



Budget Submission

Budget cycle 2020-2024

Arthritis ACT was a grant recipient from 1 July 2016-30 June 2019 of a Health Promotions Grant to establish a network of Strength and Balance classes across the ACT. The report follows this notation including recommendations which we bring to this budget cycle for consideration. In particular, we note that whilst this program has gone on to be funded through Sports Australia into 30 December 2020 we know there will be no further funding from that source. This kind of program is generally considered a 'state/territory responsibility' through Primary Health Agreements with the Commonwealth.

We would urge the ACT Government, who's own program that lasts 8 weeks refers the majority of it's clients to us for ongoing support, fund, from 1 Jan 2021, an ongoing Strength and Balance program through Arthritis ACT to provide community based ongoing classes to older Canberrans who are at risk of, or have already incurred, a minimum trauma fracture. The best evidence states that for this at risk group 3 hours of strength and balance exercise should be undertaken each week to reduce the risk of further fractures and the complications and high risks of early death as a result. Evidence also suggests that people are more likely to be compliant with exercise if they have to attend a 'centre' to do all or part of it.

Recommendation: That Arthritis ACT is funded on an ongoing basis to continue accessible, low cost strength and balance classes within the Canberra community.

Final Report

Strength and Balance ACT

Executive Summary

Aim

We aimed to improve the health and well-being of people in the Canberra region living with the risk of falls or a history of a minimal trauma fracture through a ten-week intervention of a strength and balance class. The intervention was designed to increase participant awareness of their falls risk, to understand the actual risk to their lives of falls and to engage with exercise through a program that they could both attend in a face to face class but also would receive a written program which they could continue at home. The program included an initial assessment on falls risk and their strength and balance, the program was able to be adapted to the individual, and then a follow up review was undertaken at week 10. All individual's had the scores recorded along with an explanation of what this meant in their workbooks as proof of the effect of specialized exercise programs. feedback.

The original goal was: The program goal is to provide a series of 10 week courses, in locations that facilitate participation for people with osteoarthritis. Each course will be delivered 1 day each week for 10 weeks and aims to improve strength, balance and function in people who have chronic musculoskeletal problems in the over 65s.

Objective 1: By the end of the 10 week program, 90 % of participants have an increased understanding of the role of physical activity and weight management in the management of osteoarthritis and other chronic musculoskeletal conditions, since program commencement.

Objective 2: By the end of the 10 week program, 50 % of the participants report they have a decrease in pain levels since program commencement.

Objective 3: By the end of the 10 week program, 50% of program participants have an increase in overall function and balance as measured by the 'timed up and go, 30 second sit to stand, and single leg balance' tests.

Objective 4: On completion of the 10 week program, daily physical activity levels have increased in 50 % of participants.

Objective 5: Increase the availability of our classes to the greatest growth areas of Canberra in the over 65 age group (Belconnen, Tuggeranong and Gungahlin)

Objective 6: 50% of participants will remain engaged with follow on classes or another form of regular exercise at 6 months post initial 10 week program

Method

We recruited from:

- the Fracture Clinic at The Canberra Hospital (initially through an invitation from the nurse reviewing all minimum trauma fracture clients through the Minimum Trauma Fracture Liaison Service until this face to face work ceased to occur),
- through GP's who had an interest in engaging their patients with exercise programs,
- through advertising on radio and in print media,
- through information stalls including the COTA Seniors Expo each March, local shopping centres and other community expos
- through partners in the community sector including SHOUT,
- through the ACT Health Falls Program

A total of 1328 participants commenced the program, male and female, who ranged in age from 36 to 94 years. Participants were provided with an introductory talk, usually lead by the lead physiotherapist, then exercise physiologist from 2019 due to a change in personnel. We introduced small exercise physiology classes in 2018 as we had growing demand from clients who could not operate in the larger class or had more extreme needs, including some who could not balance without 1:1 support. We undertook individual exercise plans with some of these participant so they could undertake exercise sessions at home with carers as coming to the program was too difficult.

