for the fact that I was running around out every Wednesday for training or every game, well I would have a lull through winter. I have no doubt whatsoever that that activity.. the endorphins, the comradery, yeah just boost you." (018, Reclink player/ coach, Male, 48 years old).

- The football, and other activities related to football, offered opportunities to face fears and reduce anxiety.

  "For me it would be the starting off point to push myself to overcome fears about making connection. The thing I talked about, the violence, and just going out there and giving it a go and being part of something… I ended up saying to myself, 'I want to overcome the fear.' (005P, Reclink player, Male, 44 years old)."

- Building a positive identity, self-respect and self-esteem.

  "I know I've got the experience to go up and talk to people and help them...that helps self-confidence which picks up the self-esteem." (001P, Reclink player, Male, 54 years old).

  "…it's not only needed, it's like they want you to play, they want—they give you the opportunity and like you don't….coming from where we come from, sometimes we don't get that … and getting that from the staff and Reclink was pretty….made me feel good about myself." (020P, Reclink player, Male, 20 years old)

  "I suppose just gaining confidence, I never had any confidence. I always thought people would judge me going out in shorts and a t-shirt and I just…. yeah I've always lacked self-confident so I've just got that up to not… so I don't care anymore if people judge me. I'm out there having a good time so that's all that matters." (015P, Reclink player, Female, 25 years old, O52)

- Experiencing success, and an opportunity to create and achieve goals generating a sense of pride in their performance.

  "Because we find a lot of the participants who come there, they've had that feeling resonating through them probably a fair percentage of their life. You know, 'you're not a winner, you don't fit anywhere, you'll never make it', all that sort of stuff. And a lot of this mindset trying to actually eliminate a lot of that by creating that environment of providing the right gear, so that when they come there they're actually playing the game… and they feel proud." (005A, Volunteer, Assistant coach).

  "To be recognised because of the hard work that I'm putting into myself. Reclink's given me the opportunity to excel at something I'm really good at. It's allowed me to acknowledge all the good traits about me and that acceptance stuff for who I am. It's given me a lot. It's given me a lot of hope" (007, Reclink player, Male, 28 years old).

- Generating a sense of ownership and contributing to a team.

  "What Reclink provides is… it is a community, and it does give the people a sense of ownership, and they're very engaged with it. It's really, that aspect is really beneficial for the client group we service because often they're disenfranchised from everything else." (004A, Lead agency representative, Team manager).

  "It means that I mean something to the club and that if I can't play personally, at least that I have something and some involvement with the club." (014P, Reclink sports trainer, Female, 25 years old).

- Providing an opportunity to be a leader and to support others.

  "Everyone looks up to me like I'm the leader down there and it makes me feel very good. Everyone comes….. they don't go up to the coaches and stuff and ask them for advice, they come up to me and like it feels good to know that like, other than the coaches, they come to you and they ask you for advice and stuff like that. It's good that you get recognition from your peers that you play footy with." (013P, Reclink player, Male, 23 Years old).

  "It helps build my confidence talking to people and stuff and being a leader and all that." (025P, Reclink player, Male, 25 years old).

  "I'm just going down there to help, you know, those guys. I've got full time employment so I don't really need to play. It's not like the organisation is for me, I'm there to support the other guys you know, that way they get a game, and they're all good..... I'm not doing it for myself. I'm doing it for these guys here." (028P, Reclink player/umpire, Male, 36 years old).

- Creating an environment in which participants can learn and develop self-discipline and anger management.

  "Like I said before, I wouldn't be the person I am today if it wasn't for Reclink and honestly it's changed my life a lot. Like I was a fucking angry little turd back in the day mate, like, you know and so now…. I've changed my attitude towards everything in life." (013P, Reclink player, Male, 23 years old).

  "The guys actually…. because they achieved something, they achieved self-control after an incident, it actually gave them a sense of achievement. That was good, we actually pulled ourselves back together and finished the game well…. So I've seen some really positive things come out of working through what is anger and to some more self-control that I think is a teaching part of the… it's a life skill thing that they can learn." (021A, Supporting agency representative, Team chaplain).

LIFE IMPROVEMENT

It was clear from the data collected in the stakeholder and participant interviews that the sum of all the social, physical and mental health benefits produced by being involved in the Reclink Australia Victorian Football League, was an opportunity for life improvement.

"It's not just about playing sport. It's actually about providing opportunities for people to progress."

"This is where my life was at then and this is where I'm at now. Now I couldn't have done this without active sport and I couldn't go without help and comradery...You know for a young Aboriginal man, and this is where I am at now… and my life is better." (027P, Reclink player, Male, 35 years old).

Involvement in a football team offered an opportunity for participants to connect with an advocate (within or outside their support agency) who cared for them as a person, built trust and connected them to services when needed in a less confronting environment than traditional agency or service providers.

"For example at the beginning of this year we had a new female player and then I think

she played a couple of games and then at a training session one day she told me that she was pregnant so she's stopped playing football now but she's been up to speak to me about her pregnancy and then I've asked her if she's got all the support that she needs and I suggested some things to her. So yes we are there for that reason but I would say it's those concrete referral pathways that we're providing people and they feel like they've got someone to go to if they need." (020A, Lead agency representative, Team manager).

"Well I'm more like a mentor for a lot of them. Some of them will ring me in the middle of the night. Some of them may be having a rough time in their life, and they'll ring me up for a bit of a chat, and I'll try to talk to them as much as I can and try and make them realise what life's all about." (009A, Volunteer, Coach).

Many participants reported that being a member of a Reclink Australia Victorian Football League team provided their life with meaning, an opportunity for life improvement and hope.

"It steers us on a different path. It gives us hope. It allows us to have opportunities to live a fulfilling life rather than, you know a destructive life, yeah. It's really important. It's important for us to have Reclink as a support service." (007, Reclink player, Male, 28 years old).

"Yeah, definitely. (Reclink provides).. Opportunity to change and hope" (005P, Reclink player, Male 44 years old).

"Well if I didn't have Reclink and footy – I don't know, like a lot is – footy gets me through life so if I didn't have footy then I don't think I'd have a life…… (I'd miss out on..) A lot of friends, a lot of fitness, exercise, a lot of support…I would spend that time just at home...Yes I'm going to stay with Reclink football until I'm 88" (009, Reclink player, Male, 22 years old).

"(Without Reclink football) ….. we wouldn't have that thing to say 'this is what we do' and we wouldn't be able to say to everyone "this is the activities we do and this is what we look forward to every week." (014N, Reclink sports trainer, Female, 25 years old).

More concretely, participants reported that Reclink football provided them with:

- Something to look forward to each week.

  "I wake up and I look forward to it, even if it's rain or it's what not, you know, I just look forward to it." (027P, Reclink Player, Male 35 years old).

  "Yeah because I'm finding it hard to get a job so footy is basically all I've got that gets me out of the house." (010P, Reclink player/ team vice president, Male, 23 years old).

- A routine to their week that otherwise might be chaotic and unstructured.

  "… I know what's happening week after week." (016P, Reclink player, Male, 34 years old).

  "Like on a Wednesday, worried about what I'm going to do. I get up, and I go, right, this is what I've got to do today. So I focus myself up….Yeah, I've found myself – it gives me something on that day. I'm focussed on that day." (027P, Reclink player, Male 35 years old).

  "Well three years ago, I was virtually going day by day, not knowing what's going to happen the next, to stable living and having something to look forward to". (016P, Reclink player, Male, 34 years old).

- An opportunity to transition into community sport.
- An environment to develop and demonstrate their interpersonal skills relevant for employment such as: leadership; time management; teamwork; reliability; and being able to take direction.

  "It's teaching them about being part of the team and following rules and having boundaries and skill building and all of those things. The same thing as you would have in a work environment or a volunteering

environment. It's just builds those life skills." (003A, Lead agency representative, Team manager).

"I suppose time management and being reliable, being there before the game and training… especially with trainings I've been in. Make sure you do train so you do get a game. Like definitely reliable would come into it I think as mainly being more time efficient, getting there before we start, having a pre training and then go out and play your game. So just having time management and being reliable." (015P, Reclink player, Female 25 years old).

- Networks to connect with employment opportunities.

  "My son got a phone call one day from a lady who came out of nowhere and said "I work for so-and-so. I'm not going to mention names. But you might like to know that this young fellow is the fourth generation of a family that's never had a job. And now he's got a job, his brother's got a job, and his mother's got a job"." (18A, Volunteer, General helper).

  "I know a bloke that's playing for us that, because of the football, he's gotten a job." (012P, Reclink player, male 38 years old).

  "You know, like some people can offer jobs and that, you know, I've got some work coming up – any guys interested in getting some work. Yeah, no worries. Get you that way Brian as well, he's quite happy to help them if they approach him, and Brian's got some companies like – in construction and house building and all that stuff. He's got a few guys doing a bit of sponsorship there, and they're always looking for people to work, so, you know. He's sort of said, yeah, you know." (028P, Reclink player/umpire, Male, 36 years old).

  "We definitely see people that are unemployed become you know, employed. ….. so you're seeing people volunteering and getting back into paid work as well." (029P, Reclink player/coach, Male, 36 years old).

- Opportunities to leverage relationships with agency staff and volunteers to obtain employment, housing and legal references.

  "Yeah my mate... that lives with me now he does that. Like when he applies for a job and stuff he puts the officers and that down as his references because they're the people closest to him." (013P, Reclink player, Male, 23 years old).

  "They'll come up to me, and they'll tell me they've got job interviews and that sort of stuff. If any of them need references, we're quite happy to write references for them. Like, we've had blokes go and move out, and try and get their own houses and that, and they will ring me up and ask if they can put me down as a reference to talk to... I've had quite a few phone calls over the years." (009A, Volunteer, Coach).

Benefits to participating agencies

In addition to the benefits to individuals who participated in the Reclink Australia Victorian Football League described above, the interviews with stakeholders revealed that the lead and supporting agencies also experienced a wide range of benefits.

SERVICE PROVISION BENEFITS

Several agencies—both lead and supporting—highlighted that their involvement in the Reclink Australia Victorian Football League added value to the services their agency delivered and strengthened their capacity to undertake their primary activity. Many of the participating agencies had a remit to provide services to hard to reach sections of the population who do not usually engage with service providers (e.g. homeless young males, young indigenous people, young people with mental health or drug and alcohol addictions). They reported that involvement in the Reclink Australia Victorian Football League was a useful tool for them to reach and engage with these groups.

> *"But they're probably getting more than they would, than if it was the standard support plan. They're actually probably getting greater impacts through the football team.....So it's a great platform, and really supports and enhances case management practice. There's no doubt about that". (013A, Lead agency representative, Team Manager).*

> *"Our YSAS and Headspace, our partners…. They'd be working with them and they would use that as a tool in their back pocket to say, have you ever played footy. Are you interested in getting involved in footy? A lot of the time they're saying yes." (014A, Lead agency representative, Coach)*

> *"Rotary obviously is a service… community service provider, that's what we do. Service of our self, so in a sense it provides a local avenue for service and most of the Rotarians who help are really pleased to do that". (021, Supporting agency representative, Team chaplain).*

The agencies represented in the interviews conducted for this study work with the community's most vulnerable and isolated people—those who experience mental illness, disability, homelessness, substance abuse issues, addictions, and social and economic hardship. As such, their work is often challenging and emotionally draining. Several interviewed agency representatives highlighted that the Reclink Australia Victorian Football League enabled their agencies to be involved in program which built a positive organisational culture for both agency staff and clients.

> *"They love particularly the school teachers, they get along really well with everyone here and the DHS staff that come out on game day are fantastic too so I'm sure it does create a bit more of a stronger bond amongst everybody." (008A, Lead agency representative, Coach).*

The agencies that were involved in leading and supporting teams in the Reclink Australia Victorian Football League clearly felt that their involvement in the football program enhanced their capacity to both access and meet the support needs of their clients. Interestingly, the only agency that expressed any degree of concern or dissatisfaction with their involvement in the football program did so on the basis that they were unsure that it still met the needs of the majority of their clients who were getting older and including more females.

BENEFITS FOR AGENCY STAFF AND VOLUNTEERS

Not only did involvement in the Reclink Australia Victorian Football League provide benefits to individual participants and the agencies that supported teams, it was consistently reported that it also provided benefits to agency staff and volunteers. Involvement in the football program was seen as a highlight for many staff as it provided a platform to interact with clients and engage with their communities in a positive way. It also created an environment that facilitated trust and positive relationships between agency

staff and clients, particularly hard to reach groups of clients (such as young males), and a unique opportunity for staff development.

"It's been probably the most enjoyable part of my job so far this year…. so it's all positive from my end." (008A, Lead agency representative, Coach).

"I think I said to you before; if you have a little win occasionally, and someone pulls you up down the street…There's a young bloke that is now the Assistant Manager of cleaning services at the market place... He played football with us three years ago, and he always comes up to me when I go to the market place and he keeps saying to me "This is because of you, you know." And you get chuffed about that don't you? This kid's now got a permanent job." (008A, Volunteer, General Helper).

"Not only further my development as a trainee in the sporting field, but also give me more exposure, in a multitude of backgrounds." (002A, Supporting agency representative, Team Manager).

"Typically this demographic of young males, 20–30 odd don't look for authority figures or professional agencies or whatever. …. Football actually creates a therapy, or at least an avenue for those people to be able to ask for help eventually once they build trust." (21A, Supporting agency representative, Team Chaplain).


AUSTRALIAN FOOTBALL COACHES ASSOCIATION
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10. Logic map and calculation of the SROI of the Reclink Australia Victorian Football League

From identifying the resources (inputs), activities (outputs) and outcomes of the Reclink Australia Victorian Football League, a logic model has been developed in order to establish how value outputs can be attributed to the league's activities (Table 2). In addition to this, the pathway mechanism that the Reclink Australia Victorian Football League provides to participants to support them at each stage of their life recovery has been established and illustrated in Figure 1. This information has been used to form the basis of the Social Return on Investment (SROI) calculation for the Reclink Australia Victorian Football League.

As explained in the method, to calculate the SROI of the Reclink Australia Victorian Football League, the outcomes received by each stakeholder from the league's activities are listed and the extent of this outcome, or change, is determined. A financial proxy is then attributed to this outcome and a final calculation is then compared to the resources required to operate the league.

From the case study conducted, the SROI for the Reclink Australia Victorian Football League has been calculated at a $8.94 social value return for every $1 invested into the league.

NOTE: The sources of funding (i.e. grants, donations, lead agency contributions) are not calculated as an input resource because this funding directly pays for the resources needed (i.e. bus, BBQ etc) and the SROI method calculates the cost of these resources as the input figure.

Table 2: Logic model of the Reclink Australia Victorian Football League inputs, outputs, and outcomes

INPUTS TO RECLINK AUSTRALIA

- Government funds;
- Corporate fundraising;
- Agency membership;
- Social fundraising.

SUPPORT AGENCY

- Transport;
- Food and beverages;
- Volunteers;
- Facilities;
- Coaches and trainers.

COMMUNITY and OTHER SPORT ORGANISATIONS

- Facilities;
- Volunteers;
- Coaches and trainers.

RECLINK AUSTRALIA DIRECT TO LEAGUE and TEAMS

- Umpires;
- Coaches (for two teams);
- Development, training and social education.

RECLINK AUSTRALIA to LEAD AGENCIES

- Co-ordinate, administer and schedule the league;
- Support during team formation;
- Uniform and equipment support;
- Insurance;
- Media support.

LEAD AGENCY

- Coordinate and manage participants and volunteers;
- Uniform and equipment;
- Transport;
- Food and beverages;
- Coaches and trainers.

LEAGUE (FOOTBALL) ACTIVITIES

- Teams (13);
- Regular players (average 23 per team who play 5 or more games in a season);
- Other participants (up to another 30 participants per team who play, train or participate in some way during the season);
- Games in a season (9);
- Training sessions in a season (16).

OTHER ACTIVITIES

- Social activities;
- Social support from players and team agency;
- Identify issues and access to support agencies;
- Opportunities for team leadership;
- Opportunities for public speaking and promotion of league.

RECLINK AUSTRALIA DIRECT ACTIVITIES

- Grand Finals;
- Peter Cullen Medal;
- Development days;
- Coaching and training courses;
- Sports first-aid accreditation courses.

AGENCY

- Connection to their target group;
- Connection to other sport opportunities (i.e. AFL in Winter and Reclink basketball or cricket in summer);
- Involvement in a resource sharing, leveraging and building community;
- Increased employee retention from being involved in a positive activity.

PLAYERS

- Sense of belonging and pride;
- Increased physical activity and physical health;
- Reduced risk of preventable diseases;
- Increased mental health and wellbeing;
- Social support network;
- Access to support services;
- Increased interpersonal skills;
- Increased leadership skills;
- Increased employability;
- Connection to employment opportunities;
- Less likely to be involved in negative and risky behaviours (e.g. crime, violence, drugs or alcohol abuse).

OTHER SUPPORT ORGANISATIONS and VOLUNTEERS

- Opportunity to work with a target group they would not have usually had (e.g. SEDA students, AFL trainee);
- Personal altruistic satisfaction.


