Mental Health SIG Update

Michael Smith, Co-convener, Mental Health SIG

Along with 300 other people, I attended the National Social Inclusion and Complex Needs Conference that was organised by the PHAA in Canberra on 15-16th April 2013. The mix of presentations was diverse across both the public health system and NGOs. Topics covered mental health, AOD, Indigenous health, CALD, GBLTI, sexual health, refugees and corrections health to name a few. The biggest challenge for attendees was deciding on what sessions to attend with such a diverse and interesting scope of topics.

The first two speakers, John Falzon from the Social Inclusion Board and Robert Tickner from Red Cross, provided an insight into the complexity of challenges that face the most vulnerable in our community. The morning session was completed by the Hon Member Mark Butler MP who spoke about the work that has been done and needs to be done by the federal government.

All presentations and posters I attended were excellent and highlighted some amazing work being done throughout the health and NGO sector. What is clearly evident is that the NGOs and some individuals produce work that offers social inclusion and removes complex needs with limited resources.

A highlight of the conference for me is the work being done by Lexie Jury (Sex Worker Outreach Program) and sex worker awareness training. This program is innovative and the scope of the people who have accessed the training will challenge perceptions and improve knowledge of safe sex. It is well worth having a look at this work.

I was able to present my work with people with HIV and Mental Health issues. I explored the term complex and how the use may be inhibitive to social inclusion. Health services can often present as complex to clients and may be difficult to negotiate when a person has both cognitive and mental health issues. In the area of HIV the definition differs between hospital and community and also differs between the medical profession and other professions. Using a presentation highlighting a client using our service the terms ‘complex needs’ and ‘client’ were questioned and the complexity of health services identified. With the complexity of health services removed the complex needs of the client were no longer evident.

The closing panel provided attendees with the chance to listen to experts break down the structural and systemic barriers to achieving better outcomes for people with complex needs. Dr Ian Webster spoke about the work of the National Mental Health Commission. I had the opportunity ask Dr Webster about his views on
Mental Health SIG Update

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mental health promotion and prevention as a method of decreasing mental health problems and the resulting complex needs and asked that the Mental Health Commission raises these issues within the report card. Dr Webster acknowledged the area is important but no commitment was given in regards to the Mental Health Commission.

It was good to see mental health heavily represented in presentations by both government and non-government agencies. Mental health and the social determinants of health were represented by agencies as a cause of complex needs and social exclusion. An area that was highlighted was the poor outcomes of marginalised women in comparison to men.

The conference highlighted the excellent work being done by people and services and also recognised the challenges faced when working to provide services and advocacy that encourages social inclusion and address complex needs. It was great to see this work recognised and celebrated in the public health field. Now it is up to us all to ensure that government at all levels: recognises the marginalised populations within Australia, supports the services working with these populations, and explores and implements policy that addresses the social determinants of health resulting in social inclusion and decreased rates of mental health.

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Richard Crane, Senior Manager Healthier Workplace WA

It has been a busy time in Western Australia with the launch last month of the Healthier Workplace WA, a joint Australian, State and Territory Government initiative under the National Partnership Agreement on Preventive Health. The project is being delivered in Western Australia by the Heart Foundation WA, in collaboration with the Cancer Council WA and the University of Western Australia. A free service designed to tackle health in all Western Australian workplaces, has been launched.

Held at the newly completed Perth Arena overlooking the construction works of the Perth Rail City Link project, the April launch drew over 200 business and health representatives from all over the state as well as a strong media presence eager to learn of the latest developments in workplace health. Local and interstate health professionals were invited to speak including University of Newcastle, NSW Professor Phil Morgan and University of WA Professor Fiona Bull.

They were joined by local sporting identity West Coast Eagles Football Club CEO Trevor Nisbett, Unions WA secretary Meredith Hammat, Heart Foundation and Healthier Workplace WA representatives Trevor Shilton and Richard Crane, and RAC executive Erica Haddon to raise awareness of the physical and financial benefits of promoting workplace health.

The packed house heard how long work days spent sitting, poor nutritional diet and smoking takes a financial and physical toll on WA businesses and their workers. Not only are Western Australian lives being lost and affected by chronic diseases including: heart disease, some cancers and diabetes because more people are overweight, obese and not active enough, business is suffering heavily due to productivity losses. According to estimates, a healthy worker can be up to three times more productive than an unhealthy worker and take an average of nine fewer sick days per year.

Research shows workplaces that don’t promote health and wellbeing are also more likely to lose talented staff in the next 12 months and could experience increased rates of injury, workers’ compensation claims, absenteeism and sick leave. Heart Foundation spokesman and Healthier Workplace WA chair Trevor Shilton described the new service as better all round and that it would be a win-win proposition for the worker, for business and for the community.

An interactive website, healthierworkplacewa.com.au, has been set up to help business identify specific health issues in the workplace as well as provide downloadable resources and advice. Of particular interest to employers is the online workplace health audit tool which provides health recommendations in a printable document.