Results

We found a very high level of compliance among participants with more than 70% of people completing 80% of classes and engaging in the pre and post program evaluations. We had a surprising 45% of participants re-enrolling, with some continuing in the program in one way or another for the entire 3 years. The program had more than 90% of participants who participated in follow up evaluations at 6 months and 12 months still maintaining engagement in some sort of purposeful exercise (that is, not exercise that is encompassed in activities of daily living). Overall, participants reported that they found the course appropriate to their needs, they have seen ongoing improvement in their strength and balance, and other than 3 reports in 3 years of falls leading to minimum trauma fractures following participation on the program, there have been no reports of falls leading to large secondary fractures, particularly fractured femurs, which are costly to repair and often lead to increased rates of mortality.

Introduction

This document reports the results of the 3 year funding program 'Strength and Balance', which was conducted by Arthritis ACT funded via an ACT Government Healthy Ageing grant. The project was conducted from July 2016 until June 2019.

Background

Minimum trauma fractures are the leading cause of morbidity and mortality via trauma in the over 65's. Recently, musculoskeletal conditions have become the leading cost burden on the Australian health budget, overtaking cancer, diabetes and cardiac conditions. The Australian health system provides reduced support to the general community for musculoskeletal disease support, with limited and reducing PBS support for medication, limited access outside the private fee for service supports for ongoing programs related to building strength and balance particularly in at risk communities, and limited access outside the private fee for service opportunities for radiological imagery related to bone density or arthritic joint review. There are also limited opportunities with long waiting times for medical review of osteoporosis via endocrinologists particularly in the ACT, and even less access to rheumatologists for arthritic conditions. A joint approach particularly in less mobile older persons in which a co-ordinated approach between medicine, hospitals, private allied health practitioners and community based intervention programs is proven to be most beneficial and leads to the best health and wellbeing outcomes is lacking, and leads to a largely piecemeal approach to providing client centered health and wellbeing programs.

The current research indicates that after presentation with a minimum trauma fracture there is likely to be a second fracture within a period of 2 years and this is likely to be a more major fracture such as a neck of femur. The cost of the surgical intervention and subsequent rehabilitation of a neck of femur is approximately \$25,000. With approximately 40% of attendees to the program having experienced an initial minimum trauma fracture, and no reports of a secondary major fracture, this intervention has saved the tertiary health system a considerable cost burden.

Methodology

Program design

The project used a ten-week exercise program which incorporated an education talk about falls prevention in week 1. As the program progressed there was a high percentage of program attendees wishing to learn more about reducing their arthritis symptoms as well, including wishing to reduce their likelihood of joint replacement surgery, so this was incorporated into the talk. The talk included input from our dietitian on tips of increasing calcium and vitamin D into the diet for bone strength, and achieving and maintaining a healthy weight range. Persons who have been classically underweight are at higher risk of osteoporosis. Persons who are overweight will find large reduction in arthritis symptoms through the loss of 5% of body weight, even if this does not return them to a healthy BMI status. Both these measures

were included in the talks and written information provided to clients. Some clients chose to engage with the dietitian separately to work on achieving healthy eating outcomes as a result of the program.

Participants were provided with a work book that included the main points of the information included in the initial education session. It also provided them with an overview of the exercises undertaken as part of the program and how to adapt many of these to the home setting to encourage participants to undertake further exercise at home. In addition, following the first 10 week program, the Arthritis ACT exercise room was opened up twice a week to all program participants to come and utilize the exercise 'circuit'. Research shows for many to remain engaged in an exercise program they need to have a 'place to go' and 'a reason to go there'. We found these sessions, with definitive times meant people had both the place and reason, and as a result they engaged in increased levels of meaningful exercise.