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LA TROBE UNIVERSITY | CENTRE FOR SPORT AND SOCIAL IMPACT

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Reclink National Program

The Centre for Sport and Social Impact at La Trobe University was commissioned to evaluate the Reclink National Program, which is funded by the Department of Health, Preventative Health and Chronic Disease Support, and is being delivered in 25 of the most disadvantaged communities across Australia. In particular, the evaluation was designed to:

- Assess the impact of the Reclink Australia national program on the lives of participants
- Assess the relationships formed by Reclink Australia in order to mobilise the unique model that enables delivery of the national program

In its first 12 months, the Reclink National Program has:

- Engaged over 3,200 people experiencing disadvantage
- Delivered over 45,500 sport and recreation participation opportunities
- Partnered with over 290 community agencies
- Worked with over 600 volunteers.

The evaluation sought to establish the proportion of participants who had experienced a 'better outcome' via their participation with Reclink, defined as those people who reported a positive change in at least one of seven life events since their participation with the Reclink National Program.

71% of respondents reported a better outcome since participating with Reclink

Of those who reported experiencing a life event in the 12 months prior to participating:

58%	accessed mental health services less
57%	spent less time in a drug or alcohol facility
80%	reduced their drug or alcohol use
78%	spent less time in a correctional centre
81%	had less involvement with police
81%	had more stable housing
79%	had a reduction in problem gambling

In addition:

27%	had been able to get a job or increase the number of hours they worked
37%	had started or undertaken more skill or work-based training

This report is presented in two sections:

1. The Reclink Model

This section provides the findings of the qualitative data collection, namely the 40 interviews conducted with Reclink Australia national program stakeholders.

2. The Impact of Reclink

This section provides the findings of the quantitative data collection, namely the 529 surveys completed by Reclink Australia national program participants

1. The Reclink Model

The value of the Reclink hub and spoke model

Reclink provides sport and recreation opportunities to the most hard to reach cohorts of the community:

- Culturally and linguistically diverse backgrounds (CALD)
- People with a disability
- Individuals with at-risk behaviours (such as drug and alcohol abuse, gambling etc)
- Homeless
- Youth offenders
- Aboriginal and Torres Strait Islander populations

They do this by using a hub and spoke model whereby they collaborate with community groups who care for target cohorts (participant providers) and organisations who can support sport programs (sport providers).

Participant providers interviewed in this research included representatives from community support groups, police, local council, health providers, alcohol and drug rehabilitation program providers, and youth justice.

Sport providers interviewed included representatives from state sport associations, community sport clubs, facility managers, and local government.

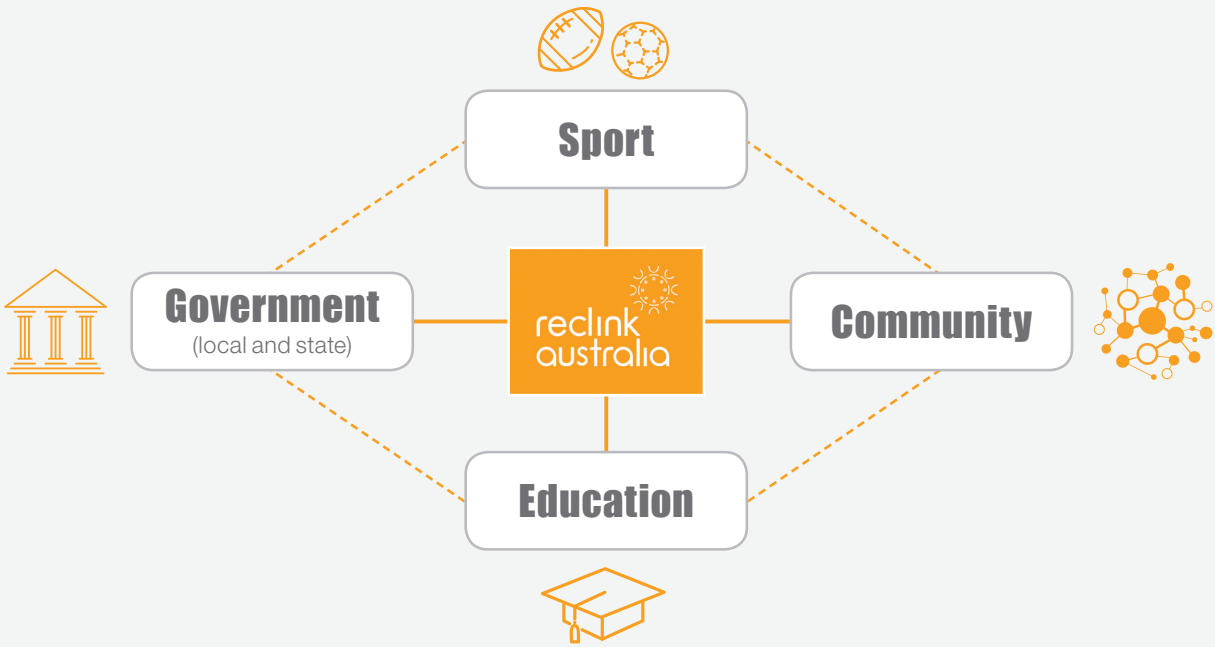
Stakeholders re-iterated through every interview that there was no other organisation in Australia that provides the valuable service that Reclink does, and that if Reclink did not exist, in all likelihood these opportunities would cease to be delivered.

The preparedness of Reclink to develop and deliver programs for participants who were not served through any other sport or recreation offering, and who benefited so greatly from these opportunities, was unique and valuable.

The Reclink hub and spoke model was identified by stakeholders as unique and valuable system for two main outcomes:

1. **Community and participant development**
2. **Unique and efficient bridge between community, sport and government**

There was evidence that capacity issues within Reclink (i.e. staff time and availability) affected the quality of some relationships and limited outcomes in some areas. With increased staffing and a more strategic approach to capacity building, Reclink has the potential to create stronger community networks and deliver more sport and recreation opportunities to more participants in need.



Community and participant development

Where delivered successfully, the Reclink program could support community development and social cohesion by building capacity within the community to deliver sport and recreation opportunities for vulnerable people.

Barriers to sport and recreation participation can be complex for vulnerable people. They can be individual (social, psychological, cognitive or physical barriers); environmental (location); and also structural. For example, the traditional sport club structure could be limited in its ability to offer flexible opportunities at a cost that was accessible to Reclink participants. Flexibility was a key component to delivering programs successfully to targeted participants and for traditional sport clubs or opportunity providers this could be challenging – particularly where paid coaches were booked for sessions / programs and Reclink participants did not turn up or had irregular participation patterns. Additionally, traditional club members were considered less equipped to develop opportunities and welcome Reclink participants into their club.

Where strong relationships had been built between sport organisations and Reclink, this relationship could result in building club capacity and local based relationships between clubs and community groups. There were examples of clubs who were committed to creating welcoming and inclusive environments and valued the opportunity to work with Reclink to increase exposure of their sport, and also club attendance. This did not always mean club membership, but ensuring that where Reclink programs were delivered to a targeted group, that the group felt genuinely welcome, safe and was invited back to the club for a different opportunity (e.g. to meal night or to another activity).

For many target cohorts, accessing sport clubs or other recreational opportunities could be a traumatic experience. Yet the opportunity to participate in sport and recreation delivered valuable benefits to improve their quality of life and support them to integrate with their community. As one representative from a live-in drug and alcohol rehabilitation centre described for their participants, participating in sport opportunities was a way for them to *"normalise, it helps recovery by normalising them because most of them having played sport in years. It helps with their mental health their social health and their recovery. No other organisation would take these guys out to play sport, Reclink is the only one I have found".*

Reclink programs when delivered successfully were able to overcome many of the individual, environmental and structural barriers to sport and recreation for target cohorts. Therefore the value of Reclink to those participants who were most often the very hard to reach, was extensive.

Specific benefits of sport mentioned by those interviewed included:

- Building confidence
- Integrating participants into the community
- Improving sense of belonging in the community
- Improving their social connections.
- Developing skills of teamwork

Tangible outcomes for some participants reported included:

- Employment opportunities
- Reduced recidivism
- Accessing community services such as housing and health care
- Prevention or control of substance abuse and other at-risk behaviours such as gambling

Reclink provided a positive environment and opportunity for community services to connect and build trusting relationships with vulnerable people.

Programs were a place where police and council workers could attend and build connection with participants in a positive environment, the building of trust and social connection through sport provided the *"opportunity to build a more genuine and sustainable relationship" (Police).* This could lead to participants and their families having greater say in further program development or accessing care. For example, where Reclink had supported a community group to develop a local soccer program for a CALD group, council representatives were able to attend and have direct access to the women / mothers who were on the sideline. Through these conversations they discussed what activities the women would like to do and they identified swimming as a desirable activity. Council, Reclink and the community group were then able to go to a local pool facility to develop a swimming program for these women.

By working closely with community organisations, Reclink were able to identify opportunities to access disadvantaged community members through partner initiatives. For example, in one area Reclink gathered sport equipment and gave this away during a partner's food provision program. This way a hard to reach target group had access to free equipment that they may not otherwise of engaged with.

Reclink provided a positive environment and opportunity for community services to connect and build trusting relationships with vulnerable people .

Unique and efficient bridge between community sport and government (participant providers and sport providers)

Having well-connected Reclink staff in local areas was an efficient strategy to improving relationships, networks and sport and recreation delivery to those most vulnerable in our community.

It takes time to build the strong relationships required to develop and deliver sport and recreation to target cohorts. There are four main reasons:

1. Participant providers who are charged with the care of the most vulnerable people within our community need to be assured that program providers they partner with are trusted and experienced to deal with their clients.
2. Participant providers gave priority of resources to basic needs (safety, food, shelter, medical services) and had limited resources to develop and facilitate sport and recreation programs and/or develop relationships with sport providers for their clients
3. Traditional sport opportunities are rarely attended by vulnerable groups, and therefore sport providers had limited opportunity to build capacity in this area
4. Sport providers rarely had the resources to pro-actively seek collaborations with participant providers and build relationships.

Reclink provides community organisations and sport organisations with a pathway for connection that would not otherwise exist. Community organisation and sport organisation representatives interviewed explained that they "talked a different language" to each other and had different styles and needs from sport delivery. For sport and participant providers, 'linking' in with Reclink and their existing relationships through the hub and spoke model was a more efficient strategy than building the direct relationships themselves.

> *"I am limited in my ability to get out there and organise coaches and trainers and hire facilities and organise programs. We (the council) are here to support the delivery of programs, but we don't have time or resources to plan out delivery ourselves, we are at capacity with our workloads already. So Reclink can work with our community groups and deliver programs to them, or support them by providing guidance to plan and develop programs for themselves." (local council, participant provider)*

The Reclink program provided an efficient method of utilising sport and community organisational capacity to deliver sport and recreation to the most vulnerable in our community in a cost affordable way.

For participant providers with limited resources, utilising the Reclink program was an efficient method for accessing sport and recreation opportunities for their clients at a minimal cost.

For sport providers, they were able to provide support to Reclink in various ways that were realistic and achievable. This included:

- Providing facilities and/ or equipment
- Upskilling Reclink deliverers to deliver each sport
- Providing sport deliverers to deliver programs
- Providing connection between clubs and community groups

Reaching target cohorts and providing welcoming, safe and supportive environments for participation is a growing focus for sport organisations. The opportunity Reclink provides to sport is an efficient opportunity to build capacity within their organisations.

> *"For us it's the contact with that target of demographic, that part of the population that in our normal activity as we sponsor clubs we are not going to have any interaction with these types of clients. So Reclink gives us access to a portion of the population we might not otherwise access. We try to have partnerships with groups like those that deliver sporting opportunities for people with disabilities such as (organisation name), they have the expertise in the field with their client base and we have the expertise with our sport. We said "We'll scratch your back and you scratch ours." Everyone benefits." (Sport organisation)*

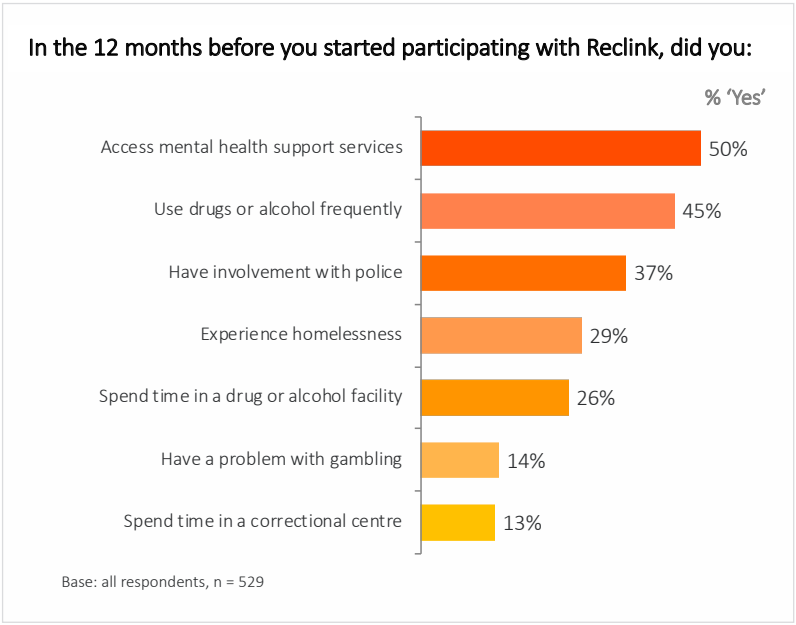
> *"From a business perspective, its being able to tap into the different communities and different networks in society that we generally wont connect with. We have structured, social and semi-organised opportunities traditionally, but Reclink has allowed us the business the opportunity just connecting with people and groups we wouldn't connect with generally." (Sport organisation)*

Life events before participation

Participants in the Reclink Australia national program were asked to identify whether, in the 12 months prior to their participation, they had experienced any of the following:

- Accessed mental health support services
- Used drugs or alcohol frequently
- Had involvement with police
- Homelessness
- Spent time in a drug or alcohol facility
- Had a problem with gambling
- Spent time in a correctional centre

80% reported experiencing at least one of the above life events, with 1 in every 2 Reclink participants reporting having had experience with two or more, indicative of the interdependence of many of these issues.



1 in 2 **49%**

respondents mentioned they had experienced two or more of the above life events.

4 in 5 **80%**

reported experiencing one or more of the above life events

Breaking this down further ...

30% Used drugs/alcohol frequently and had involvement with police

24% Used drugs/alcohol frequently and accessed mental health support services

21% Accessed mental health support services and had involvement with police

2. Impact of the Reclink Program

What is a 'better outcome'?

Participants in the Reclink Australia national program who identified that they had experienced a life event or issue in the 12 months prior to participating, were asked to report whether there was now a better outcome following their participation. In this context, a better outcome is defined as including those respondents to the survey who indicated a positive change on at least one of the seven life events since their participation in the Reclink program.