Healthier Workplace WA will also offer support in the form of grants, events and training to support all WA business, no matter how big or small, to improve the health of workers and in turn business productivity. These resources will be a boon to small business in particular, given the time and cost pressures often associated with tackling workplace health issues.

In the meantime though, simple steps such as replacing unhealthy snacks with nutritious alternatives are a good start in helping workers become healthier. Little things such as replacing the cookie jar with a fruit bowl is a simple change workplaces can undertake to make their work environment healthier. A walking group during lunch time is another small step that businesses can take to build a healthier workplace.

If you would like further information about Healthier Workplace WA, please visit: healthierworkplacewa.com.au, Healthier Workplace WA (Facebook), @HealthierWA (Twitter), or call 1300 550 271.
How to Get Enough Winter Sun for Vitamin D

Craig Sinclair, Chair of Australia’s Public Health Committee and Director of the Cancer Prevention Division at Cancer Council Victoria

The sun’s ultraviolet (UV) radiation is the major cause of skin cancer and the best source of vitamin D; essential for strong bones and overall health. It is important to take a balanced UV approach to help with vitamin D levels while minimising the risk of skin cancer. Our bodies only store enough vitamin D to last between 30 and 60 days so some people who don’t get outside in the sun much during winter are at risk of having their vitamin D levels depleted over the colder months.

Sun exposure alone may not be a sufficient source of vitamin D for some sections of the population. Those most likely to be at risk of vitamin D deficiency include people with naturally very dark skin, individuals with little or no sun exposure including those that are housebound or institutionalised, those who wear concealing clothing for religious or cultural purposes, breastfed babies whose mothers are vitamin D-deficient and people with conditions or medications affecting vitamin D metabolism.

Low levels of vitamin D may have no obvious symptoms but without treatment, can have significant health effects. Vitamin D is crucial for bone and muscle development and in the prevention of osteoporosis. Low vitamin D and deficiency also causes bone and muscle pain, poor bone mineralisation (softer bones) leading to rickets (bone deformity) in children and osteomalacia in adults. There have been links with an increased risk of bowel cancer, heart disease, infections and auto-immune diseases, although more research is needed for any conclusive evidence to be derived.

During summer, in the southern parts of Australia and all year round in the north, most of us need only a few minutes a day of mid-morning or mid-afternoon sun exposure to the face, arms and hands (or equivalent area) to help with vitamin D levels. Be extra cautious in the middle of the day when UV levels are most intense. People with naturally very dark skin may need 3-6 times this amount.

Regular use of sunscreen does not greatly decrease vitamin D levels over time. When sunscreen is tested in lab conditions it has been shown to decrease vitamin D production, however regular use in real life has been shown to have little effect on vitamin D levels. This is probably because people who use more sunscreen spend more time in the sun, so naturally will have higher vitamin D levels and most people apply far less sunscreen than is recommended by manufacturers.

During winter, in the southern parts of Australia where UV radiation levels are below 3 all day, most of us need about 2-3 hours of midday winter sun exposure to the face, arms and hands (or equivalent area) spread over each week. The more skin you have exposed to the sun, the more vitamin D you’ll make, so roll up those sleeves. Keep yourself warm by walking fast or jogging. Daily exercise will assist your body with production of vitamin D. Sun protection is not required unless near highly reflective surfaces such as snow, outside for extended periods or when the UV reaches 3 and above.

If you are worried that you do not get the recommended dose of sunshine during winter, visit your GP. Levels can be tested with a simple blood test and low levels can be treated with supplements.

Track your sun exposure for vitamin D using the free SunSmart app. Find out more at sunsmart.com.au
Behind the Wire - Assessing Cannabis Withdrawal Upon Entry in Custody

Michelle Coleman, James Cook University

As a recent graduate of Laurier Brantford’s Criminology program, I have been privileged to obtain practical experience in my field of interest in Far North Queensland, Australia. I have been involved in a project entitled Cannabis Withdrawal among Indigenous Inmates (NHMRC#1020514 CI: Alan Clough). The project involves engaging with Indigenous (Aboriginal and/or Torres Strait Islander) males and females, aged 18-40 who are in police custody or newly incarcerated in prison. Recruitment begins at the local Watch House, which is a busy and hectic location. After identifying those who meet initial selection criteria, we meet each individual behind thick glass of an interview room to conduct an eligibility assessment. Should the person be recruited, we then conduct eight assessments over a 28 day period to measure cannabis use, psychological stress, withdrawal symptoms and biological markers of stress. Each assessment is between 15 minutes to one hour.

