



## **Exercise & Sports Science Australia submission to the Senate Standing Committees on Community Affairs**

# **Accessibility and quality of mental health services in rural and remote Australia**

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Thank you for the opportunity to submit feedback to help inform the Senate inquiry into *the accessibility and quality of mental health services in rural and remote Australia*.

Exercise & Sports Science Australia (ESSA) is a professional association representing over 6,000 members, including university qualified accredited exercise scientists, accredited sports scientists and accredited exercise physiologists (AEPs).

People with severe mental illness live between 10-32 years less than the general population. A major contributing factor to the lower life expectancy is poor physical health and higher rates of chronic illnesses, such as cardiovascular disease and diabetes. Low levels of physical activity is a key modifiable risk factor contributing to the increased burden of poor physical health in this population. However, despite low levels of physical activity being a major risk factor for ill-health, approximately 50% of Australians' are insufficiently active.

People living in rural areas are often considered to be more physically active than urban residents, due to a persistent perception that a large proportion of rural residents work in labour-intensive occupations such as agriculture, forestry and fishing; however, those living in rural areas are **1.16 times more likely to be sedentary**.

Too often the blame for inactivity is levelled at the individual. This is unfair.

The [ESSA for an Active Nation](#) campaign is calling on the Australian Government, our stakeholders and the community to commit to building a nation where everyone is supported to be active. The main goals of the campaign are to:

1. promote Access, Fairness and Quality in the development of health policies on exercise services provided by accredited exercise physiologists and exercise scientists
2. propose priority policies that cements physical activity and exercise services as essential in health
3. seek support from the Federal Government to commit more resources in the 2019 Federal Budget to ensure all Australians can access exercise services provided by accredited exercise physiologists and exercise scientists
4. seek support from key stakeholders in the health and sport sectors to facilitate and create opportunities for consumers to better access services and programs that will increase their physical activity level

## 1. The nature of the mental health workforce: The role of accredited exercise physiologists within the treatment of mental disorders

AEPs specialise in clinical exercise prescription for the management of chronic conditions. AEPs are allied health professionals with the highest level of training for prescribing exercise to individuals. AEPs hold, at a minimum, a 4-year bachelor degree that meets the Australian Qualification Framework (AQF) Level 7 requirements. This equips AEPs with the knowledge, skills and competencies to design, deliver and evaluate safe and effective exercise interventions for people who have acute, sub-acute or chronic medical conditions, injuries and disabilities. These interventions include health and physical activity education, advice and support, and lifestyle modification with a strong focus on achieving behavioural change.

There is an increasing body of evidence regarding the efficacy of exercise interventions for both physical and mental health outcomes of people experiencing mental illness [1-6]. Mental health is an area of growing prominence for AEP practice.

### Exercise for better mental health

The importance of including AEP interventions for improving both physical and mental health outcomes, for people living with a mental illness, has been well-established in clinical research [5]:

#### Physical health outcomes

- Weight management (weight loss, maintenance and prevention of weight gain)[7-9]
- Reduce the risk of chronic disease (i.e. cardiovascular disease, metabolic syndrome & T2DM)[10-14]
- Improved psychosocial function i.e. activities of daily living, social and occupational functioning[15-19]
- Contribute to longer life expectancy through improvements in cardiovascular fitness and reduction in cardio-metabolic risk [20, 21].

#### Mental health outcomes

- Decrease symptoms of depression, anxiety, stress and schizophrenia[2, 3, 22-24]
- Decrease social isolation [25]
- Improve sleep quality [26, 27]
- Increase engagement with treatment and service utilisation [7, 11]
- Reduce cravings and withdrawal in substance use disorders (SUD) and alcohol addiction[28-30]

- Increase self-esteem [31]
- Improve quality of life [3, 32, 33]

### **The role of AEP led interventions within mental health services**

With the permission from the authors, the following information has been extracted from the [ESSA consensus statement on the role of accredited exercise physiologists within the treatment of mental disorders](#) [5].