This might include:

- Spending less time in a mental health or drug facility
- Having less involvement with the police
- Experiencing a reduction in problem gambling
- Accessing mental health support services less
- Less use of drugs or alcohol
- More stable housing
- Spending less time in a correctional centre

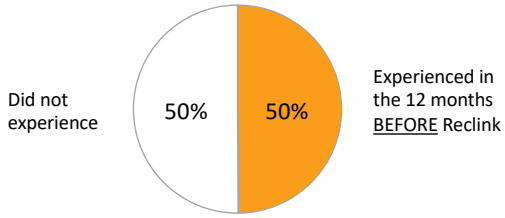
529

respondents provided feedback in the survey

71%

of respondents reported a 'better outcome' since participating with Reclink

Mental health support services

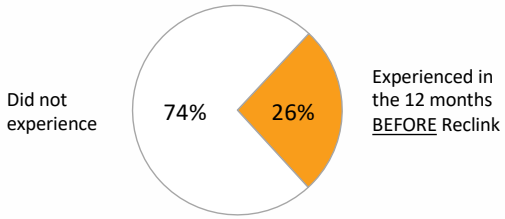


257 respondents "Accessed mental health support services" in the 12 months before Reclink

58% of respondents reported a 'better outcome' since participating with Reclink

Better outcome:
ACCESSED MENTAL HEALTH SUPPORT SERVICES LESS

Time in a drug or alcohol facility

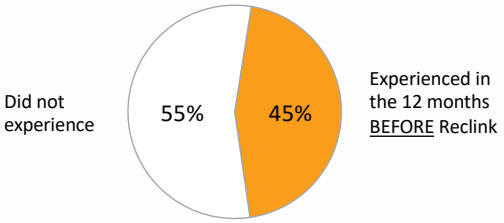


135 respondents "Spent time in a drug or alcohol facility" in the 12 months before Reclink

57% of respondents reported a 'better outcome' since participating with Reclink

Better outcome:
SPENT LESS TIME IN A DRUG OR ALCOHOL FACILITY

Frequent drug or alcohol use

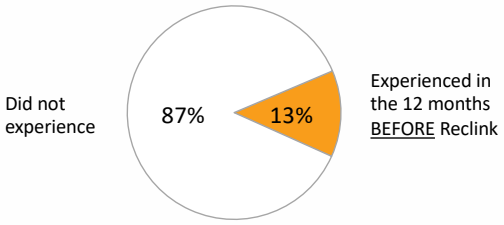


235 respondents "Used drugs or alcohol frequently" in the 12 months before Reclink

80% of respondents reported a 'better outcome' since participating with Reclink

Better outcome:
REDUCED USE OF DRUGS OR ALCOHOL

Time in a correctional centre

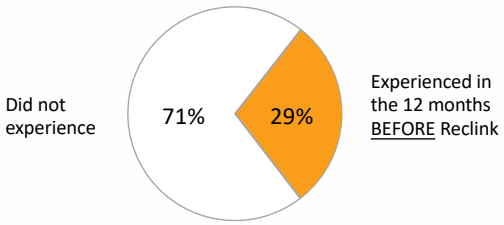


67 respondents "Spent time in a correctional centre" in the 12 months before Reclink

78% of respondents reported a 'better outcome' since participating with Reclink

Better outcome:
SPENT LESS TIME IN A CORRECTIONAL CENTRE

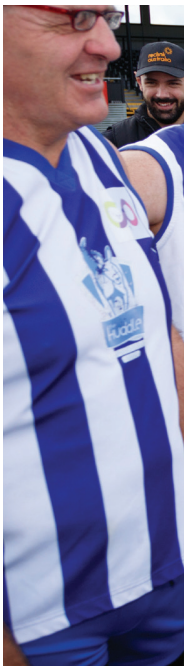
Experience homelessness



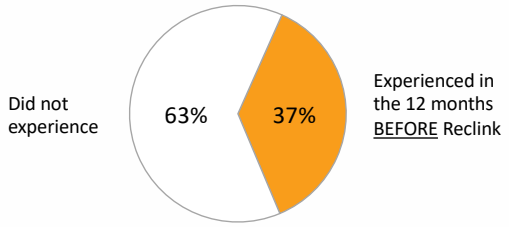
149 respondents "Experienced homelessness" in the 12 months before Reclink

81% of respondents reported a 'better outcome' since participating with Reclink

Better outcome:
HAD MORE STABLE HOUSING



Involvement with police



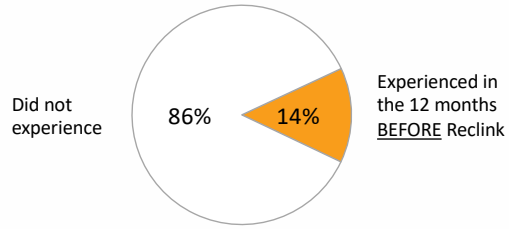
187 respondents "Had involvement with police" in the 12 months before Reclink

reclink australia

81% of respondents reported a 'better outcome' since participating with Reclink

Better outcome:
HAD LESS INVOLVEMENT WITH POLICE

Problem with gambling



71 respondents "Had a problem with gambling" in the 12 months before Reclink

reclink australia

79% of respondents reported a 'better outcome' since participating with Reclink

Better outcome:
HAD A REDUCTION IN PROBLEM GAMBLING

Employment and training

Participants in the Reclink Australia national program were asked to report whether there was now a better employment or training outcome following their participation. In this context, a better outcome is defined as including those respondents who:

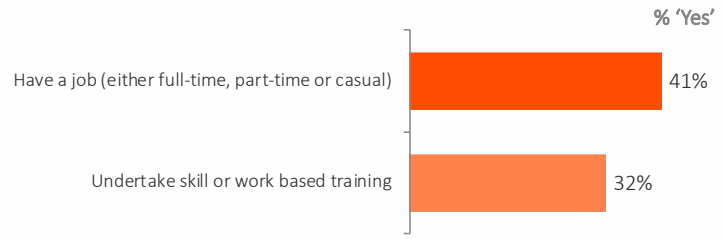
- Increased the number of hours they work (for those who had a job in the 12 months prior to participating in a Reclink Australia program)
- Been able to get a job (for those who did not have a job in the 12 months prior to participating in a Reclink Australia program)
- Undertaken more skill or work based training (for those who had in the 12 months prior to participation)
- Undertaken skill or work based training (for those who had not in the 12 months prior to participation)

Participants in the Reclink Australia national program were asked to identify whether, in the 12 months prior to their participation, they had:

- A job (either full-time, part-time or casual)
- Undertaken skill or work based training

The results are reported below.

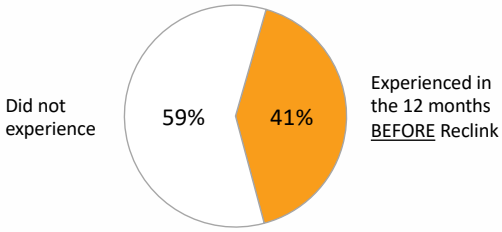
In the 12 months before you started participating with Reclink, did you:



Base: all respondents, n = 529

Employment

Have a job (either full-time, part-time or casual)



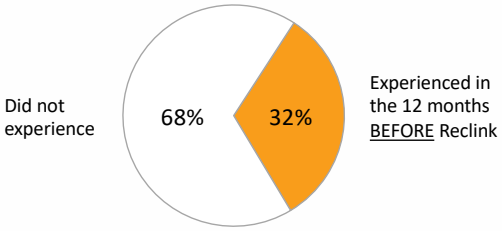
ALL respondents answered the question in regards to "having a job (either full-time, part-time or casual)" in the 12 months before Reclink

27% of respondents reported a 'better outcome' since participating with Reclink

Better outcome:
INCREASED THE NUMBER OF HOURS WORKED (IF HAD A JOB IN THE 12 MONTHS BEFORE RECLINK)
OR
ABLE TO GET A JOB – EITHER FULL-TIME, PART-TIME OR CASUAL (IF DID NOT HAVE A JOB IN THE 12 MONTHS BEFORE RECLINK)

Training

Undertake skill or work based training



ALL respondents answered the question in regards to "undertaking skill or work based training" in the 12 months before Reclink

37% of respondents reported a 'better outcome' since participating with Reclink

Better outcome:
UNDERTAKEN MORE SKILL OR WORK BASED TRAINING (IF UNDERTOOK IN THE 12 MONTHS BEFORE RECLINK)
OR
UNDERTAKEN SKILL OR WORK BASED TRAINING (IF DID NOT UNDERTAKE IN THE 12 MONTHS BEFORE RECLINK)

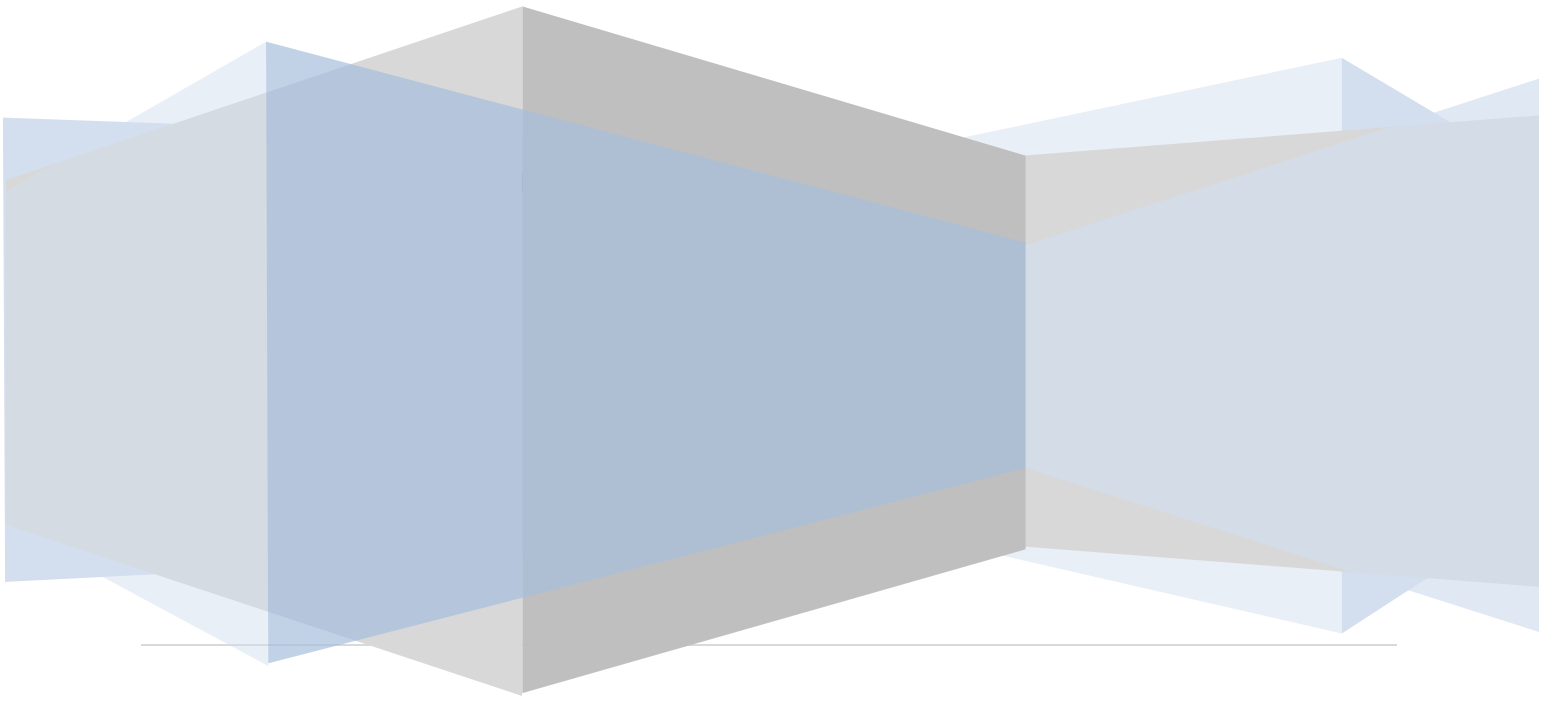
For further information on this project contact:
Reclink Australia at www.reclink.org
Centre for Sport and Social Impact at www.latrobe.edu.au/cssi

Ministerial Advisory Committee on Mental Health

Improving the physical health of people with severe mental illness

No mental health without physical health

Report



Foreword

High premature mortality rates due to physical illness have been reported for people with severe and enduring mental illness for many years.

The life expectancy of people with a severe mental illness is estimated in some international studies to be as much as 25 years less than the general population. Such a reduction in life span is unacceptable by any standard. It implies a higher incidence of disease, a worse course of disease or both. This is a major social and public health issue that warrants urgent and sustained attention by all levels of government.

Many causes of death and illness which contribute to this reduction in life expectancy can be treated or prevented through timely access to targeted health promotion effort, preventative physical health care and effective chronic disease management care. The level of physical health inequality experienced by people with severe mental illness is also driven by complex, inter-related factors including poverty, homelessness and poor living conditions.

In response to this pressing issue, the Minister for Mental Health asked the Ministerial Advisory Committee on Mental Health to provide advice on the specific role specialist mental health services (clinical and Psychiatric Disability Rehabilitation and Support Services) should play, as part of the broader health care system, in reducing the prevalence of physical illness and premature mortality experienced by many people with a severe mental illness.

The evidence collected in the course of this project clearly identifies that significant barriers to physical health treatment persist for this population group. This raises serious questions of equity in health care provision for people who are mentally ill.

The literature challenges any view that people with a mental illness are not motivated to improve their physical health. This is not the case. Clients of specialist mental health services look to their case manager or key worker to play an active role in encouraging and supporting them.

It was also evident from the consultation process that specialist mental health services believe they have an important role to play in supporting people with severe mental illness and enduring psychiatric disability to improve their physical health as part of a holistic approach to their overall health care. However, this is clearly not the responsibility of the specialist mental health service system alone. General practitioners and other primary health and allied health services, including Community Health, have a central role in the provision of preventative health care and medical treatment.

A whole of system approach involving specialist mental health services, general practice and Community Health is needed to improve access to timely and effective physical health care for people with severe mental illness. Achieving this will require a stronger focus on accountability for outcomes by all stakeholders.

This report makes recommendations for consideration by both the Victorian and Australian Governments as the respective funders, policy and system managers of the specialist mental health and primary health care service systems. Bringing about the cultural, practice and system change envisaged by this report will require concerted, coordinated action and adequate resourcing across both service systems, supported and guided by strong committed leadership from government and service providers.

I commend this report to the Minister for Mental Health for her consideration.

Bill Brown
Chair, Physical Health MAC Sub-committee

Acknowledgements

Members of the Physical Health Ministerial Advisory Committee on Mental Health (MAC) Subcommittee:

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John McGrath, Chair, Ministerial Advisory Committee on Mental Health

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Many thanks to everyone who contributed to the development of this report. We would particularly like to thank Ann Bates from the University of Western Australia for sharing her knowledge and expertise with the subcommittee.

Executive Summary

Preamble

In the last decade, there has been growing recognition and understanding of the complex interrelationship between physical and mental health. The high level of physical ill health experienced by many people with a severe and enduring mental illness has a direct impact on their life expectancy and quality of life, notwithstanding the fact that mental illness itself does not have any inherent causative connection to physical illness.

The evidence on the level of health inequality and higher incidence of physical illness experienced by people with a severe mental illness, relative to the rest of the population, is extensive. What is clear is that much of the physical health co-morbidity associated with mental illness is potentially preventable through lifestyle modification and early recognition and treatment of common physical diseases such as cardiovascular disease and diabetes.

The evidence indicates that a significant amount of the health burden experienced by people with a severe mental illness is directly linked to the detrimental side effects of psychotropic and mood altering medication. However, poor living conditions, a product of the entrenched socio-economic disadvantage experienced by many people with severe mental illness, is a significant contributing factor to this burden.

This is further compounded by the way many mental health and medical professionals respond to physical health matters for this population group, resulting in missed opportunities for prevention and early detection and treatment of common physical health conditions.

The evidence strongly supports the need for the development of an integrated health response that supports prevention and the early diagnosis, treatment and management of physical health problems as part of the overall treatment and care provided to people with severe mental illness.

What do we want to achieve?

The MAC strongly advises concerted action and investment to address the physical health inequality experienced by many people with severe mental illness, targeting key diseases to achieve demonstrable improvement in physical health. The aim is to reduce the premature mortality rate and the prevalence of co-morbid physical health problems, particularly cardiovascular disease, diabetes and oral health problems. This will involve reducing the risks associated with poor health that are common to this population group including obesity, smoking, poor nutrition, low levels of physical activity and drug and alcohol misuse.

We want people with severe and enduring mental health problems to have access to the same standard of physical health care as the general community. *This population group requires a higher, sustained and tailored level of support to achieve physical health outcomes that are at least equivalent to that in the general population. Affirmative action is both a principle and a responsibility.*

The Australian Government has a critical role to play in closing the gap on health inequality by improving access to high quality responsive General Practice (GP) and primary health care funded through the Medical Benefits Scheme and the broader health budget. At the state level, the Victorian Government must support the specialist (clinical and Psychiatric Disability Rehabilitation and Support Services (PDRSS)) mental health service system to embed physical health into its core business.

The recommendations contained in this report seek to build a multi-system response to the physical health needs of people with severe mental illness. The MAC proposes that coordinated action be taken by the Australian and Victorian Governments to build a comprehensive system response that will result in:

- **Easy to navigate pathways** to affordable and responsive GP and primary health care and allied health services for people with a severe mental illness.

- **All people with a severe mental illness having a general practitioner** who will play a proactive role in the early detection and treatment of physical illness, the management of chronic physical disease, as well as the provision of preventative health support.

- Clients of specialist clinical mental health services **accessing comprehensive health assessment with supported referral** to appropriate assessment, treatment and support from the broader GP and primary health care system, including Community Health services.

- **Improved continuity of care** achieved through strengthened coordination and collaboration at the local level between specialist mental health, GP and Community Health services.

- Sustained action being undertaken to address the **social and economic determinants of good physical health,** with particular attention to improving access to affordable housing, employment and adequate and nutritious food.

Role of the specialist mental health service system

Community based specialist clinical mental health services

The MAC is of the view that specialist clinical mental health services should, as part of their core business, have a mandated role in improving the physical health of service users as part of a holistic approach to client care. This role should include early detection and intervention, through physical health assessment and supported referral, and a focus on prevention, through health promotion, education activities and targeted health interventions.

It is recommended that specialist clinical mental health services be adequately resourced and mandated to have the following core roles and responsibilities:

- **Comprehensive physical health assessment**. As standard practice, community based clinical mental health clinics will undertake a comprehensive health assessment for all case managed clients on their entry to, and exit from, the service and at regular intervals during the period of treatment and support. This assessment should provide a systematic appraisal of lifestyle, health and medication side effects. It should form part of an integrated physical and mental health plan and be subject to standard review, monitoring and follow-up processes.

- **Supported referral[1] and linkage** to:

  - General practitioners for assessment and appropriate investigation and the provision of medical treatment and health consultation as needed. With the permission of the client, the GP and the clinical case manager should share an integrated health care plan with both sectors fully understanding their roles and responsibilities to the patient/client in respect to the implementation, monitoring and review of this plan.
  - Allied health services such as dieticians, podiatrists, diabetes educators and oral health (dentistry) services in the private, Community Health and other relevant service sectors.
  - Local providers of healthy lifestyle services such as exercise groups, gyms and recreational activities.