Working within a correctional facility comes with obstacles that you wouldn’t normally encounter in a workplace, such as being conscious of personal space, safety regimes, appearance and dress. The prison is a 2.5 hour round trip and once there, it is central to realize where you are working and whom you are working with. Once through the rigorous security clearance, there are other factors to be constantly aware of: scanning the room before entering, placement of self and remaining alert to limit risk. On another note, attire is ultimately conservative to ensure that the center of attention remains on the research. Dressing in loose fitting clothes, free of cosmetics/any perfumes, minimal jewelry and sensible shoes are essential to conducting professional business amongst the inmates. This study also required collection of saliva and thus biosafety was an important consideration due to working with bodily fluids.

Custody settings run according to strict schedules, based around routines and procedures. It is imperative to fit within these restrictions to succeed in aspects of your research. These settings can be a stressful atmosphere for everyone. Workloads are high, hours are long, the environment can be unpredictable and officers deal with people who are highly emotive, can have unknown conditions e.g. mental health problems and could be under the influence of various substances. There are a number of services entering the facility and unsurprisingly, data collection for research is not the highest priority. For that reason, it is prevalent that you are friendly and easygoing, and helpful with the staff to make their job flow trouble-free. Patience is paramount, so a demanding researcher looking for participants will likely take a back seat opposed to someone who is understanding and considerate of the rules and procedures.

Although I have an academic/theoretical background in this field, in order to participate in the data collection of the Cannabis Withdrawal Project, I have had to undergo months of training and courses which include; a ‘Custodial Awareness Program’ (critical because it allows for unescorted access within the prison), ‘Cultural Awareness’ (to ensure cultural appropriateness) and a ‘Biosecurity Course’ offered by James Cook University for handling biomedical samples or specimens. Practical training also came from visiting the Indigenous communities among Cape York on a volunteer basis on other projects undertaken by James Cook University. On the job training under supervision by the Senior Research Officer occurred until we both were comfortable that I had developed the necessary research skills. The training was undertaken during the testing of the questionnaires for question placement, understanding, cultural appropriateness and feasibility. It was important to get the views of the prisoners through forming an inmate reference group who advised on necessary modifications before going ‘live’ with the study.

These courses and training benefitted me with the skills necessary to conduct cross-cultural research and particularly with building rapport and trust with Indigenous participants. Reflecting back on my time with the Cannabis Withdrawal Project, I am fortunate to have had the opportunity to work in these restricted environments. I have gained insight on what field I would like to pursue following my involvement with this study. My hope is to return to Canada at the end of the year and assess whether a similar project can be replicated with First Nations given similar endemic cannabis misuse rates and related problems.
In February 2013, the NHMRC released revised Infant Feeding Guidelines (IFG) and Australian Dietary Guidelines (ADG). This fourth version of the guidelines, provides information for people across the life-course (infants, children, adolescents, adults, older people, pregnant and breastfeeding women) on the types and amounts of foods, food groups and dietary patterns that promote health and wellbeing and prevent chronic diseases. The new guidelines have a much stronger focus on whole foods and food choice for good health and the prevention of chronic disease, which is important to note in a media and food environment that often promotes individual nutrients and added ingredients to processed foods. The 2013 guidelines supersede the 1999 Dietary Guidelines for Older Australians and 2003 issues of the Infant Feeding Guidelines, Dietary Guidelines for Children and Adolescents and Dietary Guidelines for Adults.

Since 1982, the guidelines have been a cornerstone of scientifically based nutrition advice for Australians and today remain a comprehensive, up to date, evidence based resource. The PHAA has commended the hard work and rigorous process by the NHMRC and the expert Committee they convened. The process included two public consultation processes on the ADG and one on the IFGs, with the PHAA providing submissions for all of these consultations.

The 2013 Dietary Guidelines integrate the revised Australian Guide to Healthy Eating (AGHE). This was the first time that the NHMRC revised both of these key nutrition tools together, a positive step as it reinforces key messaging and consistency. The Dietary Guidelines include five clear statements or guidelines (three of which have several sub points):

1. To achieve and maintain a healthy weight, be physically active and choose amounts of nutritious food and drinks to meet your energy requirements
2. Enjoy a wide variety of nutritious foods from these five food groups every day
3. Limit intake of foods containing saturated fat, added salt, added sugars and alcohol
4. Encourage, support and promote breastfeeding
5. Care for your food; prepare and store it safely.

The AGHE provides information on the amounts and kinds of foods we need to eat for health and wellbeing. A range of resources have been released that support use of the Australian Dietary Guidelines, these are available for download and/or order from www.eatforhealth.gov.au.

The 2013 IFG are targeted to health workers and aim to provide consistent advice to the general public about infant feeding as inconsistent advice from health professionals was one of the key issues identified by parents. The IFG include advice and recommendations on breastfeeding, supporting mothers and parents, introducing solids and preparing infant formula and provide a comprehensive evidence-based resource for all health workers. The 2013 IFGs recommend exclusive breastfeeding to around six months of age. Over 90% of mothers choose to initiate breastfeeding, but rates of exclusive breastfeeding at three and six months indicate a rapid decline and need for further work to achieve this recommendation.