We additionally found that so many participants were so engaged with the program that we could not move them on. We had originally planned to have volunteer lead classes that would become self-sufficient (we would have provided the space and the equipment) however the reality was the participants were largely unsuitable for volunteer classes (age, level of dependency on staff) and volunteers who were suitable to carry out these sessions were people that should be employed due to the level of responsibility. We had also assumed that a percentage of participants would move on to the private gym sector once they had completed the program. Again, the age and level of dependency of participants who engaged with the program largely prohibited this (and most were not interested in engaging with private gyms as they are not geared towards the older client). We did have a small number of participants who moved on to the YMCA at Chifley that has a greater gym set up but is still not as off-putting to the older client type of gym of the private sector. The number of participants wishing to remain engaged in the program meant the number of classes grew more rapidly than had been planned.

After 12 months we incorporated a 'balance 30' class for those who had undertaken the full program. This allowed us to incorporate more classes into our schedule. Balance 30 participants were those that wanted more support than utilizing the self-lead circuit, but could actually do most of the circuit alone. In balance 30 they had a 30 minute session with the physiotherapist or exercise physiologist, and then spent up to another 45 minutes undertaking the circuit independently whilst the group leaders worked with the next group.

Participants

Recruitment was conducted through internal channels including the Arthritis ACT newsletter and website, local media, online media, referrals through the Minimum Trauma Fracture Liaison Officer at TCH, GPs, partner organizations, the ACT Health Falls Program and word of mouth through both community stalls and health and wellbeing expos. A total of 1328 participants enrolled in the program. Participants had an age of range of 36-94 years and the majority

(83%) identified as female. This is in line with current research which shows females are more likely to engage in health promoting activities. Of the men who attended, many attended with female partners, and two same sex male partners attended (that were disclosed to staff). We noted many women also engaged with friends to participate in the program, and where friends attended together, these partnerships largely remained connected to the program for a longer period of time. Accommodations for friends/partners were always made in the program to ensure greater consistency of participation.

Measures

All participants were evaluated with the following measures pre and post first 10 week program. If attending ongoing programs participants were reassessed each 6 months and on request. It was noted that participants continued to improve in their outcomes the longer they remained engaged in the program.

The assessment summary is below, and this was maintained in the participant's workbook so they had the sense of owning their own information. Research has shown patient held records allow the 'patient' to take greater control of their health status, and gives them the power to be an equal partner in a health interaction rather than a passive recipient of an 'experts' opinion.

Strength and Balance Assessment Summary

Name: _____

Dates Attended: _____

Test	Date : Week 1	Date : Week 10	Additional Information
Timed up and go			
30 second chair stand			
Balance on one leg			If reach 30 seconds, try eyes closed balance

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Timed Up and Go Test

Normal values

Normative age reference ⁽¹⁾

Age Group	Time (s) (95% CI)
60 – 69 yrs	8.1 (7.1, 9.0)
70 – 79 yrs	9.2 (8.2, 10.2)
80 – 99 yrs	11.3 (10.0, 12.7)

Older adults who take longer than 14 s to complete the TUG have a high risk for falls ⁽²⁾.

30 Second Chair Stand Test

Normal values

Normative scores (i.e. between the 25% and 75% percentiles) for the 30-s CST in community dwelling older people aged 60-94 years ⁽¹⁾

Age range	Average count for women	Average count for Men
60-64	12 to 17	14 to 19
65-69	11 to 16	12 to 18
70-74	10 to 15	12 to 17
75-79	10 to 15	11 to 17
80-84	9 to 14	10 to 15
85-89	8 to 13	8 to 14
90-94	4 to 11	7 to 12

Risk zone for falls: Scores of less than 8 stands for women and men ⁽²⁾.

Strength and Balance Assessment Summary

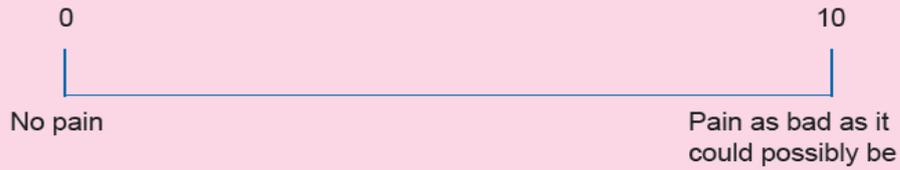
Name: _____

Dates Attended: _____

Questionnaire WEEK 1

The following questions relate to your pain

1. Place a perpendicular line below that represents the pain who have experienced in the last four weeks.



2. How much bodily pain have you had during the past 4 weeks? Please circle your answer.

None Very Mild Mild Moderate Severe
 Very Severe

3. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? Please circle your answer.