[1] Supported referral means the case manager/lead worker actively assists the client to find and engage with the service provider they are referred to and provides follows up support to ensure ongoing engagement occurs.

- **Health promotion and targeted interventions.** As standard practice, clinical mental health services should provide health promotion education, advice and information with a particular focus on smoking cessation, reducing alcohol consumption, weight management and nutrition, sexual health and physical activity. They should also have the capacity to provide targeted interventions such as healthy lifestyle counselling and physical activity programs.

- **Supported decision making.** Support patients to be involved in decisions about their medical treatment and care within the compulsory treatment framework governed by the *Mental Health Act 1986*.

Psychiatric Disability Rehabilitation and Support Services

The MAC recommends that Psychiatric Disability Rehabilitation and Support Services have the following core roles and responsibilities:

- Ensure that initial assessments of all new clients identifies their known physical and oral health needs and embed physical health in the client's Individual Support Plans.

- Provide supported referral and linkage to general practice, allied health services, Community Health and oral health services where issues are identified.

- Deliver tailored healthy lifestyle programs in collaboration with Community Health (e.g. healthy diet and weight management) and local government and other providers (e.g. walking groups and physical activity programs).

- Provide health promotion education, advice and information and modelling of appropriate lifestyle and dietary choices.

What is needed to make this happen?

Integrating and embedding physical health into the policy, practice and service delivery of the specialist mental health service system will require a clear policy and authorising environment (from government and within Health Services and the PDRSS non government sector), coupled with strong leadership and careful, sustained investment in infrastructure and system capacity.

On this basis it is recommended that the Victorian Government, through the Department of Health:

1. **Develop a clear policy and authorising environment** that has high level engagement within Health Services and the PDRSS sector, to drive the structural, practice and cultural change required within the specialist mental health service system.

2. **Invest in the necessary infrastructure and capacity building** required to support the specialist mental health service system to embed physical health into core practice and work collaboratively with local GP and Community Health services.

3. **Establish a statewide physical health advisory body** to oversee the system reform and development needed to drive outcomes in this area, including research and the development of clinical guidelines, heath promotion resources and targeted health promotion strategies and interventions.

4. Ensure **policy and operational frameworks and funding guidelines** for current and planned investment in public primary health and acute health services prioritise and optimise physical health outcomes for people with severe mental illness.

5. **Develop physical health outcome measures and performance indicators** for inclusion in existing reporting and accountability frameworks for specialist mental health services.

6. Invest in **research and evaluation** to ensure evidence based physical health best practice, assess impact of investment and support continued improvement in service provision.

The Victorian Government, consistent with the policy directions articulated in the *Victorian Mental Health Reform Strategy 2009-2019*, has a key role to play in supporting policies that address the social and economic determinants of good physical health, particularly access to affordable housing and employment. The MAC strongly supports continued and sustained effort in these areas on the basis that unless basic life needs are meet, people with severe and enduring mental illness will remain compromised in their ability to self manage their mental and physical health.

Role of the general practice and primary health care service system

Any meaningful analysis of the role of the specialist mental health service system in improving the physical health of people with severe mental illness must take into account the role and performance of the broader primary health care system, including general practice and Community Health.

It is the view of the MAC that positive discrimination is needed to remove the barriers to adequate medical treatment and primary health care for people with severe mental illness. General practice has a central, critical responsibility for the provision of medical treatment, chronic disease management and preventative health care to all members of the community, including people with severe mental health problems.

As the funder, policy and system manager of general practice health care, the Australian Government must take proactive, sustained action to close the health inequality gap experienced by people with severe and enduring mental illness. This can only be achieved by improving access to affordable and responsive medical treatment and preventative health care, and linking providers of these services to state-funded allied health and primary health services to ensure these service sectors provide people with a severe mental illness, as a minimum, the same level of physical health care afforded the general community.

There are currently significant disincentives for GPs to treat people with severe and enduring mental illness, most notably the cost disincentive. This client group often requires more time for a consultation and can miss appointments making them a 'risk' in any for-profit business model. Coupled with the perceived 'difficulty' of treatment by the GP, many clients of the specialist mental health service system do not receive any or adequate medical treatment.

Improving access to general practice health care, however, will require more than simple market incentives. It will involve the provision of GP education and training; targeted capacity building (such as the expansion of Mental Health Nurse Incentive Program) and infrastructure support; and the development of stronger links between GP, specialist mental health and Community Health services.

It is recommended that the Victorian Government advocate for and work proactively with the Australian Government to develop a GP and primary care policy that ensures:

- All people with a severe and enduring mental illness have a general practitioner and that barriers to access (geographical and financial) are addressed. Given the level of chronic physical health problems experienced by people with a severe mental illness, it is proposed that an adequately funded system of voluntary 'patient enrolment' (currently in place for people with diabetes) be extended to this population group.

- Cost disincentives for general practice to provide medical treatment, chronic disease management and preventative health care to people with severe and enduring mental health conditions are systematically addressed.

- Where GP health care services fail to adequately respond to the physical health needs of people with a severe mental illness, the Australian Government take action to address this issue in collaboration with the Victorian Government through, for example, block funding to selected GP practices and Community Health services and the use of credentialed nurses where GPs are unable or unwillinging to provide treatment and care to this client group.

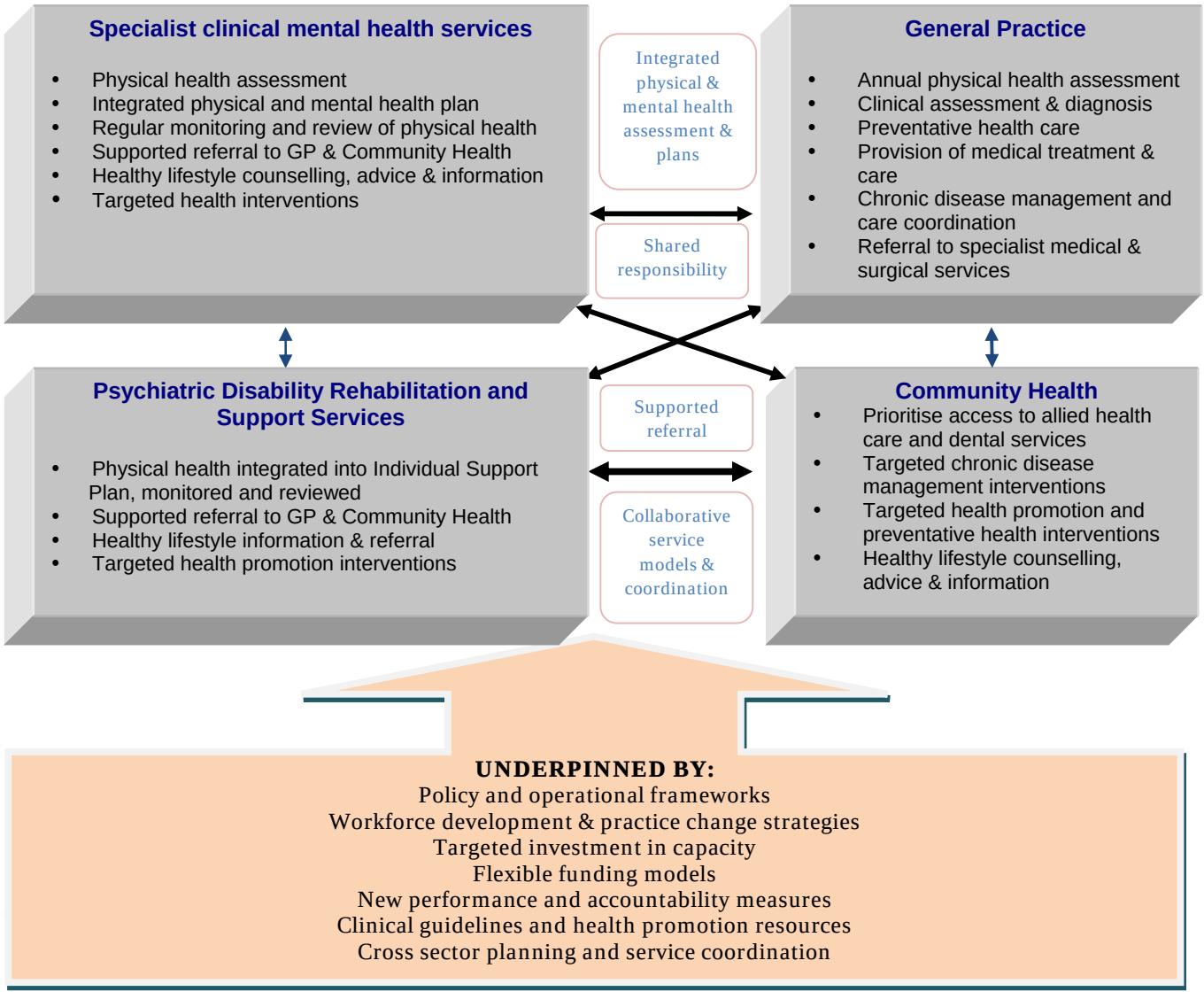
- The Primary Health Care Organisations (Medicare Locals) being proposed as part of the National Health and Hospital Reforms are required to prioritise the physical health of people with severe mental illness in all aspects of the work of these entities.

- The *Healthy Communities Reports* to be developed by the proposed Medicare Locals be required to include outcome measures and targets related to the physical health of people with a severe mental illness as well as population mental health outcomes more broadly.

- New or existing performance and accountability frameworks for general practice health care take account of the physical health of people with a severe and enduring mental illness. This is critical to strengthen accountability for outcomes and ensure clear and transparent reporting.

The proposed roles and responsibilities of the specialist mental health service system in relation to Community Health and General Practice are summarised in Diagram 1.

Diagram 1: Overview of proposed key roles and relationships



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1 Project 0verview

1.1 Introduction

The Ministerial Advisory Committee on Mental Health (MAC) has prepared this report for the Minister for Mental Health to assist her to identify the concrete action needed to improve the physical health of people with a severe mental illness living in Victoria. This area was identified for early priority attention in the *Victorian Mental Health Reform Strategy 2009-2019*.

The report was produced by the Physical Health MAC subcommittee which was composed of members of the MAC and co-opted members with expertise in areas relevant to the project. The sub-committee was chaired by Bill Brown, a MAC member and Area Manager, Goulburn Valley Area Mental Health Service.

The terms of reference of the project were to provide the Minister for Mental Health with practical recommendations on how:

- The specialist public mental health services[2] can contribute to reducing the prevalence of common physical health problems and associated risks (e.g. obesity, substance misuse, poor nutrition, poor oral health and smoking) experienced by people with a severe and enduring mental illness.
- Specialist mental health and primary health care services can work more effectively together to proactively address common, preventable physical health problems and improve health outcomes for this cohort.
- Access to established chronic physical disease management programs for clients with severe mental illness can be improved.
- Targeted health intervention and health promotion could be used to encourage positive health behaviours, self management and reduce the common risk factors associated with poor general health and illness.

The report focuses on the role and functions of the specialist public clinical mental health services and Psychiatric Disability Rehabilitation and Support Services (PDRSS) in improving physical health outcomes for young people (16-25 years), adults and older people with severe mental illness, and the role of these service sectors as part of a broader system of health care.

1.2 Project methodology

The project methodology involved a review of literature, reports and relevant initiatives in Victoria and other jurisdictions. Best practice and exemplar service models and programs operating in Victoria and other jurisdictions were also examined.

A series of forums were conducted to identify the role and scope of function of the specialist mental health service system in improving the physical health of people with a severe mental illness. This included forums with general practice, Community Health, the PDRSS sector, and clinical mental health services with an interest in young people, adults and older people with severe mental illness. The analysis of the issues, barriers and solutions identified in these forums, coupled with the evidence provided by the literature review, provide the basis for the strategic actions recommended in this report.

[2] Specialist mental health services are defined as clinical mental health and psychiatric disability rehabilitation and support services.

2 Policy context

2.1 Mental health reform strategy

Improving the poor physical health status of people with severe mental illness has been identified as an area for early action in the *Victorian Mental Health Reform Strategy 2009-2019*. The strategy provides a broad ranging reform agenda to guide the development of mental health services over the next decade. It places emphasis on the role specialist mental health services can play in supporting clients to better manage their physical health as part of a broader system of health care. It highlights the importance of specialist mental health, general practice and primary health services working together to ensure timely access to preventative and chronic disease management care.

2.2 Development of the new mental health legislation in Victoria

People who experience a severe mental illness may be subject to compulsory treatment and care which is governed by the *Mental Health Act 1986*. The Review of the *Mental Health Act 1986*, which commenced in May 2008, will examine whether the safeguards in the Act appropriately protect human rights. A key Government reform proposed is the introduction of a supported decision making model of treatment and care. The new Act could provide mechanisms to give effect, wherever possible, to the person's wishes and place greater emphasis on respect for their autonomy[1].

Part of this reform includes improving patient access to physical health checks as well as facilitating coordinated care of both a patient's mental and physical health. This is in recognition of the need to improve the physical health of patients as part of their overall health care and promote recovery and wellbeing.

2.3 COAG National Health and Hospital Network agreement

On 20 April 2010, the Council of Australian Governments (COAG) agreed (with the exception of Western Australia) to establish the National Health and Hospital Network Agreement. This Agreement introduces changes to Commonwealth and State roles and responsibilities in respect to the funding and management of public hospitals and primary health care services.

As part of this agreement, the Australian Government will become the majority funder of Australian public hospitals, by funding 60 per cent of national efficient price for hospital services delivered to public patients. State governments will remain system managers and purchasers (through Service Agreements) for all public hospital services to be delivered by Local Hospital Networks (LHNs).

The Australian Government will also assume full policy and funding responsibility for primary mental health services for people with mild to moderate disorders, as part of the Commonwealth assuming full responsibility for primary health care services[2].

The *National Primary Health Care Strategy*[3] details key priority areas and initiatives to support the proposed reform of primary health care system across Australia. Addressing inequalities and gaps and improving access to health care, improved chronic disease management and an increased focus on prevention are identified priority areas. The MAC notes the proposed strategies include the establishment of Primary Health Care Organisations (Medicare Locals); a national eHealth records system; capacity building in the primary care health workforce; and investment in primary health care infrastructure including GP super clinics.

The MAC notes that e-health developments on the national level, including the recent passing of legislation to establish an Individual Health Identifier and plans to develop Personally Controlled Electronic Health Records, will significantly support more efficient and effective inclusion of a range of health providers, including GPs, in managing people with complex care needs.

3 The Case for Change

3.1 Prevalence of physical ill health

In comparison with the general population people with a severe mental illness have higher rates of mortality and physical morbidity. Recent research from the USA identified that clients of public mental health services die an average of 25 years earlier than the general public[4] - many of the causes of death were found to be similar to the cause of death for all other persons and could be treated or prevented through timely access to effective health care and information.

The literature suggests that people experiencing poor social and economic circumstance have twice the risk of serious illness and premature death[5]. People with severe mental illness are more likely to experience poverty, unemployment, homelessness, social isolation and exclusion which are key determinants of poor health.

The *Duty to Care*[6] report produced by the University of Western Australia highlighted some alarming statistics on the physical health of people with serious mental illness[7]. This report noted the number of excess deaths in the mentally ill due to ischaemic heart disease (IHD) has increased in women and remained roughly constant for men, despite a downward trend in IHD mortality in the general community. This report identified that hospitalisation rate ratios were often lower than corresponding mortality rate ratios suggesting that people with a mental illness may not have received the level of health care commensurate with their illness. It was also of note that despite very high rates of smoking, cancer incidence was no different in people with mental illness than in the general population. However, once a cancer was diagnosed there was a 30 per cent higher case fatality in users of mental health services.

There is now widespread acceptance of the direct relationship between physical and mental health, especially the poor physical health of people with severe mental illness. The physical health of people with schizophrenia, for example, is typically poorer compared to the general population (an estimated 50 per cent have a co-occurring physical illness[8]) with the prevalence rate for obesity up to three times greater for this group[9].

New analysis of 1.7 million records of primary care patients in the UK found that people with a diagnosis of schizophrenia or bipolar disorder are more than twice as likely to have diabetes than other patients and also more likely to experience ischaemic heart disease, stroke, hypertension and epilepsy[10]. Obesity and hypertension are the most prevalent medical co-morbidities amongst this group in the UK[11].

People with a severe mental illness often have poor dental health and have a higher prevalence of smoking (70 per cent smoke compared to 20 per cent of the Australian public[12]). Gum disease is exacerbated by high levels of tobacco use. There is also a growing evidence base to support a close relationship between poor oral health and poor physical health. A significant number of people with severe mental illness also have co-occurring substance abuse problems[13] – the long term health impact of harmful levels of alcohol consumption and other forms of substance abuse are significant.

3.2 Health impacts of psychiatric medication

The risk of obesity is compounded by the side effects of prescribed psychiatric drugs, particularly the newer atypical antipsychotics, which may lead to considerable weight gain[14]. Research suggests that between 40 and 80 per cent of patients taking antipsychotic medication experience weight gain that exceeds ideal body weight by 20 per cent or greater[15]. Weight gain is also found to reduce the likelihood of adherence to medication regimes, which is likely to have profound effects on the severity of the illness[16].