Over the 3 – 4 years it has taken to revise the Australian Dietary Guidelines revision, the PHAA advocated on a number of issues. One of these was that sufficient capacity and funds be devoted to the development of resources that would support all Australians to interpret and apply the guidelines and that a sufficient and sustained dissemination strategy be developed, shared and evaluated. Whilst the resources and tools on the Eat for Health website are user friendly and practical, there appears to be little evidence that an adequate dissemination strategy has been developed or being implemented. Without a sustained dissemination and promotion campaign few people and organisations will be aware of the existence for these important resources supporting Australians health and wellbeing.

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The PHAA, has for some time, advocated for a much stronger focus in the ADGs on the environmental impact of the food supply and what food choices consumers can make to minimise this impact. Whilst the NHMRC acknowledged the need to consider the environmental impact of food “from paddock to plate”, environmental considerations have not integrated into the ADG. The recommendations that were made were limited, were fairly generic and relegated to an Appendix where their importance is likely to be largely overlooked. The PHAA acknowledges the complexity and limitations of evidence on food and the environment, but believes where sufficient evidence exists for the Australian context, these should have been integrated into the guidelines and AGHE. Issues like balancing fish consumption recommendations with sustainability of Australian fish stocks, limiting the consumption of bottled water, eating seasonal fruit and vegetables and reducing food waste could have been included.

Australia has been a world leader in its ongoing commitment to developing robust, evidence-based Dietary Guidelines. Since 1982 we have evolved, refined and improved our processes and subsequent guidelines in line with current evidence. In 2003, the NHMRC acknowledged that future dietary guidelines would probably have a greater emphasis on sustainability as “the problems caused by non-sustainable systems become more starkly obvious”. PHAA believes that this emphasis was not achieved in the 2013 ADGs, and strongly supports investment in filling the evidence gaps now. Australia could lead the world in releasing guidelines that take into account the food and environment interconnection, and allowing all Australians to continue to enjoy affordable food, that sustains good health, now and into the future.
Wow, attending the PHAA National Social Inclusion and Complex Needs Conference was an eye opener into the realm of public health, social inclusion and complex needs. As a student having only learnt in a classroom, along with the various volunteer work I have been involved with, this conference showcased the years of theory and hypothetical situations into real life successes. It was great to listen to a wide range of speakers, topic areas and effective initiatives, to tie together my University education and get a taste for the opportunities available after graduation.

The plenary 1 opening was such a great start to the conference, with the addresses by speakers including Michael Moore and The Hon Mark Butler MP being engaging, inspiring, and leaving me with butterflies. I was so excited to hear about all the successful collaborative efforts in service delivery around Australia and even more so to meet the people behind these achievements.

The key themes throughout the conference surrounded collaboration, partnerships and a whole-of-system approach, and although all speakers integrated these themes, there was one speaker that really stood out to me. Sue Murray, from Suicide Prevention Australia, discussed a framework for a collective impact approach. This resonated with me as Sue displayed an approach in which collaboration and partnerships can be successfully achieved. I saw this as a key tool in successful service delivery as I believe it can be applied to a wide range of public health issues.

I am extremely grateful to have received a scholarship to attend the PHAA Social Inclusion and Complex Needs Conference. I can't thank the NSW branch enough for providing this invaluable opportunity, as well as the PHAA, conference team, chairs, speakers, other scholarship winners and attendees for this memorable experience. I have not only advanced my knowledge, but also connected with a range of public health professionals, who I will hopefully be working alongside in the near future.

Hi! My name is Cath and I am currently in my fourth year studying nursing and paramedicine at Australian Catholic University. I just wanted to take this opportunity to thank the Primary Health Care Special Interest Group, who sponsored my attendance at the recent Public Health Association Australia National Social Inclusion and Complex Needs Conference in Canberra.

During my time on placement so far, I have witnessed some of the difficulties faced by those who experience mental health issues, compounded by alcohol and drug dependence. I found it really interesting to attend the conference, as it taught me about successful strategies and programs being conducted around the country to help people with complex needs. What really stood out to me, was listening to Dr. John Falzon identifying a key determinant for improving social equality. He said that listening to vulnerable populations is essential when we are working with them to achieve positive outcomes. Another highlight was a speech presented by Robert Tickner: the CEO of the Red Cross. He said that from little ideas, big things grow. He also explained that we need to continuously talk through tough issues, commit to a collaborative culture and form partnerships to implement change. I loved these messages! They were a reoccurring theme throughout the entire conference.

I hope to contribute to this movement by listening carefully to those I help in the future. I feel very privileged to have attended the conference and meet so many wonderful people! Thank you so much!
The School of Population Health is rated in the top five Australian universities for Public Health research and has a proven record of achievement in preventive, clinical and occupational (chronic diseases) epidemiology.