- Design and implement evidence-based physical activity interventions to improve the physical health profile and prevent/manage the development of metabolic and cardiovascular disease [5].
- Work as part of a multidisciplinary team to conduct and promote regular physical health screening and metabolic monitoring (body weight, body mass index (BMI), waist circumference, blood glucose levels and blood pressure) as part of standard care and in line with treatment guidelines.
- Provide individual and group education sessions, outlining the benefits of physical activity for people experiencing mental illness.
- Consider clinical outcomes, risk factors and comorbidities such as cardiometabolic health, aerobic fitness, strength, movement capacity, and other health parameters (e.g. medication side-effects, sleep, fatigue and/or pain) that will inform the appropriateness and specificity of exercise interventions.
- Play a key role in the prevention/management of psychotropic-induced weight gain by increasing physical activity levels, reducing sedentary behaviour [7] and providing basic healthy eating advice.
- Contribute to the mental health team through a client-centred approach incorporating recovery and strength-based models to achieve client-specific health related goals. Incorporate health coaching techniques such as motivational interviewing, physical activity education sessions (individual or group-based) regarding the benefits of physical activity, and goal-setting strategies to encourage effective and sustainable behaviour change for people with mental illness [34]. Using such strategies will aid in empowering independent physical activity/ exercise participation.
- Promote ‘Healthy Active Lives’ for people experiencing mental illness, to achieve the physical activity targets outlined in the HeAL declaration[35], developed by an international working group comprising clinicians, researchers and consumers, which was endorsed in 2014 by Exercise & Sports Science Australia (more information at <http://www.iphys.org.au/>).
- Work collaboratively with mental health clinicians and other health professionals involved in the multidisciplinary team to provide a holistic and integrated approach to care. This would meet the International Organization of Physical Therapy in Mental Health (IOPTMH) call for ‘shared responsibility’ of health

care providers, general practitioners, psychiatrists, policy makers and society as a whole to promote healthy and active lifestyles [20].

- Facilitate linkages with general practitioners (GPs), other allied health professionals (e.g. dietitians, occupational therapists and social workers), community gyms and sports teams that can assist with a multidisciplinary approach to better health management.
- Assist in reducing the stigma and minimizing barriers for community-based clients utilising mental health services. Exercise is a normalised activity, particularly for young people, and therefore can act as a facilitator ensuring greater engagement with mental health services [11, 36, 37].

### **Workforce distribution**

Approximately 20% of the AEP workforce provide services in rural and remote communities [38]. The inclusion of AEPs as part of the multidisciplinary mental health team will lead to improved physical and mental health outcomes for people with mental illness [5, 39] in rural and remote Australia.

## 2. Opportunities that technology presents for improved service delivery

Clinical depression is the most common mental condition treated by AEPs [39]. There are a large number of meta-analyses demonstrating that exercise is highly effective and has strong anti-depressive and anxiolytic benefits for both the general population and those living with mental illness [3, 6, 40-42]. Also, no negative side effects attributed to exercise interventions have thus far been reported, as opposed to antidepressant medication [43]. Despite the growing evidence supporting exercise interventions within targeted mental health settings, AEPs remain an underutilised resource [39] due to a number of systemic barriers to accessing AEP services.

It is widely acknowledged that Australians who live in rural and remote areas experience poorer health than those who live in capital cities or major towns, largely attributed to the disparity in geographical distribution and access of health services [44]. For example, there is a forty-fold difference between Medicare Benefits Schedule (MBS)-funded utilisation of AHP services in metropolitan areas versus rural areas.

Telehealth provides people living in rural and remote areas access to timelier health care via remote consultations with health care providers. Access to exercise physiology services, via telehealth video consultations, have been shown to be both cost-effective and efficacious in increasing health outcomes through addressing physical inactivity and the associated chronic disease burden [45, 46].

Telehealth consultations are currently limited to specialists and selected medical and healthcare professionals, imposing barriers for patient access to the specialised input of AEPs. Expanding Telehealth MBS items to include AEPs will extend the reach of mental health services into rural and more remote areas, addressing inequality in health care access, patient compliance and subsequent adverse health outcomes in this population and enhance the prevention, early detection and treatment of chronic diseases in Aboriginal and Torres Strait Islander people.