In addition, antipsychotic medications (such as clozapine and olanzapine) used to treat psychiatric illness may result in other distressing physical side effects such as hyper-salivation and have been clearly associated with increased cholesterol and blood sugar level which can lead to diabetes.

The evidence base on the health impacts of new psychotic medications is still developing. Clinical observations in Victoria suggest that while the mental health of individuals has improved as a result of these medications and they have reduced the mortality rate associated with suicide and traumatic death, physical health is getting worse. In effect while mortality rates are decreasing in the short term, chronic physical disease can be expected to increase over the longer term.

The consequences of this dynamic are not fully known at this stage. This is an important reminder that not all patients need to be prescribed atypical rather than older antipsychotics. As both the older and newer drugs have a range of side effects, the drug used should be tailored taking into account the relative risks and benefits of each class of drugs to the person receiving the medication.

3.3 Social and economic determinants of good health

The health inequalities experienced by people with severe mental illness cannot be explained by physical health factors alone. The drivers for health inequality amongst people with severe mental illness are complex and interrelated and include poverty, homelessness, social isolation, lifestyle and living conditions, problems accessing health assessment and medical treatment in addition to the side effects of anti-psychotic and mood stabilising medication.

These socio-economic stressors directly affect the individual's capacity to care for their own health and pay for private medical services. The struggle to eat properly coupled with low levels of exercise can have long term health impacts and contributes to weight gain and obesity experienced by many people with severe and enduring mental illness. These issues are significantly compounded for those who are homeless or living in insecure housing[17]. The transient life experienced by this vulnerable population group dislocates them from health services which leads to inadequate or no treatment or no patient-practitioner relationship. This is supported by a recent study in Western Australia[18] of over 200,000 users of mental health services which found that those with no fixed address (4 per cent of users surveyed) were unlikely to receive any medical care.

Improving physical health outcomes for people with a severe mental illness requires action that will improve their access to basic life needs, particularly affordable housing and nutritious and adequate food. Without this, the individual's capacity for self-management of reasonable good health is markedly reduced.

3.4 Access to responsive physical health care

There is a substantial body of evidence that some mental health and medical professionals interpret physical health symptoms and concerns as a mental health rather than a primary health issue - a phenomenon called 'diagnostic overshadowing'[19]. As a consequence, medical professionals often fail to identify and treat physical health problems.

Research also suggests that medical professionals may be challenged by people with a co-morbid physical health and mental health problem and as a result may fail to identify physical health problems or provide adequate treatment and care, routine preventative services (e.g. weight management and smoking cessation) or actively involve the person in decisions relating to their physical health treatment and care. Medical professionals may also experience frustration working with individuals who appear resistant to sound medical advice or fail to attend appointments, without understanding the reasons why people may find this difficult and that a different type of effort is needed to engage them.

There also appears to be differences in perception between people with a severe mental illness, professionals and carers regarding their desire to improve their physical health. More recent literature has found that medical and mental health staff and carers think people who experience severe mental illness are unmotivated and are not concerned with improving their physical health. The literature challenges this view.

People with a severe mental illness typically view their case manager/lead worker as their principal health care resource[20]. Evidence suggests that the relationship between professionals and service users has the greatest influence on life changes.

This is a critical issue as many mental health clients often do not receive consistent medical care or have a designated general practitioner and may have difficulty accessing Community Health services. The 2010 census of PDRSS clients[21] in receipt of home based outreach support (HBOS) identified that approximately 20 per cent accessed GP care and only 7 per cent accessed Community Health services. In contrast, it is estimated that 25 per cent of PDRSS HBOS clients have chronic physical health conditions.

While it is true that a person's motivation to do something about their physical health is often impaired by their mental health condition, this only highlights the critical importance of active encouragement, support and practical assistance. The evidence also suggests that any effort to improve the physical well being of people with a severe mental illness will need to improve their ability to self manage their physical health.

People with a severe mental illness have expressed frustration and difficulties navigating the complexity of mental health and broader health and social support service systems[22] - a situation made even more problematic when these services do not work in a coordinated manner. These barriers impact directly on their ability to access timely medical treatment and care and the development of an ongoing, trusting relationship with a local GP or primary health care provider.

3.5 Access to health information

A study into the design of a self-management intervention for improving the physical health of adults with serious mental illnesses[23] found service users had limited knowledge and low self-efficacy regarding active self-management of their physical health. Despite their interest in learning more about health promotion, most participants expressed a sense of personal futility and powerlessness in improving their health.

Research suggests psychosocial rehabilitation programs and day programs can provide important settings for the delivery of health promotion efforts. Research has also found consumers especially liked getting health promotion information from other people, including health care professionals, friends and family. Print literature, the internet, and library services were found to have various limitations - consumers involved in the research were generally unfamiliar with community health fairs and related events. Trustworthiness, proximity and availability, and the specificity and depth of information provided by a communication source were considered by clients when getting health information[24].

The unacceptably high level of physical health problems experienced by people with severe and enduring mental health conditions and the resultant impacts on their quality of life and life expectancy, highlights the need for fundamental change.

HealthRight Project (Western Australia)

The HealthRight *project is a funded initiative of Western Australian Health Department Mental Health Division, based at the University of Western Australia (UWA) [25]. The project aims to reduce the incidence of chronic physical disease for people with mental illness. It was inspired by the* Duty to Care report *produced in 2001 by the UWA.*

In September 2002, the then Office of Mental Health established the HealthRight Advisory Group (HRAG) to respond to the Duty to Care report. *A project worker was employed to implement recommendations of the HRAG which were published in the* Who is Your GP? *report in 2004. The project has developed strategies and resources to:*

- *Raise awareness of the physical health needs of mental health consumers.*
- *Include physical health care in the routine care of mental health clients provided by mental health services (linked to standards and quality).*
- *Strengthen inter-sectoral linkages to facilitate better coordination and integration of relevant health services for physical and mental health care.*
- *Recognise the central role of General Practitioners in the management of the physical wellbeing of mental health consumers.*
- *Enhance the voice of consumers, their families and carers.*
- *Strengthen tertiary education and postgraduate training for health professionals, emphasising overall health care.*
- *Deliver targeted health promotion and illness prevention.*
- *Research, monitor and evaluate the impact of new services and programs developed as part of the project.*

4 Strategic action

This section of the report identifies concrete action to address the issues, barriers and opportunities identified in the consultation process. The recommendations and areas for action are summarised in Appendix 1 of this report.

4.1 Building the capacity of the specialist mental health service system

4.1.1 Role of community based clinical mental health services

There is broad consensus that specialist clinical mental health services should, as part of their core business, have a mandated role in improving the physical health of the estimated 60,000 Victorians who use these services every year.

Mental health clinicians and service managers involved in the consultation process felt that effort should focus on early detection and intervention (through physical health assessment, monitoring and supported referral) and prevention (through health counselling and promotion and education activities) to reduce the prevalence of common physical illness and the subsequent development of chronic physical disease. Services were of the view that this should form part of a holistic approach to client care.

This view is consistent with the literature which argues mental health nurses and allied health professionals should play an active role in health promotion, primary prevention and the early detection and management of physical health problems in all areas of clinical practice and that health information (such as nutritional advice, exercise counselling and healthy lifestyle education) and health monitoring should be delivered in tandem with the initiation of any psychotropic medication as part of routine practice.

Clinical mental health services, particularly those working with young people, identified a role in education and awareness raising for clients and their carers regarding medical conditions that are specific to certain mental health disorders, such as psychosis and anorexia.

The consultations noted that it is difficult to shift lifestyle behaviours related to ill health and effectively manage chronic disease in the general population and that this further emphasised the critical importance of prevention, early intervention and development of clear pathways to physical health care for young people, adults and older people with a severe mental illness.

Clinical mental health services were unanimous that the provision of preventative health, medical treatment and the clinical management of chronic physical disease was the central responsibility of the primary health care system, particularly general practice. While the specialist clinical mental health system felt they had an important role to play, they were part of a broader system of health care that had a **shared responsibility** to work together to achieve improved physical health outcomes for people with severe mental illness.

The MAC identified the following key roles and functions for community based clinical specialist mental health services:

- Provision of comprehensive physical health assessment for all case managed clients at point of entry into the service, at regular intervals after entry and at point of discharge from clinical mental health case management. On entry to a specialist clinical mental health service, if the client has a GP, they should be contacted to provide a summary of past and current medical problems and medication.

- Inclusion of the health assessment as a documented part of an integrated mental health and physical health treatment and care plan which would be subject to regular review, monitoring and follow-up in collaboration with the client and their carer/s.

- Supported referral to GP and allied health services (such as podiatry services, oral health, dieticians, diabetes educators and sexual health services) for further testing and treatment and other key services such as school nurses and healthy lifestyle services provided by local government and other community providers.

- Active collaboration with general practice to support GP led chronic disease management plans.

- Regular assessment of the side-effects of medication and where an adverse impact on physical health is identified, consideration will be given to an alternative treatment regimen.

- Healthy lifestyle counselling, education and promotion to encourage healthy behaviours and support clients to improve their ability to self manage their physical health.

- Provision of targeted health interventions, which could be delivered in collaboration with Community Health and the PDRSS sector.

- Creation of health promoting environments in bed and community based mental health service settings including ensuring smoke free environments and modelling by staff of good health behaviours e.g. smoking and healthy food choices.

- The role of case managers as a motivator, using a health coaching approach, Cognitive Behavioural Therapy and other motivational techniques.

- Collecting information against agreed clinical performance indicators in order to monitor impacts and outcomes achieved and strengthen accountability.

The MAC notes that over the last decade Victoria has strategically invested in the provision of specialist clinical mental health expertise to support primary mental health services, particularly general practice, to improve their skill and expertise in the early identification, diagnosis and treatment of people with a range of both high and low prevalence mental health disorders[3].

This specialist expertise, delivered through primary mental health early intervention teams located in adult clinical mental health services, provides a critical interface between tertiary and primary health services for the management of demand between these two sectors. The MAC proposes that any planned redevelopment or enhancement of this service model include consideration of its role in strengthening access to GP health care for people with severe and enduring mental illness.

In order to better support clients to adopt health lifestyle behaviours and provide the practical support needed to navigate access to medical, surgical and allied health services, the MAC recommends the use of trained Peer Mentors be investigated and closer links between public specialist mental health services and the Commonwealth funded Personal Helpers and Mentors Program be encouraged.

While out of scope of this report, the MAC recognises the important role of private psychiatrists and psychologists in identifying physical health issues in their client population and supporting their referral to appropriate medical treatment and primary health care.

Impact of psychiatric medication

A key issue identified in the consultation process was the role played by the new/second generation (atypical) antipsychotics in the increased prevalence of obesity, diabetes and metabolic syndrome amongst people with severe mental illness.

The MAC notes that large clinical trials have failed to show a difference between the older and new classes of antipsychotics in terms of clinical outcomes[26]. This raises a significant question regarding the continued use

[3] This service model provides assessment, secondary consultation and training to general practice and other primary health care providers. It also supports shared care arrangements and provides a pathway for people to enter/re-enter the specialist mental health system from primary care.

of an atypical antipsychotic for people at risk of developing long term life-threatening physical health problems and emphasises the important need to consider the likelihood of physical health side effects when deciding the most appropriate medication for an individual.

The MAC recommends that, given the relative risks and benefits of the older (typical) and new (atypical) antipsychotics in respect to physical health side effects, that their use be reviewed and clinical guidelines developed to inform practice.

Adult mental health services also reported the need to support clinicians to resolve the inherent tension between telling people about the potential impact of antipsychotic medication on their physical health and the resultant risk of non-adherence, particularly for those who are involuntary clients. This tension was significantly less prevalent in youth and aged specialist mental health services as physical health was regarded as a more integral part of client overall wellbeing.

St Vincent's metabolic screening program

St Vincent's has introduced metabolic screening in its community mental health clinics in response to the levels of physical health problems in clients and the impact of medication on their weight and consequent physical health and self-esteem. This service has been operating at St Vincent's for two years.

Implementation was initially met with a high level of resistance from mental health clinicians who did not understand the extent of the problem and did not feel they had the resources to deal with it. These issues were overcome by providing education on key physical health issues (such as diabetes) and providing equipment such as scales, blood pressure cuffs etc, for clinicians to use with clients. Keeping things simple, as well as putting physical health into policy documents (such as the strategic plan) and developing guidelines, helped embed change in organisational culture and practice.

Outcome of metabolic assessments are provided to GPs and also to clients if they wish. A booklet has been produced for clients and includes an example of the metabolic screening form. These forms are used by clinicians as part of the Individual Service Plan (ISP) review process. Clients are also screened for dental health, family history etc. New clients are assessed for baseline physical health information on admittance to the service and GP details are collected. Contact is made with the GP to discuss shared care arrangements.

Staff have been trained as QUIT educators. Physical health checks are done by St Vincent's staff and referrals are made to GPs if an issue is detected. Feedback from clients indicates that they want and expect their mental health clinician to work with them to improve their physical health.

4.1.2 Role of acute and sub-acute mental health services

The consultation process identified that the short length of stay in acute inpatient settings provides a small window of time to deal with physical health issues. There was also a view that the acute phase of illness may not be the most appropriate time to discuss healthy behaviours and lifestyle change. Notwithstanding this, optimising the quality of physical health assessments undertaken when people are admitted to hospital and the action taken in response to the assessment (including consistent monitoring and follow up on discharge) is critical. The inpatient unit also provides the opportunity to obtain specialist medical assessment by physicians and surgeons in the co-located medical and surgical units of the general hospital.

Improving access to acute medical and surgical treatment for people with a severe mental illness, including those under the care of a general practitioner, was identified in the consultation process as an area for development. Consideration could be given to expanding the existing consultation and liaison (CL) psychiatry function in hospitals to work with, and provide support to, medical and surgical staff providing care to people with a mental illness.

The MAC notes the uneven distribution of CL services was identified as a major barrier to such care. Even amongst the major metropolitan hospitals the type and level of CL service is variable; in regional and rural services these services are absent.

Sub-acute Prevention and Recovery Care (PARC) services provide an opportunity to follow up issues identified in the physical assessment undertaken while the client was in hospital. PARC services should also be mandated to undertake physical health assessments for new clients entering from the community (which

could also be delivered by a GP 'in-reach' response), ensure individual service plans include the clients physical health status and needs, actively link clients to appropriate primary health care services and provide healthy lifestyle counselling.

The Hospital Admission Risk Program (HARP) service model demonstrates the value of working with clients to link them to community-based health and broader social support services on discharge from hospital and the Emergency Department. Consideration could be given to expanding this model to support people with a severe mental illness (after admission to acute psychiatric inpatient ward as well as after admission to a medical/surgical ward), focusing on those with chronic physical disease conditions.

Crisis Assessment and Treatment (CAT) and Case Management teams, as part of their discharge planning role, can support patients to link to appropriate health services and ensure information regarding medical conditions identified while the person was in hospital is communicated to their treating clinician and GP.

As the joint funders and system managers of public hospitals, the MAC recommends that the Victorian Government in collaboration with the Commonwealth, take all necessary action to ensure the physical health of people with a severe mental illness are prioritised by the acute health care system. This includes ensuring the Local Hospital Networks (LHN) proposed as part of COAG National Health and Hospital Reforms are held directly accountable for their performance in this area and that this is reflected in LHN service agreements and related performance standards and measures.

Case Studies from the United Kingdom[27]

A health screening pilot was conducted in a long term inpatient unit. *82% of patients sought a health screen delivered by a practice nurse or GP. 59% of patients had a BMI over 25; 59% smoked; 27% had ear problems; 17% had raised blood pressure and 11% had sight problems. 50 of the 66 patients had recommendations for action and only 66% of those were followed up. This pilot raised the need for nurses on wards to take a more proactive health promotion role with additional training and support, and for patients to be provided with follow-up support post discharge.*

GP led weekly primary care service in an acute inpatient unit*. 22% of all patients admitted to the acute unit attended the GP service over a 10 month period. Presenting complaints include a wide range of acute and chronic conditions. New medication was prescribed for 66 consultations, existing medication altered for 8 and watchful waiting was relevant for 49 consultations. As well as treating specific complaints, the GP undertook health promotion directly with 97% of cases. The doctor also provided information and advice to staff on wards about physical health assessments, care and maintenance. This program could also be delivered by nurse practitioners.*

4.1.3 Role of Psychiatric Disability Rehabilitation and Support Services

The MAC has identified specific roles and functions for the PDRSS sector in improving physical health outcomes for clients with a severe mental illness and associated psychiatric disability.

A clear policy and authorising environment is required, as with the specialist clinical mental health service sector, to ensure physical health issues are addressed in organisational policy and practice. This needs to be linked to capacity building, workforce development and targeted investment in health promotion.