Advanced Epidemiology
30 September - 4 October 2013
Five-day intensive unit PUBH5759

Presented by Professors Jane Heyworth and D’Arcy Holman, this intensive five-day unit broadens and extends understanding of the methodological concepts underpinning the science of epidemiology. Guest lectures will be given by senior epidemiologists with particular expertise on the topics under discussion.

Background
The course will address the development of modern epidemiological thought and explore its supposed precepts through the lenses of history and critical philosophy. The evolution (and revolution) of epidemiologic ideas, from early concepts to paradigms of the ‘modern epidemiology’ movement of the 1970s and 1980s; and extension to present day will be explored.

The seminal contributions associated with names like Hume, Farr, Snow, Hill, Cornfield, Mantel, Haenzsel, Elandt-Johnson, Miettinen, Rothman, Morgenstern, Maclure, Suissa, Greenland and other groundbreakers and mythbusters of the field will be outlined on a canvas that depicts how the still-youthful and dynamic discipline of epidemiology has developed historically and continues to evolve today.

Building upon these theoretical concepts, the practical application of advanced modern epidemiological principles to current issues in epidemiology will also be presented, with particular emphasis on outcome and exposure assessment, selection bias, gene-environment interactions, causal diagrams and integration of data across studies.

This advanced-level course assumes familiarity with the basic epidemiologic lexicon and a level of understanding of principles and methods commensurate with successful completion of introductory to intermediate epidemiology units taught at the postgraduate level.

Who should do this unit?
Suited to current Masters level students or persons currently working or undertaking doctoral research in related areas, this unit is ideal for those who wish to deepen their understanding of epidemiology.

Further information
For further information please contact Professor Jane Heyworth jane.heyworth@uwa.edu.au

Enrolment and fees
For enrolment links, fees and other information, please visit sph.uwa.edu.au

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Smoking Cessation in Drug and Alcohol Centres

Dr Amanda Wilson, Department of Medicine and Public Health, University of Newcastle

More than 100,000 Australians access drug and alcohol treatment services each year. Some are there for addictions to illicit drugs such as heroin, cannabis, cocaine and amphetamines, and a substantial number seek treatment for alcohol dependency. But the number one drug of addiction in Australia, the most expensive and lethal drug of them all is tobacco. It is also a substance that creates the largest preventable burden of disease.

In Australia, overall smoking rates are falling. But most people giving up – or not starting at all – come from higher socio-economic groups, meaning that smoking is increasingly concentrated among the poorest and most disadvantaged groups in our population, where smoking rates remain high. These same high rates are found in people seeking treatment for drug and alcohol problems, where close to 100 per cent of this population smokes – a rate five times higher than the overall population.

The rising cost of tobacco, together with the substantial impact on their health, means that smoking comes at a high social and financial cost for the smokers themselves, and their families, as well as for the broader society. Non-smoking policies aimed at reducing second-hand smoke in public and private areas have also helped turn an already marginalised group into social pariahs.

Last year, behavioural health researcher Associate Professor Billie Bonevski from the University of Newcastle was awarded a four-year grant of $1 million from the National Health and Medical Research Council to conduct a national study looking at the best ways to reduce smoking in clients of drug and alcohol programs. The study team includes highly respected researchers from Australia, the UK and USA as well as a partnership with Cancer Council NSW.

"Despite the high number of smokers in these treatment centres, studies show they are rarely offered help to quit smoking," Associate Professor Bonevski said.

"Some of the biggest barriers in quitting come from the treatment centres themselves. Many of them don’t have smoke-free work places and high numbers of centre staff smoke, often bonding with clients over a cigarette. Staff generally believes their clients are not interested in quitting or that quitting with effect their addiction treatment.

"In fact, the opposite is true. A lot of these smokers do want to quit and with the right support, they can. Also, quitting smoking doesn’t affect treatment for other drugs and in some cases, such as alcohol treatment, has even been shown to improve the effectiveness of the treatment."

The Newcastle study is known officially as a "systems change" intervention, taking the form of a cluster randomised controlled trial. In practical terms, the project will target drug and alcohol services across Australia, both public and private sector. These services will be asked to change the way they address smoking when treating their clients, who will then be followed up by the researchers to see if these changes have had an impact on smoking rates among those who have taken part.

The participating drug and alcohol services will be asked to identify the smokers among their clients, and ask them if they are interested in quitting smoking. They will repeat this process at every visit. Clients who want to quit will be offered a range of supports including nicotine replacement therapy and counselling services like "Quit for Life".

Centre staff will be helped with quit smoking education and resources to support clients. A dedicated staff ‘champion’ will lead the project in each centre, with responsibility for motivating other staff on their team. Centres will also be asked to introduce non-smoking policies and provide quit programs to staff and clients.

If successful, this kind of program could be used in other settings with high rates of smoking such as prisons, mental health and social services. It could also be applied to other problematic health behaviours such as obesity and a lack of physical activity.

