

Back On Track Health (BOTH)

PROJECT

PRA

mental health recovery

living, learning, working in the community

Back On Track Health (BOTH) PROJECT

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“Outside In:

Community responses to complex and diverse needs”

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Back On Track Health (BOTH) PROJECT

What is the Back On Track Health (BOTH) Project?

It is a dedicated approach for people living with persistent mental health problems and complex needs in rural, regional and urban areas of NSW where PRA integrates:

- Holistic care
- Flexible, coordinated individual support
- Identification and response to neglected or unidentified chronic disease, or poor physical health states

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Background

Physical health needs of people living with a mental illness have been neglected in the past 2-3 decades.

Due to poor health care, people with a mental illness are more likely to develop:

- Chronic diseases at a younger age
- Have increased drug and alcohol use
- Have greater lifestyle risks
- Complex health needs and co-morbidity
- Less likely to get evidence-based treatments and health checks
- Face barriers in accessing services
- Die 15 to 25 years earlier than others in the population

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The importance of mental health in maintenance of good physical health and in recovery from physical illness is well documented:

1. WHO & World Organization of Family Doctors, ***Integrating mental health in primary care - a global perspective Report***, Oct 2008
2. ***Duty to Care, Preventable physical illness in people with mental illness***, Coughlan, et al. UWA, 2001
3. Disability Rights Commission, ***Equal Treatment: Closing the Gap, A formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems, Part 1***, UK, 2007
4. Highland Users Group, ***Mental Health and Physical Health Report***, UK, June 2008
5. Minot, I., The Mental Health Repercussions of the Current Economy And The Interrelationship Between Physical and Mental Health, ***Mental Health News***, Vol. 10, No. 4, 2008

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The majority of service users of PRA have experienced socio-economic disadvantage, discrimination and limited, or absent, comprehensive health care services

Detection and prevention of chronic health conditions are essential to begin addressing co-morbidity

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Why get involved in physical health matters?

Research shows links between:

- Depression and anxiety with cardiovascular and cerebrovascular diseases
- Chronic pain and suicide
- Psychotropic medication and metabolic disorders e.g. cardiomyopathy, obesity & diabetes
- Co-morbidity and depression

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PRA currently supports 2800 people living with persistent mental illness, and their families/carers with a range of community-based, work-based, and home-based initiatives in 32 locations in rural, regional and urban NSW.

Any illness or side effect of psychotropic medication can impact on an individual's ability to function at an optimum level, reducing wellbeing and compounding mental health problems.

An effective, integrated, monitored, coordinated and sustainable chronic disease and complex physical health care program will benefit consumers, families, carers and staff.

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Benefits of the BOTH Project will be:

- Reduced health inequalities
- Social and emotional wellbeing
- Improved quality of life and life expectancy
- Enhanced self-esteem
- Self-determination and control of one's own health needs
- Enhanced resilience and coping skills
- Improved physical health
- Increased physical activity
- Positive impact on mental health



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What?

The BOTH Project will survey consumers, pre and post, to determine the extent of unmet physical health needs. A comprehensive, sustainable, culturally aware staged program will:

- Promote active participation in self-care
- Enhance and meet complex physical health care needs
- Provide primary health promotion and prevention strategies
- Identify and manage risks



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How?

The Project will address identified needs by:

- Review of organizational policies and procedures
- Establish a BOTH Project Steering Committee to monitor and review progress
- Develop a consumer/staff education package
- Provide initial staff training and support
- Develop gender specific Health Checklists
- Link with individual GPs, and through the Divisions of GPs



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How?

- Increase the detection of chronic health conditions
- Increase consumers' confidence in self-management of mortality risks and physical health issues
- The establishment and maintenance of MOUs
- Enhanced health care networks and referral pathways with multidisciplinary health care providers
- Supply health education resources e.g. The *ABC of Healthy Living* folder (HNEAHS)



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Outcomes

For benchmarking purposes it is proposed that a random selection of 10% of all service users be surveyed in the Pre Evaluation stage.

PRA anticipates the evaluation will indicate:

- Service users achieved sustainable positive health outcomes
- Increased engagement with health services
- Participation in health education
- Consumer access to health resource kits



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Outcomes

- Increased instances of making/ attending medical appointments
- Increased follow-up of health related visits
- Active pursuit of lifestyle and risk modification activities
- Consumers prioritising health related topics in CANSAS self assessments



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Where to?

PRA is committed to the establishment and management of new and unique health and support services, that involve creative and flexible service provision for people living with a mental illness.



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How will this be achieved? By -

1. Acknowledging the unmet health needs of consumers
2. Actioning structured health interventions through the BOTH Project
3. Seeking financial support
4. Incorporating health actions into PRA's activity
5. Gradually implementing this project regardless of funding

PRA aims to ensure the BOTH Project is effective, coordinated, monitored, reviewed & sustainable.