Identified roles for the PDRSS sector include:

- System advocacy to improve access to local GP and Community Health services.
- Embedding physical health in the client's Individual Support Plans and providing supported referral to GP, Community Health services and other allied health services.
- Provision of education, health promotion information and healthy living/lifestyle interventions delivered through psychosocial rehabilitation outreach programs and day programs. Healthy living interventions could be delivered in collaboration with Community Health and other local services.
- Delivery of a peer support model for health promotion (e.g. quit smoking, weight management and diet) and to provide practical support to clients to attend medical appointments.
- Support the introduction of health assessments in PARC services in collaboration with the client's mental health case manager and general practice.
- Implementation of smoke-free workplace policies with cessation support programs for both clients and staff.
- Practical support for clients to improve their oral health (for example by supplying toothbrushes, paste and dental floss linked to education and health promotion on basic dental hygiene) and the development of stronger links to Community Health and other providers of public dental services to facilitate referral and priority access to public dental services.
- Modelling lifestyle behaviours, such as teaching clients to cook their own food and thereby reduce their reliance on high fat/high sugar take away food.

4.1.4 Role of Emergency Department

Keeping people with a severe mental illness healthy and out of hospital should be a key aim. From an efficiency perspective it is worth ensuring that people with a mental illness do not use the Emergency Departments (ED) for a primary physical health care response.

This highlights the importance of the interface between hospitals and specialist mental health care services and the need to align hospital and primary health policy frameworks and accountability structures.

The MAC understands that Emergency Departments are not necessarily the best location to undertake a comprehensive physical health assessment or to commence health education for a person with a severe mental illness, but it may be the only health service people with a mental illness make contact with. On this basis this service setting provides an invaluable opportunity to assess for physical health issues.

The consultation process identified that when people with a mental illness present to an ED with co-existing physical health problem their psychiatric presentation tends to be prioritised. As a result the person is often given only a cursory health check unless admitted to a hospital ward. The consultation suggests this may be occurring for a number of reasons:

- Inadequate time being allowed to assess people with mental health conditions for underlying physical health issues when they present to the ED due to the assessment targets in the ED of four hours.
- Many staff may lack the confidence to enable them to appropriately interact with a person with a mental illness in order to conduct a more comprehensive physical health assessment in the ED.
- Tendency for 'diagnostic overshadowing' resulting in ED staff overlooking physical symptoms when an individual has a mental health condition.
- Skill and competency of ED staff in the diagnosis of physical conditions in mental health patients.

The MAC recommends that a strategy be developed to strengthen the role of ED in respect to the physical health of people with a mental illness. This may include consideration of: standardised physical health assessments; education and training for staff in the ED to improve skill, confidence and competency in the diagnosis of physical illness in this target group; performance measures to strengthen accountability for outcomes in this area; and a review of the four hour target for assessment in the ED to allow adequate time for a physical assessment to be undertaken.

What is needed to make this happen?

Supporting specialist mental health service system to play its part in achieving the client outcomes identified in this report will require:

- A policy driven authorising environment and strengthened accountability
- Workforce capacity development
- Targeted investment in system capacity
- Strengthened cross sector planning and coordination
- A robust evidence base
- Development of health promoting physical environments.

Creating the authorising environment

The MAC strongly advises the Victorian Government develop a policy framework to drive the structural, practice and cultural change required to embed physical health into clinical and PDRSS practice. The absence of this was identified in the consultation process as a key barrier. High level engagement within Health Services and at the clinical director and nurse/service manager level was identified as critical to ensure organisational policy and strategic frameworks include physical health.

The experience from other jurisdictions, such as the United Kingdom, indicates that while policy and accountability frameworks are critical to creating the authorising environment needed to drive action in this area, this by itself is not enough.

Bringing about change will require sustained effort and leadership within the mental health service system supported by targeted investment in capacity, workforce development and support for culture and practice change.

There was also a general sense from the consultation process that public mental health services needed to be more flexible and move to a new paradigm that places physical health as a critical, integral part of the client's health needs. This includes creating an expectation that all clients of the specialist mental health service system be in a shared care arrangement with a GP for their physical health needs.

It is recommended that the Victorian Government invest in the 'in house' capacity needed to embed physical health in organisational frameworks, drive cultural and practice change, and assist Area Mental Health Services and the PDRSS sector to build and sustain the partnerships needed to achieve coordinated action across specialist mental health and the broader primary health care service sectors.

The MAC also recommends that a state-wide physical health advisory body be established to oversee the system reform and development needed to drive outcomes in this area. Such a body could also assist with the development of best practice clinical guidelines and support resources for physical health assessment. This body could also provide expert advice on performance measures, the design of targeted physical health interventions and health promotion strategies and resources.

The MAC has identified the need for performance measures to be developed to assist all public specialist mental health services to monitor improvement in physical health outcomes and strengthen accountability.

The MAC notes consideration is being given to improving patient access to physical health checks as well as facilitating coordinated care of both the individual's mental and physical health in the development of the new Victorian mental health legislation. The MAC fully supports this action.

Consideration should also be given to including an assessment of system activity regarding physical care as part of the planned reintroduction of the Chief Psychiatrist Office reviews.

It is the view of the MAC that without this matrix of effort the shift to a new paradigm that places physical health as a critical, integral part of the client's overall health needs, will not be achieved.

Building workforce skill and competency

Mental health staff require ongoing training to update skills and knowledge in physical health care[28]. Areas identified in the consultation process include skills development in physical health assessment and monitoring, lifestyle counselling tailored to the needs of particular age groups and mental health conditions (particularly advice on nutrition and exercise), health modelling and strategies for motivating people.

It is recommended that a professional development package be developed and implemented to train and support nurse clinicians and allied health workers in these areas. This professional development package should be supported by evidence based clinical guidelines and resource material.

In addition, the MAC recommends that the Victorian Government liaise with professional organisations (e.g. College of Psychiatrists, the National Health Practitioners Board and Australian College of Mental Health Nurses) and tertiary educational organisations, to ensure they support and drive this approach and that relevant curriculum reflects the importance of physical health.

Targeted investment in service system capacity

The capacity of existing clinical staff to undertake physical health assessments, health lifestyle counselling and targeted health promotion activities was identified as a key constraint. There was a strong view that consideration should be given to funding specialist physical health nurse positions/nurse practitioners to undertake this role. These positions could work across a number of service settings including PARC, bed based clinical rehabilitation services and community-based mental health clinics.

The MAC is of the view that this new capacity should be targeted to child and youth, adult and aged mental health teams that do not have nurse clinicians, and high volume mental health clinics. These positions could also provide secondary consultation to mental health clinicians to facilitate supported referral and a follow up response to general practice and Community Health.

The MAC also recommends that consideration be given to further investment in CL psychiatry to enable mental health teams to provide treatment and support to people with mental illness admitted to medical and surgical wards. Consideration should also be given to extending the HARP service model to people with severe and enduring mental illness and chronic physical health conditions.

UK based pilots using nurse practitioners[29]

Pilot programs in the United Kingdom using mental health nurse practitioners to deliver health improvement programs have been proven successful. The UK pilots suggest most effective results occur when nurse practitioners see 20 patients per week for checks, assessments, consultations and reviews as well as running health improvement groups and playing a lead role in liaison with primary and secondary health care. Identified success factors include: program lead having the right skills; clear boundaries between nurse practitioner and clients community mental health nurse; and effective communication/shared information. The nurse practitioner role was regarded as a pioneering position so a high level of training and support including clinical supervision was required.

Building the evidence base and driving practice change

It is the strong view of the MAC that practice must be contemporary and evidence-based with validated approaches actively promoted for wider use. Areas identified for priority development include:

- Evidence based clinical guidelines for physical health assessments and healthy lifestyle counselling, including the use of motivational techniques.
- Review of the relative benefits and risks of older versus newer antipsychotic medication with respect to physical health and development of evidence based guidelines to inform clinician use of both classes of antipsychotics medication and other psychiatric medication.
- A model of good practice in nutrition linked to a training program to up-skill clinicians and other relevant staff in its use.
- A chronic physical disease management framework tailored to the specific needs of people with mental health problems. The Early Intervention in Chronic Disease (EliCD) initiative in Community Health, which aims to move from an episodic/reactive care model to a chronic (planned, managed, ongoing) care approach, is a good example of the type of approach that could be adopted for use for people with a severe mental illness.

Strengthened cross sector planning and co-ordination

Action is required at the system level to strengthen referral pathways and the co-ordination of care between specialist mental health services, general practice and Community Health. Area Mental Health Services and the PDRSS sector must be supported and encouraged to build and sustain the local partnerships needed to achieve coordinated action.

Areas identified by the MAC for priority action include:

- Facilitate sharing of patient/client health information by supporting and encouraging specialist mental health services to become early adopters of the Individual Health Identifier (IHI) and the Patient Controlled Electronic Health Records (PCEHR) currently being developed by NeHTA.
- Improving local area planning and service coordination and building stronger referral pathways between specialist mental health, general practice and Community Health through Primary Care Partnerships and the proposed Medicare Locals. This should include requiring the newly created mental health planning and service coordination positions located in Department of Health Regions to take a lead role in facilitating an integrated local area health response to people with severe mental illness and chronic disease conditions, drawing on existing service sector partnerships and networks, including Primary Care Partnerships.
- Any planned redevelopment or enhancement of specialist primary mental health early intervention teams to give consideration to the role of this service model in promoting access to GP health care for people with severe and enduring mental illness.
- Consider establishing a statewide General Practice Mental Health Liaison Officer program in Area Mental Health Services, modelled on the existing General Practice Liaison Officer hospital program, to support improved access to GP care and continuity of care.
- Report on outcomes achieved in this area as part of annual reporting for Area Mental Health Services and outcome reporting associated with the implementation of the *Victorian Mental Health Reform Strategy*.

Creating health promoting physical environments

Internationally, there is increasing pressure on psychiatric inpatient settings to adopt smoke-free policies.

The consultation process identified a strong consensus that all mental health service environments should be smoke-free with pressure put on health care networks to ensure this policy gets implemented.

Lawn et al[30] examined smoke-free policies across psychiatric inpatient settings in Australia and identified factors that may contribute to the success or failure of smoke-free initiatives in order to better inform best practice in this important area. The authors concluded that a smoke-free policy is possible within psychiatric inpatient settings but a number of core interlinking features are important for success and ongoing sustainability. They include clear, consistent, and visible leadership; cohesive teamwork; training opportunities for clinical staff and fewer staff smokers; effective use of nicotine replacement therapies; consistent enforcement of a smoke-free policy; and health modelling by workers.

Given it is highly problematic to expect involuntary patients to stop smoking when they are experiencing an acute episode, support including nicotine replacement therapy (NRT) and behavioural therapy is critical. This support should continue post discharge from inpatient settings. Refer to 4.3.1 for specific recommendations regarding smoking cessation.

4.2 Working with General Practice and Community Health services

The literature presents a strong argument for primary physical health and mental health services to work together to provide holistic care in order to reduce the significant physical health inequality experienced by people with a severe mental illness. It also argues that an integrated approach to the provision of primary health care services for this population group will yield economic benefits through appropriate use of, and improved access to, health services (including hospital services) and will increase the take up of preventative measures.

Achieving this outcome will require local area service coordination and shared accountability between specialist mental health, general practice and Community Health services.

4.2.1 Role of General Practice

The MAC strongly asserts, as a core principle, that all people with a severe and enduring mental illness, *irrespective of whether they are clients of the specialist mental health service system or the nature or acuity of their mental illness*, should have a general practitioner responsible for their physical health care.

There was unanimous consensus from all service sectors consulted in the development of this report that general practice has a central role - defined as 'birth to death', whole of patient care – in the provision of medical treatment and preventative health care to people with a severe mental illness.

While specialist mental health services must play an important role in physical health assessments, healthy lifestyle counselling and health promotion, it is <u>not</u> the role of this sector to provide medical treatment for physical health problems. Both service sectors have a responsibility to prioritise the physical health of people with a severe mental illness with the role of the specialist mental health services system focused primarily on initial assessment and referral to GP services for in-depth diagnosis, treatment, preventative health care and lifestyle modification support.

The MAC recognises that general practitioners can and do provide good, comprehensive health care for many people with a mental illness. General practitioners are able to establish and sustain ongoing trusting relationships with patients and, in many cases, their families.

A number of GPs have noted, however, that it is particularly difficult to ensure ongoing health care for this population group when the patient is in crisis, is isolated and/or unsupported, under financial stress, or experiencing symptoms of mental illness which mitigate against compliance with medical appointments, use of medication and health prevention advice. A clear message from the consultation was the need for additional support to general practice to help achieve and maintain engagement with this patient group.

The key patient and system issues regarding GP health care identified in the consultation process are summarised in Appendix 2 of this report.

Improving access to general practice health care

It is the view of the MAC that general practice must have the lead role in chronic physical disease management for people with a severe mental illness, including facilitating their access to coordinated health care. The MAC notes that the current Commonwealth MBS funding model, however, does not adequately 'incentivise' care for patients with co-morbid chronic physical disease problems and severe mental illness - improving physical health for this patient groups takes considerable time, needs to be introduced step by step in order to be accepted by the individual and requires sustained effort by the GP.

To better enable people with a severe and enduring mental illness to access basic medical services provided by GPs, the MAC advocates for an adequately costed Medical Benefits Scheme (MBS) item for '*complex needs*' to enable GPs to take the time needed to effectively assess and treat this patient group, particularly those with chronic physical disease. To address the business risk/loss of income issue presented by this client group, the Australian Government must also consider 'block funding' selected GP practices which will enable people living with severe mental illness to get their primary health care needs met. Consideration could also be given to funding credentialed nurses to 'fill the gap' where GPs are unable or unwilling to provide physical health care to this patient group.

In addition, the MAC recommends specific MBS items be created to enable people living with severe and enduring mental illness to access a comprehensive annual health assessment, as well as regular dental care.

Chronic Disease Management under Medicare Benefits Scheme

Currently, the MBS includes a number of chronic disease management items designed to support multidisciplinary care for patients with chronic conditions, such as diabetes or ischaemic heart disease. The General Practice Management Plan (GPMP) (Item 721) allows for an extended GP consultation and plan for the management of a chronic medical condition (defined as one that has been or is likely to be present for at least six months).

A corollary item, the Coordination of Team Care Arrangements (TCA) (Item 723) supports a multidisciplinary approach (a team of at least three health or care providers including the GP) for the treatment of diabetes, for example, where a diabetes educator, podiatrist and general practitioner may provide (MBS rebated) services to the patient under the TCA.

The MAC notes there are several limitations to the utility of these MBS items in respect to adequately supporting health care for people with enduring mental illness. The total number of allied health services (five) allowed per calendar year is too few to support good health for this client group; the rebate is insufficient as an incentive for providers and inadequate for patients if they cannot meet gap payments; and the organisation and paperwork for the GPMP and TCA must be undertaken by busy GPs who find this a disincentive to co-ordinating care. Consequently, and anecdotally, few GPs use these items to arrange care for their patients with a mental illness.

It is recommended that the Victoria Government advocate to the Australian Government to:

- Introduce an MBS item for an annual GP physical assessment of patients with a severe mental health illness as a minimum requirement.
- Implement an adequately funded 'voluntary enrolled' GP population approach for people with severe mental illness on the basis of the degree of health inequality experienced by this population group.
- Reduce or eliminate 'gap' fees for people with severe and enduring mental illness who are economically disadvantaged.

- Provide 'block funding' to selected GP clinics, including Community Health Services, to ensure the prioritisation of access for people with severe and enduring mental illness.
- Consideration funding block funding credentialed nurses to 'fill the gap' where GPs are unable or unwilling to provide physical health care to this patient group.
- Review, expand and tailor the existing MBS Chronic Disease Management items (particularly the under the Team Care Arrangement) to provide additional and more affordable allied health services to people with severe mental illness.
- Review and make the current diabetes Lifestyle Modification Program openly available to, and appropriate for, people with severe mental illness referred through general practice.
- Investigate the tailoring of existing health promotion and lifestyle programs, currently delivered through general practice to patients with chronic disease, to the needs of people with a severe mental illness.

Mental Health Nurse Incentive Program

The Commonwealth funded Mental Health Nurse Initiative Program (MHNIP) currently operating in GP clinics was identified by GPs and the clinical mental health service system as highly successful. This service model offers significant potential to link clients of the specialist mental health service system to GP care. Under the program, Mental Health Nurses may deliver case-management, counselling and appropriate medication administration as required. Amongst many benefits, the capacity to follow up patients who do not attend medical appointments and encourage regular medical attendance was considered to be a noteworthy strength of this program.

The holistic approach to care delivered through this service model ensures that the patient can be managed systemically and in conjunction with the GP for any physical health concerns. Opportunistic intervention is facilitated by the co-location of the Mental Health Nurse with the GP. Patients have been enthusiastic about this program because it is fully funded (no cost to the patient) and there is less stigma associated with attending a mental health nurse in a GP clinic.

Mental Health Nurses in the Melbourne East GP Network

The mental health nurse in the Melbourne East GP Network routinely screens for physical health issues as part of a holistic approach to patient care. This provides a baseline for physical health monitoring and includes BMI and Vitamin D tests. The mental health nurses have a strong focus on physical activity not necessarily related to weight loss but as part of a strategy to improve overall general fitness, motivation and nutrition and reduce late onset diabetes.

Patients have been found to respond well to this holistic approach and feel less stigmatised in relation to their mental health issues.