"Treatment guidelines here and overseas recommend that smokers with chemical dependence be offered help to quit," said Associate Professor Bonevski "This study looks at finding the best ways to do that."
Climate Change in the Pacific

Dianne Katscherian & Jeff Spickett, School of Public Health, WA

Pacific islands have the potential to be severely affected by sea level rise, a change in the frequency and intensity of tropical storms, increased temperatures and other predicted effects arising from climate change. These changes are already occurring and having impacts on the health and well-being of the people of these countries.

The Health Ministers of the region in recognition of the vulnerability of the citizens of their countries, committed to action on climate change and health. Individual countries with the support of the World Health Organisation (WHO) undertook to develop National Climate Change and Health Action Plans (NCCHAP).

The WHO Collaborating Centre for Environmental Health Impact Assessment at Curtin University was invited to assist the countries of Vanuatu, Solomon Islands and Nauru in the development of their NCCHAP. A Health Impact Assessment (HIA) framework was developed. Health Impact Assessment (HIA) is a formal process that considers potential health issues during the planning stages of proposal development. HIA's aim to identify and examine both the positive and negative health impacts of activities and provide decision makers with information about the manner in which the activity may affect the health of people.

It was decided that, for this project, a process would be developed using the HIA framework. With some modification, this framework provided for the prediction of potential impacts based on a single possible scenario of future climatic conditions and biophysical changes in these countries. The process used in this investigation is expected to form the basis for updates in the development of strategies for the mitigation and adaptation with respect to the health impacts of climate changes as more information becomes available on the predicted changes to climatic parameters. The key elements of this process include consideration of vulnerability, assessment of risk and planning for adaptation.

By way of context for this work some background on each of the three countries is as follows.

Vanuatu is an archipelago of approximately 80 islands with a land area of 12,335 square kilometres located south of the equator in the Western Pacific ocean between latitudes 12° and 23° South and 166° and 173° East. The predominantly Melanesian population of approximately 240,000 (234,023 in the 2009 Census) is growing at a rate of 2.3% per annum, and is expected to double by approximately 2030. The economy is largely driven by tourism (which accounts for approximately 40% of Gross Domestic Product, GDP) and primary industries (agriculture, fisheries and forestry which together account for roughly 15% of GDP). Vanuatu has the unusual distinction of belonging to the group of Least Developed Countries despite exceeding the threshold per-capita GDP for inclusion in this group; this distinction is due to the assessment of Vanuatu’s economy as being particularly vulnerable to natural disasters and other “exogenous shocks”.

The Solomon Islands is an archipelago of 997 islands lying just south of the equator between latitudes 5° and 12° South and longitudes 152° and 163° East, encompassing a total land area of 28,785 square kilometres. The estimated 2009 population was approximately 520,000, of whom approximately 95% are Melanesian, with the remainder of Polynesian (3%), Micronesian (1.2%) and other ethnic origins. The majority of the predominantly rural population depends on subsistence farming and fishing; the economy is driven largely by agriculture, forestry, fishing, manufacturing and services.

Nauru is a small, raised coral atoll of approximately 21 square km, situated some 42km south of the equator in the central Pacific. Its climate is tropical, with air and sea-surface temperatures remaining fairly...
Climate Change in the Pacific

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constant throughout the year: a “dry” season from May to October and “wet” season from November to April. The population of the island in 2011 was 9,376 with Indigenous Nauruans comprising approximately three-quarters of the population (the remainder comprised mostly of i-Kiribati, Tuvaluans, other Pacific Islanders and Chinese).

The process identified potential health impacts arising from the projected environmental changes, assessed the risks to the community from these and developed potential adaptation responses that could be used by the government and others in decision making. As many of the potential impacts to health are associated with the activities of other sectors such as water, energy, food, housing and so on, it was essential that a consultative collaborative approach was used. Representatives from the areas of biophysical environment, socio-economic sectors, infrastructure, environmental diseases and food were engaged in the 18 month long program.

An extensive range of impacts and relevant adaptation responses were identified. The process acknowledged that the health impacts to people where not new impacts, rather that climate change would add to the burden of disease already experienced by communities. For example, phosphate mining is an important activity in Nauru. In recent years, rainfall levels have been significantly reduced and with limited water availability, dust suppression is not as feasible. Inflammatory respiratory disease has increased and between 2007 and 2011, was one of the top three outpatient diagnoses at the hospital.

