NSW Health

# Older People's Mental Health Physical Health Practice Improvement

Project Report

December 2024

NSW GOVERNMENT

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The NSW Ministry for Health acknowledges the traditional custodians of the lands across NSW. We acknowledge that we live and work on Aboriginal lands. We pay our respects to Elders past and present and to all Aboriginal people.

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# Foreword

People living with mental health conditions die between 10 and 23 years earlier than the rest of the population, and this is usually preceded by years or decades of poor physical health. The Equally Well 2024 national data linkage study(1) showed people living with mental health conditions were:

- Seven times more likely to die of lower respiratory diseases
- Six times more likely to die of breast cancer
- Five times more likely to die of prostate cancer, or colon cancer, or diabetes
- Four times more likely to die of diseases of the urinary system
- Three times more likely to die of influenza.

Early detection and treatment of physical health conditions are key to address the life expectancy gap for older people living with mental health conditions. As people age, the causes of death change, and the risk of premature death doubles.[1] This underscores the imperative to protect and improve the physical health of older people living with mental health conditions.

Over 57% of all suicide deaths are associated with poor physical health.[2] Poor physical health is a common factor associated with suicide deaths,[3] especially in older people.[2,4] Further, poor physical health is associated with a four times increase in psychological distress.[5]

The life expectancy gap for people living with mental health conditions has been known (and calls for action made) for decades.[6,7] Yet still not enough has been done. Every day in Australia there are over 100 potentially preventable[8] deaths of older people living with mental health conditions.[1]

Built on the foundations of essential elements of the Equally Well National Consensus Statement,[9] and the WHO Multilevel Intervention Framework,[10] the NSW Older People's Mental Health Physical Health Practice Improvement Project has coordinated action right across the state.

There are several notable aspects of this project:

- It is action-focussed, with an emphasis on feasible, sustainable innovation.
- It is built on Lived Experience and place-based expertise.
- It used a distributed leadership model, which includes local champions, central policy support, researchers, community partners and experts by experience.
- It weathered the disruption of COVID-19 and consequent staff churn.
- It demonstrably improved health and saved lives.

I commend this report to anyone interested in leadership, practice improvement, implementation and/or practical, feasible and sustainable initiatives to improve the physical health of people living with mental health conditions. The descriptions, reflections and learnings highlighted within this report are 'golden'.

**Russell Roberts, PhD**
Professor, Leadership and Management
National Director, Equally Well Australia

# Acknowledgements

The Older People's Mental Health (OPMH) Physical Health Practice Improvement Project is the result of the work of many people and reflects the active participation of a number of organisations and services. The NSW Ministry of Health would particularly like to thank the members of the OPMH Physical Health Practice Improvement Project Reference Group for their guidance, Local Health District 'project champions' and supporting managers for their enthusiasm and commitment in taking forward local practice improvement projects, and the NSW Health Mental Health Branch (MHB) OPMH Services Advisory Group for their significant contribution. The project team would also like to thank the Health Education and Training Institute (HETI) for their support in hosting our initial physical health practice improvement workshop, the Clinical Excellence Commission (CEC) for their support in quality improvement training and resources, our community managed organisation partners for their commitment to our joint efforts, and the Equally Well and Charles Sturt University teams for their support throughout the project, including in research partnerships and supporting collaborative connections.

## Project team

**Adjunct A/Prof. Rod McKay** – Clinical Advisor, MHB OPMH Policy Unit

**Dr. Kate Jackson** – Director, MHB OPMH Policy Unit

**John Stevens** – Senior Policy Officer, MHB OPMH Policy Unit

## OPMH Physical Health Project Expert Reference Group



| | |
|---|---|
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| Director, MHB OPMH Policy Unit | Dr Kate Jackson |
| Senior Policy Officer, MHB OPMH Policy Unit | John Stevens |
| OPMH peer worker/consumer representatives | Bharat Nepal, Geoff Davidson |
| LHD OPMH Coordinators | Kristen Szulik, Dr Suman Tyagi, Andrew Clement, Joanne Dwyer |
| Psychiatry | Dr Carmelo Aqulina |
| Nursing | Chenjerai Chikara, Maryann Matikainen |
| Allied Health | Danielle Gately, Melinda Adamcewicz |
| NEAMI National representative | Stephen Suttie |
| CALD representative | Dr Diba Pourmand |
| Mental Health Carers NSW representative | Peta Smit-Colbran |
| NSW Mental Health Commission representative | Sage Green |
| Aged health services representative/geriatrician | Dr Susan Wass |
| Primary Health Networks representative | Leah Eddy |
| Other experts | Professor Russell Roberts, Professor Dimity Pond, Sally Wooding |

# LHD project champions and supporting managers

| Representing | Champion | Supporting manager | Project |
|---|---|---|---|
| **St Vincent's Health Network** | Sophie Zammit-Haber<br>Lianne Rowland | Dr David Burke | NEAMI physical health prompt - a multi-site trial<br>In partnership with NEAMI National (Vicki Langan and Stephen Suttie) and NSW Ministry of Health |
| **Mid North Coast LHD** | Elizabeth Gralton<br>Donna Widdison<br>Natalie Scraysbrook | David Noble | |
| **Southern NSW LHD** | Kersten Davis | | |
| **Murrumbidgee LHD** | | Andreia Schineanu | |
| **South Western Sydney LHD** | Dr Carmelo Aquilina<br>Lachlan Best<br>Lachlan Best<br>Ruth Ferrington<br>Meg Thomas<br>Rebecca Abrahams | Patrick Parker | The LIVE WELL Intervention: Promoting health behaviour change in older people living in South Western Sydney |
| **Nepean Blue Mountains LHD** | Michelle Johnson | Anne Vevers | Piloting the Flourish physical health prompt 'PhysiCards©' within an older person's community mental health population<br>In partnership with Flourish Australia (Jade Ryall) and Charles Sturt University (Marcelle Droulers and Rachel Rossiter) |
| **Illawarra Shoalhaven LHD** | James Bradbury<br>Jess Peters | Carol Martin | Manage My Health: a coaching approach to assist older mental health consumers to better manage their own physical health |
| **South Eastern Sydney LHD** | Daniella Kanareck<br>Dr Kate Mullin<br>Natalie Narunsky<br>Helen McIntosh<br>Ti-Arna Madigan | Dr Patrick Bolton | OPtiMHize improving health outcomes of older people with a lived experience of mental illness |
| **Northern Sydney LHD** | Brian Tomney | Andrew Clement | Increasing the rate of metabolic screening and monitoring in the older mental health consumer |
| **Western NSW LHD** | Sue Kerwick | Dr Patrick Bolton | OPtiMHize improving health outcomes of older people with a lived experience of mental illness |
| **Western Sydney LHD** | Chenjerai Chikara<br>Bharat Nepal<br>Sonia Main,<br>Bincy Punnoose,<br>Molly O'Brien,<br>Melinda Adamcewicz | Dr Suman Tyagi | A Pilot Study: The Positive Impact of Exercise on holistic health for Older Adults with Mental Illness |

## Project team

- **Vicki Langan and Stephen Suttie** – NEAMI National
- **Jade Ryall** – Flourish Australia

## Charles Sturt University academic partners

- Prof. Russell Roberts
- Assoc. Prof. Rachel Rossiter
- Dr Caroline Robertson
- Dr Gavin Buzza
- Dr Jack Cannon
- Dr Tegan Hartmann
- Marcelle Droulers
- Sonia Diab

## Acronym summary

| | |
|---|---|
| **CEC** | Clinical Excellence Commission |
| **CSU** | Charles Sturt University |
| **GP** | General practitioner |
| **LHD** | Local Health District |
| **CMO** | Community Managed organisation |
| **NSW** | New South Wales |
| **OPMH** | Older People's Mental Health |
| **OPMHS** | Older People's Mental Health Service |
| **WHO** | World Health Organisation |

# Executive summary

This report details the key processes and outcomes of the NSW Older People's Mental Health (OPMH) Physical Health Practice Improvement Project. The project sought to address the relatively poor physical health outcomes of older people with mental illness and the identified 'implementation gap' in relation to effective interventions through a range of local practice improvements projects in OPMH services. Local project teams were supported by a statewide project team and processes, and key partnerships. Commencing in late-2019, the project involved collaboration between 11 local health districts, two community managed organisations and a university partner. Eight projects were successfully implemented across 11 districts, focusing on empowering consumers around physical health, physical health screening and assessment, and physical activity. Projects covered all three domains of the Liu et al implementation framework adopted by the World Health Organisation to support action on the 'implementation gap' in this area of healthcare, with five projects in various stages of peer reviewed publication. Project outcomes have been shared through various mechanisms, with most projects now embedded into ongoing practice in relevant local health district OPMH services. The "start where you can" project approach proved resilient to the system disruptions of the COVID-19 pandemic. This project has potential application to other initiatives to improve the physical health of people living with mental illness and to other contexts.

This project was initiated by the NSW Ministry of Health, Mental Health Branch in response to statewide older people's mental health (OPMH) clinical benchmarking and policy work which identified that OPMH services were challenged by addressing some of the physical health needs of OPMH consumers. The policy impetus of the Equally Well Consensus Statement and NSW Health's commitment to improve the physical health of people with mental illness helped ensure support for the project. The project built on previously developed mechanisms[11] NSW for statewide collaboration between OPMH clinicians, service managers, policymakers, and key stakeholders, fostering engagement in statewide practice improvement in OPMH services. Policy commitment and statewide engagement mechanisms were crucial for both initial and sustained support.

This statewide project was an evolution of an existing model used for the OPMH Recovery Oriented Practice Improvement Project, adopting a 'start where you can' approach and using existing resources. Key elements of this approach included:

- establishing a statewide project plan, expert reference group and other project processes such as regular communiques
- developing a toolkit and other supporting resources to assist local project leads in developing projects

- identifying and supporting local project champions and teams to plan, implement and evaluate local projects as part of the statewide project, and
- evaluating, showcasing and sustaining practice improvements.

Using an adaption of an implementation framework by Liu et al[12] developed for the World Health Organisation, the project plan incorporated strong leadership and partnerships to support Local Health District (LHD) project champions to develop local practice improvement projects. The recruited champions and their supporting managers workshopped potential projects before collaborating with other project partners. Key partners included community managed organisations (CMOs) and academics who were able to assist LHD champions in progressing some of the projects through project design, ethics approval and publication in peer reviewed publications. Local project teams were encouraged to involve people with lived experience in the development of their projects. The statewide project was undertaken without additional state funding (although some projects did seek local seed funding).

The project approach was broadly successful, despite some challenges and limitations, in particular the COVID-19 pandemic which significantly disrupted the project. The project approach underlines the need to create the right environment and processes to support statewide practice improvement. Key elements that supported project success included:

- the *distributed leadership approach* of the project, involving leadership at the statewide and local levels, as well as leadership from key project partners, in the context of a complex health system
- the *statewide project team and expert reference group* to guide and support local project leads throughout implementation
- *ongoing communication and engagement strategies* such as project communiques, project initiation workshops, collaborative processes and showcasing events to build and maintain leadership and collaboration throughout the project
- *ongoing commitment to the project aims and persistence, alongside flexibility to adapt* in the face of challenges and disruptions.

The OPMH physical health practice improvement project has been broadly successful in developing and implementing a range of practice improvement initiatives across metropolitan and rural NSW. Eight projects were completed as part of the OPMH physical health practice improvement project, involving eleven LHDs and two CMOs. These projects were in three key focus areas:

- Empowering consumers around physical health improvement
- Physical health screening and assessment
- Physical activity/exercise

The projects covered all three domains of the Liu et al implementation framework. They were implemented in OPMH clinical services (predominantly in community settings) and CMO services. Since the target group for these services is older people with more severe and/or complex mental illness, this was the broad target group for the projects. Many of these projects have been embedded into ongoing practice in OPMH services, and some have been taken up within other services.

Academic partners collaborated on four projects, as well as the statewide project. Five of the eight projects are expected to be published in peer reviewed publications, along with the findings from the statewide project. The lessons and outcomes from all projects and the overall statewide project have been shared in various forms, supporting the 'collective impact' approach of Equally Well and the broader objectives of the project in contributing to collective efforts in this area. This is a significant contribution to addressing the 'implementation gap' in improving the physical health of people living with mental illness.

Key enablers of the project included: creating the right environment and processes to support statewide practice improvement (including the distributed leadership approach and ongoing communication and engagement strategies), the 'start where you can' approach, and sustained collaboration and partnerships across the range of people and organisations involved in the project. Key challenges included the impacts of the COVID-19 pandemic and developing effective processes for academic collaboration with LHDs that facilitated academic partners for all LHD projects.

The projects are outlined on the following page and summarised within this project report.

| Project | Project leads/ partners | Research partner & publication status | Focus area |
|---|---|---|---|
| **NEAMI physical health prompt - a multi-site trial** | NEAMI National<br>St Vincent's Health Network<br>Mid North Coast LHD<br>Southern NSW LHD<br>Murrumbidgee LHD | Charles Sturt University<br>*Publication in progress* | Empowering consumers around physical health improvement |
| **The LIVE WELL Intervention: Promoting health behaviour change in older people living in South Western Sydney** | South Western Sydney LHD | *Findings published* | Empowering consumers around physical health improvement |
| **Piloting the Flourish physical health prompt 'PhysiCards©' within an older person's community mental health population** | Flourish Australia<br>Nepean Blue Mountains LHD | Charles Sturt University<br>*Publication in progress* | Empowering consumers around physical health improvement |
| **Manage My Health: a coaching approach to assist older mental health consumers to better manage their own physical health** | Illawarra Shoalhaven LHD | | Empowering consumers around physical health improvement (with screening element) |
| **OPtiMHize improving health outcomes of older people with a lived experience of mental illness** | South Eastern Sydney LHD | | Physical health screening and assessment (with consumer empowerment element) |
| **Increasing the rate of metabolic screening and monitoring in the older mental health consumer** | Northern Sydney LHD | | Physical health screening and assessment |
| **Adapting Fit For Your Life to the regional context.** | Western NSW LHD | Charles Sturt University<br>*Findings published* | Physical activity/exercise |
| **The impact of exercise on holistic health for older adults with mental illness: a pilot study.** | Western Sydney LHD | Charles Sturt University<br>*Publication in progress* | Physical activity/exercise |

In order to support continued good practice and practice improvement in NSW Health services to address the physical health needs of older people with mental illness, it is recommended that:

### Local Health Districts

- Review the projects outlined in this report, including key focus areas and implementation lessons.
- Identify key practice improvement priorities and strategies in physical health care within OPMH services and/or across LHD mental health services, informed by these projects and local needs and service contexts.
- Support continuation of strategies initiated within this project, and/or commencement of further local projects based on the analysis above.

### NSW Ministry of Health Mental Health Branch

- Uses the project learnings and outcomes to support a continued focus on improving the physical health of OPMH service consumers through statewide OPMH benchmarking processes, models of care, and policy and service development work.
- Builds on the project approach and learnings for future statewide mental health practice improvement work, including initiatives to improve the physical health of people with mental illness within the NSW Health system.

In order to support the broader objectives of Equally Well and address the 'implementation gap' in relation to actions to improve the physical health of people living with mental illness, it is recommended that:

- NSW Health share the project findings and publications (both peer reviewed and grey literature) with relevant NSW, national and international networks, including through Equally Well Australia.

# The OPMH Physical Health Practice Improvement Project

The Older People's Mental Health (OPMH) Physical Health Care Practice Improvement Project aimed to promote improvements in the physical health assessment and care of OPMH service consumers. This body of work progresses national and NSW policy priorities concerning improving the physical health outcomes of people with mental illness, and supports NSW Health's commitment to the Equally Well Consensus Statement.[13] The project scope included OPMH community and inpatient services across NSW and sought to encourage local health district (LHD) teams to develop small local, achievable practice improvement projects.

This project was successful in progressing improvements in physical health care for older people with mental illness in New South Wales (NSW). This was accomplished by promoting and supporting effective collaborations between LHD OPMH teams, community managed organisations (CMOs) and academic partners. This report summarizes the project approach and methodology, the approach, outcomes and findings of each local project, and the lessons learned from the overall statewide project.

The project sought to build on the substantial published evidence about the comparatively poor physical health of people with mental illness and its impacts, supporting the need to improve physical health care for people with mental illness. While there is significant national and statewide policy support for action to address this issue, there remains limited published evidence and guidance to draw on to support practical strategies and solutions (the 'implementation gap').

This statewide project sought to respond to this challenge in partnership with OPMH inpatient and community teams across NSW, CMO partners and academic partners to develop local quality improvement projects in LHDs that were able to participate. An opt-in, 'start-where-you-can' project approach was adopted for this work, building on the methodology previously used for the NSW Health OPMH Recovery Project.[14,15] This approach utilizes a distributive leadership model where local health districts are each encouraged to develop their own local projects utilizing existing resources, with centralized support through a state-level project team and expert reference group established by the NSW Ministry of Health.

## Background

There is substantial evidence in Australia and internationally that the risk factors for chronic physical disease are higher among people living with severe and persistent mental illness than in the general population.[16] People living with mental health conditions have a lower life expectancy than the average Australian, and those with a severe mental illness die 10-15 years earlier.[17] Australia's Mental and Physical Health Tracker found that around 2.4 million people have both a mental and physical health condition, with more than three-quarters of the excess mortality coming from chronic physical health conditions, and that many of these deaths are preventable.[17]

The World Health Organisation's Mental Health Action Plan 2013-2020 also puts a focus on comprehensive, integrated and responsive care to attend to the physical healthcare needs of people with mental illness. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has highlighted the seriousness of the problem and called for a systematic, collaborative approach between psychiatrists, other health disciplines, the pharmaceutical industry and governments to reverse the culture of endemic low aspirations and system fragmentation that contributes to the poor physical health outcomes of people with a mental illness.[18]
In 2016 the National Mental Health Commission released the Equally Well Consensus Statement[9] outlining guidance to health service organisations to help bridge the life expectancy gap between people living with mental illness and the general population. The physical health of people living with mental illness was also named as a key priority area in the Fifth National Mental Health and Suicide Prevention Plan.[19]

As the NSW population ages, the number of older people with a diagnosable mental illness is projected to increase significantly, rising from approximately 190,000 in 2016 to approximately 260,000 in 2026.[20] As outlined in the NSW Ministry of Health *OPMH Service Plan 2017-2027*,[21] the presentation of mental illness in older age is often atypical and mental illness often co-occurs with other physical health conditions. Older people frequently have complex care needs, respond differently to medications compared with younger people, and require longer recovery times. Importantly, mental health therapies are as effective in older people as in younger people, and older people with mental illness usually experience improved mental health with the right care and treatment.

OPMH services are a key component of the broader system of care and support for older people with or at risk of mental health problems, providing specialist clinical services for older people with mental health problems. Key partners in this broader system include GPs, private psychiatrists and psychologists, geriatric and aged health services, community care and support services and residential aged care services.[21] For NSW OPMH services, there is an internally generated body of evidence from OPMH benchmarking and policy work that has indicated a need to explore solutions to bridge the identified implementation gap by translating an understanding of the physical health issues experienced by OPMH consumers into actions to respond more effectively to these issues.

In exploring the well-understood issues around the physical health needs of people with a mental illness, special populations who have a higher rate of medical comorbidities are historically rarely mentioned in guidelines[22] or literature around developing solutions within health systems. In 2021, during the period that this project was actively implementing solutions to the issues, NSW Health published the updated *Physical health care for people living with mental health issues guideline*.[23] This updated guideline presented an opportunity to ensure that specific populations such as older people with a mental illness were considered both in the assessment of, and strategies to address, the physical health needs of older people.

### The implementation gap

Despite the evidence about the problem of physical health comorbidity and early mortality in older people with mental illness, and an understanding of the need to address physical health needs as part of a holistic, integrated approach to mental health care, there is a gap in the literature and practice around effective, practical strategies to respond. An extensive review of the literature was undertaken for this project, finding little in the way of published, effective interventions to improve the physical health outcomes of older people with mental illness (publication in progress).

A 2023 NSW Ministry of Health workforce survey of mental health professionals working in OPMH services[24] found nearly 40% of respondents reported a moderate to high training need in relation to identifying and meeting the physical health needs of OPMH consumers. This highlights an ongoing need for targeted training and resources to equip mental health professionals with the skills to effectively address the physical health needs of older people with mental illness.

There is limited evidence and practical guidance on strategies to better address the physical health of people with mental illness[25] and where effective strategies have been developed, they are not always easily translated to an older population of service users or a range of service settings such as inpatient and community settings. The gap in published solutions presents a clear need to develop specific strategies and programs that better promote effective, integrated care to enhance the physical health outcomes of older people with mental illness. In considering the issues and the complexity of the health system in NSW, this project identified that a multipronged interdisciplinary approach through OPMH inpatient and community-based services collaborating with consumers and carers, GPs and community care partners was needed. Embedding solutions within the mental health system where practical should help address the implementation gap and in turn improve physical health outcomes and quality of life for older people with mental health issues and untreated or unidentified physical health issues.

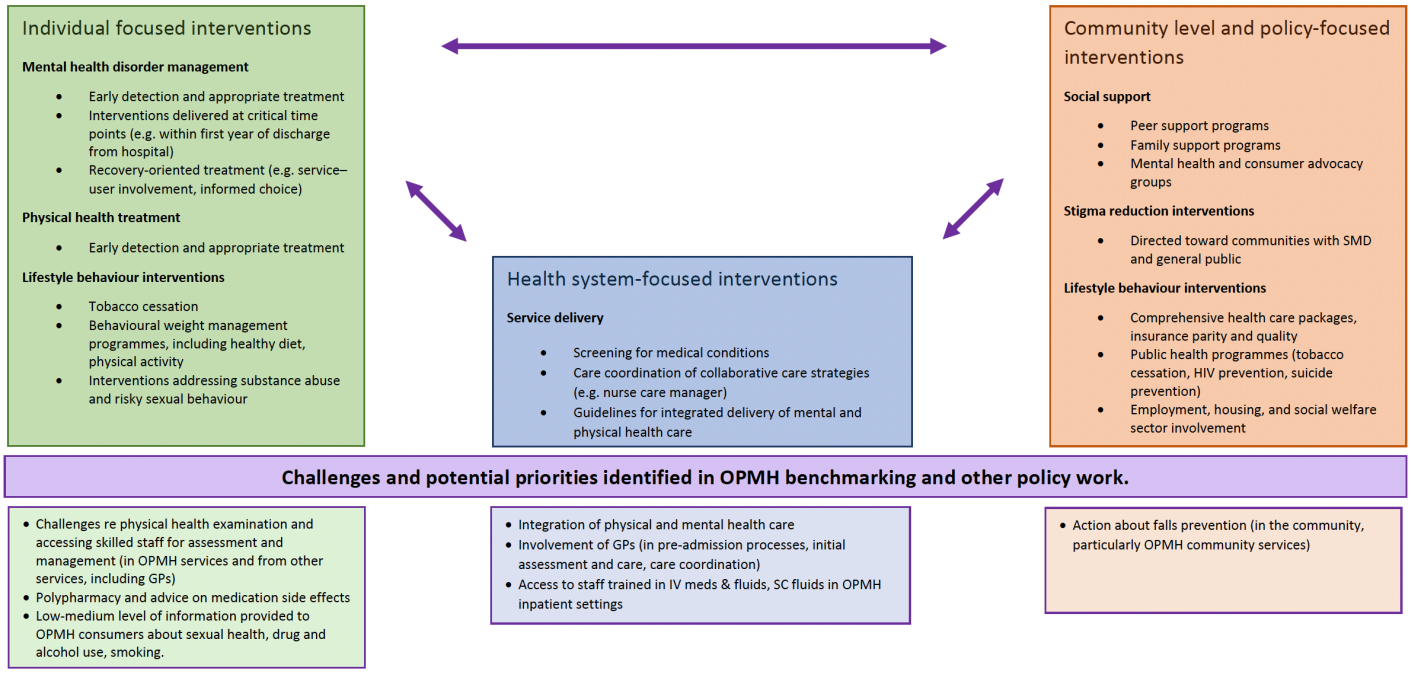
## Project objectives and approach

The Older People's Mental Health (OPMH) Physical Health Practice Improvement Project aimed to promote improvements in the physical health assessment and care of OPMH service consumers by addressing the well-known implementation gap. The approach built on a previously successful methodology in developing practice improvements around recovery-oriented practice in OPMH services. (14,15) With the support of a statewide project expert reference group, the project team developed an

adapted version of the practice improvement framework outlined in Liu et al[12] to guide the project. The adapted framework (*Figure 1* below) mapped the physical health practice challenges identified in OPMH benchmarking and statewide policy work to the intervention domains of the Liu et al framework: individual focussed interventions, health system-focussed interventions and community and policy-focussed interventions.

The adapted framework was used in the initial establishment workshop with local health districts to support local project planning and prioritisation. To further assist project champions in working through project ideas, the project team developed a statewide project resource toolkit, with the various supporting resources colour-coded to the domains of the adapted Liu et al framework.

**Figure 1: Adapted from Liu et al. 2017: the WHO implementation framework.**



## Project Methodology

The statewide project used a staged approach building on a previous statewide OPMH practice improvement project: the NSW Health OPMH Recovery Project[14,15]. One key addition to the previous plan was to include a research and evaluation element with academic partners as a fundamental part of the project design. The statewide project team approached Charles Sturt University and Equally Well Australia to assist in this aspect of the project.

An identified area for improvement from the previous OPMH Recovery Project[15] was the missed opportunity to add to the existing published literature in the practice area in many (though not all) local projects. The project team therefore sought to link LHD teams with academics who could assist with local project design, ethics approval, evaluation and publication. Previous experience with the OPMH Recovery Project highlighted that the process of publication is not typically a core skill of many of the frontline clinicians who would be implementing projects. From the academics' perspective, involvement in local practice improvement projects presented an opportunity to partner with health services for research and publication purposes.

Collaboration between CMOs committed to Equally Well and LHD OPMH services was also a new element which grew from the collective impact approach of Equally Well implementation, and the collaborative project approach.

The CMO and academic partners for LHD projects were onboarded to the project following the project workshopping phase. The NSW Health Clinical Excellence Commission partnered in the development of the project toolkit and early establishment of local projects.

The key phases of the final project methodology for this project are outlined below in Figure 2.