It is noteworthy that not all general practitioners have Mental Health Nurses engaged by their practice. Currently, there are approximately 60 Mental Health Nurses statewide employed by Divisions of General Practice who work sessionally in local general practices.

The MAC notes practice guidelines for Commonwealth funded Mental Health Nurses working in GP clinics restricts them from seeing patients who are clients of specialist mental health services. However, at least two Victorian divisions of general practice (North East Valley and Geelong divisions) have arrangements with their local Area Mental Health Service to "lease" Mental Health Nurses to work for several sessions per week in local general practices whilst remaining employed by the Area Mental Health Service. This model provides excellent continuity of care to patients once they are engaged with general practice and supports the Area Mental Health service discharge planning. This model also ensures that the GPs patients have timely access to acute care when needed.

Significant opportunity exists to strengthen the interface between Mental Health Nurses in GP service settings and the specialist mental health clinicians. The MAC recommends the Victorian Government advocate to the Australian Government to:

- Expand the Mental Health Nurse Incentive Program and mandate this program to include the physical health of people with severe and enduring mental illness.
- Expand the sub-contractual model of employment of Mental Health Nurses in general practice through Divisions of General Practice and Area Mental Health Services. The MAC, however, notes such a strategy may have significant workforce planning implications.
- Develop of a team-based approach between both service sectors to support the patient to access timely GP care and improve the management of chronic physical disease. This would require expanding the health role for Mental Health Nurses to include support to the specialist mental health clinicians to undertake, review and monitor physical health assessments.

Building a stronger, more connected system of health care

The consultation process identified that many clients of the specialist mental health service system, particularly young people and adults, do not access or maintain sustained engagement with GP services. Navigating GP and specialist medical/surgical services was recognised as particularly difficult for people with severe mental health problems of all ages. The consultation process identified strong support for expanding and improving initiatives that provide coordinated care for clients with severe and enduring mental illness and health and other multiple needs.

It was also noted that unless a GP has a special interest in mental illness they may not see people with a severe mental illness with any frequency. Consequently, specialist mental health services find it difficult to identify and liaise with a GP for every client registered in their service.

The consultation process identified that a significant disconnect currently exists between these service sectors. Building local service relationships and effective communication between general practice and specialist mental health services was identified as critical. It was noted that relationship building takes considerable, sustained effort by both parties.

It was stressed that recent processes, such as Area Mental Health Service discharge planning protocols, put in place to improve two-way access between specialist mental health services and GP care, are not currently uniform or adequate across Victoria. Access to primary care and specialist services, from the clients' perspective must be straightforward and based on a "no wrong door" approach. Given the intermittent contact clients may have with the specialist clinical mental health system (driven by the episodic nature of the mental illness itself and the throughput nature of the service model) a trusting ongoing relationship with a primary health provider is particularly critical.

Early health intervention can have a major influence on the lifelong health of a young person with a mental illness. An integrated, no wrong door approach is especially important for young people with severe mental illness. In response to this issue, the MAC recommends consideration be given to developing the capacity of the Commonwealth funded *headspace* program to delivery physical health promotion, preventative health care and healthy lifestyle interventions tailored to the health needs of young people with a range of mental health conditions.

In addition, consideration could be given to establishing a statewide General Practice Mental Health Liaison Officer program in Area Mental Health Services, modelled on the existing General Practice Liaison Officer Hospital Program, to support improved access to GP care for clients of the specialist mental health service system. The MAC also recommends that the Victorian Government advocate to the Australian Government to expand the brief of Personal Helpers and Mentors to support clients under shared care GPs/specialist mental health service arrangements to access health care services, including routine visits to GPs.

Specialist clinical mental health specialist services should be supported and encouraged to become early adopters of the Individual Health Identifier (IHI) and the Patient Controlled Electronic Health Records (PCEHR) currently being developed by NeHTA. These initiatives will support the sharing of health information, such as medication and physical status, and should improve continuity of care for shared clients.

4.2.2 Role of Community Health Services

The MAC has identified the following specific roles for the Community Health service sector:

- Work collaboratively with the specialist (clinical and PDRSS) mental health sector to build their capacity in the area of physical health screening, healthy lifestyle coaching, local service networks and referral pathways.
- Provide integrated allied health services, health promotion and chronic disease management programs/interventions to people with severe and enduring mental illness (e.g. smoking cessation, diabetes education, oral health, weight management programs and strength training) with a focus on prevention/early intervention. This could occur in a range of service settings and could be delivered in partnership with both specialist clinical mental health and the PDRSS sector.

The MAC notes that, given policy and funding responsibility for primary health funding of Community Health is flagged for potential transfer to the Australian Government by 2016 (as part of the COAG National Health and Hospital reforms) future action in this area would require joint planning by both tiers of government.

Improving access to health care in Community Health

Community Health services have fewer geographical and eligibility barriers and are well placed to provide a consistent, streamlined access point (a 'no wrong door approach') to the provision of primary health care for all vulnerable population groups, including people with a severe and enduring mental illness.

Further, Community Health services provide a flexible, broad, integrated primary healthcare service delivery platform and have strong and established partnerships with acute services, general practice and Primary Care Partnerships.

The MAC notes that Community Health services have a track record in providing targeted health and wellbeing programs and chronic disease management support in a de-stigmatised environment for marginalised groups, including those who are socio-economically disadvantaged and who experience cultural barriers to service access. Some Community Health services have considerable experience in working with people with severe mental health problems through programs such as complex care outreach, SAVVI (a Supported Residential Service initiative) and as a PDRSS provider.

Community Health services identified the need for a policy-driven, authorising environment, linked to concrete investment in infrastructure and service delivery capacity, to improve the sectors responsiveness to the physical health needs of people with a severe mental illness. While Community Health does and is required to prioritise access to services for a range of groups, including people with a mental illness from July 2010, a priority referral and service access policy would streamline access for people with mental illness to physical health services provided by this service sector.

Such an approach would, however, likely exacerbate demand pressures on this Community Health services. The consultation process identified that many Community Health services struggle to prioritise one group over many others (e.g. refugees, young people, Indigenous people, those with mental illness and the aged) and face significant funding challenges in meeting demand. The limited resource base reduces capacity to adopt stronger affirmative outreach strategies known to be effective for people with a severe mental illness.

Evidence demonstrates that where Community Health is allocated targeted funding to provide particular services, such as refugee health and chronic disease programs, significantly improved outcomes can be achieved for particular high need client groups. The MAC recommends that Community Health be funded to provide tailored health services to young people, adults and older people with severe and enduring mental illness, particularly for oral health, diabetes education, podiatry, PAP screening, sexual health and health self management coaching. The funding model needs to take into account the flexibility and time needed to effectively engage with, and deliver care to, people with a severe mental illness, particularly those who are homeless (as they tend to not seek out support) and cannot afford to pay for services.

Some Community Health services have GP clinics as part of their service platform. However, these clinics often struggle with financial viability due to recruitment issues and the MBS funding model which requires quick flow-through of patients. Community Health settings often provide services to those with the most complex presentations but must rely on bulk billing. While recent changes to the MBS has resulted in better remuneration for this work, there continues to be pressure on some Community Health services to close their GP practices due to viability issues.

The MAC recommends that the Victorian Government give consideration to:

- Providing Community Health with incentives to meet performance targets for people with a severe mental illness. The current funding model should be reviewed in acknowledgement of the additional time and resources required to achieve outcomes for this client group (using the refugee health funding as a potential model).
- Funding selected Community Health services to provide integrated health promotion programs tailored to the needs of people with a severe mental illness taking into account the needs of different age groups and mental health conditions.
- Identifying and evaluating good practice in health promotion in Community Health targeted to people with a severe mental illness and bring these initiatives to scale selectively across this service sector.
- Undertaking training and workforce capacity building in Community Health to increase staff competence and confidence to engage mental health clients and remove stigma often associated with this client group.
- Working with the Australian Government to co-locate block funded general practitioners in selected high volume Community Health services and specialist mental health clinics to improve access to preventative health, medical treatment and chronic physical health disease management.

Building a stronger, more connected system of health care

As part of the Victorian Department of Health Early Intervention in Chronic Disease initiative, a demonstration project was established to improve the early detection of chronic disease of people with a serious mental illness and facilitate timely access to primary health care services. Operating in two catchment areas, led by Eastern Access Community Health (EACH) and Inner South Community Health (ISCH), the demonstration project confirmed the critical importance of providing dedicated resources to build system capacity and connectedness.

The key findings of the demonstration project to date include:

- Physical health assessment of clients of the specialist mental health service system should be the responsibility of the Area Mental Health Services.
- Policies and procedures related to this function should be developed, adopted and embedded in the practice of mental health clinicians.
- Training and workforce development - for the mental health and health/allied health workforce - is critical to support practice and attitude change in this area.
- Referral pathways between specialist mental health, Community Health and general practice need to be defined and agreed and communication between these service sectors strengthened.
- The use of peer mentors should be explored to assist with attending appointments and following a health plan.

The MAC notes that the demonstration project builds on the foundations of service coordination being supported by Primary Care Partnerships (PCP)[4]. Since their inception in 2000, the work of PCPs in Victoria has supported system and organisational planning and practice change to ensure better consumer access to services (particularly those with chronic disease) and improved continuity of care.

The MAC recommends that protocols and policies be put in place and capacity building be undertaken, to improve information sharing, strengthen referral pathways and shared care arrangements between Community Health, GPs and specialist mental health services, using the service coordination platform provided by PCPs and drawing on the learnings of the demonstration project.

Improving access to oral health services

Poor gingival (gum) health and multiple tooth decay is very common in people with mental illness, particularly those who are homeless and have substance misuse and physical health problems. Gum disease is exacerbated by high levels of tobacco use. Dry mouth, a side effect of psychiatric medication, can increase the effects of plaque acids. Other contributing factors include sugary drinks, neglect of personal oral care, other medical conditions and poor nutrition (due to low income, lack of nutritional knowledge and poor cooking skills or facilities).

[4] Primary Care Partnerships provide a platform for joint planning to support the implementation of integrated health promotion, integrated chronic disease management and better service coordination across a range of member agencies, including mental health, primary health and community and aged care services. Divisions of General Practice and Community Health Services are part of the core membership of PCPs.

What works well in Community Health

The consultation process identified the following good practice models, approaches and opportunities:

- *The Early Intervention in Chronic Disease (EICD) management models used by Community Health and the learning's accrued with groups experiencing significant health inequality, such as Aboriginal people and refugees, could be applied/adapted for people with severe mental illness. Intervention approaches that could be extended to people with a severe mental illness include health coaching, adoption of the Active Service Model principles and motivational interviewing techniques.*
- *Self management support approaches promoted by Community Health could be used to support and empower people with a mental illness to develop the skills and confidence needed to better manage their health and engage with health services.*
- *Existing health literacy and health promotion programs could be tailored to this group.*
- *Primary healthcare could be provided on an assertive outreach basis. The mobile dental program targeted to people who are homeless in the inner south and outer east, are examples of such as service.*
- *Ability to refer internally to GPs working in Community Health.*
- *Using general practice to write 'lifestyle' scripts which the client is then supported to implement has proven successful.*
- *Open Health Day sessions to familiarise clients with Community Health service settings and services. This has worked well clients with mental illness as well as refugees and Aboriginal people.*
- *Some Community Health services have developed 'health interest' working parties with local GP and mental health services to further local area planning and cross sector collaboration.*

People with severe mental illness may also display extreme dental phobia, anxiety and paranoia, with high do not attend and treatment refusal rates. They may also fear judgement regarding the personal neglect of their teeth. The combined impact of these issues makes dental treatment for this group more time-intensive and expensive. Clearly, affordability is a key barrier to accessing dental care.

The MAC strongly recommends that:

- Dedicated block funding be allocated to public dental clinics in Community Health, Multi Purpose Services and Rural Health Services to provide free dental services for people with severe mental health problems (targeting those experiencing socio-economic disadvantage). These services should be delivered both onsite and through outreach venues.

- That service models like the *Dental as Anything* program be enhanced and expanded in selected sites in recognition of the particular barriers to accessing dental health care faced by people with a severe mental illness who are homeless.

'Dental as Anything' program[31]

This program is a collaborative partnership between mental health, dental and administrative teams in Inner South Community Health Services (ISCHS) using a cross-team approach delivered through assertive outreach. A dentist, dental assistant and mental health outreach worker take dentistry and mental health to a variety of settings, targeting hard to reach people living rough, in rooming houses and Supported Residential Services (SRS). It provides a flexible program incorporating engagement, clinical care, education and support in response to client needs.

The program rotates through these venues providing weekly sessions to create familiarity. Education sessions are also provided to staff at SRS and mental health clinics. The combination of assertive outreach and health promotion appears to be critical in delivering effective programs to this group. This program has been operating for six years and is part of ISCHS wider dental program. Success factors include: assertive outreach; health promotion; use of a peer model for engagement; cross-team collaboration; efficient, flexible and sensitive care; and block funding, which guarantees a fee free service.

4.3 Targeted health intervention and health promotion

The literature recognises that if supported to lead healthier lifestyle, people with a severe mental illness will improve their physical health as well as their psychological wellbeing. It also provides a strong evidence base for the health benefit of smoking cessation, physical activity and diet management for this population group.

4.3.1 Smoking cessation

Smoking is the largest cause of preventable illness in the United States, the United Kingdom, Canada, Australia, and many other countries. Smokers with mental illness smoke significantly more than the general community and therefore experience even greater smoking-related harm.

Smoking may be the most modifiable risk factor for decreasing the excess mortality and morbidity people with a mental illness face[32]. While research demonstrates that tobacco interventions can be effective for this population group, they are not commonly utilised in clinical practice. In addition to a high risk for metabolic syndrome, smokers with mental illnesses have more psychiatric symptoms, increased hospitalisations and require higher dosages of medications[33].

Smoking also increases the metabolism rate of many psychotropic medications used to treat mental illnesses such as schizophrenia, reducing both medication effectiveness and side effects[34]. Persons with mental illnesses may, in part, smoke to reduce medication side effects such as akathesia[35].

Research conducted by Access Economics for SANE Australia[36] estimates the total financial cost to Australia from smoking by people with a mental illness was $3.52 billion dollars in 2005. The report makes recommendations for cost effective interventions in smoking cessation for people with mental illness which include proactive telephone counselling coupled with Bupropion or Nicotine Replacement Therapy (NRT).

The VicHealth Centre for Tobacco Control advocates the use of NRT over Bupropion in a paper prepared for the Australian Pharmaceutical Benefits Advisory Committee. Bupropion is cited as a risk factor for serious neuropsychiatric symptoms [37]. The MAC notes the nicotine patches have been approved by the Pharmaceutical Benefits Scheme (PBS) and are awaiting government approval.

Quit Victoria

Quit Victoria's Quitline callback service offers an additional tailored service for smokers with a history of depression. The service model involves Quitline and GP co-management of smoking cessation and depression, and tailored counselling that promotes strategies that assist with both smoking cessation and mood control. Analysis of this service model [38], demonstrated that quitting smoking was associated with improved mood and was not reliably associated with precipitation or exacerbation of major depressive disorder. The findings allayed concerns about the safety of quitting for smokers with a history of depression and have resulted in Quitline policy and practice changes.

Research suggests few mental health providers currently ask patients about smoking or advise them to quit. Research by Morris et al[39] has found that people with a severe mental illness often want to quit smoking, but struggle to find assistance and encounter barriers to accessing effective tobacco cessation services within the public mental health system. Insufficient resources are exacerbated by lack of knowledge and the negative expectations of both patients and providers. It does not help that many mental health workers also smoke, often at higher rates than health providers in other fields.

The Mac notes that current treatment options for smoking cessation in general populations are not tailored to the unique characteristics of people with mental illness and quit rates are still substantially lower than the general population.

Another paper by the VicHealth Centre for Tobacco Control[40] proposes that people living with extreme social disadvantage warrant special support with assistance to quit smoking, arguing that costs could be minimised by incorporating smoking cessation treatment into standard treatment and service protocols, mandated by governments in funding agreements.

The MAC recommends the following action areas be considered to reduce high prevalence of smoking by people with a severe mental illness:

- Address the misconception that smoking cessation is unrealistic in people with a mental illness and recognise that smoking is a coping strategy for anxiety and boredom.
- Acknowledge that people with a mental illness have the same desire to stop smoking as the general population and they find it difficult to cease this behaviour due to the addictive nature of nicotine.
- Recognise that smoking is an addiction and that targeted specialist strategies are required and should be developed by relevant agencies to assist this client group.
- Actively promote and police smoke-free clinical environments, supported by replacement therapy and behavioural change, in all specialist mental health service settings including inpatient services.
- Provide mental health staff with information on the benefits of smoking cessation for themselves and their clients.
- Develop and implement a training program for mental health staff on smoking cessation (to be delivered as a standard part of clinical treatment) and fund a targeted smoking cessation program tailored to the needs of this client group (could be delivered through Community Health).
- Consider providing peer to peer support services to promote smoking cessation and other healthy lifestyle behaviours.