Not at all A little bit Moderately Quite a bit
 Extremely

The following questions relate to your understanding of your physical activity requirements

4. What is the recommended minimum amount of physical activity per day that adults should do for health benefits

_____ (minutes)

5. How many times per week should you be engaging in Physical Activity for Health benefits?

3 times per week

4 times per week

5 times per week

It does not matter and the total minutes can be done in one go

6. Which activities are good for bone strengthening? Please circle. There may be more than one answer.

Running Jumping Bike riding Swimming Walking
Resistance training

7. Which statement describes best your level of physical activity (this includes any activity and exercise)

I have never been active

I have been active only a few times in the past month

I am active a couple days of the week

I am active most days of the week

8. Which exercises are the most effective to reduce your risk of falls?

Walking

Strength training

Swimming

Tai chi

Balance

There are no exercises that are useful

These questions relate to your understanding of the role of diet/weight management in helping your arthritis or other chronic conditions

9. How does my weight affect my arthritis or condition? Please list 2 answers.

(1) _____

(2)- _____

10. List two ways you can assist your condition with diet?

(1) _____

(2)- _____

11. Which is not a physical change of ageing? Please circle one answer.

Loss of muscle mass

Loss of bone strength

Gaining weight

Decreased metabolism

Increase fat tissue

A full data analysis has not been completed on the entire cohort, however, a University of Canberra Intern undertook a study on the client cohort who identified osteoarthritis as the main reason for their enrolment in the course. Studies have been undertaken on the likelihood of falls related to knee pain in particular, and have found a direct link between falls and knee pain. This was to help us establish if a more concentrated program on improving the outcomes of those living with knee and/or hip osteoarthritis would be beneficial. As a result of this work Arthritis ACT commenced working with The Bone and Joint Institute at the University of NSW and have collaborated with Professor David Hunter and Matthew Williams to propose a holistic osteoarthritis chronic care program for the ACT. The results showed definitive improvement for participants. The outcomes are outlined in the following poster:

Does a 10-Week Strength and Balance Exercise Intervention Improve Functional Capacity in Individuals with Osteoarthritis?

Gwen Estigoy, Arthritis ACT

Introduction

- Osteoarthritis (OA) is the most common form of arthritis in Australia, affecting roughly 21% adults over 45 years old.¹
- OA can negatively impact on everyday activities and is associated with decreased muscle strength and increased risk of falls.²
- Previous research favours exercise as a non-pharmacological approach for the treatment and management of OA.³

Aim: To investigate whether a community-based 10-week strength and balance exercise intervention improves functional capacity in individuals with OA.

Methods

- A sample of 97 adults (91 women and 6 men) with OA participated in the 10-week exercise program (mean age: 69 ± 8.61)
- Pre and post measures of functional capacity were taken, consisting of
 - Dynamic Balance and Agility (Timed Up and Go Test (TUG))
 - Muscular Strength (Sit to Stand Test (STS))
 - Single Leg Balance (30 Second Balance Test (SLB))
- Group classes were once a week for 60 minutes over 10 weeks – focusing on upper & lower body strength, and balance
- A paired samples t-test was used to investigate the mean differences between participant's scores at baseline and after the 10-week exercise intervention

Results

- Participants TUG scores significantly improved by 1.05 seconds post intervention (8.07 ± 1.68) compared to baseline (9.12 ± 2.08), $p < .001$
- Participants STS score significantly improved by 1.68 reps post intervention (911.11 ± 3.29) compared to baseline (9.24 ± 3.04), $p < .001$
- Participants SLB time significantly improved for both left (3.18 sec) and right leg (4.31 sec) post intervention (left 21.39 ± 12.49) (right 21.74 ± 12.95) compared to baseline (left 18.21 ± 11.56) (right 17.43 ± 12.03), $p < .001$