**Figure 2: Staged project plan**

## Service context

This project aimed to progress practice improvement largely within NSW older people's mental health (OPMH) services and through OPMH service collaboration with consumers, carers, and service partners. The project aimed to enable these collaborations to improve physical health assessment and care for OPMH service consumers. The scope of the project included both OPMH inpatient and community services, depending on local prioritisation.

NSW OPMH services provide specialist mental health assessment and care for older people, generally over 65 years of age and some people under 65 years who present with ageing related problems.[21] Currently, there is variation in the scope and capacity of OPMH services across different Local Health Districts (LHDs) across NSW. However, all LHDs and speciality networks in NSW have well-established OPMH community services. The majority of LHDs have specialist OPMH acute and/or non-acute inpatient units. And a number of LHDs have specialist mental health-residential aged care partnership services for older people with complex mental health needs and aged care needs.[21]

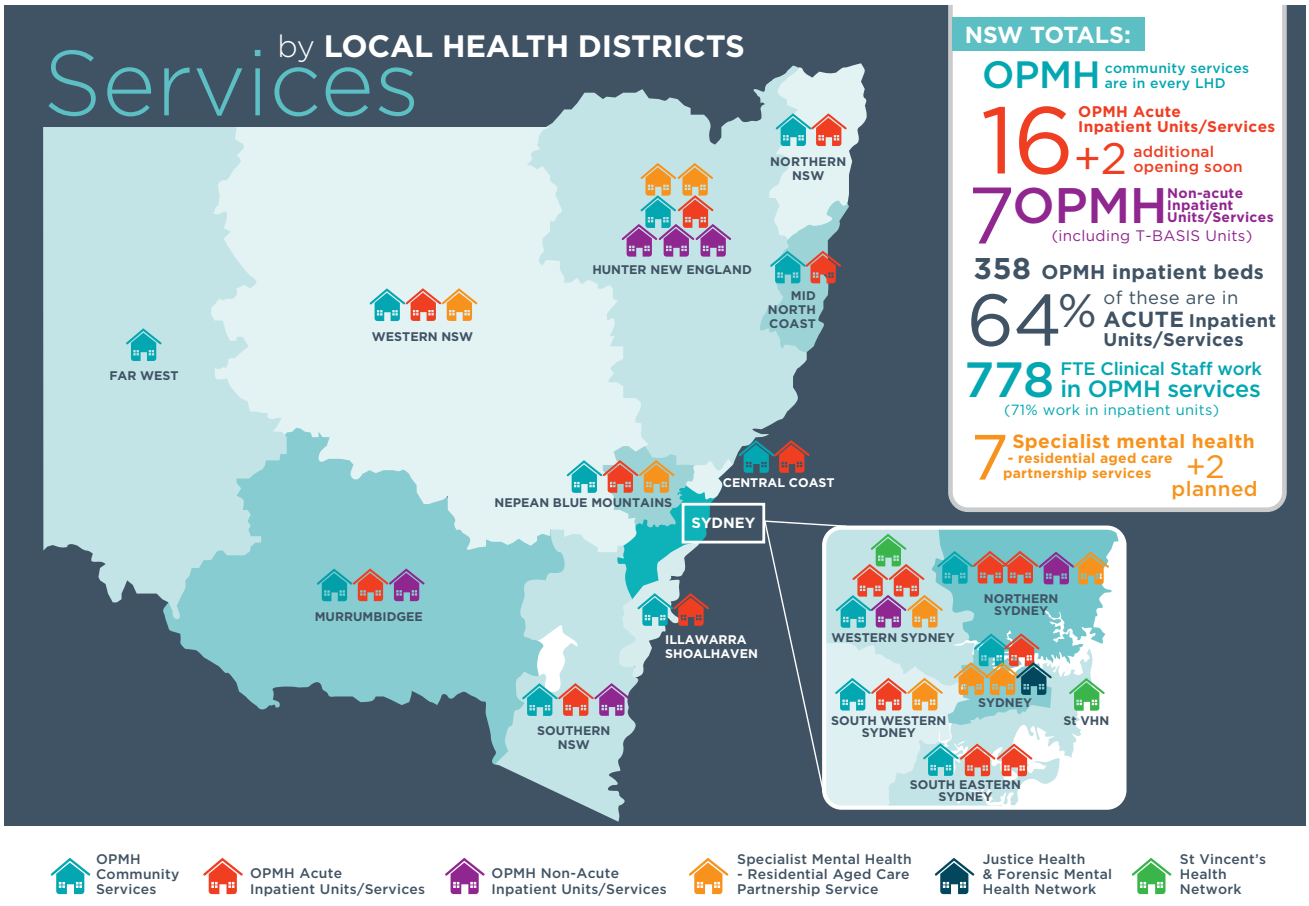
## Project leadership, management and partnerships

Both leadership and collaboration are essential in addressing the 'implementation gap' in improving the physical health outcomes of older people living with mental illness. This project used a distributed leadership model, comprising of several key components:

A three-person ***statewide project team*** in the NSW Ministry of Health provided overall vision, leadership and support for the project. This allowed a smaller team to efficiently conceptualise the project aims and broad methodology before consulting with a larger pool of experts to provide guidance and advice.

A larger ***expert reference group*** was formed, comprising over 20 experts representing a variety of health disciplines and perspectives, including lived experience, carer and peer worker perspectives. This was established as a mechanism for leadership and collaboration for the overall state project and also as a resource for local project champions to seek guidance and feedback on their individual projects.

**Figure 3: NSW OPMH Services (2016)**



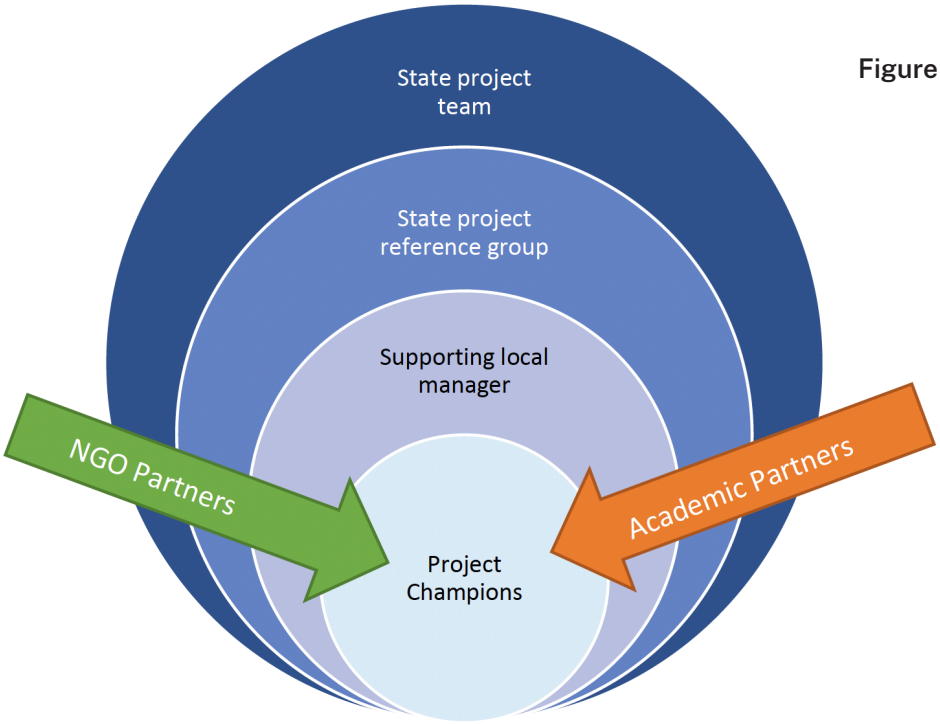



**Figure 4: Project leadership framework**

Each ***local health district*** that participated in the statewide project was asked to nominate a local manager along with their project champions, with champions ideally being a mix of nursing, medical and allied health clinicians. With a supporting manager and at least one (but preferably more) project champions, local projects would have more executive support to progress, and with cross-discipline engagement, there was a reduced risk of projects not progressing to completion if a key person was to move on from the project. Local project leads were also encouraged to seek involvement from people with a lived experience of mental illness, as well as carer and peer worker involvement in their projects where possible. Where this was a challenge, consumer and carer input could be provided by the state-level reference group where lived experience and peer worker representation was embedded as part of the membership.

Partnerships were an essential aspect of several projects with academic partners and collaboration with external non-government organisations. The non-government organisations that participated had a senior person allocated to the project who was able to liaise with the project champion directly as well as their organisational leadership. CMO and academic partners worked closely with LHD champions and their managers and liaised with and/or were part of the state project reference group. To help coordinate the academics as a team, a senior academic sat on the project reference group.

## Recruiting project champions

The NSW Ministry of Health's OPMH Services Advisory Group facilitated the recruitment of LHD project champions and managers. The OPMH Services Advisory Group is a regular state-level meeting that acts as a mechanism for LHD OPMH service managers and clinical directors from across the state to collaborate on key areas of practice. This group had supported the establishment of the statewide project. The initial expression of interest saw strong engagement from local health districts, with 50 project champions and supporting managers from a diverse range of professional backgrounds nominated across 15 LHDs and speciality networks to participate in the project.

## Partnerships

Developing strong partnerships was a key element to the project methodology. Partnerships enhanced LHD project design and also allowed project champions to bring in expertise, filling local knowledge or skill gaps for their projects. Partnerships also lightened the workload of the LHD project champions by distributing elements of the project to partners with specialised skills and expertise. Progressing ethics approval for projects via the support of academic partners is an example of this. As there were multiple projects with varying levels of complexity and resourcing, and

project champions with a variety of skill sets and experience, a range of partnerships was essential to help progress projects.

### Consumer, carer and peer worker perspectives

The statewide project plan, resources and establishment processes emphasised the importance of involving people with lived experience in local project development and implementation, including co-design where possible. The benefits of involving carers and peer workers were also emphasised. The project expert reference group had consumer and peer worker representation as well as representation from a peak organisation representing carers of people with a mental illness. A number of the LHD projects also included the lived experience of older people with mental illness and adopted a co-design methodology. For example, NEAMI National utilised a co-design methodology in revising its health prompt for use with older people with a mental illness. This involved convening a group of older people with live experience to help revise and create an OPMH version of the prompt. This prompt was then in turn piloted in local health districts as a multi-site trial project. Peer workers were also involved in the development and implementation of a number of local projects.

### Clinical Excellence Commission partnership

The project team partnered with the Clinical Excellence Commission (CEC) to identify ways where they could support quality improvement project planning. The CEC's Quality Improvement Academy includes a suite of existing tools and programs were included in the project toolkit resource document for local project champions. The project team and the CEC recorded a training session for project champions on how to use the CEC's Quality Improvement Data System (QIDS) for their projects if they chose to do so. This system provides users at all levels of an organisation with a single point of access to information and tools for the purpose of improving the quality and safety of health service delivery. Two online training sessions were provided, with several local health district champions deciding to use this system to plan and manage their projects.

### CMO partnerships

Flourish Australia and NEAMI National both agreed to partner in the project. Both are national community-based organisations that have developed physical health prompts that support people with mental health issues to identify and then self-manage physical health issues (with the support of their GP). These tools are typically completed with the assistance of a support worker, providing the person with a hard copy of the identified concerns that they can then follow up with their primary care physician. Both partners were interested in seeing if their tools could be adapted for use with older people's mental health consumers and were interested in exploring their usefulness within the context of support provided by community mental health clinicians. More information on the health prompts and their use are provided in the relevant project summaries.

### Charles Sturt University (CSU) and Equally Well partnership

Under the leadership of Prof. Russell Roberts, several Charles Sturt University academics supported local health district projects in progressing ethics approval with a view to peer reviewed publication. This was an opportunity for the academics to be involved in a project with NSW Health clinicians and service users, and an opportunity for the local health district project champions to leverage the skills of an academic to enhance their project and help progress it to publication.

Equally Well supports a priority action of The Fifth National Mental Health and Suicide Prevention Plan championing a national commitment to putting the health care of people living with mental illness and the rest of the population on an equal footing. This project also sought to feed into multiple Equally Well initiatives at the national level, including presenting progress and learnings at annual symposiums and engaging in the Equally Well communities of practice.

The project team conducted a brief literature review in partnership with Charles Sturt University at the outset of the project to support statewide and local project planning. This indicated that there was some published evidence about the physical health challenges of older people with serious mental illness, but limited evidence about effective interventions to address this. A more comprehensive literature review is being finalised for publication.

### Practice improvement workshop and development of project toolkit

The project team developed a 30-page project toolkit with input and endorsement from the project expert reference group to support local project champions. . The tool kit included background on the project, links to guiding documents, relevant literature, and processes to develop and prioritise a project as well as frameworks, practical tools and ways to evaluate projects.

The OPMH physical health practice improvement workshop took place in late-2019. The workshop was designed to leverage the toolkit resources, the adapted Liu et al framework and project methodology to workshop project ideas with each of the participating local health district champions and their managers, who all attended.

The workshop was held at NSW Health's Health Education and Training Institute (HETI). The day included presentations from a consumer representative and a carer advocate, statewide project clinical and policy leads, the CSU/Equally Well academic lead and CMO project partners NEAMI. A senior OPMH clinician and OPMH peer worker discussed approaches to consumer involvement and co-design in previous LHD OPMH projects.

Following the workshop, 15 LHDs and speciality networks each identified one local project to progress. Each project idea was taken back to the champion's local health district for further input and development into a project plan for local executive approval. The projects ranged from developing better screening and monitoring through to implementing exercise programs and targeted partnership initiatives to enhance GP collaboration. Overall, the projects initially proposed aligned with the Lieu et al[12] framework with a bias towards enhancing screening and assessment of physical health issues. This differed somewhat to the issues identified through OPMH benchmarking and policy work that guided the initial development of the project. While these issues did include screening

and assessment of physical health issues for older people with a mental illness, a range of other issues were also identified including working collaboratively with general practice in relation to a consumer's physical health needs, staff training in relevant areas (physical examination, IV medication and fluids, SC fluids), action around falls prevention and accessing skilled staff (physios, dieticians, GPs) for both assessment and management of physical health issues.

Project ideas were all framed from a 'start where you can' approach, enabling flexibility to take account of variability in local service capacity, priorities and context. A 'start where you can' approach was also essential as the project was undertaken without additional resources, so this allowed local project leads to scale their plans based on the staff and resources they could commit to a project at the local level. Asking for services to develop local projects without additional funding can pose a challenge. However, the project's distributed leadership model helped local project champions to progress their projects with support from the statewide project team, project expert reference group, CMO partners and academic partners.

### Project subgroups and academic engagement

Under the leadership of Prof. Russell Roberts, an expression of interest invitation was sent out to Charles Sturt University academics to seek their interest in being involved following the project workshop event. Fourteen academics expressed initial interest and the project team and academic lead hosted a meeting to showcase the initial LHD project ideas and seek to pair academics with LHD projects.

The project team identified four sub-groups of LHD projects with a similar focus area:

- Screening and assessment (9 LHDs)
- Physical health and length of stay (2 LHDs)
- Empowering consumers and consumer behaviour change (re: physical health) (5 LHDs)
- Physical activity/exercise initiatives (3 LHDs)

Meetings were convened in early 2020 to bring LHD project leads undertaking similar projects together for peer support and networking, and to streamline the academic partnering process for these projects. Most projects progressed to final local approval and started implementation by mid-2020, noting that the COVID-19 pandemic was to significantly disrupt progress and extend project timeframes.

## Project communication strategy

### Project communiques

Throughout the life of the project, brief project communiques were produced and disseminated drafted to inform and orientate all project champions, key stakeholders and LHD executives about project objectives and progress and maintain engagement and support for the project. This proved an effective strategy, providing a positive feedback loop that helped sustain engagement over the life of the project. This became increasingly important as project timeframes extended in the context of the COVID-19 pandemic.

### Equally Well presentations

Predating the project, Dr Kate Jackson and Dr Rod McKay presented at the 2019 Equally Well Symposium on *What do we know about the physical health of older people with mental illness, and what does this mean for improving care?*[26] This explored mental health and physical health in the context of an ageing population, our understanding of the physical health needs of older people with mental illness (including different sub-groups of older people) and how we can meet those needs, particularly in mental health services and mental health service partnerships. It highlighted the potential of a statewide practice improvement project. All of the Equally Well papers and presentations made as part of this project can be found in Appendix 3

#### *Older People's Mental Health Equally Well Webinar*

Dr Kate Jackson and Dr Rod McKay co-presented at the 2020 Equally Well webinar with local project leads Brian Tomney, Dr Carmelo Aquilina and Steve Suttie and on supporting the physical health of *older people's mental health service consumers: practical tips, research, and practice improvement*.[27] The webinar outlined practical advice and the latest research evidence on improving the physical health of older people living with mental illness. A recording of the session is available online at https://youtu.be/GqgfTpNw2nw

#### *Leadership and collaboration: statewide physical health practice improvement for older people with a mental illness*

Dr Kate Jackson and John Stevens presented at the 2022 Equally Well symposium (following the cancellation of the 2021 symposium due to the

COVID-19 pandemic). The presentation focused on how to create the right environment and processes to support collaboration on state-wide practice improvement, highlighting the distributive leadership approach and cross-sector partnerships. The abstract from the presentation can be found via the Equally Well website.[28]

### Other communication strategies

Both the statewide and local projects were showcased at a range of other events, including events hosted by other Australian jurisdictions and forums associated with the launch and progression of the NSW Health Physical Health care guideline[29]. This aligns with the collaborative approach of the statewide project and the collective impact approach of Equally Well.

### Showcasing event

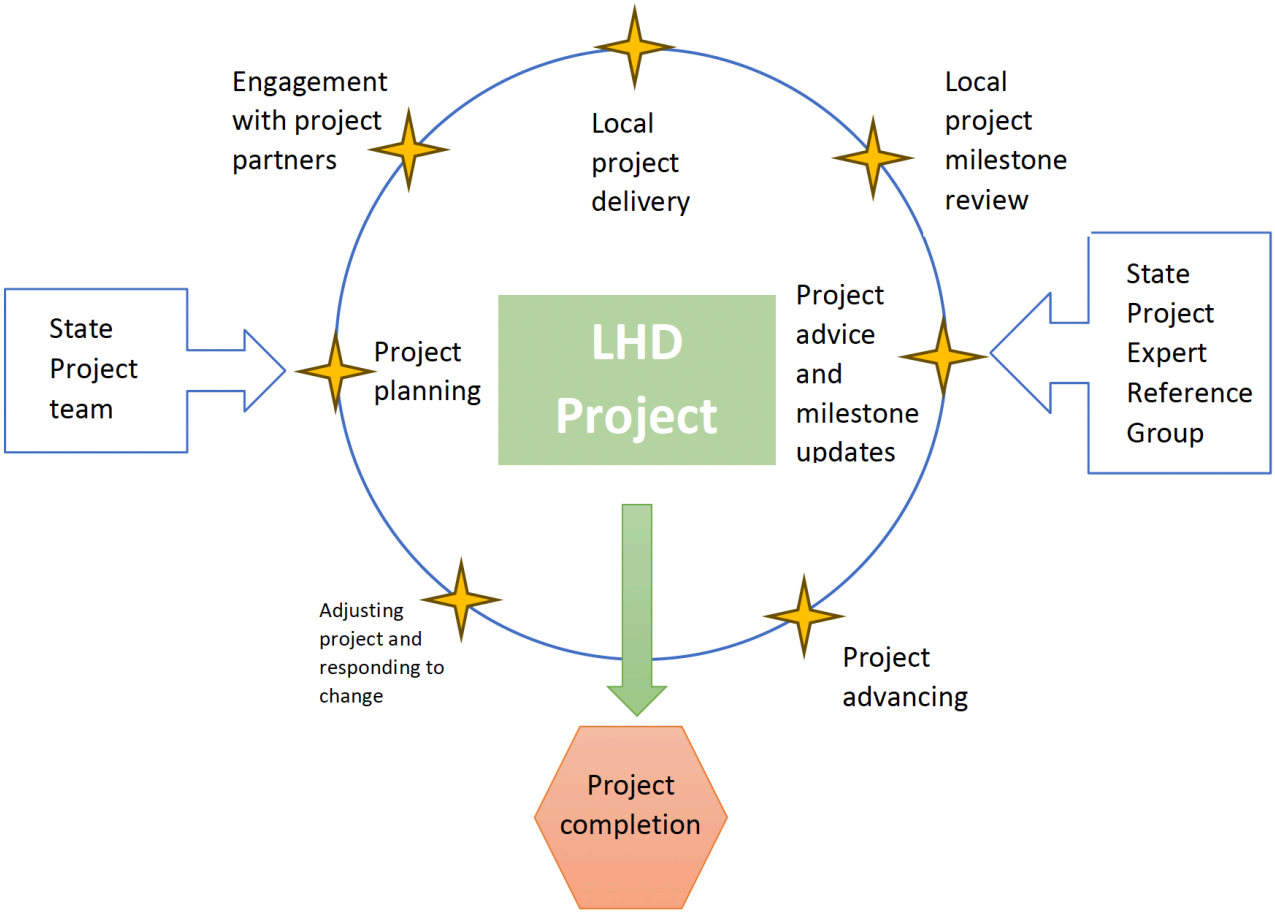
In line with the project methodology, the collective efforts of LHD OPMH services, CMO and academic partners as part of the OPMH Physical Health Practice Improvement Project were showcased at an event on 7 November 2022. This helped to spread project learnings and ideas, and encourage ongoing efforts in physical health practice improvement in OPMH services across NSW.

Highlights and recordings from the showcasing event have been published online on the NSW Health website.

## Project implementation and outcomes

Project implementation followed an eight-step cycle that ran multiple cycles for most projects before transitioning to completion.

**Planning**. For each project, the planning phase started with collaborative discussions with the state project team, either in the form of workshopping or online meeting sessions that developed ideas that were achievable within the limitations of local resourcing. This stage also identified key project milestones, ranging from ethics applications, and establishing specific partnerships, to delivery timeframes for different aspects of the project.



**Engagement with project partners.** Those projects requiring partnerships progressed to engaging with project partners. This may have included academic partners and community managed organisations who collaborated on progressing a plan to move the project into the delivery phase.

**Local project delivery.** Projects were implemented in the local project delivery phase. This involved working with consumers and other OPMH staff to deliver the project as planned with any project partners.

**Local project milestone review.** LHD champions reviewed project milestones quarterly to track how their project was progressing against what was planned. This flagged any issues where advice might be needed.

**Project advice and milestone and review updates.** The state project team sought updates from LHD champions quarterly. Updates were included in state project communiques. This was also an opportunity for LHD champions to flag any issues or challenges and seek input from the state project expert reference group, which also met quarterly.

**Project advancing.** LHD champions advanced their project towards completion with advice provided by the state project expert reference group.

**Adjusting projects and responding to change.** To varying extents, all of the LHD projects had a period of needing to adjust to significant change. The COVID-19 pandemic had an impact on all projects requiring project plans to be adjusted, or in some cases projects to be rethought entirely. This was also a phase where workforce changes resulted in some changes to project champions/teams. In some cases, projects were abandoned and where possible those LHDs were incorporated into the NEAMI health prompt project, which enabled LHDs to remain involved with less commitment of resources.

Projects looped back through the cycle until they could be progressed to completion.

**Project completion.** Projects were considered completed once the LHD champion was able to outline their project outcomes, provide input into the state project report or present findings at the project showcasing event in addition to having a plan on how the changes made could be sustained in their local service.

The original planned timeframe for the statewide project was approximately 18 months from the workshop phase to the showcasing of completed projects. The project planning and establishment phase commenced in late-2019 with the project establishment and workshopping forum taking place in early-2020. There were a number of challenges that disrupted these timeframes, key among them being the COVID-19 pandemic and the resulting disruptions to OPMH workforce and service capacity.

As the challenging aspects increased the project team leaned on the enablers to sustain the project. Being adaptable and flexible in light of other external pressures on the project was a key element to sustaining engagement with the LHD champions, creating the right environment for success and supporting them to successfully complete projects.

A total of eight projects were completed as part of the OPMH Physical Health Practice Improvement Project, involving eleven LHDs and two CMOs. This was despite the project being implemented in the face of a global pandemic that brought about major workforce, resourcing and capacity disruptions. These projects were in three key focus areas:

- Empowering consumers around physical health improvement
- Physical health screening and assessment
- Physical activity/exercise

The projects covered all three domains of the Liu et al implementation framework as outlined below. They were implemented in OPMH clinical services (predominantly in community settings) and CMO services. Academic partners collaborated on four of the eight projects, as well as the statewide project.

The eight projects completed under the statewide project are listed below, grouped by project focus area and mapped to the Liu et al implementation framework. A summary of each project is provided in the following section of this report.

| Project | Project leads/ partners | Academic partner | Focus area | WHO (Liu etc) implementation domain |
|---|---|---|---|---|
| **NEAMI physical health prompt - a multi-site trial** | NEAMI National<br>St Vincent's Health Network<br>Mid North Coast LHD<br>Southern NSW LHD<br>Murrumbidgee LHD | Charles Sturt University | Empowering consumers around physical health improvement | Health system focussed intervention |
| **The LIVE WELL Intervention: Promoting health behaviour change in older people living in South Western Sydney** | South Western Sydney LHD | | Empowering consumers around physical health improvement | Community level and policy focused intervention |
| **Piloting the Flourish physical health prompt 'PhysiCards©' within an older person's community mental health population** | Flourish Australia<br>Nepean Blue Mountains LHD | Charles Sturt University | Empowering consumers around physical health improvement | Individual focused intervention |
| **Manage My Health: a coaching approach to assist older mental health consumers to better manage their own physical health** | Illawarra Shoalhaven LHD | | Empowering consumers around physical health improvement (with screening element) | Individual focused intervention |
| **OPtiMHize improving health outcomes of older people with a lived experience of mental illness** | South Eastern Sydney LHD | | Physical health screening and assessment (with consumer empowerment element) | Health system focussed intervention |
| **Increasing the rate of metabolic screening and monitoring in the older mental health consumer** | Northern Sydney LHD | | Physical health screening and assessment | Health system focussed intervention |
| **Adapting Fit For Your Life to the regional context** | Western NSW LHD | Charles Sturt University | Physical activity/ exercise | Individual focused intervention |
| **The impact of exercise on holistic health for older adults with mental illness: a pilot study** | Western Sydney LHD | Charles Sturt University | Physical activity/ exercise | Community level and policy focused intervention |

# Local Health District project summaries

Each of the eight projects completed under the umbrella of the statewide project is summarised below. These summaries are based on the more detailed project summaries provided by LHD project champions and their supporting managers and CMO partners (see Appendix 1).