In addressing climate change, there is thus the potential to improve the current status of health of the people of these countries. The HIA framework used is adaptable to other circumstances and is available on the WHO Collaborating Centre’s website at: http://ehia.curtin.edu.au. For further information contact Prof Jeff Spickett at: J.Spickett@curtin.edu.au

Promoting Mental Health in Small to Medium Workplaces

Angela Martin, Business in Mind Chief Investigator, University of Tasmania

Owners and managers of small-to-medium businesses face many psychological and financial pressures, often without people or resources to turn to for support, or the knowledge and skills to effectively manage these pressures. Stress and poor mental health can have a negative impact on productivity and both personal and professional relationships. Large organisations and public service sectors typically have access to human resource support and employer sponsored psychological services, but smaller organisations and non-government organisations can struggle to find the time and money for similar services. Business in Mind is an innovative program developed by Dr Angela Martin and colleagues at the University of Tasmania which aims to improve the mental health and well-being of people working in a small-to-medium workplace setting. The Business in Mind research project has been set up to evaluate the effectiveness of these resources, and find out more about the types of psychological support needed in the small-medium business sector.

Key findings to date have revealed the sample of owner/managers participating in the evaluation study reported a high prevalence of high/very high psychological distress. However, follow up data, obtained three months after the participants had received their DVD and Resource Kit, showed significant pre-post improvements for psychological distress. There were also notable improvements in job satisfaction, work-life balance, satisfaction with life and a reduction in job tension and depression stigma. Qualitative data collected also showed that participants who completed follow up were generally very positive about the program and the outcomes they gained from it. Strengths of the program that were commonly identified related to its broad applicability to a range of industries and types of people, the powerful nature of the real case studies/stories of business owners, and the accessibility and practical nature of the information in the DVD manual. Further analyses will be completed as data collection continues.

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The Business in Mind program uses a free DVD and Resource Kit to show managers ways of approaching some of the stresses and challenges around running smaller businesses. The DVD features business owners talking about their own experiences of the stress in running a business, provides advice from experts in organisational and clinical psychology, and is designed to be both preventative of and responsive to current mental health issues. In addition to information about managing mental health issues in the workplace, the DVD and accompanying Resource Kit provide information about maintaining a positive work-life balance by identifying personal strengths and improving time management, and promoting business growth by planning ahead and formulating personal and professional development strategies. To find out more, visit www.businessinmind.utas.edu.au. You can also contact the project team via email at business.in.mind@utas.edu.au or phone (03) 6226 2713. You may also contact the Chief Investigator, Dr Angela Martin, via email, Angela.Martin@utas.edu.au.

A Consumer Conundrum Caused by a Cornucopia of Screening Tests

Mary Osborn, PHAA Member

I believe I am a perfectly healthy person. However over the last six months I have begun to have doubts. This uncertainty has been generated by a cornucopia of invitations to take part screening programs such as mammography, bone density testing (Global Longitudinal Study of Osteoporosis in Women (GLOW) and funded by Sanofi http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690851/), cervical screening, checks for skin cancer, bowel cancer screening and most recently a personalised letter from "Screen For Life". This must be screening in action because you have to be healthy to be screened. I've had angry responses from people who tell me about someone they know who if they hadn't been screened would have been dead. When you ask if they had regular screening the answer is often no and they were picked up on the basis of their symptoms. That is not screening.

My concern about most of the invitations I receive is that there are often no explanations about the ethics of screening and no explanation about the limitations and potential harms of screening as an intervention. I strongly believe in the ethical principle of consumer autonomy as part of health care. This means that consumers must be informed and given the understanding that screening may not increase life expectancy and may be associated with adverse effects. If provided with this information most consumers will decline and those who choose to be screened are making decisions on the basis of their preferences. This is a strategy that can be agreed on by the individual doctor, their professional organisations, consumers and advocacy groups. Most of what is in the invitations was about fear mongering or as Ray Moynihan describes as disease mongering. Disease mongering expands the "disease" to "health" thereby increasing the market for products positioned as "healing and preventing the worst".

I would like to use my most recent invitation from "Screen for Life" as an example of what concerns me. The letter does not provide any disclosure about financial arrangements for the screening program or about how the organisation receives your details. If you call "Screen for Life" they describe themselves as a "preventive health screening agency" and I was informed that my details were obtained from Acxiom (http://www.acxiom.com.au/about_us/Pages/About-Acxiom.aspx). Acxiom could not reveal where they got my information from but said they take a "proactive approach in protecting consumer privacy, with policies and procedures that comply with the highest privacy standards". "Screen For Life" present what may look like a very compelling case to pay up and

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make an appointment for a clinic near you by using brightly coloured pictures of diseased organs and suggesting that you can save $101 “by acting now.”

The information provided in the letter is not balanced, that is it does not provide me with the pros and cons of stroke screening. Instead it informs me about the dangers for people my age who are likely to have a stroke and how “Screen For Life” can identify plaque build up in my arteries. In small print “Screen For Life” provide a list of references. The claim that atrial fibrillation can increase my risk of stroke up to five times is attributed to the Framington Heart Study. What “Screen For Life” does not tell you is that there are no single risk factors or clinically useful risk models that incorporate multiple factors that are able to clearly discriminate against people who have clinically important arterial disease from people who do not. The US Preventive Task Force in a study suggest that actual stroke reduction from screening asymptomatic patients and treatment is unknown. The benefits are limited by a low overall prevalence of treatable disease in the general asymptomatic population and harms from treatment (WOLFF, T., GUIRGUIS-BLAKE, J., MILLER, T., GILLESPIE, M. & HARRIS, R. 2007. Screening for Carotid Artery Stenosis: An Update of the Evidence for the U.S. Preventive Services Task Force. Annals of Internal Medicine, 147, 860-870).