References

1. Commonwealth of Australia. Osteoarthritis 2017 [Available from: <http://www.the.gov.au/topics/health/conditions-and-diseases/osteoarthritis>]
2. Dineen AC, O'Leary TM, Murray TS, et al. Lower Extremity Osteoarthritis and the Risk of Falls in a Community-Based Longitudinal Study of Adults with and without Osteoarthritis. *J of Arthritis Care & Res* 2011;33(7):1243-1250.
3. McInnes TR, Bennell KJ, Collins MC, et al. GRAC guidelines for the non-surgical treatment management of knee osteoarthritis. *Arthritis and Cartilage* 2014;22(2):163-168.
4. Takami J, Kiyomoto H, Ohtani J, Ogasawara M, Hironaka M. Dynamic balance training improves physical function in individuals with lower extremity osteoarthritis: a randomized controlled study. *Arch Phys Med Rehabil* 2017; Aug;98(8):1584-1590.

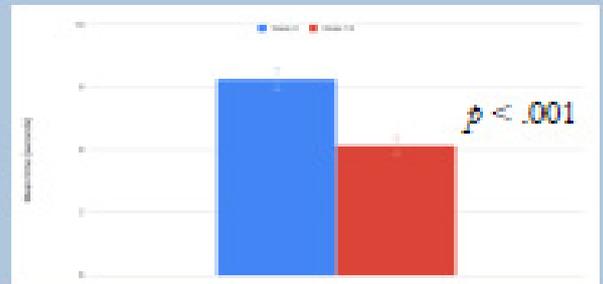


Figure 1. Mean time (seconds) for participants for Timed Up and Go Test at Week 0 and Week 10.

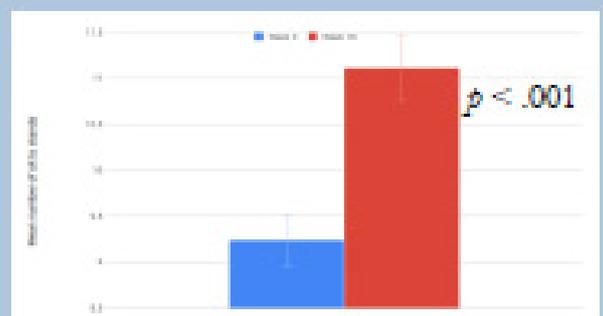


Figure 2. Mean number of Sit to Stand within 30 seconds for participants at Week 0 and Week 10.

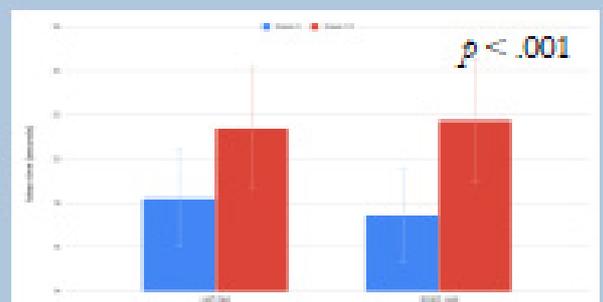


Figure 3. Mean time (seconds) for Single Leg Balance for both right and left leg for participants at Week 0 and Week 10.

Conclusion

A 10-week strength and balance exercise intervention elicits significant improvements in dynamic balance and agility, muscular strength and single leg balance in adults with OA.

- Improvements in functional capacity seen in people with OA is associated with enhanced participation in activities of daily living, lower risk of falls and may reduce the burden on the healthcare system.⁴
- Due to limitation of resources, the current study did not include a control sample or measure differences in psychological factors and quality of life.
- Future studies could include a comparison group and should investigate whether a similar exercise intervention impacts on psychological well-being and quality of life.

Data analyses

The data collected during the program has been stored on the participant held records and in the Arthritis ACT client management program 'Nookal'. No hard copy data is stored at Arthritis ACT. Access to records is restricted to staff working at Arthritis ACT and clinical students from various tertiary institutions for the period of their clinical practicum only, and after the agreement to a confidentiality policy. Data utilized for the student intern study was collated and analysed using Microsoft Excel and SPSS v21.