# NEAMI physical health prompt – a multi-site trial

## Murrumbidgee LHD, Mid North Coast LHD, Southern NSW LHD, St Vincent's Health Network and NEAMI National

**Project Champions:** Vicki Langan, John Stevens, Sophie Zammit-Haber, Lianne Rowland, Elizabeth Gralton, Donna Widdison, Natalie Scraysbrook, Kersten Davis.

**Supporting managers:** Stephen Suttie, Dr David Burke, David Noble, Andreia Schineanu.

**Project team professional discipline mix:** allied health, nursing, peer work, management, policy

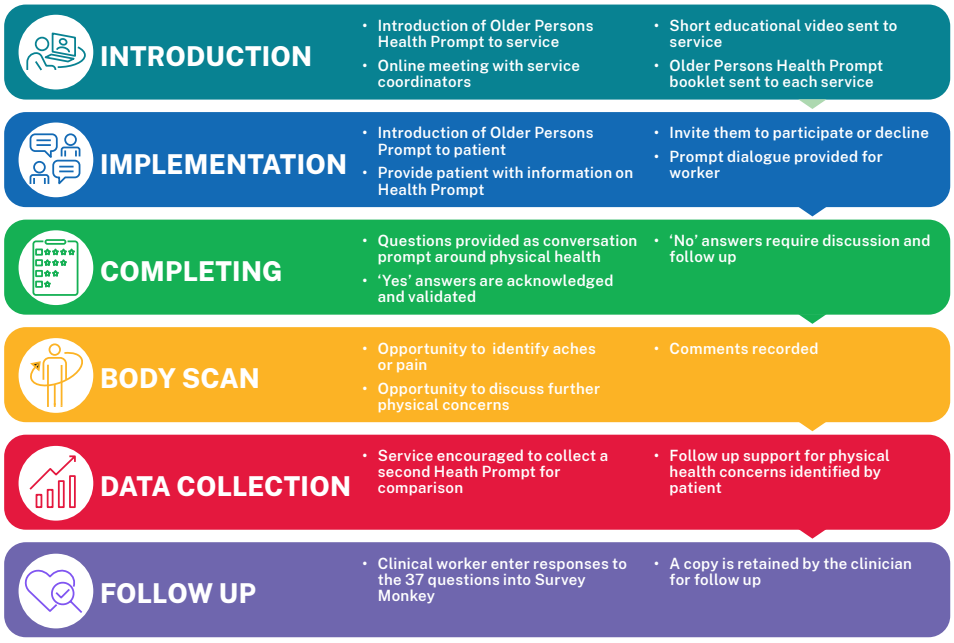
**Project citation:** This project is currently in draft for peer reviewed publication.

This project was a collaborative effort between the NSW Ministry of Health, four local health districts and NEAMI National. The project involved the adaption of a general adult NEAMI health prompt resource to develop a user-friendly Older Persons Health Prompt through co-design with older people, and a multi-site trial of the Health Prompt to enhance physical healthcare outcomes for older adults in NSW with an ongoing mental illness. The trial was undertaken within OPMH inpatient and community settings in three rural LHDs, in OPMH service in-reach into a residential aged care setting in the metropolitan St Vincent's Health Network region, and in a CMO setting (NEAMI services). The Older Persons Health Prompt was co-designed with older service users and CMO staff over the age of 65.

The project aimed to equip older mental health consumers with the knowledge and skills to proactively manage their physical health, identify concerns and confidently seek further care from their GP. A secondary aim was to foster strong partnerships between CMOs and public health organizations, promoting a person-centred approach to healthcare delivery.

The NEAMI health prompt is a physical health screening resource designed to reflect a strengths-based, recovery-oriented, holistic approach to physical health. It consists of 28 questions and a Body Chart to indicate physical health issues, pain or concerns, and has been translated into additional languages and adapted for various demographics. This project held a unique role within the broader statewide project and helped maintain engagement from some LHDs amidst COVID-19 impacts to service capacity. Within this multi-site trial the Older Persons Health Prompt was delivered by a mixture of NSW Health specialist OPMH clinicians, CMO staff and peer workers depending on the setting where the prompt was being implemented.

Results showed that most consumers who participated in the health prompt trial had a positive experience. The prompt was successful in consumers taking issues identified as part of the process to their GP, particularly concerning cancer screening. The health prompt had good acceptability for OPMH clinicians and CMO staff, including peer workers. It continues to be used in NEAMI services and has been adopted for ongoing use by two LHDs in their community mental health services.



# The LIVE WELL Intervention: Promoting health behaviour change in older people living in South Western Sydney

## South Western Sydney LHD

**Project Champions:** Dr Carmelo Aquilina, Lachlan Best, Ruth Ferrington, Meg Thomas, and Rebecca Abrahams

**Supporting manager:** Patrick Parker

**Project team professional discipline mix:** medical, allied health, management

**Publication citation:** Aquilina, C, Best L, Mohsin, M and O'Callaghan C (2024) The Live Well Intervention: Promoting healthy lifestyles during routine older people's mental healthcare, Australasian Psychiatry

The Live Well Project is a clinical initiative aimed at developing a brief intervention to promote healthy behaviours in various domains such as physical activity, social activity, healthy eating, mental activity, mental wellbeing, and positive thinking. This project is based on the Canadian Fountain of Health model and is funded by the South Western Sydney Primary Health Network. The Live Well intervention was undertaken in an OPMH community setting in a metropolitan LHD.

In the trial, potential participants accessing an OPMH community service were invited to discuss their lifestyle and the Live Well intervention. They chose one domain to focus on and wrote a SMART goal. The Health and Wellness Questionnaire was used to measure their health at pre- and post-intervention, with follow-ups at 6 and 12 weeks. The trial involved OPMH clinicians from a mix of disciplines including allied health and nursing staff.

The project team created new tools for clinicians, including a Health and Wellness Questionnaire, a Consumer SMART goal sheet, animated videos, consumer & carer guides, and brochures in six languages. For clinicians, the team developed training sessions, posters, a clinician toolkit, manuals, QR codes for video access, and a Local Resource Guide. The project also commissioned the development of a new brand identity and navigated the legal considerations around copyright. A research protocol was established, and ethical approval was sought for a clinical trial.

The project recruited 65 participants, with 52 completing the full intervention. Results showed positive outcomes in goal achievement, wellbeing change, and satisfaction. However, the intervention was not adequately tested with enough participants from different languages and cultures, so the results are not fully generalizable.

The project has been well-received by participants and OPMH service staff. Future directions include expanding the intervention to different age groups, populations, and cultures, enhancing the program, and strengthening evaluation. The aim is to integrate Live Well into routine care and increase its reach through new delivery methods and online training modules.

# Piloting the Flourish physical health prompt 'PhysiCards©' within an older person's community mental health population

## Nepean Blue Mountains LHD

**Project Champions:** Michelle Johnson, Marcelle Droulers and John Stevens

**Project team professional discipline mix:** Nursing, academic, policy

**Submitted for publication.**

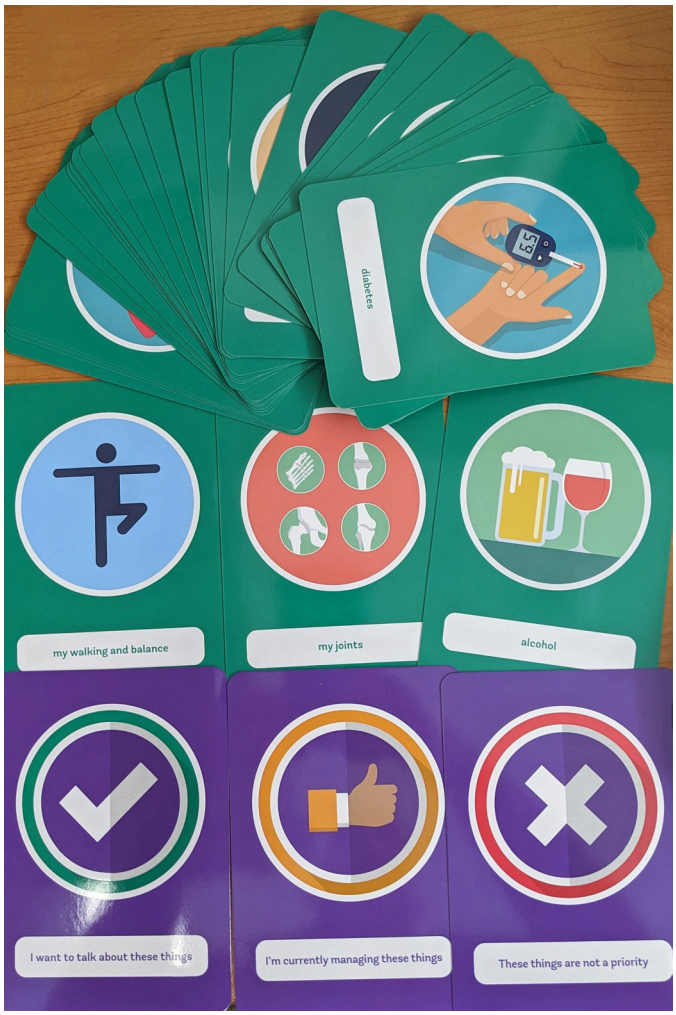
This project was a collaborative effort between Flourish Australia, Nepean Blue Mountains LHD, the NSW Ministry of Health and Charles Sturt University. The project sought to improve the physical health outcomes of older people with mental health issues accessing care through an OPMH community service. The project employed the PhysiCards© tool developed by Flourish Australia - a set of visual health cards with prompt-based questions, designed to facilitate the identification and prioritization of physical health concerns.

The project was conducted within the Nepean Blue Mountains LHD OPMH community OPMH team, which serves both metropolitan and rural locations. It piloted the use of physical health prompt cards as a visual communication aid during community mental health home visits, with the goal of encouraging positive health behaviours. The pilot involved OPMH clinical nursing staff.

Twelve OPMH community consumers were purposively sampled for the pilot. The participants used the cards to identify and prioritize physical health issues they wanted to address, creating a personalized 'My Health Needs To-do List' to take to their GP for follow-up. Semi-structured qualitative interviews were conducted with participants after they had used the tool with their community mental health clinician and had time to follow up with their GP.

Data from the interviews was analyzed using Thematic Analysis (TA), which revealed themes related to the consumer experience in using the tool. The project took place during the COVID-19 pandemic, with several disruptions due to changes in the clinical lead's role. Despite these challenges, the project was completed, and consumers found value in using the tool as part of the OPMH clinician home visits.

The findings suggest potential clinical and social benefits for consumers going through the process with this tool, aligning with policy aims of consumer empowerment and targeted physical health gains for this population. Future directions include evaluating the value of embedding this tool or a similar one into OPMH community team practice and further testing its adaptation for use with an older population.



# Manage My Health: a coaching approach to assist older mental health consumers to better manage their own physical health

## Illawarra Shoalhaven LHD

**Project Champions:** James Bradbury and Jess Peters

**Supporting manager:** Carol Martin

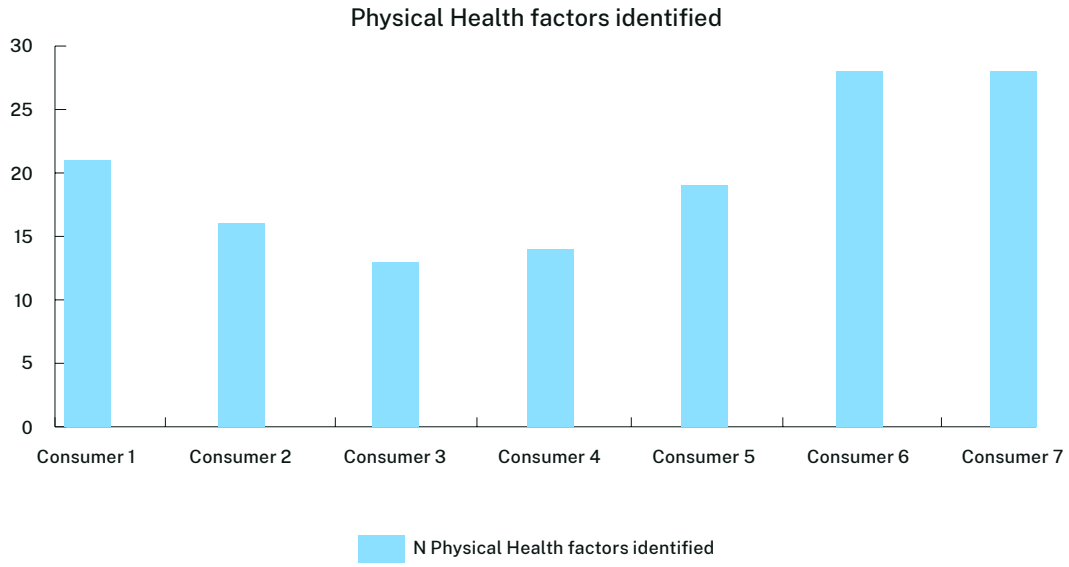
**Project team professional discipline mix:** Nursing, peer work, management

This project aimed to enhance the physical health management of older mental health consumers in a community OPMH setting. Recognizing the challenges in accessing physical health care for older mental health service consumers, the project employed a coaching approach to address potential barriers and build motivation towards adhering to health strategies and lifestyle changes.

The project followed a seven-step methodology, including a physical health screening, discussion, empowerment, coaching, care plan development, examination, and monitoring. Consumers, carers, and family were actively involved in this process, with the intention of promoting consumer and carer engagement in choice and decision-making for health gains.

The project was piloted over two phases, with a small cohort of OPMH community consumers. In the first phase, a pre- and post-intervention series of questions were used, while the second phase introduced a more comprehensive screening tool to identify physical health issues more effectively. The second phase also incorporated a peer worker in the screening process, which was found to yield better results. The pilot involved OPMH clinicians from a mix of disciplines including nursing staff and a peer worker in the second phase as outlined.

The Manage my Health coaching intervention was piloted with 7 consumers in the project period. Preliminary results showed an overall increase in consumer awareness, knowledge, motivation, and confidence regarding their physical health. However, challenges were encountered during the COVID-19 pandemic, which impacted home visits and workforce availability. Future directions for the project include the adoption of the Health Improvement Profile (HIP)[30] to further improve the physical health screening tool. The project was successful in demonstrating a promising approach to improving the physical health care of older mental health consumers. By focusing on consumer and carer engagement, and employing a coaching approach to address potential barriers, the project aims to support these individuals in making informed decisions about their health and achieving improved physical well-being.



# OPtiMHize: improving health outcomes of older people with a lived experience of mental illness

## South Eastern Sydney LHD

**Project Champions:** Danielle Gately, Helen McIntosh, Daniella Kanareck, Dr Katherine Mullin, Natalie Narunsky, and Ti-Arna Madigan

**Supporting manager:** Dr Patrick Bolton

**Project team professional discipline mix:** Medical, allied health, nursing.

OPtiMHize was developed as a pilot project to empower OPMH service consumers to identify health issues and actively engage in their physical health care, so as to promote better physical health outcomes and improved quality of life. The project also aimed to provide older mental health consumers with accessible pathways to address their identified health issues.

The pilot project was conducted within a South Eastern Sydney LHD OPMH community service setting. It recognised that older people are more susceptible to developing poor physical health due to the impact of mental illness on social and cognitive function, decreased energy levels, and lack of motivation to take care of their health. Encouragingly, all of the participating OPMH consumers already had high engagement with a GP.

The project team developed a questionnaire to help identify a consumer's physical health issues. The questionnaire was informed by various relevant clinical guidelines and standards including the NSW Health Physical Health Care for People Living with Mental Health Issues guideline[29]. It covered several domains of physical health including medication, physical fitness, pain, constipation and incontinence, weight loss, falls, regular check-ups, vision, hearing, dental, cancer screening and immunizations. The pilot involved OPMH clinicians from a mix of disciplines including allied health, nursing and medical staff.

Twenty-three consumers participated in the pilot project. The majority of participants reported that they found the questionnaire useful and enjoyed talking about non-mental health issues. In response to feedback from participants, the format of the questionnaire was revised during the pilot period to be more user-friendly. All 23 participants identified health issues of concern and many identified issues they would like to follow up with their GPs. The findings indicate a high rate of vision aids, less than half using hearing aids, and less than a quarter of the participants identifying having dental pain or ill-fitting dentures. Over half the participants reported taking more than five medications, placing them at risk for adverse reactions due to polypharmacy. Only 5 (22%) indicated they would like more information on the medications they had been prescribed. Within the pilot period, the project was not able to progress pathways to care or evaluate outcomes for participants.

The project has potential strengths, such as empowering consumers to enhance their overall well-being and quality of life and strengthening links to General Practice. However, limitations include the impact of COVID-19-related lockdowns on accessing routine medical care, and the unknown frequency that the questionnaire needs to be done to impact outcomes. Future directions for this work include the development of an information pack, promotion of discussion across the SESLHD Mental Health Service, endorsement of the use of a physical health questionnaire as a routine screening tool, and providing GPs with resources to support follow-up on the questionnaire via the local Primary Health Network's Health Pathways.

# Increasing the rate of metabolic screening and monitoring in the older mental health consumer

## Northern Sydney LHD

**Project Champions:** Brian Tomney

**Supporting manager:** Andrew Clement

**Project team professional discipline mix:** Nursing, management

The NSLHD OPMHS Physical Health Care Practice Improvement Project aimed to increase the rate of metabolic screening and monitoring to at least 75% across four OPMH community teams in the Northern Sydney LHD. The project aimed to address the increased risk of physical health problems such as cardiovascular disease and diabetes among individuals with severe mental illness, who are likely to die 20 years earlier than the general population. Metabolic monitoring was an existing focus of LHD mental health services and NSW Health guidelines for physical health care for people with mental illness. However, implementation of metabolic monitoring was challenging. The project followed the Clinical Excellence Commission quality improvement methodology, with the help of a working group and a, expert reference group consisting of experts from various organizations.

A baseline audit of electronic medical records in March 2020 revealed that between 1% and 42% of consumers across Northern Sydney LHD OPMH community services had metabolic monitoring completed at any point during their contact with services, with rates of metabolic monitoring within the previous year between 0% and 35% and within the last 6 months between 0% and 24%. To address this issue, the project implemented various tests of change, such as the development of a standardized checklist for OPMH case managers and the implementation of the Wellness on Wheels program, which offered consumers the opportunity to have metabolic monitoring and physical health and wellbeing screening attended to at home.

Three teams achieved the goal to increase the rate of metabolic screening and monitoring to at least 75% within the initial project period, with the fourth team expected to meet the objective by the end of 2021. The recruitment of Senior Mental Health Clinicians in June 2020 to Hornsby, Ryde, and Northern Beaches, as well as an exercise physiologist working across the three sites, played a significant role in increasing the rate of metabolic monitoring. The senior clinicians raised the profile of metabolic monitoring and physical health and wellbeing with the whole multidisciplinary team and facilitated all clinicians in carrying out or enabling metabolic monitoring and physical health and wellbeing assessment.

To sustain and build on the improvements achieved, the LHD OPMH service is making ongoing efforts to improve metabolic monitoring, collaboration for better care planning and reviews, streamlining routine and opportunistic monitoring, and the development of escalation pathways for abnormal results. The project leads also aim to disseminate its knowledge through presentations at various conferences. The project lead actively works with OPMH lead clinicians and staff to improve metabolic monitoring, care planning, and escalation pathways for people with mental health issues, with a focus on collaboration and consumer involvement.

# Adapting Fit for your Life to the regional context

## Western NSW LHD

**Project Champions:** Sue Kerwick, Gabrielle McNamara, Hannah Nunn and Kristen Szulik

**Academic partners:** Associate Professor Rachel Rossiter, Dr Caroline Robertson and Dr Tegan Hartmann

**Project team professional discipline mix:** Allied health, nursing, management, academic

**Publication citation:** McNamara, Gabrielle, Robertson, Caroline, Hartmann, Tegan, & Rossiter, Rachel. (2022). Effectiveness and Benefits of Exercise on Older People Living With Mental Illness' Physical and Psychological Outcomes in Regional Australia: A Mixed-Methods Study. Journal of Aging and Physical Activity. Advance online publication. https://doi.org/10.1123/japa.2021-0514.

The aim of this project was to demonstrate physical and mental health improvements for older people using OPMH community services through participation in a 9-week physical activity program. The program consisted of three 60-minute sessions per week, led by an Accredited Exercise Physiologist (AEP) and an OPMH clinician. The project sought to assess the physical health and mental health improvements that can be achieved in older people with a mental health condition through participation in a structured exercise program in a regional location.

The LHD project team partnered with Charles Sturt University researchers for a robust research design. The project was supported by Western NSW LHD Research Directorate seed funding and involved OPMH clinicians and an Accredited Exercise Physiologist. The program was evaluated by participants.

Outcomes were measured via physical health and activity data and mental health quantitative data, taken pre and post-exercise program. Semi-structured interviews with participants were conducted pre and post-program to gather a narrative of exercise engagement and views of the program, and identify changes in the participants' views.

The project demonstrated improvements in physical activity and mental health for participants. Participants identified the benefits of social engagement with others who understood their experiences (i.e., others living with mental illness), with improved psychosocial functioning (Beck, et al., 2016; Bethancourt, et al., 2014; Noh & Kim, 2022; Rai, et al., 2020). OPMH service staff consider the effects of physical health and activity as an important part of the service more than before.

The next steps for this project include exploring ways to re-establish the program in the current climate and continuing to advocate to build knowledge and skills of others in government, clinical, and community settings to incorporate physical activity into mental health care for older people. The team also intends to explore funding opportunities to support the implementation and evaluation of the program on a larger scale. The findings of the study have the potential to contribute to the evidence base for the benefits of structured exercise programs for older people with mental health conditions and could inform the development of guidelines and best practice recommendations for the delivery of such programs in regional settings.

# The impact of exercise on holistic health for older adults with mental illness: a pilot study.

## Western Sydney LHD

**Project Champions:** Dr Suman Tyagi, Bharat Nepal, Sonia Main, Bincy Punnoose, Molly O'Brien, Chenjerai Chikara, and Melinda Adamcewicz

**Supporting manager:** Dr Suman Tyagi

**Academic partners:** Dr Gavin Buzza and Dr Jack Cannon

**Project team professional discipline mix:** Allied Health, nursing, peer work, management, academic

**Submitted for publication.**

This project aimed to compare the physical and psychological health outcomes of older mental health consumers receiving usual care in a community mental health setting with those receiving the same usual care combined with a clinically supported exercise program. It was hypothesised that older mental health consumers receiving usual mental health care combined with a clinically supported exercise program would have improved physical and psychological health outcomes. The project learnings and outcomes could then be used to support developments in OPMH community services. The LHD project team partnered with Charles Sturt University researchers for a robust research design.

The project involved OPMH allied health and nursing staff in community OPMH services and a peer worker. The pilot study included 22 participants aged 65-85 years who were accessing ongoing support from a community OPMH service. All of the participants were living independently in their own homes. Each participant received usual mental health care and support while participating in a 13-week exercise program focusing on balance and lower-body muscle strength.

Participants completed physical tests and questionnaires before and after the intervention, evaluating aspects such as mobility, balance, and psychological well-being. The exercise group showed significant improvements in waist circumference, timed sit-to-stand, and Hospital Anxiety and Depression Scale (HoNOS 65) scores. The comparison group showed a decrease in the Falls Risk Profile (FROP) score.

The exercise group reported increased feelings of connectedness, belonging, and improved mood after the program. Participants valued the program's continuation even during COVID-19 restrictions, citing feelings of being cared for and valued. Although there were no statistically significant improvements in physical health data, there were no functional declines, and a significant improvement in participants' feelings about their recovery journey was observed.

The study was conducted with ethics approval, and participants were recruited based on eligibility criteria. Data analysis and statistics were performed using a two-way repeated measures ANOVA and Wilcoxon signed rank tests. The results showed significant improvements in the exercise group, with no significant differences between groups before the intervention for any variables. The findings of this study will be used to improve care and treatment services for older mental health consumers.

# Discussion

This project grew out of statewide OPMH benchmarking and policy work which identified that OPMH services were challenged by addressing some of the physical health needs of OPMH consumers. The policy impetus of the Equally Well Consensus Statement and NSW Health's commitment to improve the physical health of people with mental illness helped ensure support for the project. The project built on previously developed mechanisms[14] for statewide collaboration between OPMH clinicians, service managers, policymakers, and key stakeholders, fostering engagement in statewide practice improvement in OPMH services. Policy commitment and statewide engagement mechanisms were crucial for both initial and sustained support. A distributive leadership approach, including state and local level leadership, and leadership from other project partners, kept the project on track within a complex healthcare system.

## Project approach

The project methodology built on a previous OPMH recovery-oriented practice improvement project[14]. Key elements of this approach included:

- establishing a statewide project plan, expert reference group and other project processes such as regular communiqués
- developing a toolkit and other supporting resources to assist local project leads in developing projects
- identifying and supporting local project champions and teams to plan, implement and evaluate local projects as part of the statewide project, and
- evaluating, showcasing and sustaining practice improvements.

Collaboration between community managed organisations committed to Equally Well and local health district OPMH services was a new element which grew from the collective impact approach of Equally Well implementation, and the collaborative project approach. Given the acknowledged 'implementation gap' in relation to effective interventions to improve the physical health of people with mental illness and learnings from the previous statewide recovery-oriented practice project in relation to publication of project findings, the project team added a new element to the project approach. This involved research partnership with Charles Sturt University and Equally Well to support academic collaboration in project design, evaluation and publication of findings.

The right environment and processes to support practice improvement

The project approach was broadly successful, despite some challenges and limitations, in particular the COVID-19 pandemic which significantly disrupted the project. The project approach underlines the need to create the right environment and processes to support statewide practice improvement. Key elements that supported project success included:

- the *distributed leadership approach* of the project, involving leadership at the statewide and local levels, as well as leadership from key project partners, in the context of a complex health system
- the *statewide project team and expert reference group* to guide and support local project leads throughout implementation
- *ongoing communication and engagement strategies* such as project communiques, project initiation workshops, collaborative processes and showcasing events to build and maintain leadership and collaboration throughout the project
- *ongoing commitment to the project aims and persistence, alongside flexibility to adapt* in the face of challenges and disruptions.

