Authenticity starts
in the heart.

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EDITORS' FOREWORD

We hope you enjoy reading these papers from the 26th annual TheMHS Conference held in Auckland, New Zealand. The papers represent a wide range of mental health topics and a broad group of people involved in mental health services. Represented in these proceedings are service providers, consumers, carers (families), researchers, educators and managers.

All papers submitted to the Editors of this Book of Proceedings by conference presenters are read by two independent reviewers. Papers are reviewed on the criteria of innovation, clarity, relevance to mental health services, coherence of the topic, and evidence. The editors have again this year, decided to include a section of highly recommended papers. These are the papers rated highest by the reviewers, against the five criteria.

HOW TO REFERENCE THIS BOOK

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TheMHS Annual Mental Health Services Conference was held at The Langham Auckland New Zealand in August 2016. There were approximately 900 people attending and approximately 250 papers and workshops were presented by people from Australia, New Zealand and a number of other countries.

EDITORS

Maria Cassaniti, Sadie Robertson, Lynne Dunbar, Fiona Orr, Michelle Everett, Liz Prowse, John Farhall, Chris Lloyd, Deb Christensen

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CO-DESIGN AND CREATIVE DEVELOPMENT OF THE OPTIMAL HEALTH PROGRAM

Marco De Ieso, NSW, Gaye Moore, Helen Wilding, David Castle,[1] VIC

ABSTRACT
The Optimal Health Program was originally created to meet the needs of people with a severe mental illness, but was subsequently expanded to include the general community with a focus on wellbeing rather than illness. In 2012 the program was redesigned in collaboration with key stakeholders including consumer and educator perspectives. The framework for the redesign included 5 important elements: (1) Collaborative Therapy principles, (2) a psycho-educational format, (3) integrity of concepts, (4) enhancing engagement and (5) genuine collaboration between people with a broad range of experiences including lived experience of mental health and recovery. The redesign used elements of co-design. We took a creative and critical approach to reviewing: (1) program materials, (2) practitioner training programs, (3) e-health options, (4) promotion and marketing strategies (5) capacity building for practitioners and participants alike and (6) the diverse applications of the program. The development and redesign of the Optimal Health Program will be ongoing into the future.

THE TRANSFORMATIONAL PROCESS OF REVISING THE OPTIMAL HEALTH PROGRAM (OHP)

Overview of OHP

OHP is a collaborative salutogenic approach (wellbeing and non-pathogenic holistic focus on the individual) to manage symptoms and produce designated levels of wellbeing determined by the participant. It draws upon many evidence based practices that sit within Collaborative Therapy, Positive Psychology and wellbeing. It also draws upon outcome informed evidence where the participant takes ownership for their own wellbeing processes, planning and interventions. OHP is therefore a framework of engagement with the content being individualised by participants. This approach requires the practitioner to create a reciprocal learning environment where relational expertise for both roles is honoured.

Revising OHP

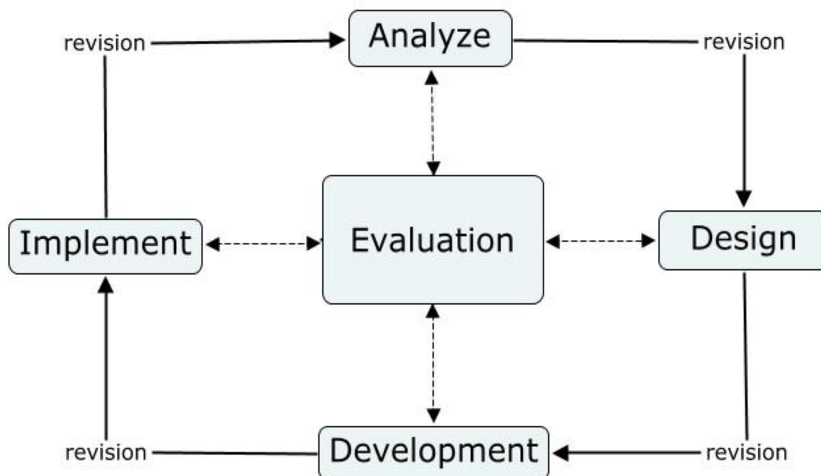
The challenge of revising OHP was the same as the core of OHP's purpose: achieve legitimate transformational engagement. It required revisiting the fundamentals of instructional design models and theories to evaluate OHP from the perspective of the end user and the practitioner, including the implications for training practitioners and practice implementation. A further challenge of revising and updating any practice or program is to ensure fidelity is maintained to the evidence that informs the model.