4.3.2 Nutrition

Evidence suggests that the excess of mortality and morbidity seen in people with a severe mental illness is, to a significant degree, the consequence of diet or weight-related chronic disease. In fact poor diet has been found to be a higher risk for premature mortality than risk of suicide, accidental and violent death for people with a severe mental illness.

The cost of buying nutritious food was identified as a significant issue for people with a severe mental illness, particularly those living alone. Cooking skills and access to cooking facilities are also identified barriers.

Nutrition was identified as a significant issue in the consultation process. Specialist clinical mental health services identified the need for training, evidence based guidelines and information on nutritional advice, including strategies for motivating clients to improve their diet.

The MAC recommends the following action areas be considered:

- Provide specialist clinical mental health services and the PDRSS sector with training and information on the provision of nutritional advice including the use of motivational techniques.
- Provide clients of the specialist mental health service system with information on the benefits of a good diet.
- Take action to improve access to dietitians in Community Health, including increasing capacity of this service sector to prioritise access to people with severe mental illness.

4.3.3 Improving physical activity

Individuals with severe mental illness are at high risk of chronic diseases associated with sedentary behavior, including diabetes and cardiovascular disease.

There is a strong link between regular exercise, improved health and wellbeing and lifestyle modification on chronic disease outcomes. Evidence for the psychological benefits of exercise for clinical populations comes from two meta-analyses of outcomes of depressed patients that showed that effects of exercise were similar to those of psychotherapeutic interventions. Exercise can also alleviate secondary mental health symptoms such as low self-esteem and social withdrawal[41].

Structured exercise program in Community Care Unit[42]

A structured exercise program was developed and implemented for residents of a Community Care Unit in metropolitan Melbourne. Six residents participated in the program over a period of three months. The findings of this study suggest that involvement in the program produced very positive outcomes, most notably in the physical fitness of residents. The individual nature of the program which enabled gradual participation and the cohesive approach of the group as a whole were considered very important factors contributing to the overall success.
Positive outcomes observed included improved mood, positive attitude change and a reduction in depression, anxiety, anger and rebelliousness.

People who exercise regularly frequently report a feel-good effect. Regular exercise also assists people to see themselves more positively as a result of changes in body image, improved fitness, strength and skill and resultant sense of self control and self efficacy. Furthermore, exercise is a key factor in effective weight control.

Exercise also offers a simple and relatively cheap alternative or adjunct to drug therapy. However, the evidence for the mental health benefits of exercise is not widely recognised outside the exercise fraternity. Some researchers have claimed that this is a result of reluctance in accepting exercise as a simple solution to 'highly clinicalised' problems[43].

Research also suggests that exercise is well accepted by people with severe mental illness and is often considered one of the most valued components of treatment. Adherence to physical activity interventions appears comparable to that in the general population[44].

The potential value of regular exercise for people experiencing a mental illness has significant implications and warrants further exploration.

Reclink – a sport and recreation service model[45]

Reclink provides sport and recreation activities for highly marginalised people, many of whom have a mental illness. A summary of social impacts from interviews conducted with 61 Reclink participants found:

- *84% reported new friendships with other participants*
- *83% reported their relationship with their support worker or agency improved*
- *64% reported their relationships with family and friends improved*
- *87% reported their physical wellbeing had improved*
- *87% reported their confidence had improved.*

Some comments from participants on their view of the benefits: "Killing Boredom"; "Relaxes me."; "Occupy mind"; "Getting off my meds"; "Getting better, not aggressive anymore"; "Being part of a group, team. Working together and supporting others. Challenge of each activity. Stepping out of your comfort zones and feeling supported by each other"; "It's like an extended family"; It helps me with my recovery from depression and drugs and alcohol." "Better relationships with team and staff members"; "Less depressed and less isolated".

The MAC recommends the following action areas be considered in respect to physical activity:

- Provide specialist mental health services with information on the benefits of physical activity and motivational techniques.
- Provide clients of the specialist mental health service system with health promotion information on the benefits of regular exercise.
- Develop and deliver evidence-based physical activity interventions for individuals with severe mental illness, including those in bed-based clinical rehabilitation services.
- Support people with severe mental illness to access local physical activity services and programs provided by local government and non government organisations, while building the capacity of these services to respond to the needs of this group. Consideration could be given to the role of PDRSS Day Programs in delivering this support.
- Work with Sport and Recreation Victoria, Department of Victorian Communities, to expand service models such as Reclink to people with a severe mental illness.

Appendix 1 Summary of recommendations and areas for action

	Specialist (clinical and PDRSS) mental health service system	General Practice	Community Health
Principles	The physical health of people with a severe mental illness should form an integral part of their overall treatment and care.	All people with a severe mental illness, *irrespective of whether they are clients of the specialist mental health service system or the nature or acuity of their mental illness*, should have a general practitioner responsible for their physical health care.	People with a severe mental illness who are socio-economically disadvantaged should have priority access to Community Health for their physical health care.
Recommendation	That the Victorian Department of Health require physical health to be integrated into the policy, practice and service delivery of the specialist clinical mental health and PDRSS service system. This will require an unambiguous authorising policy environment, coupled to strong leadership and careful, sustained investment in infrastructure, workforce development, system capacity and evidence base.	That the Victorian Government strongly advocate to the Australian Government to take proactive, sustained action to improve access to affordable and responsive general practice health care and primary health services to close the health inequality gap experienced by people with severe and enduring mental illness. Areas for action are identified below.	That the Victorian Government in collaboration with the Australian Government recognise the highly valuable role Community Health can play in improving the physical health of people with severe mental illness and take steps to strengthen the capacity of this service sector to achieve demonstrable outcomes in this area.
Areas for action			
Strengthen system infrastructure capacity & accountability	Establish a statewide physical health advisory body to oversee the system reform and development needed to drive outcomes in this area, including research and the development of clinical guidelines, heath promotion resources and targeted health promotion strategies and interventions. Develop a clear policy and authorising environment that has high level engagement within Health Services and at the Clinical Director and nurse manager level of specialist clinical mental health services, to drive the structural, practice and cultural change required. Provide an equivalent policy framework mandating PDRSS to incorporate physical health into its core business. Establish time limited positions in Area Mental Health Services to support the change management needed to embed physical health in organisational policy, practice and culture. Create an expectation that all clients of the specialist mental health service system be in a shared care arrangement with a GP for their physical health needs.	Mandate that local General Practitioners are represented on the decision-making committees for Area Mental Health Services. Advocate to the Australian Government to: • Implement an adequately funded 'voluntary enrolled' GP population approach for people with severe mental illness on the basis of the degree of health inequality experienced by this population group. • Improve reporting and accountability of GP care for people with severe and enduring mental illness.	Provide Community Health Services with incentives to meet performance targets for people with a severe mental illness, including a review of current funding model in acknowledgement of the additional time and resources required to achieve outcomes for this client group (using the refugee health funding as a potential model).

	Specialist (clinical and PDRSS) mental health service system	General Practice	Community Health
	Develop physical health outcome measures and performance indicators for inclusion in existing reporting and accountability frameworks for all specialist clinical mental health and PDRSS sector. Regularly disseminate progress against accountability measures to all sectors involved in the physical health care of this client group.		
Drive practice change & improved access	Review use of newer antipsychotics in people with significant weight gain, metabolic abnormalities or diabetes and provide medical staff with the skill, confidence and competency to explore the full range of alternative medications. Develop a chronic physical disease management framework tailored to the specific needs of people with mental health problems. Include physical health care in the planned reintroduction of the Chief Psychiatrist's Office reviews. Develop practical health promotion resources for use by specialist clinical mental health and PDRSS staff.	Advocate to the Australian Government to: • Introduce an MBS item for an annual GP physical assessment of patients with a severe mental health illness as a minimum requirement. • Review and tailor the existing MBS Chronic Disease Management items to provide more and affordable allied health services under the Team Care Arrangement to people with severe mental illness. • Investigate the tailoring of existing health promotion and lifestyle programs, currently delivered through general practice to patients with chronic disease, to the needs of this client group. • Review the Life! Taking Action on Diabetes and RESET your Life diabetes programs to be appropriate and accessible for people with severe mental illness. • Review and make the current diabetes Lifestyle Modification Program (LMP) open and appropriate for people with severe mental illness referred through general practice.	Identify and evaluate good practice in health promotion in Community Health targeted to people with a severe mental illness and bring these initiatives to scale selectively across this service sector.
Workforce capacity development	Provide the specialist mental health service system with training in the area of physical health, including physical assessments, healthy lifestyle counselling, nutritional and exercise advice and how to deliver health promotion education and advice. Provide mental health staff and clients with training and information about causes of dental decay and strategies for promoting oral health care.	Advocate to the Australian Government to strengthen training (tertiary and post graduate) for GPs in the provision of preventative health care and medical treatment for people with a severe mental illness.	Undertake training and workforce capacity building in Community Health to increase staff competence and confidence to engage mental health clients and remove stigma often associated with this client group.

	Specialist mental health service system	General Practice	Community Health
Areas for action			
Targeted investment in new capacity/expand existing capacity and resources	Consider funding mental health nurses/nurse practitioners in specialist mental health clinics to undertake physical health assessments (targeted to high volume clinics), healthy lifestyle counselling and targeted health promotion interventions. Resource and require PARC services to undertake physical health assessments and lifestyle counselling or deliver this through a nurse practitioner/GP 'in reaching' into this service setting. Establish and standardise Consultation Liaison psychiatry services in all regional and metropolitan hospitals to enable mental health teams to provide treatment and support to people with mental illness admitted to medical and surgical wards. Establish arrangements for medical and surgical staff to provide assessment and treatment for people with physical health problems who are inpatients of acute psychiatric units. Provide child and adolescent, adult and aged mental health services with funding to purchase resources needed to do physical health assessments (e.g. weighing devices and blood pressure monitors) and brokerage funding to purchase disposable items for use by clients (e.g. NRT patches, dental hygiene kits). Investigate the efficacy of using the peer support model to deliver health promotion messages to clients, for example, smoking cessation, weight management advice and healthy eating. Provide access to free dental hygiene kits in mental health clinics, PDRSS and Community Health services. Develop and deliver evidence-based physical activity interventions for individuals with severe mental illness, including those in bed-based clinical rehabilitation services. Support people with severe mental illness to access local physical activity services and programs provided by local government and non government organisations, while building the capacity of these services to respond to the needs of this group.	Explore co-locating general practitioners in high volume specialist mental health clinics/joint clinics/Community Health services to improve access to both preventative health and chronic physical health disease management. Expand the Mental Health Nurse Incentive Program and mandate this program to include the physical health of people with severe mental illness. Consider expanding the brief of Personal Helpers and Mentors to support patients of Shared Care GPs/Specialist Mental Health services to access health care services, including routine visits to GPs.	Fund Community Health to provide integrated health and wellbeing and health promotion programs tailored to the needs of people with a severe mental illness taking into account the needs of different age groups and mental health conditions. Provide dedicated block funding to public dental clinics in Community Health to provide free dental services for people with severe mental health problems, targeting those experiencing socio-economic disadvantage. Expand and enhance models like the *Dental as Anything* program in selected sites in recognition of the particular barriers to accessing dental health care faced by people with a severe mental illness who are homeless.

	Specialist mental health service system	General Practice	Community Health
Areas for action			
Strengthen cross sector planning, coordination and collaboration	Drive improved local area planning, service coordination and the development of stronger referral pathways between specialist mental health, general practice and Community Health through Primary Care Partnerships and the proposed Medicare Locals. Mandate the newly created mental health local area planning and service coordination positions located in Department of Health Regions to take a lead role in facilitating this outcome. Report on outcomes achieved in this area as part of annual reporting for Area Mental Health Services and implementation of the *Victorian Mental Health Reform Strategy*. Advocate to the Australian Government to further develop the capacity of the *headspace* program to delivery physical health promotion, preventative health care and healthy lifestyle interventions tailored to the health needs of young people with a range of mental health conditions. Consider the establishment of a statewide General Practice Mental Health Liaison Officer program in Area Mental Health Services, modelled on the existing General Practice Liaison Officer hospital program, to support improved access to GP care and continuity of care. Support and encourage mental health specialist services to become early adopters of the Individual Health Identifier (IHI) and the Patient Controlled Electronic Health Records (PCEHR) currently being developed by NeHTA. Mandate the use of existing Electronic Service Coordination tools such as S2S or the ESC system to facilitate referrals, service pathways and continuity of care between specialist mental health services, the acute health system, GPs and Community Health.	Strengthen opportunity for integrated physical health and mental health assessments and care planning between general practice and specialist clinical mental health services. Explore the role of the proposed Medicare Locals in supporting this outcome. Promote the use of existing Electronic Service Coordination tools such as S2S or the ESC system to facilitate referrals, service pathways and continuity of care between specialist mental health services, the acute health system, GPs and Community Health.	Develop the role of PDRSS and Community Health in promoting access to, or delivering, health lifestyle programs, in collaboration with general practice. Implement protocols, policies and practice change need to improve information sharing between Community Health, GPs and specialist mental health services, using the PCP platform. This includes exploring the use of care planning software such as shared electronic client files. Mandate the use of existing Electronic Service Coordination tools such as S2S or the ESC system to facilitate referrals, service pathways and continuity of care between specialist mental health services, the acute health system, GPs and Community Health.

	Specialist mental health service system	General Practice	Community Health
Areas for action			
Research and information	Invest in research and evaluation to build the evidence based needed to support good clinical practice and continued improvement in physical health service delivery. This includes research to assess the impact of different forms of psychiatric medication on physical health of people with severe mental illness.	Provide general practice with up to date information about resources that are available locally using Divisions of General Practice. Consider the use of information technology to make this information easy to access. In time, the proposed Medicare Locals should play a key role in service mapping and social network mapping to support general practitioners to provide care for this patient group.	Invest in research and evaluation in Community Health. Use of Action Research and narrative evaluation strategies which engage clients in formative evaluation processes not only add to the evidence but reinforce change.
Acute health, discharge from hospital and Emergency Departments	The Victorian Government, in collaboration with the Australian Government, should take all necessary action to ensure the physical health of people with a severe mental illness are prioritised by the acute health care system. This includes ensuring the Local Hospital Networks (LHN) proposed as part of COAG National Health and Hospital Reforms are held directly accountable for their performance in this area and that this is reflected in LHN service agreements and related performance standards and measures. Develop and implement a strategy to strengthen the role of ED in respect to the physical health of people with a mental illness. This may include consideration of: standardised physical health assessments; education and training for staff in the ED to improve skill, confidence and competency in the diagnosis of physical illness in this target group; performance measures to strengthen accountability for outcomes in this area; and a review the four hour target for assessment in the ED to allow adequate time for a physical assessment to be undertaken. Expand the HARP service model to clients with severe mental health and chronic physical health conditions. Encourage Crisis Assessment and Treatment and Case Management teams to actively support clients with physical health conditions identified while in hospital to link to their GP and/or specialist medical/surgical care on discharge and follow up with case managers regarding issues related to the physical health assessment.		

Appendix 2 Summary of Key Issues – General Practice Health Care

Key patient related barriers to GP care identified in the consultation process included:

- Affordability in situations where bulk-billing is not available.
- Geographical access, particularly in rural and outer urban areas.
- Transport to attend appointments, particularly frail older people.
- Limited knowledge about how to access GP services, especially young people.
- Lower level of health seeking behaviour by people with a severe mental illness.
- Family or social support to this client group for the care of their physical health is not uniformly reliable.
- Responsiveness of some GP services and reception staff – the consultation noted attitude, interest, experience and skill in working with people with severe mental health problems is variable.
- Tendency by some GPs to neglect physical health problems, focusing only on the person's psychiatric condition.
- Problems with inflexible appointment systems and inaccessible information.

Experience of illness and noisy or crowded waiting areas are also barriers to accessing general practice health care[46]. Research has also identified stigma and discrimination on the part of health care professionals as an additional barrier[47]. Further, studies have shown that people with a mental illness who do use health services are much less likely to be offered blood pressure, cholesterol, urine or weight checks, or to receive opportunistic advice on smoking cessation, alcohol, exercise or diet[48].

The consultation process identified the following key issues and system barriers from the perspective of general practice:

- Insufficient supply of GPs, particularly in rural areas, to address the physical care of the community generally.

- Referral pathways between general practice and the specialist mental health service system need strengthening, including exchange of information and feedback.

- Time pressures and need for long appointments make this work difficult for GPs. The relatively high 'failure to attend' rate of this client group is a significant issue both in terms of continuity of care and cost to practitioners who are running small businesses.

- The lack of mental health case managers is a significant barrier to achieving coordinated and better integrated physical health care. The limited capacity for case managers to provide long term support to mental health clients was seen by GPs as a barrier to improving physical health outcomes. The skill and competency of case managers and how they view their role was also seen as a critical issue.

- Constraints on the use of Commonwealth funded Mental Health Nurses operating in selected GP clinics.

- General practitioners need specific training and support to provide medical treatment and preventative health care for people with severe and enduring mental illness.

- Maintaining ongoing engagement with this patient group can be highly problematic, particularly with those that are transient.

- Lack of availability of, and information about suitable community services in the local area limits the capacity of GPs to support people with severe mental illness to achieve better self-management of their physical health.

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