## New collaborations and partnerships

The statewide project involved collaboration with two CMO project partners: NEAMI and Flourish. Both these partners had already developed health prompt resources (written and graphic) to support physical health conversations and actions with their service users and were willing to partner with OPMH services in trialling these with OPMH consumers. This aligned with the 'start where you can' approach of the project.

The NEAMI collaboration was particularly successful in leveraging NEAMI's commitment and capacity to offer LHDs with limited local capacity the opportunity to participate in a multi-site trial of the health prompt. This secured greater LHD participation and led to a more comprehensive trial across different regions (rural and metropolitan) and service settings (community OPMH services, OPMH outreach within residential aged care and CMO services), and with a larger number of consumers. The Flourish visual health prompt project also supported one LHD to maintain engagement with the project in the face of capacity challenges.

CMO partnerships were essential to the success of these two projects, highlighting the benefits of a collaborative, collective impact approach, particularly in the face of disruptions to organisational capacity such as those that occurred during this project from the COVID-19 pandemic.

The research collaboration with Charles Sturt University added to the complexity of the project, with the statewide project team, LHD OPMH services and academics working through their roles and contributions to the projects, partnership processes and different ways of working. However, it ultimately added rigour to the design of some projects and has led to significant publication of project findings.

## The 'start where you can' approach

The 'start where you can' approach of the project enabled action and resulted in eight completed projects involving eleven LHDs and two CMO partners. It also appears to have led to the sustainability of many projects, with completed projects embedded into ongoing practice in most participating LHDs. However, the focus on feasibility in determining the focus of local projects, may leave some of the more significant, systemic and long-term challenges in improving the physical health of people with mental illness still to be addressed. For example, none of the projects successfully pursued enhanced collaboration with GPs in a systemic way, despite this being one of the challenges identified at project initiation.

In the face of the COVID-19 pandemic, the 'start where you can' approach meant that local projects were more adaptable to change as the pandemic altered the personnel, workforce and resources available to project leads. With staffing changes and limitations and project delays, some projects have had to 'restart where they could' at various points in time.

## Involving people with lived experience

The statewide project plan, resources and establishment processes emphasised the importance of involving people with lived experience in local project development, and co-design where possible. Local project teams embedded lived experience in their projects in various ways and to various degrees, with some project teams consulting with consumers, some involving peer workers, and the NEAMI health prompt project involving co-design of the older people's physical health prompt as an adaptation of the existing NEAMI health prompt. The emphasis on lived experience involvement is reflected in the fact that four of the eight projects were focussed on empowering OPMH consumers around physical health improvement at the individual level.

## Implementation without additional resources

The state project was undertaken with no additional funding, leveraging existing resources wherever possible. Whilst some of the local projects did obtain local funding to support their project (WNSWLHD and SWSLHD), the absence of hard project timeframes tied to funding and deliverables allowed projects to proceed with more flexibility, and ultimately led to projects progressing with adapted timeframes as needed.

The evaluation of the project approach and lessons for implementation are explored further in an article being prepared for publication.

## Project outcomes: addressing the 'implementation gap'

### Initial priorities

At the inception of the project, the key challenges and potential priority areas identified in OPMH benchmarking and other policy work included:

- Challenges in physical health examination and accessing skilled staff for assessment and management (in OPMH services and from other services, including GPs)
- Polypharmacy and potential limitations in information provided about medication side-effects
- Low-medium level of information/advice provided to OPMH consumers about sexual health, drug & alcohol use, and smoking
- Integration of physical and mental health care

- Involvement of GPs in pre-admission processes, initial assessment and care, and care coordination
- Access to staff trained in IV fluids and SC fluids in OPMH inpatient settings
- Action about falls prevention in OPMH services, particularly in OPMH community services

The adapted Liu et al implementation framework adopted by WHO was used in the initial establishment and priority setting within a project initiation workshop with LHDs. The key challenges and potential priority areas were highlighted in these discussions to support local project prioritisation and planning and were mapped to the Liu et al framework (see Figure 1).

### Summary of projects and outcomes

A total of eight projects were completed as part of the OPMH physical health practice improvement project, involving eleven LHDs and two CMOs. These projects were in three key focus areas:

- Empowering consumers around physical health improvement
- Physical health screening and assessment
- Physical activity/exercise

The projects covered all three domains of the Liu et al implementation framework. They were implemented in OPMH clinical services (predominantly in community settings) and CMO services. Since the target group for these services is older people with more severe and/or complex mental illness, this was the broad target group for the projects.

Academic partners collaborated on four of the eight projects, as well as the statewide project. The project is making a significant contribution to addressing the 'implementation gap', with five out of eight projects being published or currently being written up for publication, and publications of the statewide project evaluation, literature review and project outcomes also currently being written up for publication.

The eight projects completed under the statewide project are listed below, with key summary information to highlight the outcomes of the overall project in addressing the implementation gap in evidence about effective interventions to address the physical health of people with mental illness, and specifically older people with mental illness.

| Project | Project leads/ partners | Academic partner | Focus area | WHO (Liu etc) implementation domain |
|---|---|---|---|---|
| **NEAMI physical health prompt - a multi-site trial** | NEAMI National<br>St Vincent's Health Network<br>Mid North Coast LHD<br>Southern NSW LHD<br>Murrumbidgee LHD | Charles Sturt University<br>*Publication in progress* | Empowering consumers around physical health improvement | Health system focussed intervention |
| **The LIVE WELL Intervention: Promoting health behaviour change in older people living in South Western Sydney** | South Western Sydney LHD | *Findings published* | Empowering consumers around physical health improvement | Community level and policy focused intervention |
| **Piloting the Flourish physical health prompt 'PhysiCards©' within an older person's community mental health population** | Flourish Australia<br>Nepean Blue Mountains LHD | Charles Sturt University<br>*Publication in progress* | Empowering consumers around physical health improvement | Individual focused intervention |
| **Manage My Health: a coaching approach to assist older mental health consumers to better manage their own physical health** | Illawarra Shoalhaven LHD | | Empowering consumers around physical health improvement (with screening element) | Individual focused intervention |
| **OPtiMHize improving health outcomes of older people with a lived experience of mental illness** | South Eastern Sydney LHD | | Physical health screening and assessment (with consumer empowerment element) | Health system focussed intervention |
| **Increasing the rate of metabolic screening and monitoring in the older mental health consumer** | Northern Sydney LHD | | Physical health screening and assessment | Health system focussed intervention |
| **Adapting Fit For Your Life to the regional context** | Western NSW LHD | Charles Sturt University<br>*Findings published* | Physical activity/ exercise | Individual focused intervention |
| **The impact of exercise on holistic health for older adults with mental illness: a pilot study** | Western Sydney LHD | Charles Sturt University<br>*Publication in progress* | Physical activity/ exercise | Community level and policy focused intervention |

*Four of the eight projects focussed on working with OPMH consumers to identify their own physical health needs and areas for potential improvement through the use of written and visual health prompts and individual health coaching approaches.* (One project also had a physical health screening element.) The choice of these projects reflects the 'start where you can' approach of the project and emphasis on feasibility in project prioritisation (noting three of these projects built on existing resources), the focus of OPMH services and CMO service partners on individualised, consumer-led and recovery-focussed practice, and the emphasis of the statewide project on consumer engagement and co-design. Projects were informed by evidence about the connections between physical health and mental health, and effective interventions, and by NSW Health guidelines and priorities. The design of these projects addressed a number of key challenges and potential priorities identified at statewide project inception such as integration of physical and mental health care, and challenges in accessing skilled staff for physical health intervention (by building staff confidence and skills in brief interventions).

These projects were implemented in OPMH clinical services, CMO services, and a residential aged care facility (through OPMH community outreach clinicians), across community and inpatient settings. Key implementation staff included clinical and non-clinical staff. Peer workers were involved in implementation of the NEAMI physical health prompt project in both clinical and non-clinical CMO services, and in the implementation of the 'manage my health' coaching project in clinical services. At this stage, one of these projects has been published by the LHD project team and two projects are being prepared for publication in collaboration with research partners. Most projects have been embedded into ongoing practice. The NEAMI health prompt is embedded into practice in two LHDs across their OPMH community services.

*Two projects focussed on physical health screening and assessment, with one project having a strong emphasis on consumer empowerment*. The choice of these projects may reflect the 'start where you can' project approach and emphasis on feasibility in project prioritisation (noting that these projects built on existing NSW Health guidelines and priorities), the focus of OPMH services on individualised, consumer-led and recovery-focussed practice, and the evolution of the project from the OPMH benchmarking focus on systematic, service-wide quality improvement. Projects were informed by evidence about key physical health risks for older people with mental illness and effective interventions, and by NSW Health guidelines and priorities.

The design of these projects addressed a number of key challenges and potential priorities identified at statewide project inception such as integration of physical and mental health care, challenges in physical health examination and accessing skilled staff for assessment and management, polypharmacy and potential limitations in information provided about medication side-effects, and action on falls prevention in OPMH community services. These projects were implemented in OPMH clinical services in community settings by clinical staff. At this stage, neither of these projects has been published. However, both projects have been embedded into ongoing practice in the two LHDs in OPMH community services.

*Two projects focussed on physical activity and exercise programs with OPMH service consumers.* The choice of these projects was informed by: the evidence about need, the connections between physical health and mental health, and effective interventions; consumer interest in these programs; and feasibility of the approach with limited/no additional resources. The design of these projects addressed a number of key challenges and potential priorities identified at statewide project inception such as integration of physical and mental health care, challenges in accessing skilled staff for physical health intervention, and action on falls prevention in OPMH community services. These projects were implemented in OPMH clinical services in community settings by clinical staff, with a peer worker involved in one project. The findings from both projects have been published in collaboration with research partners. One project has been embedded into ongoing practice in LHD OPMH community services.

## Challenges and limitations

### Impact of the COVID-19 pandemic

A key challenge for this project was that it commenced in late-2019 just before the COVID-19 pandemic. This had impacts on the ability of OPMH consumers to participate in project for some of the period, the capacity of services to support projects in the context of workforce capacity and staffing changes, and the capacity of key project partners to be involved. The pandemic was a key factor in some LHDs that had initially been engaged in the initiative being unable to continue their projects, and others scaling back their initial ideas. The NEAMI health

prompt multi-site trial project enabled some LHDs to shift from their original project ideas to join this project, and therefore still progress practice improvement. The pandemic extended the overall statewide project timeframe from 18 months to 3 years, with some variation in local project timeframes.

### Ethics approval and academic collaboration

Progressing ethics approval presented a challenge for a number of projects despite recruiting academics to assist with this project element. The requirements for ethics approval resulted in one project exiting the initiative entirely.

The introduction of the academic partnerships was a key evolution from the previous statewide OPMH recovery-oriented practice project, and this project element could have benefitted from further refinement. Ideally, these partnerships would have been established at the workshopping phase of the projects, enabling the academic partners to work with LHDs at the genesis of the project ideas. This may have made the ethics approval process for LHDs more streamlined and simplified and reduced the need for the project team to be so involved in finding academic partners for LHDs. Once the academics were engaged with projects, many projects then needed refinements to enable an ethics application. In some cases, an academic partner could not be identified, and those projects opted not to seek ethics approval for publication. Embedding academic involvement more systematically embedded into the project at the outset may have supported improved project design and publication for some projects.

### Project scope

The majority of the projects were focussed on identification of physical health challenges and screening, with some elements of brief intervention and facilitating pathways to care. This is a limitation in that the projects did not move beyond screening to other specific interventions which may have had further impacts. In the context of capacity constraints, little or no specific project funding and the 'start where you can' approach, many feasibility was a key factor in the choice of projects. The focus on feasibility may have limited the impacts of the project in terms of more significant, systemic and long-term challenges in improving the physical health of people with mental illness. For example, none of the projects successfully pursued enhanced collaboration with GPs in a systemic way, despite this being one of the challenges identified at project initiation.

# Summary and recommendations

The OPMH physical health practice improvement project has been broadly successful in developing and implementing a range of practice improvement initiatives within 11 LHD OPMH services in metropolitan and rural NSW and supporting a project within one CMO service. Many of these projects have been embedded into ongoing practice in OPMH services, and some have been taken up within other services. Five out of eight projects are expected to be published in peer reviewed publications, along with the findings from the statewide project. The lessons and outcomes from all local projects and the overall statewide project have been shared in various forms, supporting the 'collective impact' approach of Equally Well and the broader objectives of the project in contributing to collective efforts in this area. This is a significant contribution to addressing the 'implementation gap' in improving the physical health of people living with mental illness.

Key enablers of the project included: creating the right environment and processes to support statewide practice improvement (including the distributed leadership approach and ongoing communication and engagement strategies), the 'start where you can' approach, and sustained collaboration and partnerships across the range of people and organisations involved in the project. Key challenges included the impacts of the COVID-19 pandemic and developing effective processes for academic collaboration with LHDs that facilitated academic partners for all LHD projects.

*In order to support continued good practice and practice improvement in NSW Health services to address the physical health needs of older people with mental illness, it is recommended that:*

*Local Health Districts*

- *Review the projects outlined in this report, including key focus areas and implementation lessons.*
- *Identify key practice improvement priorities and strategies in physical health care within OPMH services and/or across LHD mental health services, informed by these projects and local needs and service contexts.*
- *Support continuation of strategies initiated within this project, and/or commencement of further local projects based on the analysis above.*

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- *Uses the project learnings and outcomes to support a continued focus on improving the physical health of OPMH service consumers through statewide OPMH benchmarking processes, models of care, and policy and service development work.*
- *Builds on the project approach and learnings for future statewide mental health practice improvement work, including initiatives to improve the physical health of people with mental illness within the NSW Health system.*
- *In order to support the broader objectives of Equally Well and address the 'implementation gap' in relation to actions to improve the physical health of people living with mental illness, it is recommended that:*
- *NSW Health share the project findings and publications (both peer reviewed and grey literature) with relevant NSW, national and international networks, including through Equally Well Australia.*

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# **Appendix 1:** Local Health District Project Reports

The following section provides the complete summary reports of each LHD project. These reports were drafted by each LHD project team and provide a more comprehensive summary of each project.

# NEAMI physical health prompt

### State project Champions

- Vicki Langan – Neami National
- John Stevens – NSW Ministry of Health

### Catchment Project champions

- Mid North Coast –
  - David Noble, District Manager – Community Mental Health
  - Elizabeth Gralton, Clinical Nurse Consultant - Older People's Mental Health
  - Donna Widdison, Manager OPMH and integrated treatment service
  - Natalie Scaysbrook, Clinical Nurse Consultant and Rehabilitation coordinator
- St Vincents Health Network
  - Prof. David Burke, Senior Staff Specialist and Clinical Lead
  - Lianne Rowland, Clinical Nurse Specialist
  - Sophie Zammit-Haber, Clinical Nurse Specialist
- Southern NSW- Kersten Davis CNC, Eurobodalla Older Persons Mental Health
- Murrumbidgee LHD - Andreia Schineanu (BSc, MSW, PhD), Acting District Clinical Lead OPMH
- NEAMI National – NSW Merrylands CLS, Western Sydney CLS, Penrith CLS services

### Submitted for publication

## Introduction and overview

This project is a collaborative effort between the NSW Ministry of Health, four Local health districts, and NEAMI National. This project conducted a multi-site trial, piloting a user-friendly Older persons health prompt Co-designed with older persons and staff over the age of 56 yrs, and collated by NEAMI' NSW Health Promotion team , adapted from their existing NEAMI health prompt. The project sought to use the prompt to enhance physical healthcare outcomes for older adults in New South Wales who also struggle with mental illness. This prompt empowers patients to take charge of their physical health. By using it with their mental health clinician, they can identify and address their needs, ultimately gaining the confidence to follow up with a doctor independently.

The project aimed to equip patients with the knowledge and skills to proactively manage their physical health and confidently seek further care from their GP. A secondary aim was to foster strong partnerships between NGOs and public health organizations, collaborating to promote a patient-centred approach to healthcare delivery.

## About the NEAMI health prompt

As a result of the increasingly significant link between mental health and physical health supported by overwhelming evidence from an international setting, initial discussions regarding the development of a physical health prompt began at Neami National in 2010. The Health Prompt is a Physical health screening resource designed to reflect a strengths-based, recovery-orientated, holistic approach, with various versions being co-designed to ensure inclusivity. This resulted in 28 questions, yes, no or NA answers and a Body Chart to indicate other physical health issues, pain or concerns. The prompt was later translated into additional languages before a youth version was developed, and an Aboriginal and Tories Straights Island Version was completed in 2023 and is being utilised across Australia by Aboriginal Liasson Officer within various Indigenous services.

In response to enquiries as part of the NSW OPMH physical health practice improvement project, it was agreed that there was scope and potential demand for an Older Persons Version of the prompt. NEAMI national led a comprehensive consumer co-design

process utilising the Neami Consumer Participation Framework to develop a 37prompt questions version of the health prompt, developed specifically for older people with a lived experience of mental illness.

The health prompt aims to Increase:

- Regularity and quality of physical health checks
- Individual awareness of physical health issues and health check processes
- Self-management of physical health
- Confidence of staff in providing information and interventions
- Referral pathways and community links to physical health, nutritional, and emotional/ psychological support services

## Aim and methodology

The project aimed to deliver the new health prompt to at least 50 OPMH community patients across local health districts in NSW. OPMH community mental health service users will complete the tool with their community OPMH clinician as part of their regular home visits, with a view to the consumer following up on the results of using the prompt with their GP within 8 weeks of completing it. Where possible OPMH community clinicians will endeavour to do a repeat measure using the tool with consumers after GP follow up to pair results for and gauge any impact or change in health behaviours and attitudes as a result of the process.

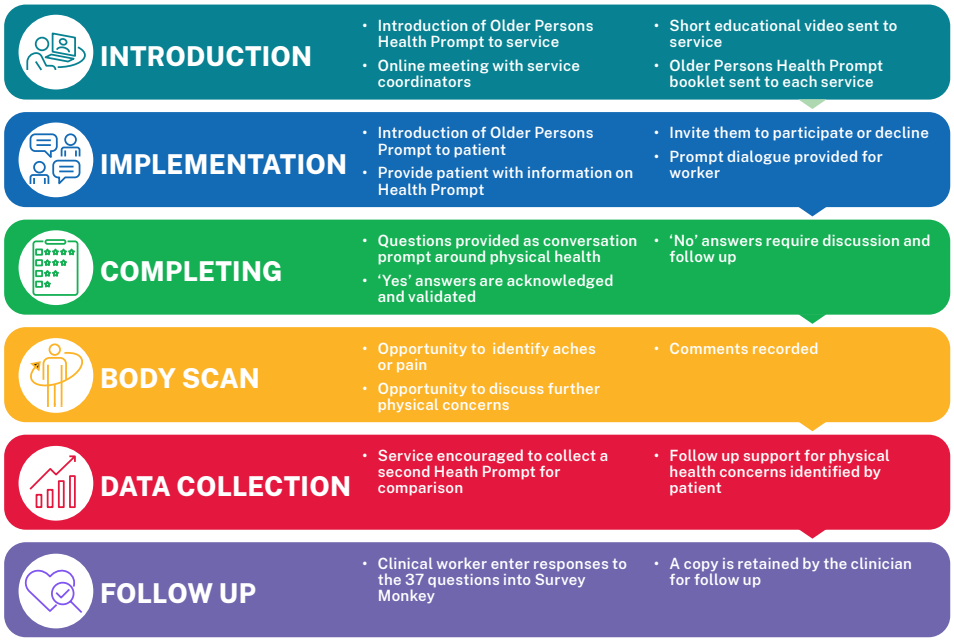
Following development of the OPMH version of the tool by NEAMI national, copies of the tool were printed in a carbon copy format for the project. The concept being that when the clinician completes the tool with a consumer, the original top layer is torn off and given to the consumer for follow up with their GP. The carbon copy was then kept for data analysis for this project, with each consumers response being coded locally by the clinician so that the project research team were unable to identify individual consumers. Scans of the results were sent to the NEAMI project lead who then kept a rolling record of the completed surveys by entering them into an online survey platform (survey monkey).

This data was later used for analysis in this report.

To train staff on how to use the tool, NEAMI also developed a Health Prompt Training Practice Video that covered how to use the Health Prompt, advice on providing follow up, how to consider incorporating the Health Prompt into current practice and working with diversity.

Broadly the process of implementing the OPMH physical health prompt (fig 1 below) involved the NSW Health project lead recruiting LHD champions from those LHDs who expressed interest in participating, and then the project team to introduce the prompt to the service, including making the training available to LHD project champions. The health prompt was trilled across different settings across the participating services, including OPMH community mental health, inpatient care and as part of OPMH community mental health providing in reach into residential aged care.

This project held a unique role within the broader statewide project and COVID-19 impacts to the project. As this project was developed as a multi-site trial, it was also offered as an alternative project for those projects that were unable to progress due to workforce disruptions stemming from the covid 19 pandemic. Several LHDs took up this option, enabling them to remain engaged in the statewide project and committing a lower level of resourcing to remain engaged and working towards improving the physical health outcomes of older mental health consumers in their catchment.



# Results

## The sample

The sample covers 8 sights from 4 services, with two community OPMH teams from Murrumbidgee LHD, one each from St Vincent's Health Network and Southern NSW LHD and four teams from NEAMI National participating. The sample includes a mix of regional and metropolitan services and consumers.

The sample covers 58 valid responses, comprising of 48 unique consumers. Of the 48 consumers, just over half (56%) were female. The average age of those sampled was 73 (median 73, Range 52-87), with one person's age not being recorded.

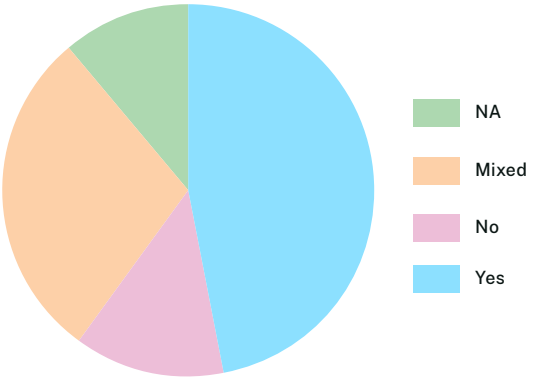
Eight of the responses are paired collections, with two of those covering three samples over time. Of the paired collections, three were of male consumers, and of the triple collections, both were female consumers.

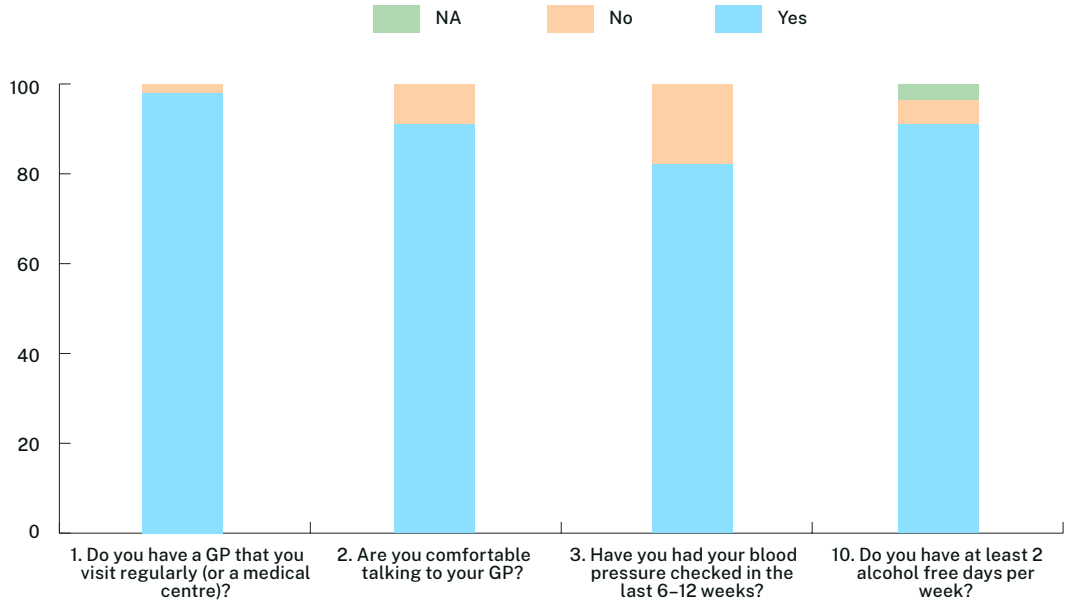
## Trends from the data set

The breakup of response from the 37 questions was interesting. Eighteen of the items (47%) were predominantly (>60%) answered Yes. Items predominantly answered 'No' made up for 13% of responses, interestingly there was a notable proportion of responses that were more mixed (40-59% yes/no) with roughly 29% of the items being a higher mix of yes and no. four of the items (11%) had a high not applicable response (>40%).

## Items predominantly rated as 'Yes'

Just under half of the questions were predominantly (>60%) answered with a 'yes' response, indicating that most of the consumers who participated in the health prompt have a largely positive and well engaged experience with health providers for nearly half of the items on the health prompt. Whilst many of these items were answered in the affirmative, the exploration of each question was an opportunity for their clinician to start a conversation about each of the health behaviours. Of these, four items stood out as particularly high.