> *“instructional design is intended to be an iterative process of planning outcomes, selecting effective strategies for teaching and learning, choosing relevant technologies, identifying educational media and measuring performance”* [Branch & Kopcha, 2014).

The instructional model employed in revising the core elements of OHP is ADDIE: analyse, design, develop, implement and evaluate. Figure 1 is a visual representation of the ADDIE model of design.

[1] Corresponding author: Gaye Moore, Program Manager, Frameworks for Health, St Vincent’s Hospital Melbourne, PO Box 2900, Fitzroy, Vic, 3065, Australia. Tel: +61 3 9231 2293 Email: Gaye.Moore@svha.org.au

Figure 1: ADDIE Model of Design



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The process drew upon the expertise of the researcher, the educator, the practitioner, the participant, the designer and the clinician, with each role intersecting with the ADDIE process to improve OHP’s form and function. To this end, balance was achieved between the desire to generate edits with evidence informed practice that guided the manner in which those edits were approached.

To support this iterative process adult learning theories were explored and incorporated in part or in whole at relevant junctures. The three principle theories were behaviourism, cognitivism and constructivism (Ertmer, 2013). The traditional pedagogical processes (child informed learning) often embedded in adult development programs were identified as being incongruent with the emerging revisions of OHP. The decision was made to use an andragogical approach (self-directed adult learning) instead. To this end the andragogical process supports constructivism to be the most significant adult learning theory that aids the participant to reconstruct a new and improved subjective reality for self.

The revised program is therefore intentionally designed to be an andragogical process (Knowles, 1984), where the participant constantly builds capacity for self, to ever enhance self-directed holistic wellbeing. Though certain elements of OHP may resonate more with one participant or practitioner than others, no one element of the program is greater than the whole. That said, OHP does have key elements that may be used as stand-alone tools or interventions, in an informal manner, which may be beneficial at certain times.

The bringing together of clinical, educational and consumer expertise ensures that the revised program is informed by and in alignment with the key elements of consumer defined recovery, being self-defined and self-determined and providing the essential mechanism of ‘how to’: that is, through self-advocacy.

The marrying of instructional design processes with adult learning theories and adult learning principles created a program architecture that improved participant accessibility whilst allowing for contextualisation by the service system, the participant and/or the practitioner.

Table 1 details the adaptive nature of the architecture upon which contextual OHP programs have been built.

ARCHITECTURE	SESSION	OHP MENTAL HEALTH	OHP SUBSTANCE USE
Situational Awareness	1	What is Optimal Health?	What is Optimal Health? Stages of Change Impacts of Substance Use
Enhancing Self-Efficacy	2	Strengths and Vulnerabilities Health Plan 1	Strengths and Vulnerabilities Resolving Ambivalence Health Plan 1
	3	Stressors and Strategies Health Plan 2	Stressors and Strategies Health Plan 2
Determinants of Health	4	Metabolic Monitoring and Medication	Harm Minimization Metabolic Monitoring and Medication
	5	Collaborative Partners and Collaborative Strategies Health Plan 3	Collaborative Partners and Collaborative Strategies Health Plan 3
Enhancing change through visioning and goal setting	6	Defining change Orientation and preparation for change	Defining change Orientation and preparation for change
	7	Creative problem solving Goal setting Reflection and celebration	Creative problem solving Goal setting Reflection and celebration
Summarising the learning and sustaining plans	8	Health Plans 1, 2 and 3 My Health Journal	Health Plans 1, 2 and 3 My Health Journal Reasons for Use Scale
	Booster	Reflecting on the learning in the transformational journey to sustain well being	Reflecting on the learning in the transformational journey to sustain well being

At the heart of OHP sit two important instruments: the “I Can Do Model” and the Health Plans. The “I Can Do Model” defines the actual as well as potential resources one can draw upon to manage any adversity in life to maintain desired levels of wellbeing. The Health Plans ensure personal autonomy is maintained at all times, including during episodes of illness. In the “I Can Do Model” we see the evolution from a stress vulnerability model into a strengths based approach layered with resilience activation and Self Determination Theory in a tangible and accessible platform for participants. This piece alone, though seemingly logical and simple, was a central focus in many conversations about marrying the educational processes with clinical practice, evidence informed practice and participant perspectives. The revised “I Can Do Model” is indicative of the transformational process OHP underwent through the collaborative engagement of stakeholders in its co-design processes.

The Practitioner Stance

Though pitch and pace of the program to some degree is determined by the parameters of the revised OHP, defining the stance of the practitioner played a crucial role in articulating the engagement or tone for which the contributors and trial participants advocated.