Screening tests can become a hook to hang all our health fears on. What we need is good information to help us make good choices. What would happen if consumers gave up screening? What a conundrum.

Judith Lissing, Mindfulness Trainer and Life-balance Coach, Faculty of Medicine at UNSW

Although ‘mindfulness’ is an ancient concept, over the last 30 years Western psychology has begun to recognise the many benefits of mindfulness training, which are now empirically supported.

‘Mindfulness’ can be defined in a variety of different ways. Jon Kabat-Zinn describes mindfulness as "paying attention in a particular way: on purpose, in the present moment, and without judgment". Mindfulness is a process of awareness. It involves paying attention to experience in the moment as opposed to being caught up in thoughts. Our thoughts can confuse us. We create our own narrative about things that happen and replay these stories until they cloud our reality. Mindfulness also asks us to relinquish judgment about what is happening because whatever the judgment, it doesn’t change the reality of the present moment. Instead we embrace an attitude of openness and curiosity. Even if our experience in the moment is difficult, painful, or unpleasant, we can be open to and curious about it instead of running from or fighting it. If the experience is pleasant, mindful presence allows us to savour it fully.

Rick Hanson defines mindfulness as "exercising attentional control". Mindfulness involves flexibility of attention: the ability to consciously direct, broaden, or focus attention on different aspects of experience. In a society that values and encourages doing many things at once, it’s not surprising that so many people have trouble focusing on only one thing. We label children with focus-problems 'Attention Deficit', whereas in adults we call it 'multi-tasking'. However research shows that when we divide our attention between several tasks we don’t do any of them as well as we could.

The relevance to mindfulness in the workplace is clear. In the current culture of workplace safety, the concept of Zero Harm at work is becoming popular. Zero Harm means sustaining a work environment that supports the health and safety of employees. It’s usually quoted in the context of physical safety, but mental and emotional health are equally important.

Physical and mental/emotional health are connected. Sustained mental stress can lead to illness, including cardiovascular disease and cancer, just as surely as incorrectly lifting heavy objects can lead to back injury.

Maximising Potential at Work With Mindfulness Training

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Physical and mental/emotional health are connected. Sustained mental stress can lead to illness, including cardiovascular disease and cancer, just as surely as incorrectly lifting heavy objects can lead to back injury.
The workplace environment with all its demands to perform efficiently and effectively can be stressful. Pressure can arise from deadlines, performance standards, long hours, juggling personal commitments, financial issues, misunderstandings or personality incompatibility with managers and colleagues.

Mindfulness at work can lower stress levels and lead to a more positive working environment. It takes us out of our thoughts and our personal narratives into what is present and real. Being present allows one to choose an appropriate response to a situation rather than impulsively reacting or judging. It also encourages a positive attitude because most of our negativity comes from our impulsive reactions and judgments. Studies show that happy, positive employees stay longer in their jobs and take fewer sick days than unhappy employees, so there are also clear consequences for workplace productivity.

Mindfulness also helps productivity by enhancing capacity to concentrate. Magnetic resonance imaging studies show increased blood flow to the parts of the brain concerned with attention and focus in brains of meditators, compared with non-meditators. Other studies have shown enhancement of other parts of the brain including the corpus colosum (the nerves that support communication between the brain hemispheres), the insula (concerned with self-awareness and social emotions, such as empathy) and the pre-frontal cortex (implicated in planning complex cognitive behaviour). Many of these changes are evident after only two weeks of regular meditation.

When looking for a mindfulness program to suit your workplace you might consider the following:

- Does the program help participants understand how stress can lead to overwhelm, anxiety and depression, and why we may react without thought when stress gets too high? Can the program provide tools to build mental and emotional strength and resilience? Much like weights may provide the formal tool for building physical strength, mindfulness can provide the foundation for building emotional strength.

- Does the program address the physical stress of spending long hours sitting at a desk, which may add to the potential for work-place injury? Simple, mindful postures and movements can be performed in a chair or on the floor, reducing physical tension and focusing the mind.

- How does the program address the negative mindset that can be self-perpetuating as stress increases? Techniques and tools for developing and maintaining a positive attitude are particularly beneficial for organisations undergoing change.

- Are your teams cohesive and supportive, or could you use a program that helps teams identify their strengths, rather than focusing on their weaknesses? A focus on weaknesses can be disempowering and may encourage a negative mindset. Spotting and naming strengths has been shown to build team cohesion and increase productivity.

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