**The other questions with higher yes results are as follows:**

4. Have you had your cholesterol checked in the last 1-2 years?

5. Have you had your blood sugar levels checked in the last year?

7. Have you talked about recommended vaccinations with your GP?

11. Do you eat 2 serves of fruit per day? (Example of 1 serve of fruit: 1 medium apple/ banana or a handful of grapes)

15. Have you checked your skin for changes in the last 3 months?

18. Are you a non-smoker?

20. Are you able to navigate through small spaces without bumping into things?

21. Are you able to keep your balance?

22. Have you been free from falls in the last 6 months?

24. Are you satisfied with the quality of your sleep?

25. Do you feel you have enough information about the medications you are taking?

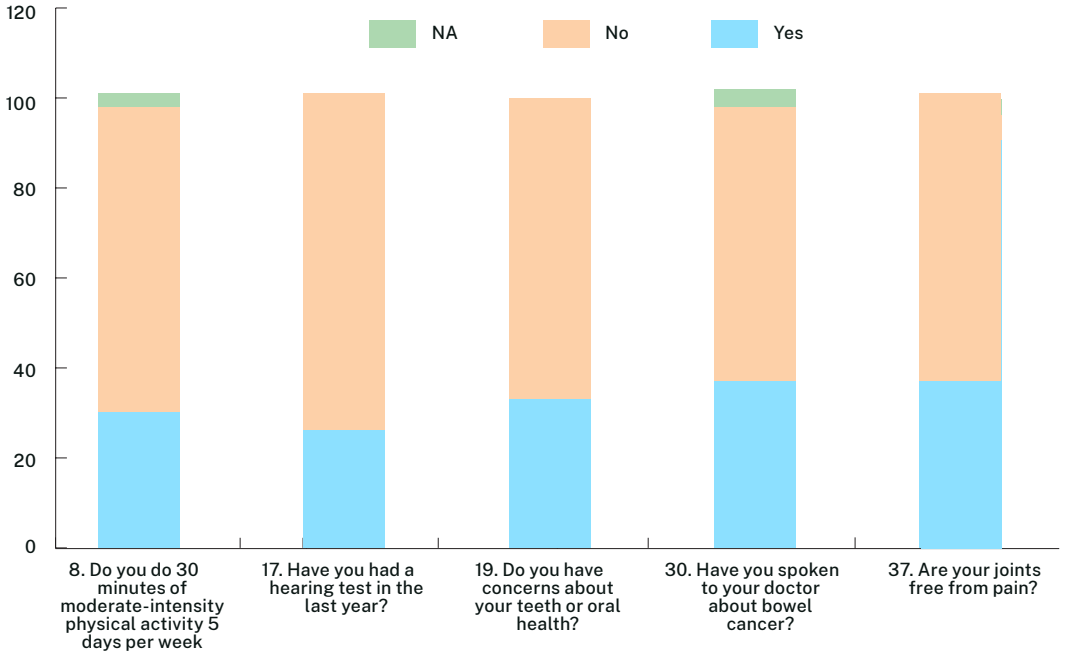
26. Do you personally have someone you can reach out to in a time of need?

27. Do you feel that you have healthy bladder function?

29. Do you feel you have healthy bowel function?

**There were five questions with a higher ( >60%) No response as follows**

All questions with a high 'No' response



## NA-specific questions and differences

Of the four questions with higher not applicable responses, three of these were more gender weighted: breast, pap smear and prostate checks. The other items that hat a high NA response was in relation to dental checks, and it may have been interpreted by consumers that dental checks did not include other aspects of oral health such as dentures and gum health.

## 50/50 items

Three of the questions that had an overall mixed response had a notable difference in further analysis between male and female participants. Question 14. *Are you comfortable with your current weight? (waist measurement below 88cm in women or 102cm in men)* – had a much stronger no result for the female participants whereas the men were more mixed in their responses to this item. Question 16. *Have you had your eyes checked in the last year?* Men respond more in the positive. Question 34. Have you had your breasts checked by a doctor in the last year? (male and female), men responded either with a no or not applicable where female respondents responded either with a yes or no.

The other questions that had a more mixed response rate did not present any notable differences between the genders of the participants.

6. Have you had a conversation with your GP about risk of cardiovascular disease (CVD)?
9. Do you do muscle strengthening exercise 2-3 times per week?
12. Do you eat 5 or more servings of vegetables per day? (Example of 1 serving of veg: 1/2 cup of cooked veg or 1 cup of salad)
13. Do you feel you drink enough water? (2L or 8 glasses is the average recommendation. What other fluids do you ingest each day?)
23. Are your feet free from sores, blisters and swelling?
28. Have you had a conversation with your GP regarding your kidney health?
31. Do you know what services to contact regarding your sexual health?
32. Are you happy with your current relationship/ intimacy?

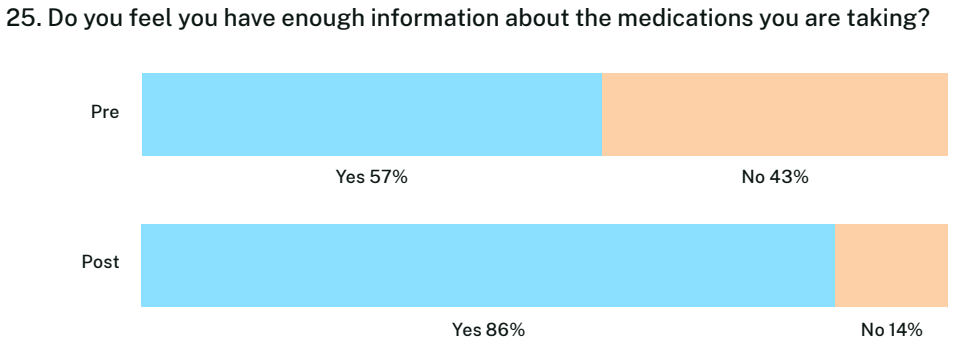
### Paired results

Seven service users in the sample had paired results. Of these, we found that 14 of the 37 (38%) of the respondents changed from 'no' to a 'yes' pre and post, using the health prompt. Just under half (49%) of the questions saw no change pre and post using the tool. There were two questions where the no scores increased and the yes scores decreased, and an additional three where the yes scores stated the same, but the NA and No scores changed, possibly indicating that the use of the prompt encouraged people to think more carefully about how they might respond on those items.

Of the 14 items that changed from a 'no' to a yes, one question stood out with a greater degree of change. Question 25 asked 'Do you feel you have enough information about the medications you are taking?' the paired results found a change for the yes results by +28.6%.

The other 13 items that changed from a no to a yes all changed by the same degree (14.3%) noting these were with different service users. The items that changed by this degree were:

2. Are you comfortable talking to your GP?
5. Have you had your blood sugar levels checked in the last year?
6. Have you had a conversation with your GP about risk of cardiovascular disease (CVD)?



9. Do you do muscle strengthening exercise 2-3 times per week?

10. Do you have at least 2 alcohol free days per week?

13. Do you feel you drink enough water? (2L or 8 glasses is the average recommendation)

16. Have you had your eyes checked in the last year?

17. Have you had a hearing test in the last year?

28. Have you had a conversation with your GP regarding your kidney health?

29. Do you feel you have healthy bowel function?

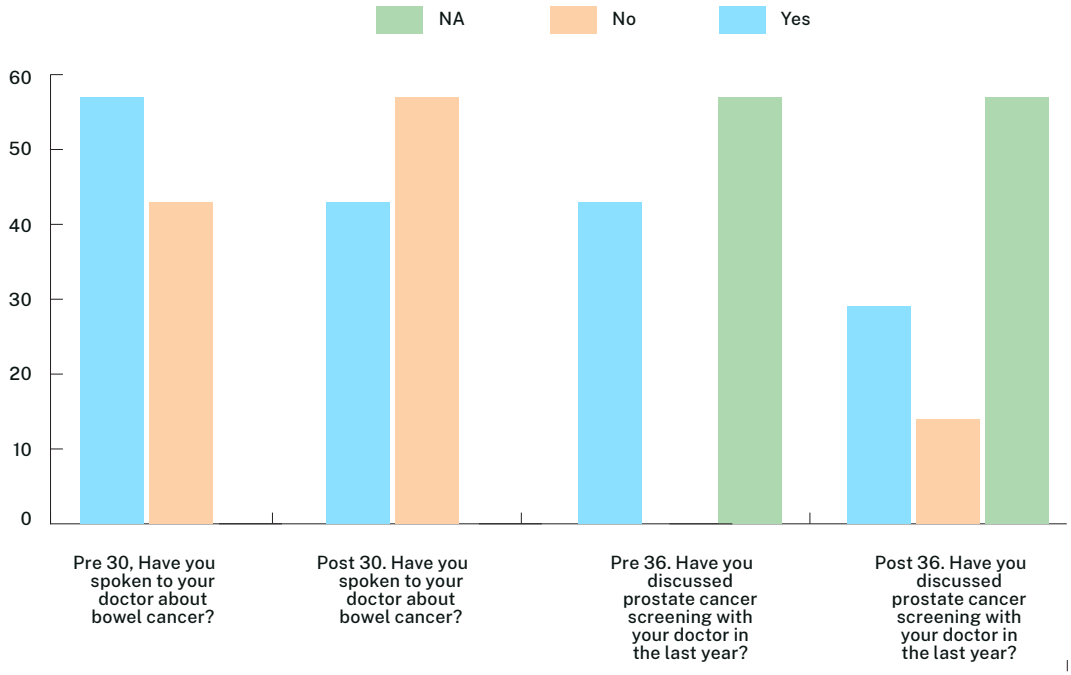
35. If under 74yrs, have you had a mammogram in the last 2 years?

37. Are your joints free from pain?

### Cancer screening items 30 and 36

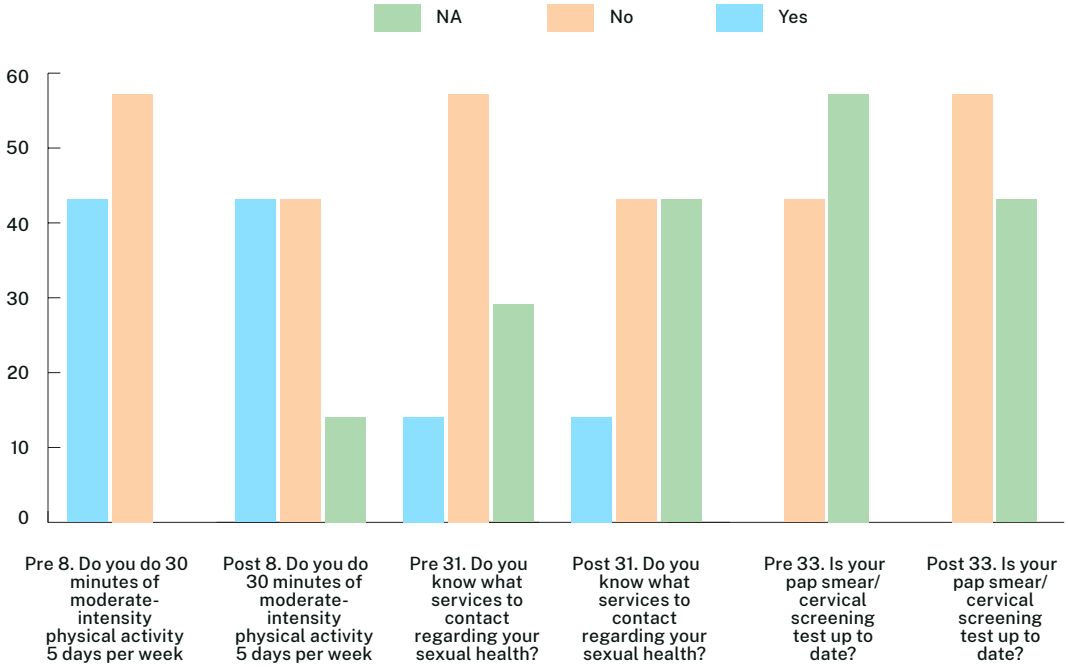
Two of the items related to cancer screening saw notable shifts from 'yes' results to more 'no' results. these were the only two paired questions where this occurred. As several consumers were identified as needing cancer screening and then subsequently were found to have cancer and started treatment, it has been assumed that the 'yes' to 'no' shift has most likely occurred due to an increase in health literacy and awareness.

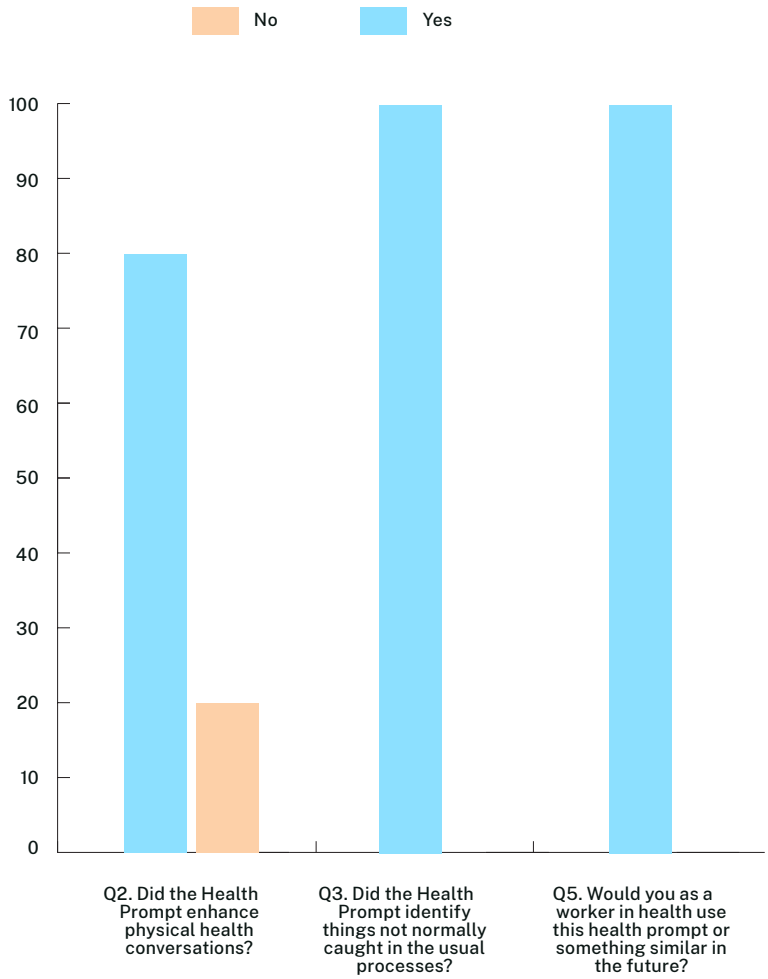
Change – Cancer screening items 30 and 36



### NA / No shift questions

3 of the health prompt questions shifted in their *No* and *Not applicable* resplices without a shift in the *Yes* results.
Item 8



## Clinician insights

The research team for the project opted to survey all the OPMH clinicians who delivered the health prompt to consumers as part of the multisite trial. Overall clinician feedback was very positive with 80% feeling it enhanced conversations around physical health and all clinicians identifying that the process identified things not normally captured around physical health in the normal processes they have with their older consumers with a mental illness.

All of the clinicians participating responded that they would use this health prompt or something similar in the future. Of Note, several (4) consumers were identified as not having had previous cancer screening. The research team were advised that in following up with their primary health clinician, these consumers were later identified as having a cancer diagnosis and were able to start treatment. For some clinicians, this underpinned the value of using the health prompt as they felt this simple tool helped save lives. Long answer feedback highlighted that from the clinician perspective most consumers of their community mental health services valued the experience of going through the process of using the health prompt.

> They appeared to enjoy being given the opportunity to chat about the physical things which are concerning them or those they had never thought to be an issue.

Some areas noted for improvement by clinicians included considering how a copy gets to the GP, one is left with the consumer to follow up with their GP independently and one is kept by health staff on file. It was felt that given the issues around unidentified conditions, it was imperative that a record kept on file and there was a contingency that a copy was sent to the consumers GP for follow up if the consumer for some reason did not follow up with the GP themselves. It was also suggested that some of the questions with higher not applicable responses could be reviewed.

## Discussion and future directions for this project

The health prompt identified areas that were on average higher yes responses, with half of the items resulting in mixed and no responses that have highlighted broad areas for consideration. The 'not applicable' items were primarily gender driven and on an individual level would highlight an easy area of follow-up for those responding 'no' to these items.

Feedback from community OPMH mental health clinicians found that they preferred this process as it was short (< 10-15 mins) and was easily completed as part of a regular home visit, with one clinician highlighting that the shorter measure seems to be less invasive for the person. The process also gives the clinician into insight to the persons relationship with the GP.

The prompt was successful in consumers taking issues identified as part of the process to their GP. This was particularly evident concerning cancer screening with several consumers being diagnosed and initiating treatment in follow-up with their GP following this pilot. Because of this one LHD is continuing with the health prompt, as LHD community clinicians have found value in using the health prompt.

# The LIVE WELL Intervention: Promoting health behaviour change in older people living in South Western Sydney

**South Western Sydney Local Health District - Older People's Mental Health (OPMH) Service, South Western Sydney LHD**

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- Dr Carmelo Aquilina, Service Director
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## Publication citation

Aquilina, C, Best L, Mohsin, M and O'Callaghan C (2024) The Live Well Intervention: Promoting healthy lifestyles during routine older peoples mental healthcare, Australasian Psychiatry

## Introduction and overview

Health is determined by lifestyle, nutrition, the environment and genetics (Patwardhan et al., 2015). Lifestyle and nutrition are determinants that are modifiable and changes in these areas can impact on overall health. It is important to address these modifiable determinants of health to increase quality of life and wellbeing. According to the Australian Institute of Health and Welfare (2018), one third of disease burden is caused by lifestyle factors.

Ageing is associated with increased morbidity (Australian Bureau of Statistics, 2006). Therefore, it is imperative to address the modifiable determinants of health as people get older to reduce morbidity and promote healthy ageing. Healthy ageing can be achieved by having good physical, mental and social wellbeing that enables a meaningful life (Sims, 2017). Older people benefit from education and support to adopt healthy behaviours. B Setting meaningful and individualised goals has been found effective when working with older people (Rietkerk et al., 2019).

Addressing lifestyle should be a core element of mental health care but the workforce does not have the time, skills, confidence or knowledge on how to do lifestyle interventions with their population.

To date there is no known study that has modified and explored the effects of the Fountain of Health (FoH) initiative in Australia. After discussion with the FoH project team it was agreed that it would be better to develop a variant of the FoH initiative which differs as follows:

1. Nutrition is included as the sixth health domain in addition to the 5 domains of FoH.
2. The intervention is sequential and not a one-off.
3. At post intervention participants will rate how they feel since setting their goal and their level of satisfaction with the intervention.
4. More extensive supporting material is provided including translations more suited to the multi-cultural population of South West Sydney with our own supporting material.

The *Live Well* Project aims to develop a brief clinical intervention based on the Canadian Fountain of Health to offer confidence, knowledge, skills and structure for clinicians and consumers to routinely enable small, cumulative changes to healthy behaviours in consumers in the following domains: Physical activity, Social activity, Healthy eating, Mental activity, Mental wellbeing, or Positive thinking. There have been

numerous studies that have shown the benefits of engaging in these domains (e.g. , Sims, 2017; Gilmour, 2012; Thorp et al., 2011, Jeste et al., 2010).

## Methodology

*The initial project development work involved* negotiating the adoption of the Canadian project as a standalone project and allow SWS to own the intellectual property for all material developed.

The project successfully secured $300,000 Funding from the SWS Primary Health Network (PHN). The project team then went about developing new clinical tools that could be applied in routine clinical encounters including a *Health and Wellness Questionnaire* to measure baseline health and wellness at baseline and follow-up and a *Consumer SMART goal sheet* to allow consumers to plan specific measurable, achievable and relevant behavioural changes to their lifestyle.

Commissioning *consumer aids was the next phase* with the commissioning 8 short animated videos on the project and essential health domains in six languages (English, Arabic, Assyrian, Vietnamese, Spanish and Chinese) to support consumer-clinician encounters. Following this the project team commissioned professionally designed consumer & carer guides, and brochures in six languages (English, Arabic, Assyrian, Vietnamese, Spanish and Chinese) to support consumer-clinician encounters. The PHN assisted the project team with the hosting of a website with information on the project for consumers and their carers

Developing *clinician aids* included:

- Developing a 90 minute training session for clinicians
- A clinic poster in six languages to let consumers know of the intervention's availability
  - a clinician toolkit with all the clinician and consumer material in one single PDF
  - a spiral bound desktop clinician manual setting out each of the steps in in the initial encounter and follow ups
- clinician QR codes sheet to allow quick access to videos that can be accessed to support the discussions
- a *Local Resource Guide* giving information on locally accessible resources that can access to support their goals

In addition to this, the project team also commissioned the development of a new brand identity with commissioned logo. Having intellectual property protected by a commons creative license for material to allow maximum distribution with attribution and no modification, and this also had to be navigated by the project team. A research protocol was developed based on both statistical and academic advice. Ethics approval for a trial to go ahead with site specific approvals and trial registration was also sought via SWS LHD Area ethics committee.

### The clinical trial

People who match the selection criteria were invited to participate in the study.

Firstly, trained clinicians start a discussion with potential participants about how lifestyle impacts health, wellbeing and resilience. Then they have a discussion on the Live Well intervention as one way to address lifestyle factors.

Potential participants are given a participant information sheet on the study and consent obtained. Participants are provided written information on the 6 domains of health and wellbeing and are shown or given details of online materials on the Live Well intervention. They then choose one domain that they want to make a difference in and are supported to write a SMART goal. The focus is on small, realistic goals gave participants a sense of achievability. Encouraging the working on one small goal at a time allowed participants and clinicians to focus on a key activity.

The participants used a Health and Wellness Questionnaire (HAWQ) at pre- and post-intervention to quantitatively measure their health in the six domains. Post intervention measures are taken at 6 and 12 weeks follow-up. At follow-up, they also measure how they feel since setting their goal and their satisfaction with the helpfulness of the intervention to achieve their goal.

The project trained 62 staff in primary health and OPMH. Outcomes were measured using the Health and Wellness Questionnaire, goal attainment, satisfaction, and wellbeing, all assessed before, during, and after the intervention. SMART goals were also set and monitored with the ability to change the goals at review.

Several factors enabled the project's success. These included support and funding from various organizations, accessible resource materials, existing relationships between participants and clinicians, and the flexibility of participants being able to access materials outside of sessions in their own time.

However, there were also challenges. Project-related issues included the need to develop new clinical materials and navigate legal considerations around copyright. Process-related barriers involved gaining informed consent, managing age-related issues, following up with participants, integrating the intervention with existing clinical tasks, addressing COVID-19 anxieties, and managing staff turnover.

## Results and findings

At the completion of the formal project, the Live Well project recruited 65 participants, with 52 completing the full intervention (minimum target of 50).

From the 65 participants, 35 were female, 30 male. 57 participants spoke English as their primary language, 2 Arabic, and 1 each of Spanish, Vietnamese, Chinese, Italian, Dutch and Lao. The age range of the participants was 65-94, with an average age of 74.8 years.

The goal domain that participants set were: Physical Activity 36%, Mental activity 20%, Mental wellbeing 15%, Social activity 14%, Positive thinking 9% and Healthy eating 6%.

Overall results of the program in Goal Achievement, Wellbeing change and Satisfaction are predominantly positive. In terms of Goal Achievement at the completion of the program, 34 reported improvement (16 "a little more," 18 "a lot more"), 16 reported no change or slight decrease (10 “no change” or 1 “a little less”) and 3 reported no progress at all on their goal (2 "not done at all" or 1 "a lot less"). After 12 weeks all domains and total scores significantly better ($p<0.05$) except for healthy eating.

Wellbeing changes were reported with improvements in 41 participants (19 "a little better," 22 "a lot better"), 12 reported no significant change ("no change" or "a little worse") and no participants reported major decrease in wellbeing (0 “a lot worse”) .Change was significant ($p=0019$)

For satisfaction with the program, 36 reported being completely or very satisfied (22 "a lot," 14 "completely"), 10 were moderately satisfied (10 "a bit") and 9 were somewhat dissatisfied (4 "not at all" or 5 "a little") Change was significant( $p=012$)

Some participants scored their satisfaction with the intervention poorly despite achieving their goals and increasing their self-reported health and wellness scores.

At week 12 the total HAWQ score (sum of all domains) was significantly correlated to program satisfaction ($p=0008$) and wellbeing ($p<0.001$)

Although the proportion of English speaking participants in the trial (86%) was not very different from the general older population (80%) the intervention was not adequately tested with enough participants from different languages and cultures and so the results are not generalisable outside the trial population.

These trial will need to be trolled out more widely in order to get more data on effects and persistence f these effects in our population of older mental health consumers.

**Impact of results on changes to the service**

Staff have the confidence, skills and tools to initiate conversations and help plan behaviour change to support healthy lifestyles with all consumers. Live Well interventions (review of health status, goal setting and support, review of goal progress) are now performed as part of routine practice. The key difference to current practice is the format in which these interventions are implemented to highlight the importance of primary health, and delivering this in a consistent, manualised approach that provides clear measurable outcomes to participants and clinicians. Staff using this are overwhelmingly positive in finding that this is another avenue of engagement with their consumers.

## Future directions for this work

Possible avenues for future work include the following areas:

### Expanding the Reach:

- Targeting new age groups and explore offering the intervention to younger mental health consumers, individuals not currently connected to services, and specific populations like healthcare professionals.
- Increasing accessibility to more groups by collaborating with others to develop the program materials in additional languages. It was noted that the participant groups wasn't reflective of the demographics of South western Sydney Local Health District.
- Develop culturally specific interventions tailored for Aboriginal populations, addressing their unique needs and preferences.

## Enhancing the Program:

- Provide education and support for staff to develop their expertise in the remaining five program domains (Healthy Eating, Positive Thinking, Mental Wellbeing, Mental Activity, Social Activity) thereby deepening the knowledge and competence of clinicians further.
- Investigate post-intervention outcomes by exploring what happens after the 12-week program ends, understanding sustainability and long-term effectiveness.
- Measure long-term impact by conducting follow-up studies to assess the lasting benefits of the intervention on participants' well-being.

## Strengthening Evaluation:

- Comparing the Live Well Health and Wellness Questionnaire (HAWQ) through cross-validation with other established tools like the SF-16, ensuring its validity and reliability.

## Impact

Overall the project is suggesting positive improvements in health and wellbeing for participants. Participants are generally positive about the intervention, report feeling better from engaging in activities related to goals set, report an improved sense of wellbeing and are satisfied with the intervention.

Most goals have so far been in the domain of physical activity, which may indicate clinicians are more at ease in encouraging these types of goals – they are easy to conceptualise, easy to measure, and easy to access (e.g. going for a walk).

The project has shown positive improvements in overall physical health outcomes. Feedback from participants and family members who have competed the entire 12 week intervention has been mostly very positive.

## Next steps

In light of recent technological advances new delivery methods in training clinicians and conducting the intervention can be explored. Video consultations could potentially reach more people, but this needs to be tested to ensure effectiveness. In addition, the development of online training modules through partnering with a training organisation to create an online, self-paced training program for healthcare professionals could expand reach and accessibility.