## References

1. Rosenbaum, S., et al., *Physical activity interventions: an essential component in recovery from mental illness*. Br J Sports Med, 2015. **49**(24): p. 1544-5.
2. Stanton, R. and P. Reaburn, *Exercise and the treatment of depression: a review of the exercise program variables*. J Sci Med Sport, 2014. **17**(2): p. 177-82.
3. Rosenbaum, S., et al., *Physical activity interventions for people with mental illness: a systematic review and meta-analysis*. J Clin Psychiatry, 2014. **75**(9): p. 964-74.
4. Stanton, R. and B. Happell, *A systematic review of the aerobic exercise program variables for people with schizophrenia*. Curr Sports Med Rep, 2014. **13**(4): p. 260-6.
5. Lederman, O., et al., *Consensus statement on the role of Accredited Exercise Physiologists within the treatment of mental disorders: a guide for mental health professionals*. Australas Psychiatry, 2016. **24**(4): p. 347-51.
6. Rebar, A.L., et al., *A meta-meta-analysis of the effect of physical activity on depression and anxiety in non-clinical adult populations*. Health Psychol Rev, 2015. **9**(3): p. 366-78.
7. Curtis, J., et al., *Evaluating an individualized lifestyle and life skills intervention to prevent antipsychotic-induced weight gain in first-episode psychosis*. Early Interv Psychiatry, 2016. **10**(3): p. 267-76.
8. Ward, M.C., D.T. White, and B.G. Druss, *A meta-review of lifestyle interventions for cardiovascular risk factors in the general medical population: lessons for individuals with serious mental illness*. J Clin Psychiatry, 2015. **76**(4): p. e477-86.
9. Bruins, J., et al., *The effects of lifestyle interventions on (long-term) weight management, cardiometabolic risk and depressive symptoms in people with psychotic disorders: a meta-analysis*. PLoS One, 2014. **9**(12): p. e112276.
10. Vancampfort, D., et al., *Risk of metabolic syndrome and its components in people with schizophrenia and related psychotic disorders, bipolar disorder and major depressive disorder: a systematic review and meta-analysis*. World Psychiatry, 2015. **14**(3): p. 339-347.
11. Vancampfort, D., et al., *Promotion of cardiorespiratory fitness in schizophrenia: a clinical overview and meta-analysis*. Acta Psychiatr Scand, 2015. **132**(2): p. 131-43.
12. Bartels, S.J., et al., *Long-term outcomes of a randomized trial of integrated skills training and preventive healthcare for older adults with serious mental illness*. Am J Geriatr Psychiatry, 2014. **22**(11): p. 1251-61.
13. Vancampfort, D., et al., *Associations between sedentary behaviour and metabolic parameters in patients with schizophrenia*. Psychiatry Res, 2012. **200**(2-3): p. 73-8.
14. Vancampfort, D., et al., *Associations between metabolic and aerobic fitness parameters in patients with schizophrenia*. J Nerv Ment Dis, 2015. **203**(1): p. 23-7.

15. Rosenbaum, S., et al., *Aerobic exercise capacity: an important correlate of psychosocial function in first episode psychosis*. Acta Psychiatr Scand, 2015. **131**(3): p. 234.
16. Vancampfort, D., et al., *The functional exercise capacity in patients with bipolar disorder versus healthy controls: A pilot study*. Psychiatry Res, 2015. **229**(1-2): p. 194-9.
17. Vancampfort, D., et al., *Relationships between obesity, functional exercise capacity, physical activity participation and physical self-perception in people with schizophrenia*. Acta Psychiatr Scand, 2011. **123**(6): p. 423-30.
18. Vancampfort, D., et al., *The functional exercise capacity is correlated with global functioning in patients with schizophrenia*. Acta Psychiatr Scand, 2012. **125**(5): p. 382-7.
19. Vancampfort, D., et al., *Aerobic capacity is associated with global functioning in people with schizophrenia*. J Ment Health, 2015. **24**(4): p. 214-8.
20. Vancampfort, D., et al., *International Organization of Physical Therapy in Mental Health consensus on physical activity within multidisciplinary rehabilitation programmes for minimising cardio-metabolic risk in patients with schizophrenia*. Disabil Rehabil, 2012. **34**(1): p. 1-12.
21. Naci, H. and J.P.A. Ioannidis, *Comparative effectiveness of exercise and drug interventions on mortality outcomes: metaepidemiological study*. BMJ : British Medical Journal, 2013. **347**.
22. Firth, J., et al., *A systematic review and meta-analysis of exercise interventions in schizophrenia patients*. Psychol Med, 2015. **45**(7): p. 1343-61.
23. Stanton, R., B. Happell, and P. Reaburn, *The mental health benefits of regular physical activity, and its role in preventing future depressive illness*. Vol. 4. 2014. 45.
24. Stanton, R. and B. Happell, *Exercise for mental illness: a systematic review of inpatient studies*. Int J Ment Health Nurs, 2014. **23**(3): p. 232-42.
25. Richardson, C.R., et al., *Integrating physical activity into mental health services for persons with serious mental illness*. Psychiatr Serv, 2005. **56**(3): p. 324-31.
26. Youngstedt, S.D., *Effects of exercise on sleep*. Clin Sports Med, 2005. **24**(2): p. 355-65, xi.
27. Rethorst, C., P. Sunderajan, and T. Greer, *Does exercise improve self-reported sleep quality in non-remitted major depressive disorder?* Psychol Med, 2013. **43**: p. 699-709.
28. Wang, D., et al., *Impact of physical exercise on substance use disorders: a meta-analysis*. PLoS One, 2014. **9**(10): p. e110728.
29. Giesen, E.S., H. Deimel, and W. Bloch, *Clinical exercise interventions in alcohol use disorders: a systematic review*. J Subst Abuse Treat, 2015. **52**: p. 1-9.
30. Glass, T.W. and C.G. Maher, *Physical activity reduces cigarette cravings*. British Journal of Sports Medicine, 2014. **48**(16): p. 1263-1264.
31. Krogh, J., et al., *The effect of exercise in clinically depressed adults: systematic review and meta-analysis of randomized controlled trials*. J Clin Psychiatry, 2011. **72**(4): p. 529-38.
32. Vancampfort, D., et al., *Health-related quality of life and aerobic fitness in people with schizophrenia*. Int J Ment Health Nurs, 2015. **24**(5): p. 394-402.