Results

Approximately half of the participants were recruited through the Arthritis ACT membership and word of mouth through those members. The other half became involved mostly through referral from another health agency including the TCH Fracture Clinic and GPs. Advertisements and contact through partner organisations brought in the least number of participants. The majority of participants were female and the males who attended were nearly all engaged through a partner or friend. The most reason for participation was a history of a fall, although not always associated with a minimal trauma fracture. The risk of falls due to knee and hip pain became apparent as the program progressed.

Improvement in the basic testing was noted in all participants, even those who attended less than 50% of classes but were available for pre and post testing. This was anecdotally reported by participants with low actual participation rates in classes as being because they became aware of the need to practice many of the basic balance exercises as part of their everyday living. Simple ways of incorporating balance exercise into everyday life was a feature of the program. All participants also received a take home book explaining the exercises incorporated into the program so as to be able to carry the exercise program out with minimal requirement for extra equipment in the home.

All participants who participated in the follow up questionnaires reported an increased engagement with ongoing exercise. 50% of participants remained engaged with the program for more than two programs, and approximately 22% of participants remained engaged from the time they began in the program for the entirety of the program. Many only became disengaged with the program because of ageing or disease progression, including entering into aged care, advancing dementia, and a small number passed away from illness including metastatic cancer and motor neuron disease.

A notable result of the program has been the community relationships that have built as part of the program. Initially a monthly morning tea was built into the program, however as participant and group numbers became larger the groups have become more self-caring. Some groups have incorporated a social get together after most sessions. Some groups get together for a social gathering at the end of each term. Whilst the program was targeted at over 65's, there have been some younger community members who have engaged due to severe

pain conditions which have resulted in them being unable to engage with activities normally associated with younger persons. The participants have included the younger members of the groups in all the social aspects and we have witnessed greatly improved mental health outcomes as a result. There is much research in current psychological research around 'social cures' and the need to include social interaction into programs such as this. Whilst many participants have interacted with the program initially with a partner or a friend, the groups have established to such a point where often the friend or partner is secondary to the other relationships in the program.

Objective Results

Objective 1: By the end of the 10 week program, 90 % of participants have an increased understanding of the role of physical activity and weight management in the management of osteoarthritis and other chronic musculoskeletal conditions, since program commencement.

- Most participants (95%) had developed an understanding of the role of physical activity, weight management and management of their conditions by the end of the enrolment process due to the input of staff and questionnaires required to participate safely in the program. All participants by the end of the program had a good understanding of these factors. A pre and post questionnaire was administered to all participants at week 1 and week 10 to measure this understanding. Those that showed a lack of understanding of the incorporation of physical activity and weight management on musculoskeletal health had co-morbid health conditions such as advancing dementia which lowered their understanding/retention of information and/or ability to understand the questionnaire.

Objective 2: By the end of the 10 week program, 50 % of the participants report they have a decrease in pain levels since program commencement.

- Approximately 75% reported they had less pain at the end of the first program, and this increased the longer they remained engaged in the program. Importantly, participants had learned how to work with their pain, how to engage with exercise to reduce pain and the associated factors that increase pain including weight loss, improved diet, distraction, pacing of activity, and improved social interaction.

Objective 3: By the end of the 10 week program, 50% of program participants have an increase in overall function and balance as measured by the 'timed up and go, 30 second sit to stand, and single leg balance' tests.

- We found all participants who completed the entire 10 week program had improved function. Importantly, those who continued within the program and therefore we had access to retest over time, continued to note improvement in functioning. For those who had disease progression, such as a participant

with MND, the social interaction and the time to do an activity with a partner was what made this program special, despite the inevitable deterioration that was associated with the disease process.

Objective 4: On completion of the 10 week program, daily physical activity levels have increased in 50 % of participants.

- Most respondents to follow up 6 and 12 month questionnaires (followed up by email and/or phone) reported increased daily activity levels. Some had moved on to more intensive programs such as the YMCA gym at Chifley. Some had engaged with hydrotherapy on a regular basis. Others had engaged with activities such as Nordic Walking. A large percentage remained engaged in this program as well as taking on other activities.