Reducing the complexity of consent to participation can simplify the implementation of the program. Staff and participants reported difficulty in navigating ethics forms. Simplifying this could make it easier for staff to engage participants and help more people benefit from the program.

The aim of the program is to embedding Live Well in routine care as "business as usual - aiming to integrate Live Well into the standard practice of physical health interventions, making it a regular part of care offered across the district.

Encouraging general practitioners to offer Live Well to their patients, with appropriate support and training, would further increase the scope of the program.

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# Piloting the Flourish physical health prompt 'PhysiCards©' within an older person's community mental health population

## Nepean Blue Mountains LHD - Katoomba OPMH Community Mental Health, Nepean Blue Mountains LHD

### Project Champions

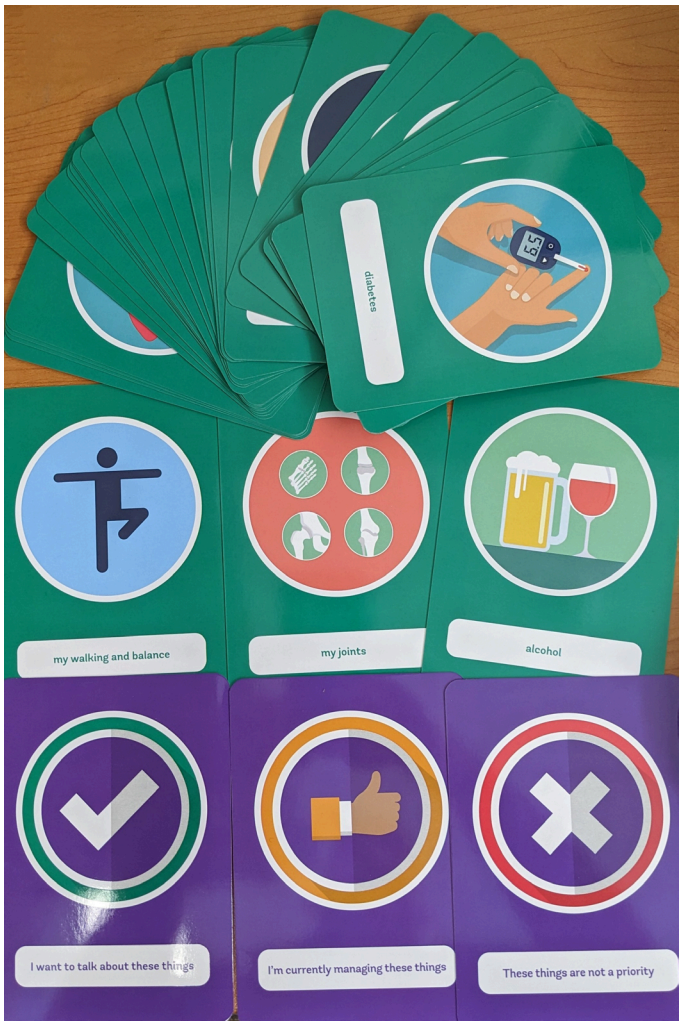
- Michelle Johnson, Clinical Nurse Specialist, Nepean Blue Mountains LHD
- Marcelle Doulers, Charles Sturt University
- John Stevens, NSW Ministry of Health

### Submitted for publication

Aquilina, C, Best L, Mohsin, M and O'Callaghan C (2024) The Live Well Intervention: Promoting healthy lifestyles during routine older peoples mental healthcare, Australasian Psychiatry

## Introduction and overview

The study is a quality improvement project aiming to improve the physical health outcomes of older people with mental health issues. The trial involved the use of a visual communication aid that helped prompt the identification physical health issues in the Nepean Blue Mountains catchment. The aim of using this tool was to initiate a process to collaboratively identify physical health issues of service users to address their physical health needs. The tool aims to empower the individual to take ownership of identified needs and independently follow up with a general practitioner (GP).The project was an CMO and public health collaboration between NSW Ministry of Health, Charles Sturt University, Flourish Australia and Nepean Blue Mountains Local Health district (LHD) with LHD service users. The tool used for this project was the PhysiCards© tool developed by Flourish Australia are a set of visual health cards with prompt-based questions on the other side. To use the cards, people sort through them to identify which issues they want to address, and place them in the order of importance they feel is relevant 1. Flourish Australia was able to provide copies of the tool for use in this pilot project, along with access to training for those staff that wanted to participate in the trial.

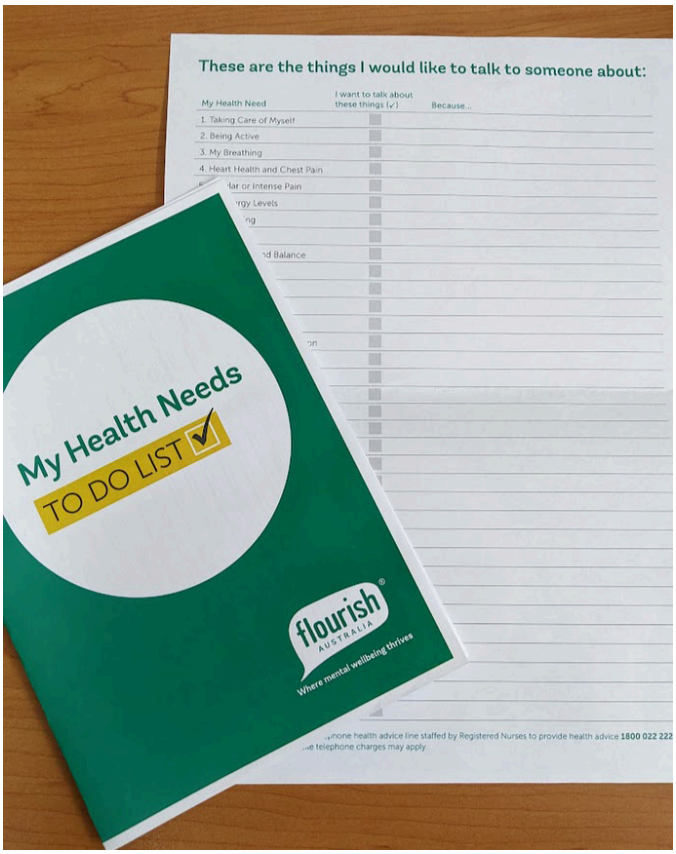



From a research perspective the project sought to capture the user experience rather than aiming to evaluate the effectiveness of tool. This was done through qualitative interviews with the CSU research

follow up from that process with their GP to discuss the issues (if any ) that were identified. Transcripts from the interviews were analysed using Thematic Analysis (TA) and themes from that analysis formed an overview of the consumer experience in using the tool.

## Methodology

The setting of the study was the NMB LHD community OPMH team whose services reach both metropolitan and rural locations. This pilot implemented the use of physical health prompt cards as a visual communication aid to start a conversation around physical health issues with OPMH service users to encourage positive health behaviours. The project used semi-structured qualitative interviews with a purposive sample (n=12). To use the cards, people sort through them to identify which issues they want to address, organising them in the order of importance they feel is relevant1. The person retains a 'My Health Needs To-do List' to take to the GP for follow up.




## Results and findings

The project took place during the COVID-19 pandemic, with the clinical lead for the project having to move roles during and following the pandemic, this meant that there were several disruptions to the project, and yet despite a global pandemic, the project was able to be completed. Furthermore consumers found value in using the tool as part of their community mental health home visits. Most participants experienced practical or qualitative benefits in using the tool and welcomed the process as part of a regular review or home visit. This study found clinical and social benefits to consumers going through the process with this tool. The innovation of using the visual communication aid afforded greater alignment with policy aims of consumer empowerment and targeted physical health gains for this neglected segment of the population.

## Future directions for this work

Now that the pilot period has completed, the LHD will seek to evaluate the value in embedding this or a similar tool into OPMH community mental health team practice. The findings from the research element of the project has been forwarded to Flourish Australia for consideration as the research found that it would be worthy of further testing if it could be adapted to be more specifically tailored for an elderly population. One limitation of the study was that implementation ultimately was done by one clinician, the research team hypothesised that Implementation of the process would be more successful with a larger cohort of staff invested/participating in undertaking the training and implementing the tool.

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# Manage My Health: a coaching approach to assist older mental health consumers to better manage their own physical health needs

## Illawarra Shoalhaven LHD

### Project Champions

- James Bradbury, Clinical Nurse Consultant
- Jess Peters, Peer Worker

### Supporting Manager

- Carol Martin, Service Manager Specialist Mental Health Services

## Introduction and overview

This project tested a coaching approach to help older mental health consumers manage their physical health. From the NSW Health Mental Health Service Policy for Physical Health Care within Mental Health Services (PD2017_033) and Physical Health Care for People Living with Mental Health Issues guideline (GL2021_006), we know that mental health consumers are entitled to quality evidence-based care and treatment for all aspects of their health, including their physical health. There is published evidence that there is a Scarcity of physical health care, with problems accessing diagnosis, advice or treatments.1

Recognizing the diverse support processes needed for lasting physical health improvements, the project explored how coaching could aid individuals who often navigate these processes alone. The program aimed to automatically address potential barriers - behaviour, emotions, situations, and thinking - while building and sustaining motivation. This holistic approach aimed to support older mental health consumers in adhering to health strategies and lifestyle changes for improved physical well-being. There is published evidence that there is a need for more authentic involvement and consumer engagement to successfully implement tailored physical healthcare.2

It makes sense then for mental health clinicians to work with consumers to be active participants in their own care, to determine their own goals and outcomes, and as far as practical, to make decisions about their own care and treatment options, whether these be mental health or physical health oriented.

## Methodology

The project focuses on seven points of care that was piloted over a 3 month period in two separate phases to assess the feasibility and efficacy of the coaching approach with a small cohort of community mental health consumers. Phase one involved asking a pre and post-vention series of questions, phase two replaced this process with a screening tool to better identify issues that could be used as a stronger basis to guide the consumers' health literacy and ability to follow up on any identified issues with their GP. Phase two utilised a peer worker as part of the screening process with the intention that it would yield better results in the screening. There is published evidence that involving peer workers would support access to physical health care3 and so the LHD project sought to involve a peer worker in the screening, assessment and follow-up as much as possible throughout the project.

The following 7-step methodology was developed to authentically involve consumer and carer engagement and was used in both phases of the project.

1. **Screening:** Everyone admitted to s received a physical health check. The initial pilot was conducted for one week with all new referrals to the catchments OPMH community service. Clinicians would utilise the screening tool on admission, using a very basic one-page health screening tool. During In phase one of the project, this was followed with a 5-point battery of questions:

    I. Right now, how aware are you of your physical health needs?

II. Right now, how knowledgeable are you of how to address your physical health needs?
III. Right now, how likely are you to follow-up with your GP or other specialists about your physical health?
IV. Right now, how confident do you feel to follow-up with your GP or other specialists about your physical health?
V. Right now, how motivated do you feel to follow up with your GP or other health specialists about your physical health?

Phase two introduced a more comprehensive (locally developed) screening process to identify issues of concern for the coaching process. The screening tool assessed 8 domains that may relate to the consumers' physical health and interrelated psychosocial functioning.

1. Medication and side effects
2. cardio-metabolic monitoring
3. Lifestyle factors (obesity, exercise, diet, smoking, dental, isolation)
4. Physical disorders (i.e. cancer, diabetes, cardiovascular disease etc).
5. Alcohol and illicit drug use
6. Psychosocial functioning (relationships, transport, trauma-informed factors, etc)
7. Special populations (over 65's factors such as cognition, frailty and falls risk etc, Aboriginal people, people with intellectual disability and people from other diverse communities).
8. Identifiable service partners such as GP, geriatrician, other specialists involved etc.

2. **Discussion:** The Consumer, their carer and family discuss the results, exploring ways to improve their physical health. The clinical team discussed the findings of the physical health screen with the consumer, carer and family to identify opportunities for health promotion, prevention, and possible treatment pathways.

3. **Empowerment:** Supporting consumers to make informed decisions about their health goals. The mental health clinician works with the person and wherever possible family carers, to empower consumer and family carer choice and decision-making around health gains.

4. **Coaching:** This is done through supporting the person and wherever possible family carers, with general recommendations and education for disease management, options for recovery and rehabilitation, and/or lifestyle change for better health outcomes and behaviour change support.

| Manage My Health Conditions | | | | |
|---|---|---|---|---|
| My physical health | My medications | My mental health | My monitoring | My triggers and risks |
| I understand and know my health conditions | I know and understand my medications | I know and understand my mental health condition/s | I have pathology and other tests when recommended | I know and manage my triggers for relapse |
| I follow treatment suggestions | I use accurate dosing and timing | I follow my care plan effectively | I see my GP regularly | I minimize alcohol consumption |
| I know to avoid infections, pain and other conditions | I recognize and act on side effects | I recognize and act on signs of improvement | I see my other specialists regularly | I minimize recreation substance use |
| I use supports and aids effectively | I seek medication reviews | I recognize and act on signs of deterioration | I attend education or other assistance programs | I minimize tobacco smoking |
| I use nutritional supplements effectively | I store my medications appropriately | I know to minimize harm from AOD | I arrange transport or use public transport | I manage my weight and waist circumference |

| Manage my Lifestyle Factors | | | | |
|---|---|---|---|---|
| My diet and nutrition | My physical activity | My stress and mood | My motivation | My social interactions |
| I know and understand fats, fiber, salt, protein and carbohydrate | I do activities to improve my cardiovascular fitness | I have strategies to improve my time management | I understand the cause and symptoms of low energy | I plan for enjoyable hobbies or interests |
| I make good food and drink choices | I do activities to improve my muscular strength | I engage in relaxation strategies | I plan and pace my activities | I am actively involved in my community |
| I control potion size | I do activities to improve my flexibility and balance | I engage in strategies to manage my emotional reactions | I engage in activities to improve my sleep quality and quantity | I know about consumer support groups |
| I avoid eating when not hungry | I do activities to improve my overall activity level | I am willing to get help from professionals | I adjust my home environment to improve daily living | I engage with friends and family |
| I choose good eating patterns | I do activities to manage my pain symptoms | I know how to access a psychologist or a counsellor | I know how to get help to reduce burden and stress | I am willing to seek support from family, friends, and others |

5. **Care plan:** The assessment is discussed with the MDT including health screening findings and recommendations, and all clinicians are prompted to contribute. The team agrees on a plan to address the physical health needs, documented for everyone involved. Care plan documentation includes Health Priorities, Consumer Goal, and Recommended Strategies.

6. **Examination:** Based on the plan, you may need further assessments or referrals. As the care plan is followed, this may trigger the need for additional physical health examination and further investigation by the clinical team or referral for specialised assistance that the mental health team cannot typically provide.

7. **Monitoring:** The consumers' progress is tracked using various measures to ensure you're on the right path. The mental health clinician monitors and evaluate agreed health activities using accepted consumer and carer measures, clinician measures and quality clinical measures.

This process provides a picture of consumer health profile from admission and provides a pathway towards improving their identified physical health care goals. It enables a straightforward process that can be monitored for change and is the basis to promoting consumer and carer engagement in choice and decision-making for health gains.

# Results and findings

## Results from phase one

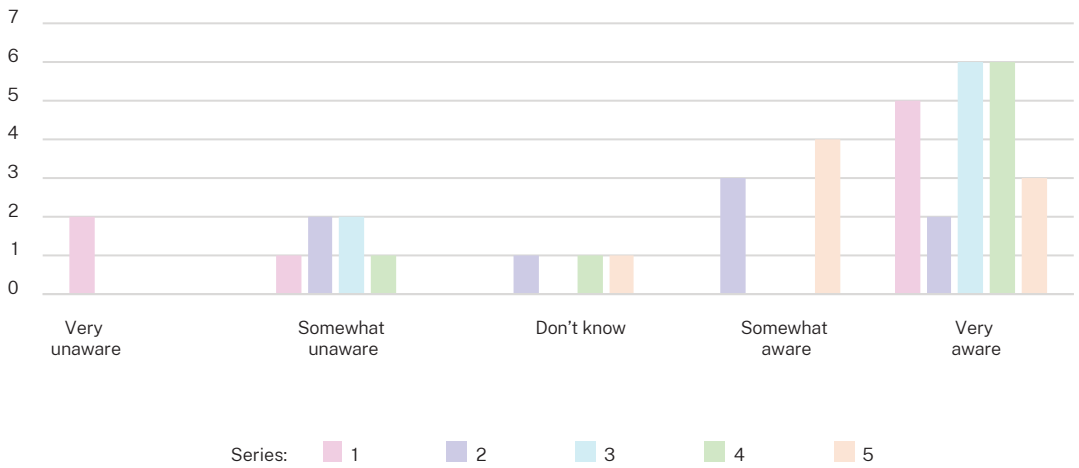
Pre and post-intervention questions and the use of health screening tools occurred during planned home visit as part of admission process for a small number of consumers (n=7) accessing community mental health support. Screening question results were kept in the paper file but were not kept electronically in EMR. Issues identified from health the screening tool were discussed with the person, and those issues identified as important and prioritised were included in correspondence to the identified treating GP.

The project also utilised five pre and post-intervention questions to assist in understanding consumer needs.

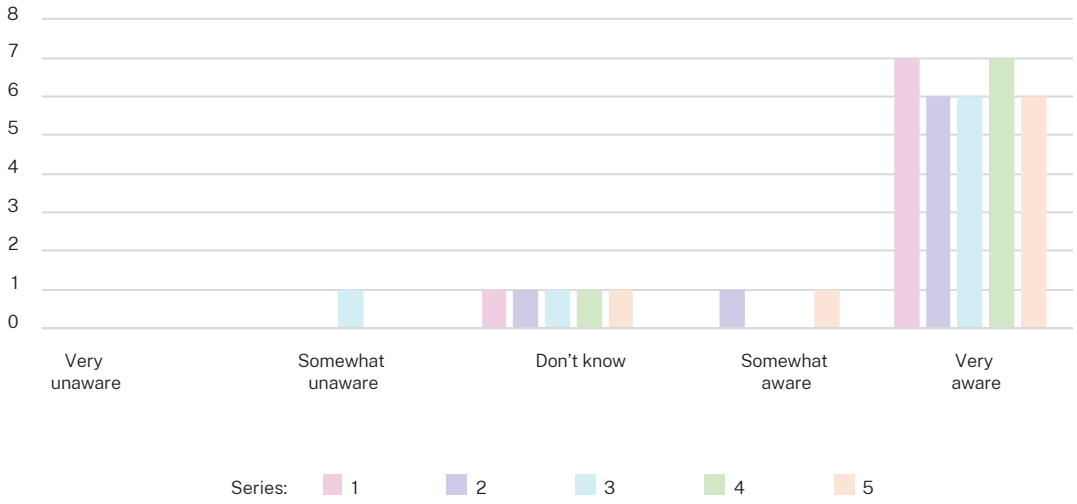
The team found an overall increase in awareness on most of the 5 screening questions from the coaching process. notably there was a larger increase in how knowledgeable people felt about their physical health needs and their motivation to follow up with primary care and specialists about their physical health, indicating an improvement in their health literacy and motivation.

1. Right now, how aware are you of your physical health needs?
2. Right now, how knowledgeable are you of how to address your physical health needs?
3. Right now, how likely are you to follow up with your GP or other specialists about your physical health needs?
4. Right now, how confident do you feel to follow up with your GP or other specialists about your physical health needs?
5. Right now, how motivated do you feel to follow up with your GP or other health specialists about your physical health?

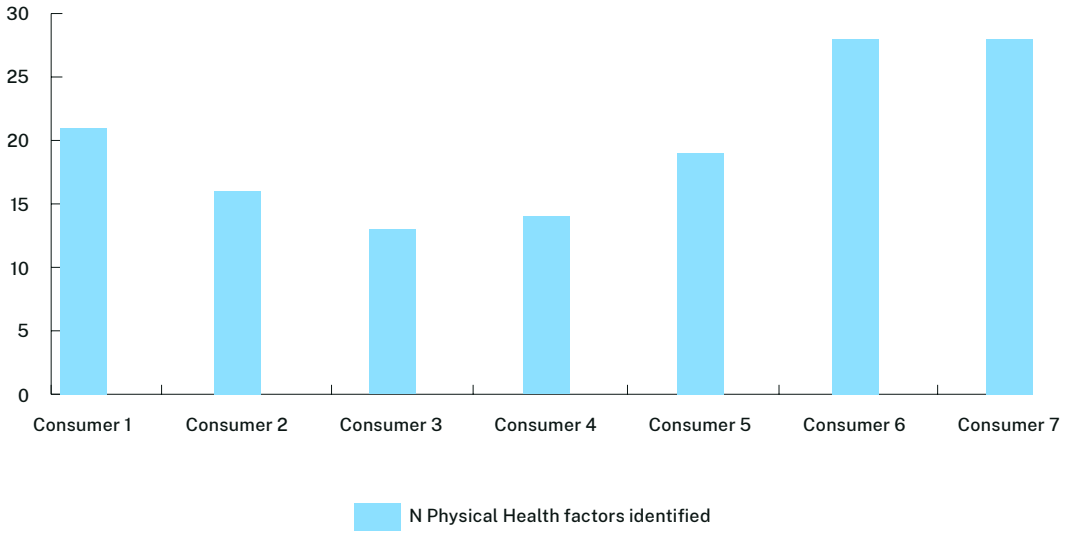
Pre health screening tool



## Post health screening tool




## Physical Health factors identified



### Phase two findings

With the coaching process now established as beneficial with the cohort, phase two introduced a peer-led screening process utilising a comprehensive physical health screening tool.4

The screening tool was piloted over a one-month period, finding on average 20 physical health factors of concern for each consumer.

Despite all consumers identifying physical health factors in the screening tool, 43% (3 of 7) did not identify barriers that required action plans, however, those who did require an action plan on average had two action plans developed to enhance physical health issues of concern with their community mental health clinician.

### Challenges and risks identified during the project.

The COVID-19 pandemic had a serious impact on this project and how it was able to be rolled out. Once the pandemic impacted the catchment area, there were restrictions on conducting home visits to consumers and significant workforce impacts that delayed the project. As the service exited the pandemic phase, workforce challenges persisted resulting in only one clinician being available to champion the project. With other competing priorities, it was challenging for one clinician to sustain progress alone.

Peer worker involvement was not to conduct the physical health screening or to evaluate the findings with consumers, it was simply to assist consumers understanding of what was being asked and how it would benefit them.

Despite interest in receiving academic support to develop the project into a research project, no academics could be identified to support the project through ethics or to develop it into a peer review paper. The project champion was supported by the state project team in sustaining the project through the pilot phase and writing it up for this report.

## Future directions for this work

Despite the physical health screening tool identifying a notable number of physical health areas of concern, the project team identified scope for improvement and will pilot a new tool (the HIP) as part of the next phase of the project. It is hoped that the new tool will be more seamless once implemented. The Health Improvement Profile (HIP)5 is a one-page form developed in the United Kingdom as a tool for mental health nurses to assess service user's physical health needs. The HIP screens service users' physical health and provides recommendations that clinicians can provide service users to improve their physical health. Adapted for use in Australia, the North-West Melbourne Mental Health Service in Victoria show it to be a suitable and acceptable screening tool for different clinicians to assess multiple lifestyle risk factors at once, which can be used across different diagnoses and settings. This study, for example, demonstrated a need to focus on promoting the flu vaccine and smoking cessation, as well as encouraging service users to visit eye and dental health services.

The Illawarra Shoalhaven Mental Health Service is currently undergoing a practice improvement project to promote these changes across the service.

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# South Eastern Sydney Local Health District

# OPtiMHize improving health outcomes of older people with a lived experience of mental illness

## Older Persons' Community Mental Health, Eastern Suburbs Mental Health Service

### Project Champions

- Danielle Gately, Occupational Therapist
- Helen McIntosh, Clinical Nurse Consultant
- Daniella Kanareck, Clinical Manager / Senior Social Worker
- Dr Katherine Mullin, Old Age Psychiatrist
- Natalie Narunsky, Senior Occupational Therapist
- Ti-Arna Madigan, Physical Health Clinical Nurse Educator

### Supporting Manager

- Dr Patrick Bolton, Eastern Suburbs Mental Health Service

## Introduction and overview

The Eastern Suburbs Older Persons' Mental Health Service (OPMHS) located at the Prince of Wales Hospital, Randwick provides a recovery orientated community outreach mental health service to people 65 years and over, or 50 years and over for Aboriginal people, and who have either:

- A mental disorder presenting for the first time in old age (usually 65 years and over), or
- A relapse of a mental disorder that occurred before the age of 65, or
- A cognitive disorder with mental health complications such as depression, suicidality, psychosis or severe anxiety.

The service provides short to medium term treatment of acute and subacute symptoms of mental illness, utilising both psychotropic medication and non-pharmacological interventions. The clinicians work in partnership with consumers' General Practitioners (GPs) throughout the episode of care, and when appropriate, transfer continuing mental health care to GPs. OPMHS has a robust multidisciplinary team who work alongside the treating psychiatrist, providing holistic biopsychosocial assessments and corresponding interventions.

### Rationale for the project

Aligning with the core themes of the Physical Health Care for People Living with Mental Health Issues (NSW Ministry of Health , 2021) which includes a responsibility to work alongside people with lived experience of mental health issues to improve their physical health outcomes and quality of life, OPtiMHize was developed as a pilot project to empower OPMHS consumers to identify health issues and actively engage in their physical health care, so as to promote better physical health outcomes and improved quality of life.

*The way that people experience their mental illnesses can increase their susceptibility of developing poor physical health. Mental illness can impact social and cognitive function and decrease energy levels, which can negatively impact the adoption of healthy behaviours. People may lack motivation to take care of their health* (Canadian Mental Health Association, n.d.). Older people are affected by both chronic medical conditions and the interplay of age-related conditions including sensory impairment, functional changes, increased adverse effects to medication and frailty.

The 2016 Greater Randwick Integrated Health Services Plan highlights vulnerable older people, particularly those who are socially isolated or frail, stating that the proportion of older residents in northern SESLHD LGAs

is expected to grow much faster than the rest of the population. *This will drive demand for services to meet the needs of this cohort, in both acute and sub-acute care. As many as 85% of people aged over 65 have three or more long term conditions* (South Eastern Sydney Local Health District, 2016). Encouragingly the consumers of the OPMHS have had a high engagement with a GP, (99% having an identified GP).

Screening tools and provision of health pathways can further improve health literacy, address modifiable physical health issues, and empower consumers to enhance their overall well-being and quality of life.