In Collaborative Therapy the client's expertise is honoured through dialogical conversations and by the manner in which we engage, relate, respond and are present with them in a natural and authentic way (Anderson, 2012).

> *"The therapist is not an expert agent of change; that is, a therapist does not change another person. Rather, the therapist's expertise is in creating a space and facilitating a process for dialogical conversations and collaborative relationships. When involved in this kind of process, both client and therapist are shaped and reshaped-transformed-as they work together." (*Anderson, 2003)

Table 2: Collaborative Therapy Principles (Anderson, 2012)

Principles	Meaning
Mutually Transforming	We learn with each engagement, both parties
Not Knowing	More to know and understand
Being Public	Practitioner open with their thoughts and line of inquiry
Relational Expertise	Participant expert in their health and practitioner expert in facilitating the conversation
Orientate towards everyday life	Belief people are naturally resilient
Living with Uncertainty – being open to the unforeseen	Being open to the unforeseen

The alignment of the practitioner stance with the objective to create authentic engagement where both parties can bring and explore their relational expertise is key to the facilitation of OHP if we are to enhance wellbeing through the prism of improved self-efficacy.

OHP: BACKGROUND AND SCOPE

The Organisational Stance

In 2001 a multidisciplinary team worked to develop a program that had a strong focus on promoting wellbeing and self-efficacy for those diagnosed with a mental illness. The program was developed by the Collaborative Therapy Unit and in 2007 the team moved from the Mental Health Research Institute to St Vincent's Hospital, Melbourne. The Unit was renamed Frameworks for Health (FFH) and the core intervention was defined as OHP. The FFH team has devoted 15 years to the development, training, delivery and research of OHP, showing significant health benefits for people with a severe mental illness in community mental health services in Canberra (Gilbert et al, 2012). In addition to health benefits the research showed significant economic benefits with a reduction in health service costs by $6,000 per person annually.

FFH supports the practitioner stance with an infrastructure that consists of three key components:

1) Program development and delivery
2) Training with an accredited program
3) Research and evaluation.

These three functions of FFH ensure fidelity and define the development and implementation of any new material, design or construct of OHP. Collaborative Therapy principles (see Table 2) underpin the direction and focus of all three components as well as any engagement with health services and communities wishing to become part of the FFH network. Currently OHP has two additional products: 1) a substance use program and 2) a workplace program that demonstrate its versatility and application. Further program development is aimed at: 1) a more generic version applicable for a broader community population, 2) culturally specific versions e.g. Malaysian/aboriginal and 3) marginalised populations such as prisoners.

In 2012, working closely with Marco De Ieso, Training Coordinator, Neami National, we started the review and redevelopment of OHP (see Table 3). We identified strengths in the core concepts but recognised a need for change in a number of areas:

1) educational content
2) visual and functional presentation
3) language
4) supplementary information and resources
5) training program
6) imagery.

TABLE 3: Optimal Health Program Session Redesign

Session	OHP	Redesigned OHP	Revised Objectives
1	Optimal Health – Optimal Health Wheel	Optimal Health – Optimal Health Wheel (OHW) (Revised OHW see Figure 1	Perceptions of health and behaviours that influence health
2	I Can Do model Part 1 – Stress	I Can Do model Part 1 – Strengths and Vulnerabilities Health Plan 1	Understanding the balance with a strong emphasis on strengths
3	I Can Do model Part 2 – Coping Strategies	I Can Do model Part 2 – Strategies and Stressors Health Plan 2	Understanding and monitoring impact. Developing Health Plan 2.
4	The How to of the I Can Do Model Health Plan 1	Medication	Medication and physical health – Metabolic Monitoring. Stronger focus on medication management and physical health
5	The I Can Do Model: Part 3 - Vulnerability	Collaborative Partners & Strategies Health Plan 3	Identification of key partnerships – Connection with key people
6	Coping Strategies for Optimal Health	Change Enhancement	Understand past events and defining change
7	I Can Do Model: Episode of Illness Health Plan 3	Visioning and Goal Setting	Creative problem solving and planning – Developing, setting and celebrating goals
8	Review: Putting it all Together	Maintaining Wellbeing	Health Plan 1, 2, 3 & Health Journal
Booster	What is my health now?	What is my health now?	Review health plans – Sign post achievements

In the co-design we engaged collaboratively with the following stakeholders:

1) consumers – at all stages of development/drafts over a 2 year period
2) educators – Neami National, St Vincent's Hospital, Australian Catholic University (ACU), Swinburne University, University of Melbourne
3) designers – marketing and branding: Stoke Street Studios, printing: Inkifingus, artwork: Helen Wilding
4) participants and practitioners – feedback from training and forums in 2012-2015
5) organisations – requiring flexibility, business opportunities, evidence-based program and contractual arrangements.