Objective 5: Increase the availability of our classes to the greatest growth areas of Canberra in the over 65 age group (Belconnen, Tuggeranong and Gungahlin)

- Classes grew more rapidly than was imagined in the original grant application. Gungahlin ended up being a problematic region to hold classes, however for the majority of the program time buses from Gungahlin enabled Gungahlin residents who did not have private transport to attend classes at Kaleen. Very few persons attended classes traveling by public transport. A number utilised community transport options to be able to attend, and this allowed them to attend a class that suited their weekly schedule rather than necessarily choosing the one that was closest.
- The Weston Creek location continued to be the most popular class location. Until the settlement of the new Stromlo suburbs Weston Creek was the most rapidly ageing area in the ACT.
- Tai Chi classes were held immediately before or after classes at each location and many participants increased their exercise dose by participating in these classes also. This generally occurred after 2 or 3 terms of Strength and Balance. Hydro Tai Chi then grew out of the suggestion of a few members who wanted to undertake even more exercise classes, but wanted to try hydrotherapy but not 'aqua aerobics' and they didn't want to do just a self-lead program.

Objective 6: 50% of participants will remain engaged with follow on classes or another form of regular exercise at 6 months post initial 10 week program

- 90% of participants remained engaged in classes after 6 months. Generally those who didn't had either dropped out of the program before completion, or had developed conditions that reduced their ability to continue to participate in exercise, or become very frail aged and ended up in full time care.

Discussion and Outcomes

This program had failed to be uptaken on 2 previous grant applications to pilot the program. In the end Arthritis ACT decided to pilot the program whilst going through the extended application process that occurred in the funding round that eventually funded the program. It is difficult for community based organisations to continue to apply for grants to institute programs which are backed by research to provide benefit to the community and cost savings to the tertiary health system. In areas of health where change is slow and incremental, it can be harder to sell an intervention to potential funders. This can be at the detriment to the community. Medical research, health promotion and philanthropic funding has tended to favour the 'sexy' areas of health – the areas where intervention is dramatic, where the cost returns are easily measured, or where the recipient of the intervention is perhaps more 'valued' by society. This is not to say that pictures of children or young women with chemically balded heads should not have lead to research into cancers that kill the young, it is not to say that a rapidly decreasing number of cardiac related deaths and related morbidity have not increased the relative health and decreased the costs to society of heart disease, however, musculoskeletal conditions have not been invested in at nearly the same rate for decades, and we are now reaping the rewards of this through musculoskeletal disease and associated disability being now the mostly costly disease burden to the Australian health budget. Simple interventions such as this program are not readily available to the general community, and yet the outcomes are significant. In a cohort of 1328 persons, 40% of whom had already experienced a previous minimal trauma fracture, no secondary major fractures were noted following engagement with the program, and research says 20% would have been expected to have a major fracture within 2 years and 10% would have died as a result. Moreover the majority of the participants were at risk of a first fall, of which 3 were noted but they were associated with other risk factors including uneven footpaths. The outcomes of these falls were a minimum trauma fracture and there again had not been a secondary fall. Importantly, there were very few who disengaged from the program to move into full time care, and those that did were at the older end of the age groups (85yrs+). A couple of deaths were noted from pre-existing conditions that had poor prognosis.

Due to the funding of this program, and the work undertaken by our University of Canberra Intern to review in particular outcomes of the program on people living with knee and hip osteoarthritis, this program has now been funded through the Australian Sports Commission for an ongoing 18 months. This program will be operating in all states and territories except Victoria and NSW, and this is due to those jurisdictions electing not to participate. Arthritis ACT has, however, extended the invitation to those jurisdictions to utilize the materials we have developed as a part of this program to improve health outcomes in those jurisdictions. The challenge for the health system will be to continue funding this type of program beyond the end of 2020. These programs are cost effective in terms of dollars saved by the health budget, but they are resource intensive on the community sector and do need to be adequately funded to ensure participants can engage to help maintain and improve their health status, remain independent and

active in their community, and reduce the social isolation that occurs when living with reduced mobility and/or pain.