The aims of OPtiMHize pilot project were to:

1. Enable consumers to identify relevant physical health issues that are relevant to them,
2. Provide consumers with accessible pathways to address their identified health issues, and
3. Seek endorsement from the Eastern Suburbs Mental Health Services Physical Health Working Group to utilise OptiMHize as a tool for addressing the physical health needs of OPMHS consumers.


The project was informed by:

- Physical Health Care for People Living with Mental Health Issues guidelines (NSW Ministry of Health , 2021),
- National Mental Health Commission - Equally Well Consensus Statement (National Mental Health Commission, 2016),
- Royal College of General Practitioners Guidelines for preventive activities in general practice to identify common health and lifestyle issues that impact people over the age of 65 (The Royal Australian College of General Practitioners, 2016), and
- Australian Commission on Safety and Quality in Health Care's National Safety and Quality Health Service Standards (NSQHS) (Australian Commission on Safety and Quality in Health Care, 2021).

## Methodology

A brief self -administered physical health screening questionnaire was drafted drawing on a review of the above standards and guidelines, in addition to clinical observations, OPMHS clinicians engaged with consumers to complete the questionnaire and to request feedback for future design.

Early in the data collection period, consumers informed the clinicians that the initial questionnaire format was confusing, subsequently an alternate questionnaire format was co-designed for easier readability. Consumers and their GPs were provided with an individualised written summary of the health issues consumers identified as concerning and/or requiring follow up.

### Eligibility for participation in the pilot project

- Had a current open encounter with OPMHS
- Had a routine review with one of the OPMHS clinicians (Old Age Psychiatrist, Mental Health Nurse, Occupational Therapist, Clinical Psychologist, Social Worker, Welfare Officer, or Medical Student) during a three-week period of data collection during August 2022
- Onset of mental illness and diagnosis were not considered
- Informed consent obtained

### Exclusion criteria:

- Acutely unwell people (medical or mental health)
- Residents of Residential Aged Care Facilities

## Targeted domains of physical health included in the project's questionnaire

| | |
|---|---|
| **Medication**  | Polypharmacy is the regular use of five or more prescribed or over the counter medications. Psychiatric polypharmacy refers to combination therapy with two or more psychotropic medicines (Kukreja S, 2013).<br>Higher prevalence of illness and chronic health conditions within the older community increases likelihood of polypharmacy. Polypharmacy {in the older community} is also associated with harms including delirium, falls, hospitalisation, reduced quality of life and premature morbidity and mortality (Australian Commission on Safety and Quality in Health Care, 2021).<br>Older people are more likely to develop side effects from psychotropic medication including anticholinergic side effects, orthostatic hypotension, electrolyte changes, cardiac conduction disturbances, reduced bone mineral density, sedation, cognitive slowing, and extrapyramidal side effects.<br>In addition, therapeutic drug monitoring is essential for people taking lithium or sodium valproate to reduce side effects and balance dose for maximum therapeutic benefit.<br>This targeted physical health domain aligns with NSQHS Standard: Continuity of medication management.<br>Participants were asked if they been prescribed five or more medications, and if they are on lithium or sodium valproate, do they have regular blood tests |
| **Physical Fitness**  | Physical fitness is important at any age and helps to improve quality of life and mental health. Being physically fit can reduce the risk of chronic health conditions, falls and cognitive impairment<br>According to the Centres for Disease Control and Prevention (Centres for Disease, Control and Prevention, 2022) adults aged 65 and older need:<br>• At least 150 minutes a week (for example, 30 minutes a day, 5 days a week) of moderate intensity activity such as brisk walking.<br>Or they need 75 minutes a week of vigorous-intensity activity such as hiking, jogging, or running.<br>• At least 2 days a week of activities that strengthen muscles.<br>• Activities to improve balance such as standing on one foot about 3 days a week.<br>Participants were asked to rate their level of satisfaction of their physical fitness on the scale below, which was provided by Dr Oscar Lederman, Exercise Physiologist, Keeping the Body in Mind Program Eastern Suburbs Mental Health Service. Fitness was defined as the ability to carry out daily tasks with vigour and alertness, without undue fatigue and with ample energy to enjoy life.<br>Level of satisfaction of physical fitness scale:<br>• Very much so – my fitness is great<br>• Somewhat – my fitness is good but could be better<br>• Moderately so – my fitness needs some work<br>• Not really – I need to improve my fitness<br>• Not at all – my fitness is poor, and I need to improve my fitness |
| **Pain**  | The International Association on the Study of Pain notes that for a proportion of the older population, psychiatric (especially dementia) and medical comorbidity, frailty, and loss of physiologic reserve may all decrease the capacity of the older individual to effectively deal with the negative aspects of untreated pain (Schofield & Gibson, 2021).<br>Chronic pain is more likely to affect women and older people. In 2016:<br>1 in 5 (20%) people aged 65–74 reported having chronic pain, increasing to 22% of those aged 75–84 and 24% of those 85 and over (Australian Institute of Health and Welfare, 2021).<br>Participants were asked to rate their level of pain from one to ten; ten being severe pain. |

## Targeted domains of physical health included in the project's questionnaire (cont.)

| | |
|---|---|
| **Constipation and Incontinence** | The possibility of constipation and incontinence increases as people age; this might herald an underlying medical condition. Constipation and incontinence can result in high levels of distress, social withdrawal and reduced quality of life and wellbeing.<br>Participants were asked if they experience incontinence or constipation. |
| **Weight Loss**  | Unintentional weight loss may be due to illness, depression or cognitive impairment. Malnutrition is closely linked with recurrent falls and fractures, lost independence requiring support and care, poor wound healing, and an increase in complications including infections, pressure sores and skin ulcers (Sampson, 2009).<br>This targeted physical health domain aligns with NSQHS Standards: Minimising patient harm - Poor nutrition and malnutrition.<br>Participants were asked if they had any unexplained weight loss. |
| **Falls**  | Falls are a leading cause of burden of disease and injury. Vulnerability to balance problems, muscle weakness, poor vision, chronic health conditions, poor general health and polypharmacy increases older people's risk of falls. Falls and fear of falling can have detrimental impact on a person's mental health independence, social engagement and quality of life.<br>Natalie Narunsky, OPMHS Occupational Therapist has developed and run a novel adaption of the Stepping On program (Stepping On, n.d.). Stepping on for Recovery which provides a tailored falls prevention program for older people with a lived experience of mental illness.<br>This targeted physical health domain aligns with NSQHS Standard: Minimising patient harm – preventing falls and harm from falls.<br>Participants were asked if they have had one or more falls in the past year; how many falls they have had, do they use any mobility aids, and are they interest in attending a Falls Prevention program. |
| **Regular check ups**<br>**Vision**  <br>**Hearing**  <br>**Dental**  | Vision and hearing impairments are prevalent amongst older people and impact routine functions, communication and social engagement, mood, and quality of life. It is important to have regular vision and auditory assessments as impairments can often be improved with aids, medication or surgery<br>In 2017–18, the majority of people aged 65 and over reported a chronic eye condition (93%, 3.4 million people). The most common chronic eye condition was long-sightedness (62%), followed by short-sightedness (41%), presbyopia (9.6%) and cataracts (9.1%) (Australian Institute of Health and Welfare, 2021).<br>In 2017–18, an estimated 1 in 3 (34%) people aged 65 and over reported complete or partial deafness as a long-term health condition. The 2018 ABS Survey of Disability Ageing and Carers also estimated that among older people, 7.7% (300,000 people) had a main long-term health condition of the ear (diseases of the ear and mastoid process), with a higher proportion of older men affected (11%) than older women (4.7%) (Australian Institute of Health and Welfare, 2021).<br>Poor oral health is linked to discomfort and pain, increased risk of infections and medical conditions, speech difficulties and malnutrition.<br>Among older Australians, the proportion with at least one tooth with untreated decay increased from 22% in 2004–06 to 27% in 2017–18. Between 2013 and 2017–18, the proportion of older people who had experienced toothache in the past 12 months also increased, from 8.9% to 13% (Australian Institute of Health and Welfare, 2021).<br>Participant were asked if they have had hearing, auditory and dental check-ups in the past year. |

## Targeted domains of physical health included in the project's questionnaire (cont.)

| | |
|---|---|
| **Cancer Screening**  | Cancer screening programs are important in early detection of some cancers. Women diagnosed through Breast Screen Australia had a 69% lower risk of dying from breast cancer, women diagnosed through cervical screening had an 87% lower risk of dying from cervical cancer and people diagnosed through the National Bowel Cancer Screening Program had a 59% lower risk of dying from bowel cancer (Australian Institute of Health and Welfare, 2018).<br><br>Participants were asked if they are up to date with the following health screening:<br>• Breast screen (females, every 2 years up to age 74)<br>• Cervical Screening Test (every 5 years up to age 74)<br>• Bowel Cancer (every 2 years up to age 74) |
| **Immunisations**  | Participants were asked if they are up to date with the following vaccinations:<br>• COVID 19 1st dose<br>• COVID 19 2nd dose<br>• COVID 19 1st booster<br>• COVID 19 2nd booster<br>• Influenza – 2022 dose<br>• Pneumococcal disease (70 years and over)<br>• Shingles - Herpes zoster (60 years and over) |
| **My Aged Care**  | Promoting social engagement is important to enhance health and quality of life. Social isolation significantly increases a person's risk of premature death from all causes and is associated with about a 50% increased risk of dementia. Poor social connections (e.g., small networks, infrequent interactions, and loneliness) are modifiable risk factors for cognitive decline (Samtani, Mahalingam, & Lam, 2022).<br><br>Participants were asked if they would like a referral via My Aged Care for community services or assistance to keep them independent in their homes. |
|  | Open question about medical concerns or issues the consumer would like to discuss with their GPs. |

## Participants' demographics

Twenty-three consumers met the eligibility requirements, and all consented to participate in the project. The twenty-three consumers who took part, all identified health issues of concern. The age range was 69 – 87 years old, average age 78 years, 8 < 75 years old + 15 > 75 years old. The gender mix was 18 female and 7 males.

# Results and findings

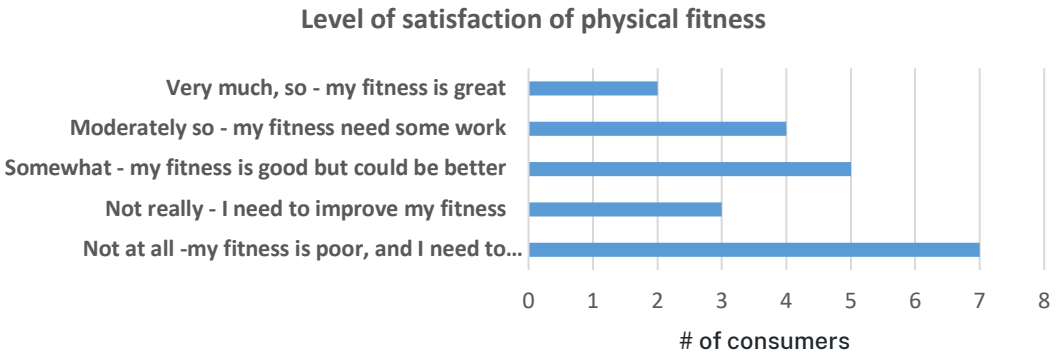
## 1. Medication

Over half the participants (52%) reported taking more than five medications, placing them at risk for adverse reactions due to polypharmacy. Only 5 (22%) indicated they would like more information on the medications they have been prescribed.

Four of the participants (all under 75 years of age) were prescribed lithium or sodium valproate. Three were aware of the required regular blood tests for therapeutic drug monitoring, the fourth person reported he was not aware that he was required to have ongoing blood tests whilst on his current medication regime but had been newly started on the medication.

## 2. Physical; fitness

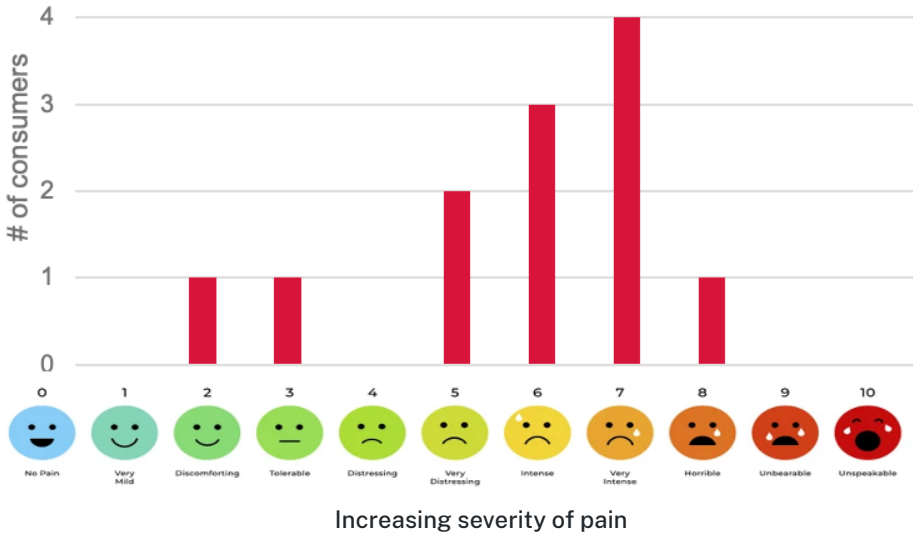
Participants overall reported low levels of satisfaction with their physical fitness as rated on the scale below.




The questionnaire did not address change in physical activity during the COVID-19 lockdowns and if this had impacted on participants' satisfaction with their level of physical fitness.

## 3. Pain

As per the pain scale graph below, over half (57%) the participants experienced pain, with ten participants noting they have had pain for over 12 months, 62% of the participants who noted pain, were taking prescribed or over the counter medication for pain.



## 4. Constipation, incontinence and unexplained weight loss

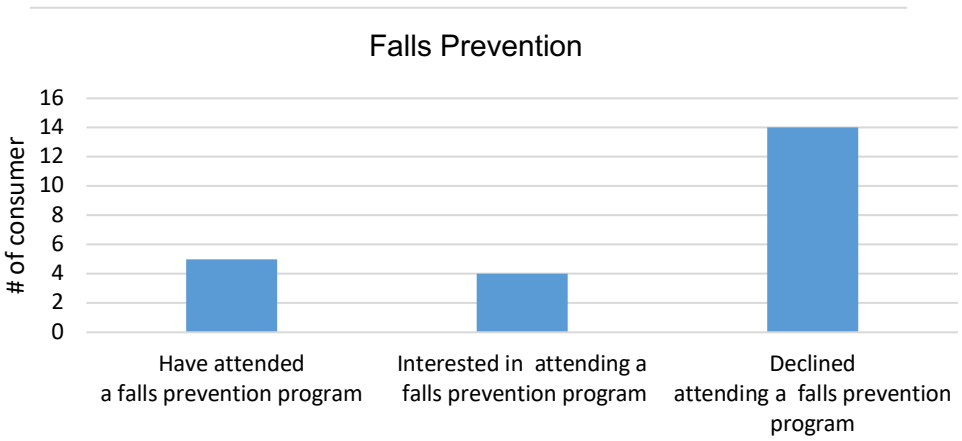
Fifty percent of the female participants indicated they experience constipation and/or incontinence. Interestingly, the question regarding experiencing incontinence was the most avoided question. Weight loss was consistent between female and males.

| | Experience constipation | Experience incontinence | Unexplained weight loss |
|---|---|---|---|
| **Female** | | | |
| **Yes** | 50% | *50%* | 31% |
| **No** | 44% | 19% | 69% |
| **Nil response** | 6% | 31% | 0% |
| **Male** | | | |
| **Yes** | 29% | 14% | 29% |
| **No** | 71% | 71% | 71% |
| **Nil response** | 0% | 17% | 0% |

## 5. Falls

Five (22%) of the participants have had a fall in the past twelve months. Ten (43%) of the participants were using mobility aids at the time of answering the questionnaire; with only one of those who reported a fall using a mobility aid. Four participants expressed interest in attending a falls prevention program, with five having already attended.

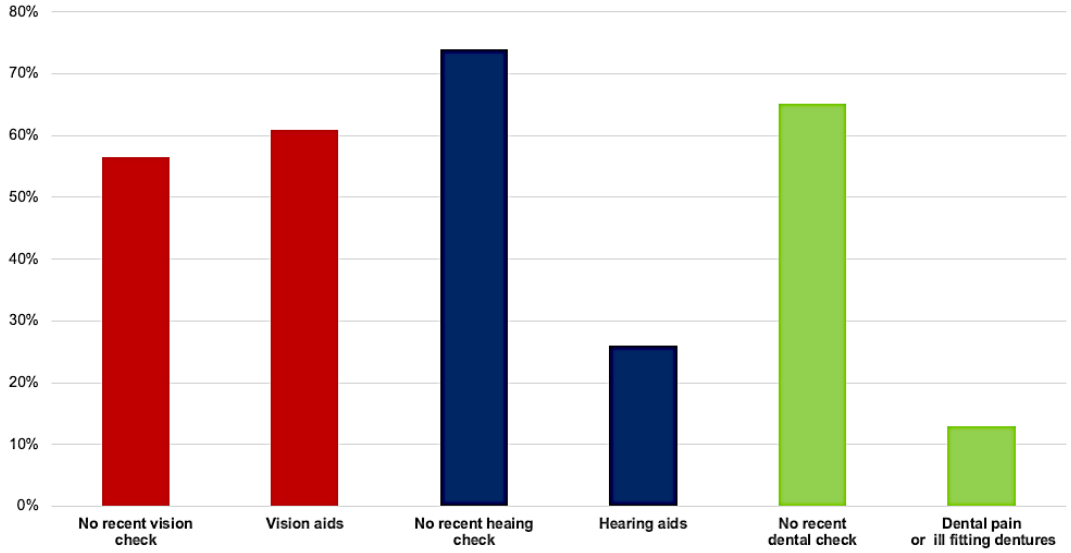
Low interest in falls prevention, which might be lack of awareness, will be followed up through further active recruitment for , a parallel program facilitated by OPMHS.



## 6. Overdue routine vision, auditory and dental check ups

Over 50% of participants had not had a recent assessment of their vision, hearing and/or dentition. This is likely to have been impacted by the COVID-19 lockdowns.

The findings indicate that among the participants, there was a high rate of vision aids and less than half used hearing aids. Less than a quarter of the participants identified having dental pain or ill-fitting dentures.




| | |
|---|---|
| Breast screen (every 2 years up to age 74) | 2/4 |
| Cervical Screening Test (every 5 years up to age 74) | 3/4 |
| Bowel Cancer (every 2 years up to age 74) | 4/8 |

## 7. Overdue cancer Screening

## 8. Overdue immunisation

One person did not respond to the above questions.

One person had had no vaccinations.

It is likely that the robust public health promotion and fear of being COVID-19 positive at the time of the project, had resulted in a high uptake of COVID-19 and influenza vaccinations. Vaccinations for pneumococcal, disease and shingles are likely to have been delayed due to fewer in-person GP consultations in the proceeding thirty months

| | |
|---|---|
| Covid-19 1st dose | 1/22* |
| Covid-19 2nd dose | 1/22* |
| Covid-19 1st booster | 1/22* |
| Covid-19 2nd booster | 9/22 |
| Influenza – 2022 dose | 4/22 |
| Pneumococcal disease (70 years and over) | 18/22 |
| Shingles – Herpes zoster (60 years and over) | 20/22 |

## 9. My Aged Care

Thirteen percent of the participants indicated they would like to discuss with a My Aged Care provider, access to community activities to combat loneliness.

Twenty-two percent of participants indicated they would like to discuss with a My Aged Care provider, services to maintain their independence in the community.

### 10. Open question

Issues participants noted they would like to raise with their GPs: included

- *Eye, ear, arthritis - rheumatoid, pain*
- *Pain in hips, ongoing severe head and neck pain*
- *Kidney EGFR concerns, cardiac check-up, rashes*
- *Too skinny - dietitian help build muscle*
- *Slight stiffness in wrist*
- *Nerves growing up the top of my spine, not sure if my current GP knows about it*
- *Dizziness on standing up' (postural BP), fatigue*
- *Maybe consider a blister pack as worried about missing taking medication and getting older*
- *I can talk to my GP about anything*

### 11. Participant feedback:

- Seventy-four percent of the participants found the questionnaire useful.
- Feedback noted enjoyment of talking about non-mental health issues.
- Feedback regarding the initial questionnaire layout being confusing, was attended to during the pilot project with a second format devised with input from the participants.

## Discussion

### Strengths

Older people are affected by both chronic medical conditions and the interplay of age-related conditions such as sensory impairment, functional delay, increased adverse effects to medication and frailty. There is a greater likelihood of increased burden on physical health for older consumers with a lived experience of mental illness. All 23 consumers who participated, identified health issues of concern.

Targeted domains of physical health selected for the questionnaire focused on areas that are modifiable and that can be followed up by consumers with minimal involvement of GPs and OPMHS clinicians. All consumers recruited for the pilot project provided consent and completed the questionnaire in the presence of an OPMHS clinician. The level of assistance and discussion differed from person to person and clinician and clinician.

Screening tools have the potential to empower consumers to enhance their overall well-being and quality of life and to address modifiable physical health issues. This project strengthens links to General Practice.

### Potential limitations:

This project was conducted in August 2022 following multiple COVID-19 related lock downs and challenges in accessing routine medical care. It is probable that some of the consumer responses are clouded by reduced engagement with health professionals. Cancelled medical care and cancer screening were more common among persons with medical conditions, anxiety and depression, even after accounting for COVID-19 deaths. Outreach and support to ensure that patients are not avoiding needed care due to anxiety, depression and inaccurate perceptions of risk will be important (Wenger, 2022). Sample size does not allow for any statistical relevance.

It is unknown if this questionnaire led participants or their GPs to address any of the issues raised. The frequency that the questionnaire needs to be done to impact outcomes is unknown

## Future directions for this work

1. The development of an information pack to sit alongside the questionnaire would enable OPMHS clinicians to provide information and resources on relevant pathways for follow up.
2. Useful vehicle to promote discussion across the SESLHD Mental Health Service about targets for physical health care that are specific for older consumers with a lived experience of mental illness.
3. Further discission with the local and District Mental Health Physical Health delegates is needed to endorse the use of a physical health questionnaire and the provision of pathways to older consumers and their GPs. This could then be considered usual practice in responding to both the Physical Health Care for People Living with Mental Health Issues guidelines (NSW Ministry of Health , 2021) and the NSQHS standards (Australian Commission on Safety and Quality in Health Care, 2021).
4. There is potential to provide GPs with resources via the local Primary Health Network's Health Pathways.

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# Increasing the rate of metabolic screening and monitoring in the older mental health consumer

## Northern Sydney Local Health District Hornsby, Ryde, Northern Beaches and Royal North Shore OPMH community mental health teams

### Project Champions

- Brian Tomney, Clinical Nurse Consultant – Older People's Mental Health

### Supporting Manager

- Andrew Clement, Program Manager – Older People's Mental Health

## Introduction and overview

The NSLHD OPMHS Physical Health Care Practice Improvement Project commenced in November 2019 with the aim of increasing the rate of metabolic screening and monitoring to a rate of at least 75% of consumers across four NSLHD OPMH community teams. Three of the 4 community teams were successful in achieving the project goal by April 2021, with plans in place for the fourth team to achieve the project goal by the end of the year. The following report outlines factors that enabled the project goal to be achieved and discussed barriers that existed in carrying out physical health screening and monitoring with recommendations for future actions that could be considered to address such barriers.

It is well established that people with severe mental illness have substantially poorer physical health than the general population and are at increased risk of physical health problems including cardiovascular disease, obesity, metabolic syndrome and dyslipidaemia. As a result, people with severe mental illness are likely to die 20 years earlier than the general population and account for approximately one-third of all avoidable deaths (Roberts, 2019). Many factors contributing to the increased risk of cardiovascular mortality are modifiable and health care providers, including mental health services, have an important role in identifying and monitoring these risks. The provision of inadequate health care for people with severe mental illness is recognised as a major form of inequality. Metabolic monitoring represents a major step towards equity in health care provision and is necessary to identify and quantify the risk of cardiovascular disease and diabetes and initiate early interventions for risk management.

A baseline audit of electronic medical records (eMR) entries of NSLHD OPMHS consumers was conducted in March 2020 and demonstrated that between 1% and 42% of consumers had metabolic monitoring completed at any point during their admission. The rate of metabolic monitoring done within the previous year was between 0% and 35% and within the last 6 months between 0% and 24%. NSW Health Guideline GL2017_019 Physical Health Care of Mental Health Consumers (updated in April 2021 with GL2021_006 Physical Health Care for People Living with Mental Health Issues) state that people over the age of 65 years should have their blood sugar level and lipid profile checked at least once every twelve months and that all consumers of mental health services should have their weight and waist circumference measured at least every six months, and more frequently if the consumer has a Body Mass Index (BMI) of 25 or over.

## Methodology

The project has been guided throughout by the NSW OPMH Physical Health Care Practice Improvement Project Expert Reference Group comprised of experts from the NSW Ministry of Health Mental Health Branch, Local Health Districts throughout New South Wales, Charles Sturt University and the NSW OPMH Advisory Group.

The NSLHD project was facilitated by a working group including members of the four community OPMH services. This group met monthly throughout the project with members attending either in person or by Skype. The project working group first met in November 2019 and a clear, measurable and aspirational project aim statement was developed. Using the Clinical Excellence Commission quality

improvement methodology, the project working group devised the driver diagram (Appendix 1) by considering underlying causes of the low rate of metabolic monitoring. These causes were then expressed as positive actions and categorised as primary or secondary drivers. Change ideas and interventions that addressed at least one of the secondary drivers were implemented. The project was uploaded onto the Quality Improvement Data System (QIDS), allowing all members of the project team to access project documents, resources and charts updating progress.