In 2014 a large randomised controlled trial called TRIPOD (Translating Research, Integrated Public Health Outcomes and Delivery) was commenced in collaboration with ACU to explore OHP in the chronic illness arena with diabetes, stroke and carers, and dialysis. The study has been recruiting participants across Victoria with a target of over 600 people. Psychology Honours students from ACU and Swinburne University have been trained to facilitate OHP engaging with participants face to face, and over the phone or Skype. The research project has given the university students an opportunity

to gain experience, explore research opportunities with Masters and PhD programs and seek employment. It has also enabled OHP to be delivered to a broader population in a harsh economic climate. The Australian Government's Collaborative Research Networks program through ACU has been an innovative collaboration both for participants receiving OHP and supporting our future psychologists and health professionals. The opportunities this creates are far reaching as we look to establish a stronger community base which is more resilient and supported to effectively navigate our acute and community health care system.

The Participant Stance

The reason for the redesign and further development of OHP was to improve engagement and create an opportunity for a 'Participant Stance'. As OHP is underpinned by Collaborative Therapy principles to empower and support an individual's self-efficacy the 'Participant Stance' is defined by the individual. The participant is the expert in their wellbeing and the practitioner is the expert in facilitating engagement. This is relational expertise in practice (see Table 2). Throughout OHP educational tools explore the meaning of wellbeing, an individual's personal experiences, strengths, perceptions, responses and values with the aim to create important strategies within three Health Plans. The creative development was an important strategy to improve engagement with the key OHP concepts and break down barriers e.g. literacy and cognition.

CREATIVE DEVELOPMENT

Booklet redesign – usability and ongoing process of refinement

The redesign of OHP included revision of the printed resources in 2013. Stakeholder feedback demonstrated a need to enhance usability and engagement, thus starting a cyclic process of continually refining and improving resources. The original A4 participant books were changed to a more convenient and user friendly A5 flip book with a uniform design and colour scheme that tied together the content and diagrams. The flip book was deliberately chosen to support the andragogical self-directed learning processes whilst enhancing participant fluidity with the resource. Readability was improved and tabs were added to the participant booklet to improve its usability for a varied group of end-users.

Branding reflecting wellbeing concepts

In 2015 graphic designers were retained to develop a cohesive new branding. This included logos and banners which reflect the philosophy, aims and 'feeling' of OHP and FFH. For example, the new logo for OHP includes a tree representing growth. It is divided into six segments which reflect the six domains of wellbeing: physical, emotional, spiritual/values, social, occupational/engagement and intellectual. Fresh, crisp, bright colours (blue, green, aqua, lime) were introduced along with imagery of trees, water and pathways to give a sense of exploration, new beginnings and future possibilities. These colour schemes and images were introduced across the participant and facilitator booklets, banners and brochures (see Figure 2). The aim was to move towards a design that reflects an inclusive and salutogenic focus that participants and facilitators alike would enjoy.

Figure 2: Example of a re-designed OHP participant booklet, including fresh branding designed by Stokes Street Studios

Stakeholder forums re the development of e-health resources
With technological advances it became clear that a website was required, and the FFH team began to consider the introduction of online training and e-health resources. Two e-health forums were held to explore stakeholder thoughts about a website and other e-health resources for OHP. Attendees included a wide variety of stakeholders: organisational representatives, trainers, facilitators, participants and designers. In addition to the extensive discussions held during the forums, surveys were distributed during and after the forum with stakeholders and workshop attendees.