The social cures aspect of these programs should be more fully evaluated and accepted as a means of supporting not only good physical health but also good mental health. There is often a disconnect between mental health support services and physical health support services. The community sector in particular often attracts a clientele who have more significant co-morbidity between physical and mental health issues. In 2007/8 the link between poor mental health and drug and alcohol use which had previously been clearly established in the literature was finally accepted by health funding and investment was made into programs and staff upskilling to improve the mental health outcomes of clients engaging with drug and alcohol services. Similar research has been well documented for many years in relation to physical health areas especially those that result in pain, reduced mobility and social isolation, but services that deal with these clients find it difficult to justify their role in the mental health services streams to gain funding for this work, and physical health streams similarly do not support mental health co-morbidity support. The anecdotal 'social cures' implemented into this program had exceptional outcomes on the client group. In many responses to our survey's, the exercise part of the program was incidental to the support the participants recognized they gained from the program leaders. Arthritis ACT has taken the decision to provide a mental health worker to support both staff and clients, however this work is not funded, and should budgets become tight, it will have to be ceased. As part of the Australia Sports Commission program Arthritis ACT will be working with the various sites offering our strength and balance program but without the additional 'social cures' aspect due to the individual program delivery models, and will assess the outcomes reported by participants to gain a clearer picture of the role of this intervention in our program.

On the initial self-funded pilot and planning for this program a healthy more independent cohort engaged with the program. As the program progressed we attracted a more highly frail elderly clientele. Volunteer lead ongoing programs had initially been planned for the program but this became impossible to implement due to the nature of the clientele engaging in the program. One staff member had been initially scoped to be able to manage a 10 client program. We found that 2 staff members were actually required, and both staff needed an understanding of working with older persons, so the secondary person could not be an untrained volunteer. At times further staff were required for very complex clients and these staff were pulled from the Arthritis ACT staff pool, of which all staff working in client services have an allied health professional background. Very complex clients were engaged at sessions held at the Arthritis ACT office complex only, and not in community locations where the risks and costs of services were higher. Some of these clients were channeled into the small EP classes where the staffing ratio was higher.

The program was scheduled to run on a strict 10 week cycle where the first session was held in week one of the school term and the last

session at week 10 of the school term. Week 1 would include the formal education component. We had many clients who would come to us early in a school term but would need to wait until the following school term. As a result we started a floating series of program delivery at Bruce. Sessions are now held on Wednesday middle day and Saturday's to allow people to engage in the program immediately. Holding the program on Saturday's allows those with carer or work responsibilities to also engage in the program. Many are utilizing these sessions to increase the number of sessions they can attend each week or to make up for missed sessions.

Historically Arthritis ACT found that engagement with services decreased between May and the end of August. Over the past 2 winters (2018 and 2019) this trend has largely disappeared. This may be related to cost of living pressures reducing the ability for many older persons to 'escape winter', or it may be related to the rapidly changing nature of Canberra where people are now coming here to retire, often to assist in family duties such as child care. This has meant classes have been more highly subscribed for the entire year and less drop outs have been noted during the winter months.

Recommendations

- That ongoing community based strength and balance programs be implemented in the program through community organisations in community locations. A generalized mapping of programs available in the community would assist health bureaucracies in establishing gaps, especially for low cost, ongoing programs.
- Ongoing programs are essential to build community knowledge of programs and increase participation rates/decrease the slide into sedentary behavior in the community. Ongoing programs are also essential for providers of programs. Short term funded programs lead to staff and organizational unrest, and programs are less likely to successfully engage with the community due to winding up/winding down processes of programs and staff mobility due to insecure funding.
- That mental health funding/support be included in programs that engage with clientele with chronic health conditions, allowing for a holistic approach to chronic health condition support and health promotion.



Rebecca Davey
CEO Arthritis and Pain Support ACT
August 2019

Client information included for information