33. Schuch, F.B., et al., *Exercise and severe major depression: effect on symptom severity and quality of life at discharge in an inpatient cohort*. J Psychiatr Res, 2015. **61**: p. 25-32.
34. Beebe, L.H., et al., *Effect of a motivational group intervention upon exercise self efficacy and outcome expectations for exercise in Schizophrenia Spectrum Disorders (SSDs)*. J Am Psychiatr Nurses Assoc, 2010. **16**(2): p. 105-13.
35. Shiers, D. and J. Curtis, *Cardiometabolic health in young people with psychosis*. The Lancet Psychiatry, 2014. **1**(7): p. 492-494.
36. Curtis, J., A. Watkins, and S. Rosenbaum, *Keeping the body in mind: an individualised lifestyle and lift skills intervention to prevent antipsychotic-induced weigh gain in first episode psychosis*. Early Interv Psychiatry, 2015.
37. Carless, D. and K. Douglas, *Narrative, identity and mental health: How men with serious mental illness re-story their lives through sport and exercise*. Vol. 9. 2008. 576-594.
38. Hetherington, S. *2015 Workforce Survey - Final report*. 2015 15 August 2016]; Available from: <https://www.essa.org.au/wp-content/uploads/2015/06/Workforce-report-2015.pdf>.
39. Stanton, R., *Accredited Exercise Physiologists and the Treatment of People with Mental Illnesses*. Vol. 2. 2013. 5-9.
40. Jayakody, K., S. Gunadasa, and C. Hosker, *Exercise for anxiety disorders: systematic review*. Br J Sports Med, 2014. **48**(3): p. 187-96.
41. Cooney, G.M., et al., *Exercise for depression*. Cochrane Database Syst Rev, 2013. **9**(9): p. CD004366.
42. Pitkälää, K., et al., *Efficacy of physical exercise intervention on mobility and physical functioning in older people with dementia: A systematic review*. Experimental Gerontology, 2013. **48**(1): p. 85-93.
43. Josefsson, T., M. Lindwall, and T. Archer, *Physical exercise intervention in depressive disorders: meta-analysis and systematic review*. Scand J Med Sci Sports, 2014. **24**(2): p. 259-72.
44. Armstrong, B.K., et al., *Challenges in health and health care for Australia*. Med J Aust, 2007. **187**(9): p. 485-9.
45. James, E.L., et al., *Referral for Expert Physical Activity Counseling: A Pragmatic RCT*. Am J Prev Med, 2017. **53**(4): p. 490-499.
46. Ewald, B., et al., *Physical activity coaching by Australian Exercise Physiologists is cost effective for patients referred from general practice*. Aust N Z J Public Health, 2018. **42**(1): p. 12-15.