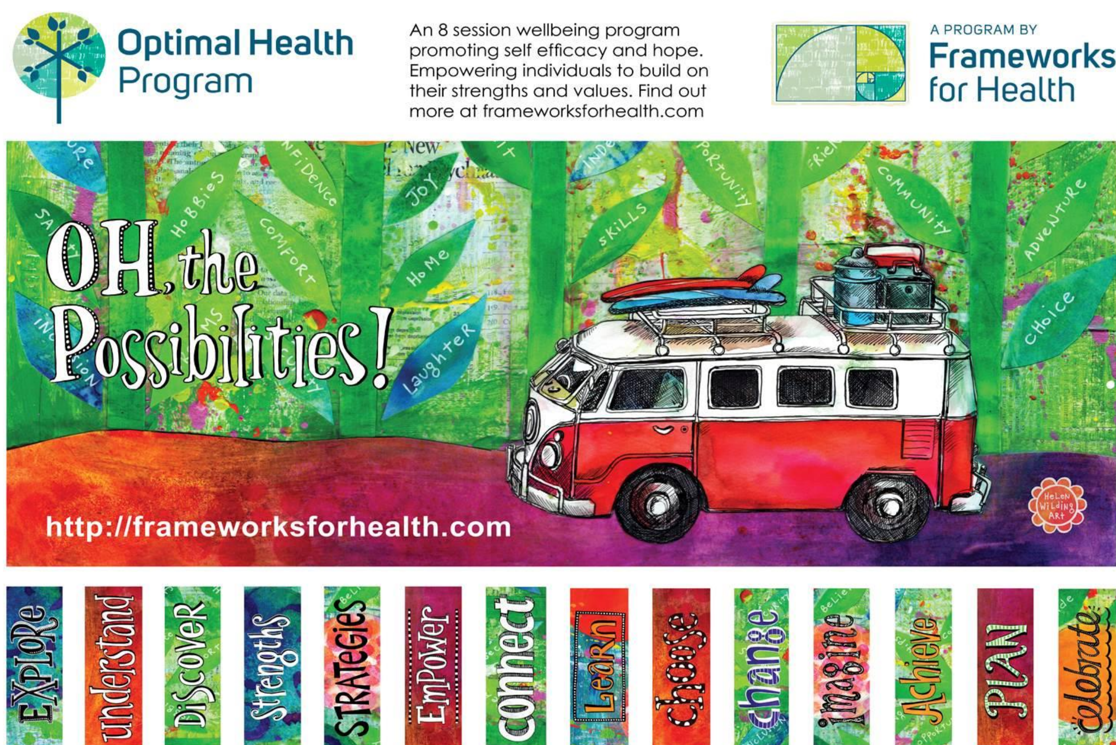
Artwork with a recovery focus created by Helen Wilding was introduced to stakeholders for the first time at this forum. A three minute video initially called "Recovery Road" and later renamed "Discover the colours in your life" (Wilding, 2014) was shown to the group to gain feedback on the potential of media to explore OHP concepts around personal recovery. The analogy of taking a road trip in a kombi van was discussed in connection with wellbeing.

> *"I recorded the process of making a multimedia artwork called "Recovery Road". My canvas began with a dark background representing a hard place, illness or injury. I built up layers little by little, reflecting a gradual transformation to a better place. At first I ripped up journal articles about clinical recovery, patching over the darkness with the black and white type. I wanted to show the contribution of science to recovery while also demonstrating the need for 'something more' which was much more personal and harder to define. Brighter and brighter colours were introduced, covering the journal articles, and paint was joyfully splattered over the canvas,*

reflecting a growing confidence and playfulness. I created brilliant inked papers, shaping and collaging them into giant plants growing towards the sky. I brainstormed words which reflected my idea of wellbeing, and wrote them on the leaves. Finally, I painted a kombi van and started it on its journey across the brand new landscape. To me the multimedia painting was not so much about the end result as it was about the process of discovering the colours in life." Helen Wilding

The overwhelmingly positive response to this short video has led to it being used consistently during facilitator training, workshops and focus groups, and it has been made available free online for use by facilitators and participants through the new FFH website – http://frameworksforhealth.com**.** Figure 3 shows an example of the kombi van concept created by Helen.

Figure 3: Artwork by Helen Wilding introducing a kombi van as an analogy for exploring your wellbeing



Artwork by Helen Wilding
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Individual CD cases full of examples of bright artwork and enhanced imagery around OHP concepts was also shared with stakeholders at the forum. These helped to enable intense discussion, thoughtful comments and the exploration of fresh ideas around the use of creative design in OHP. This has led to the decision that visual components are an integral part of the future development of OHP which we will continue to explore with stakeholders.

"Thanks for your colourful and inspiring artwork. The kombi van - can represent me on a journey experiencing the challenges joy grief I have to go through. Learning how to cope in situation and about myself." [stroke survivor, 30/7/15]

CONCLUSION

The Collaborative Therapy principles are the foundation of OHP as the program and facilitator training are revised, and the application of OHP goes beyond mental health into broader areas such as

substance use, chronic medical conditions, carers and marginalised communities. Research and evaluation will continue to be core business and collaboration with key stakeholders will also be essential to develop OHP further. The vision for FFH is to connect more effectively with our stakeholders, to increase health literacy and sector engagement to increase treatment options and improve personal outcomes, and to build a stronger community, a more empowered community.

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