An early test of change was the development at Northern Beaches of a standardised checklist (Appendix 2) completed by OPMHS case managers before mental health care reviews highlighting whether metabolic monitoring and other aspects of physical health and wellbeing assessments had been addressed. The requirement to complete the checklist prior to presentation at the Multidisciplinary Team (MDT) clinical review meeting led to a sustained increase in metabolic monitoring rates. The format provided a platform for discussion of all aspects of physical health and wellbeing in an MDT forum and an agreed plan incorporating consumer goals being documented. At the same time, clinicians at Hornsby, Ryde and Northern Beaches all offered consumers the opportunity to have metabolic monitoring and physical health and wellbeing screening attended to at home as part of the Wellness on Wheels program originally devised by the team at Ryde OPMHS. To facilitate this program additional equipment to carry out physical health screening was purchased along with bags on wheels allowing the clinicians to conveniently and safely transport the equipment on home visits. Following the implementation of these tests of change the working group continued to meet monthly and the rate of metabolic monitoring completed by each community OPMH was discussed.

### Barriers and Enablers

The recruitment of a Senior Mental Health Clinician in June 2020 to each of the community OPMH teams at Hornsby, Ryde and Northern Beaches together with an exercise physiologist working across the three sites certainly provided a major impetus to the project. The impact of the appointment of these senior clinicians can be seen in Appendix 3 with the rate of metabolic monitoring at Hornsby and Ryde increasing rapidly from extremely low baseline rates in the period commencing a couple of months after the senior clinicians started work. In the initial period after being appointed, the senior clinicians at Hornsby and Ryde carried out a significant proportion of the metabolic monitoring themselves and therefore had an immediate positive impact. While this rapid improvement in the rate of metabolic monitoring was welcome, it perhaps overshadowed the importance of the role of the senior mental health clinicians in raising the profile of metabolic monitoring and physical health and wellbeing with the whole multidisciplinary team and in facilitating all clinicians in the team in carrying out or enabling metabolic monitoring and physical health and wellbeing assessment to the extent allowed by the clinician's scope of practice. It is possible that with the creation of a specialist role focusing on physical health and wellbeing, the remaining clinicians in the OPMH community team could defer or delegate all responsibility for metabolic screening and monitoring as well as all other physical health and wellbeing issues to the senior mental health clinicians. This was avoided at Northern Beaches as the senior clinician and team leader focused on developing systems, such as the checklist shown in Appendix 2 to ensure that all MDT clinicians participated in metabolic monitoring and physical health and wellbeing screening.

For the increased rate of metabolic monitoring to have a meaningful impact on the quality of care provided, the results need to be discussed in mental health care reviews and any required interventions or ongoing monitoring need to be included in current mental health care plans. Recent audits have shown that there is a wide variation in the four community OPMH services in the proportion of consumers who have current mental health care plans, ranging from 90% of consumers to 29%, and up to date mental health multidisciplinary care reviews, ranging from 62% to 4%. In the OPMH services with low rates of care planning and ongoing mental health reviews it would seem that the results of completed metabolic monitoring are not being incorporated systematically and in a timely manner into care plans. The findings of the audits of care plan and mental health care review completion have been discussed with all four community OPMH services at recent OPMH sector meetings.

## Results and findings

The OPMH community teams at Hornsby, Ryde and Northern Beaches all met the project objective in April 2021 and achieved completed metabolic monitoring for at least 75% of their consumers. This level of metabolic monitoring has been sustained, or close to sustained, in the period since then (Appendix 3). Over the course of the project this represented an increase from a baseline of between 0% and 42% of completed metabolic monitoring at March 2020 to between 75% and 76% in

April 2021. When the baseline measurements were done in March 2020, much of the most recent metabolic monitoring recorded in the consumer's electronic medical record was well over 6 months old. By April 2021 the rate of metabolic monitoring completed within the last 6 months had increased from a baseline of between 8% to 22% in March 2020 to between 55% and 68%. It is obviously vital to have current physical health data available in the consumer's electronic medical record to inform treatment and care management decisions at care planning and care reviews. The increased metabolic screening and monitoring carried out over the last several months has led to many cases of increased cardio-metabolic risk being revealed with the OPMH teams able to implement appropriate interventions to reduce risk and improve general health and wellbeing.

## Future directions for this work

To sustain and build on the improvements achieved during the project, the following actions are planned;

### Ongoing efforts to improve metabolic monitoring:

- The working group continues to monitor rates and share strategies for improvement.
- Ensure monitoring meets Physical Health Care for Mental Health Issues guidelines.
- Ryde, Hornsby, and Northern Beaches lessons will be implemented by Royal North Shore.

### Collaboration for better care planning & reviews:

- Discussions with community teams aim to improve care planning and reviews.
- Screening and monitoring will be integrated into care plans with consumer involvement.

### Streamlining routine & opportunistic monitoring:

- Processes will be developed for all community services to facilitate regular monitoring.
- This includes basic tools like scales and blood pressure monitors in consultation rooms.
- Staff training and education are crucial for conducting and interpreting health screenings.

### Escalation pathways for abnormal results:

- Guidance needed for OPMHS clinicians when monitoring indicates elevated risk.
- Current practice involves referral to GP or direct contact for urgent cases.
- An MHDA working group is developing a specific escalation pathway guideline.

### Dissemination of project knowledge:

- Accepted abstracts for presentations at Equally Well Symposium and Mental Health Services Melbourne Conference.

This project is actively working to improve metabolic monitoring, care planning, and escalation pathways for people with mental health issues, with a focus on collaboration and consumer involvement.

## Acknowledgements

NSLHD OPMHS Physical Health Care Practice Improvement Project Working Group

- Aliya Kavuzlu
- Andrew Clement
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- Brian Tomney
- Emma Underwood
- Jacqueline Salmons
- Mairi Mcmillan
- Mandy Meehan
- Dr Megan Alle
- Rina King-Wielhessen
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### Project team professional discipline mix:

Psychiatry, Allied health, Nursing and Management

NSW OPMH Physical Health Care Practice Improvement Project Expert Reference Group

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# Adapting fit For Your Life to the regional context

## Western NSW LHD Community Older People's Mental Health Team, Orange

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- Gabrielle McNamara, District Coordinator Older People's Mental Health
- Hannah Nunn, Occupational Therapist Older People's Mental Health
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### Publication Reference:

McNamara, Gabrielle, Robertson, Caroline, Hartmann, Tegan, & Rossiter. Rachel. (2022). Effectiveness and Benefits of Exercise on Older People Living With Mental Illness' Physical and Psychological Outcomes in Regional Australia: A Mixed-Methods Study. *Journal of Aging and Physical Activity*. Advance online publication. https://doi.org/10.1123/japa.2021-0514.

## Introduction and overview

Exercise has been shown to be effective in improving physical and mental health outcomes in older people living with a mental health condition (Blumenthal, et al., 1999; Singh, et al., 2005; Stanton & Raeburn 2014; Windle, et al., 2010). For older adults, strength and balance activity can also decrease falls (Sherrington, et al., 2017; Clemson, et al., 2010). Research in older people also shows the benefit of social engagement (Beck, et al., 2016; Rai, et al., 2020).

The aim was to demonstrate improvement in physical and mental health outcomes for older people in the OPMH service as a result of participating in a 9 week physical activity program. Three 60 minute sessions per week were delivered by an Accredited Exercise Physiologist (AEP) with an OPMH clinician. It was coupled with in-built evaluation by participants.

The planned key outcome of the project was to assess the physical health and mental health improvements that can be achieved in Older People with a mental health condition participating in a structured exercise program in a regional location.

## Methodology

The team partnered with Charles Sturt University researchers to ensure a robust research design, an accredited exercise physiologist (funded) and the WNSWLHD research directorate. The team were successful in sourcing seed funding.

Outcomes were measured via physical health and activity data and mental health quantitative data were taken pre and post exercise program. Semi-structured interviews with participants were undertaken pre and post program to gather a narrative of exercise engagement, views of the program and identify changes in the participant's views.

## Results and findings

The project demonstrated improvements in physical activity data and mental health data.

Consistent with prior research, participants identified the benefits of social engagement with others who understood (i.e., others living with mental illness), with improved psychosocial functioning (Beck, et al., 2016; Bethancourt, et al., 2014; Noh & Kim, 2022; Rai, et al., 2020)

OPMH staff considered the effects of physical health and activity as an important part of the service more than before. As ongoing implementation of the program, staff have access to physical health programs suitable for recommendation to consumers of the service.

## Future directions for this work

OPMH staff highlighted the additional work required to design, implement and evaluate the program,. With more time dedicated to the research and funding for collaborative positions with academic researchers to work alongside clinical staff, a more robust full-scale study of this kind needs to be undertaken to determine the impact of quality of life and the economic impact.

**Further key actions include:**

- Review OPMH health promotion activities related to physical and mental health care;
- Exploration of re-establishing this program in the current climate;
- Continue to advocate and lobby to build knowledge and skill of others in government, clinical and community settings to incorporate physical activity into mental health care of older people.

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# The impact of exercise on holistic health for older adults with mental illness: a pilot study

**Western Sydney LHD - Merrylands OPMH Community Service WSLHD NSW Health**

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### Academic partners (External Investigators)

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### Submitted for publication

## Introduction and overview

People with mental health issues are more likely to experience physical health problems than the general population. Studies show they are six times more likely to die from heart disease, four times more likely to die from respiratory diseases, and three to four times more likely to die prematurely. Unfortunately, their life expectancy is about 20 years shorter than those without mental health issues (Roberts, 2019).

Many of these deaths are caused by preventable lifestyle-related diseases like heart disease, obesity, and type 2 diabetes. One reason for this is that one-third of people using mental health services report being very sedentary and not getting enough physical activity or exercise (Roberts, 2019).

However, physical activity can play a significant role in improving both physical and mental well-being for older adults with mental health issues. Research shows that regular physical activity is linked to a lower risk of cognitive impairment, dementia, and subjective cognitive decline (SCD) (Koh et al., 2020; Sato et al., 2021; Liu et al., 2020; Lautenschlager et al., 2006; Wong et al., 2023; Xu et al., 2023). It can also help improve the functional status of older adults and reduce the risk of heart disease and other metabolic problems (Bherer et al., 2013; Cassilhas et al., 2010; Roberts, 2019).

To investigate the effects of exercise combined with usual mental health care on physical and psychosocial health outcomes in older mental health consumers, the WSLHD OPMH team initiated a practice improvement project. The team aimed to understand consumers' perceptions of the intervention and whether those receiving a clinically supported exercise program would have improved physical and psychological health outcomes compared to those receiving only usual mental health care.

## Methods

The study was approved by the WSLHD Health Equity and Research Advisory Committee (HREA) (2020/ETH01461). To participate, individuals had to be between 65 and 85 years old, able to move around independently with or without mobility aids, provide informed consent, and receive medical clearance from their doctor. People with significant cognitive impairment affecting their daily lives were excluded.

Twenty-two participants agreed to join the study after receiving information and medical clearance. They all lived independently in the community and might have received support from paid or unpaid caregivers. Participants were randomly assigned to either a group receiving usual mental health care or a group receiving usual mental health care with a clinically supported exercise program.

### Intervention and Assessments:

Throughout the 13-week exercise program (July to September 2023), all participants continued to receive regular mental health care and support from their OPMH care coordinator. This included appointments with an OPMH psychiatrist and ongoing communication with their GP.

Those in the usual care and exercise group completed a series of physical tests and self-reported questionnaires before and after the intervention. These included:

### Physical:

- 5 x Sit to Stand Test (timed)
- 4-stage balance Test
- Timed Up & Go
- Psychological:
- RAS-DS
- GDS

### Pittsburgh Sleep Quality Index:

- K10
- HONOS 65+
- FROP-COMM

#### Exercise Program:

Participants in the usual care and exercise group attended a clinically delivered exercise program once a week at the Merrylands Community Health Centre. They also completed home exercises (guided by a booklet and instructions) for twelve weeks. The exercise sessions were approximately 45 minutes long and focused on improving balance and lower-body muscle strength.

## Data Analysis and Statistics

Before starting the study, we calculated how many participants we would need using a computer program called G*Power. Based on our desired effect size, error probability, and power, we determined that 22 participants would be sufficient.

After collecting data from all participants, we conducted a thorough analysis. This included checking for outliers, assessing the normality of distribution for continuous data, and using appropriate statistical tests. We used a two-way repeated measures ANOVA for continuous data and Wilcoxon signed rank tests and Mann-Whitney U tests for ordinal data. Effect sizes were also calculated to quantify the magnitude of differences between groups.

For continuous data, we employed a two-way repeated measures ANOVA to examine the effects of group and time on outcomes. Sidak's adjustment was used for multiple comparisons. For ordinal data, Wilcoxon signed rank tests and Mann-Whitney U tests were utilized to identify within-group changes and group differences, respectively.

We conducted interviews with participants after the program to gather qualitative data about their experiences. Thematic analysis was used to identify and interpret patterns in the data related to participant perceptions of the program. Additionally, a brief survey was administered to collect feedback, which was overwhelmingly positive. Participants expressed satisfaction with the social aspects of the program and reported improvements in their mood and feelings of connectedness.

## Initial Group and COVID-19 Restrictions:

It's important to note that the initial group of participants recruited in 2022 had to be discontinued due to COVID-19 restrictions. However, the research team remained in contact with these participants via telehealth, and they reported feeling valued by this ongoing support.

## Results

The study found that adding a clinically supported exercise program to usual mental health care for older adults can improve mental health and physical function. With the intervention having an overall positive effects on overall well-being.

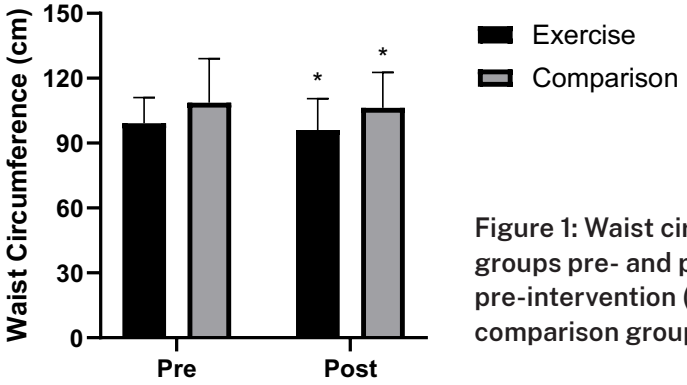


**Figure 1: Waist circumference values for the exercise and comparison groups pre- and post-intervention. *Indicates a significant difference from pre-intervention (P= 0.02; ES= -0.22 and -0.13 for the exercise and comparison groups, respectively).**

People in the exercise group experienced significant improvements in their ability to sit down and stand up more quickly (Fig 2), as well as reductions in depression, anxiety, and overall mental health symptoms (fig 3 and 4). These improvements were statistically significant compared to the control

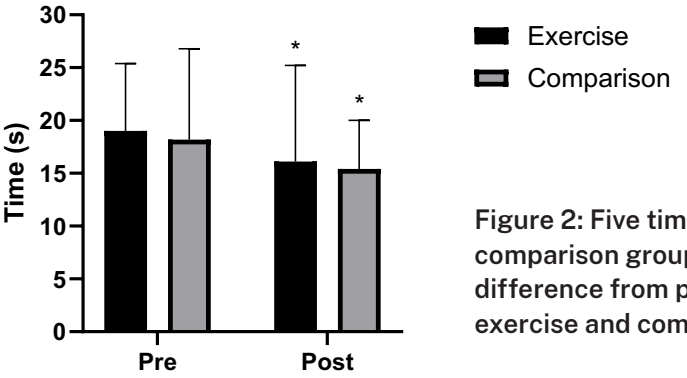


**Figure 2: Five times repeated sit-to-stand times for the exercise and comparison groups pre- and post-intervention. *Indicates a significant difference from pre-intervention (P= 0.02; ES= -0.81 and -0.38 for the exercise and comparison groups, respective**

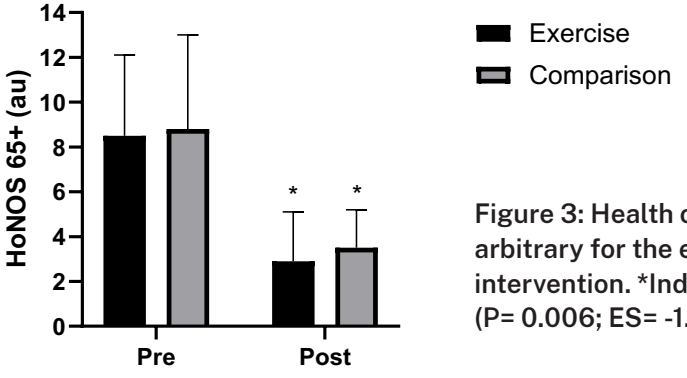


**Figure 3: Health of the Nation Outcome Scales 65+ (HoNOS +65) scores in arbitrary for the exercise and comparison groups pre- and post-intervention. *Indicates a significant difference from pre-intervention (P= 0.006; ES= -1.84 and -1.58 for the exercise**

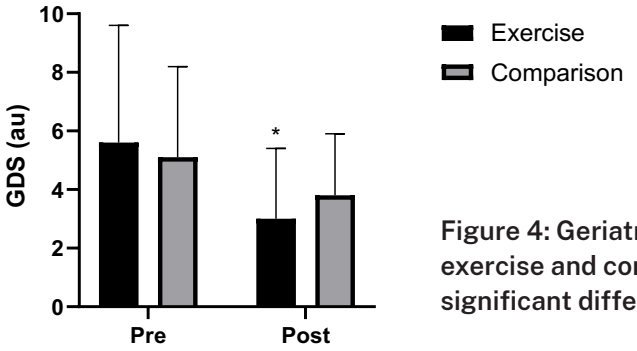


**Figure 4: Geriatric Depression Scale (GDS) scores in arbitrary units for the exercise and comparison groups pre- and post-intervention. *Indicates a significant difference from pre-intervention (P= 0.03; ES= -0.76).**

## Conclusion

Although we didn't see any significant improvements in physical health, it was encouraging that people didn't get worse either. What's more, participants felt better about their recovery journey, as shown by their improved scores on the RAS-DS.

The results from this study will help shape future changes in how we provide care for older adults with mental health issues. We can use these findings to improve policies, practices, and education, and to develop better treatment services.

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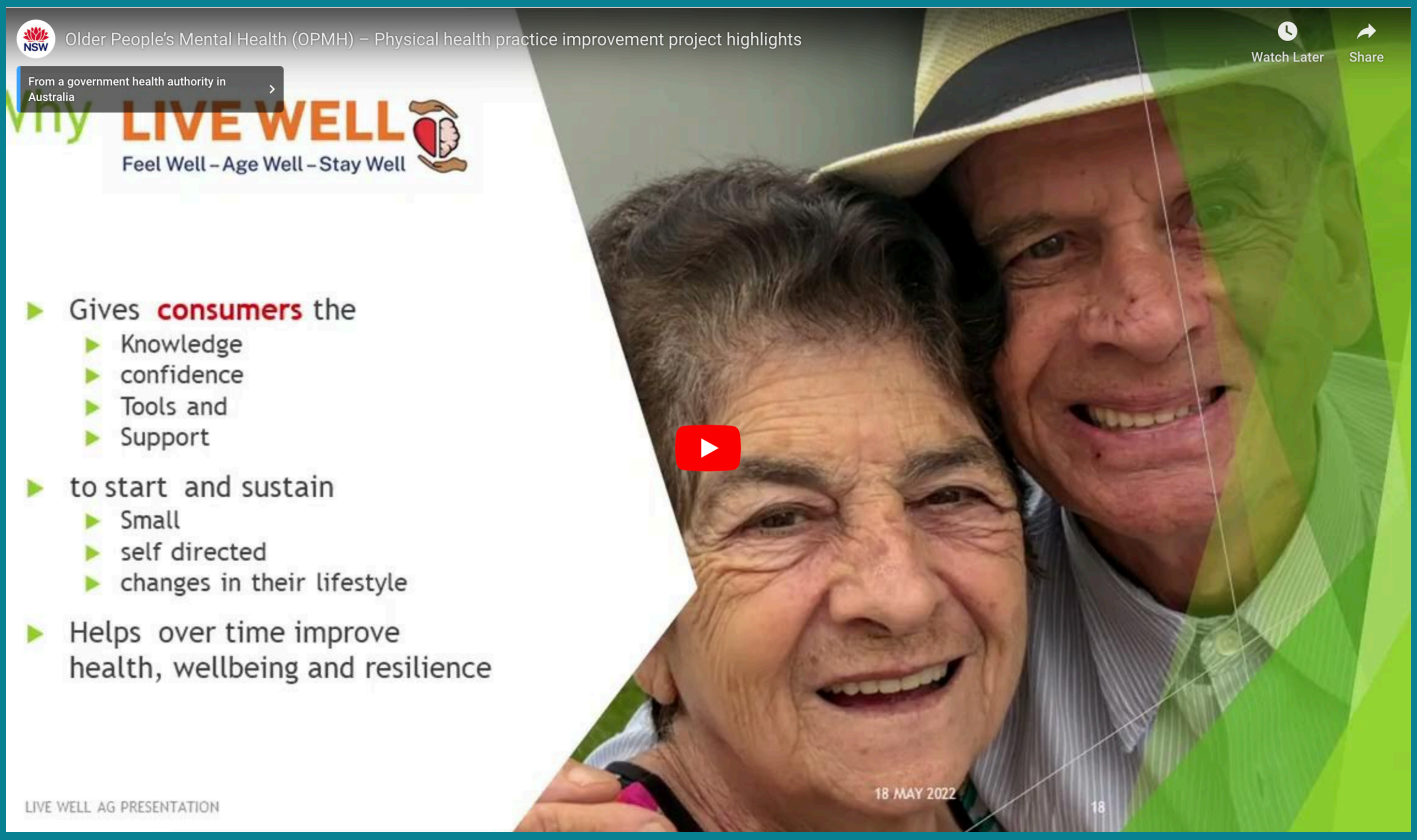
# Appendix 2: Physical Health Showcasing event

Published on the NSW Health Website, the The OPMH Physical health practice improvement project was showcased on 7 November 2022. The following video covers the highlights from the event. Additional videos for some of the projects can be found on the NSW Health Website.

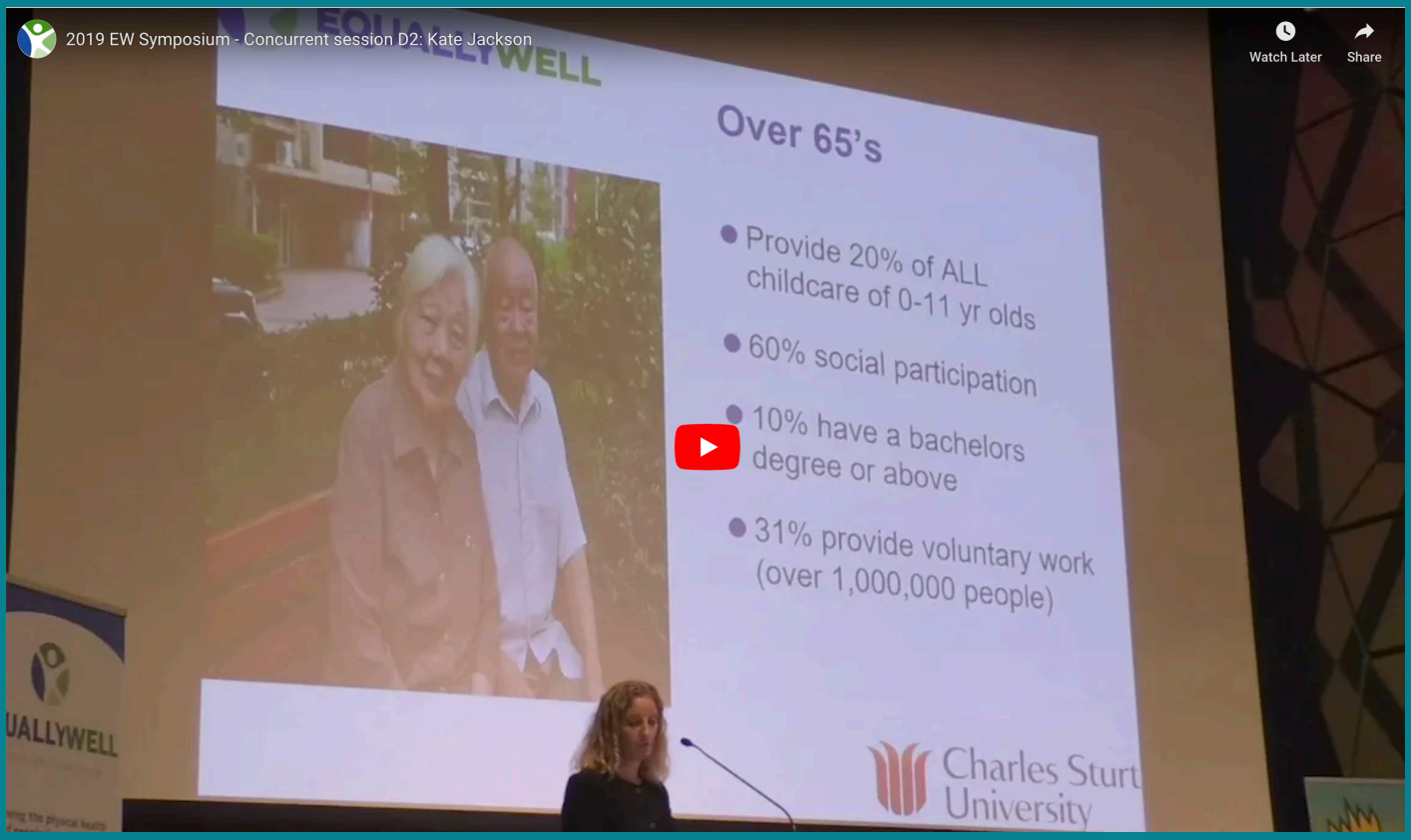


# **Appendix 3:** Equally Well Presentations

The project team presented papers throughout the project's life at the national Equally Well Symposiums, these can be found on the Equally Well websites here:

1. Jackson. K, Robets. R, McKay. R, (2019) What do we know about the physical health of older people with mental illness, and what does this mean for improving care? Presented at the 2019 Equally Well Symposium.

Adobe Acrobat Document




2. McKay. R, Aquilina. C, Jackson. K, Suttie. S, Tomney. B, (2020) Supporting the physical health of older people's mental health service consumers: practice improvement ideas building on what we know and what we have. Presented at the 2020 Equally Well webinar series.

Adobe Acrobat Document

3. McKay. R, Jackson. K, Stevens. J, (2022) Leadership and collaboration: statewide physical health practice improvement for older people with a mental illness. Presented at the 2022 Equally Well Symposium.

Microsoft PowerPoint Presenti

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