Equally well in Victoria

Physical health framework for specialist mental health services

VICTORIA State Government | Health and Human Services

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Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

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A note about language

There are a number of terms employed throughout international mental health policy, legislation and literature to refer to people accessing mental health services. These include consumers, clients, service users and patients. In this document, wherever possible, the terms 'consumer' is used.

Similarly, in the interests of brevity, the terms 'family' and 'carers' are used throughout this document. A carer may be a family member, friend or other person who has a significant role in the life of the consumer.

A word from Victoria's Chief Psychiatrist and Chief Mental Health Nurse

Each time a consumer engages with a clinical mental health service provides an opportunity to explore physical health issues, consider how they might impact on recovery goals and offer help.

This framework is the first of its kind in Victoria. It describes a range of initiatives for organisations and clinicians to work in partnership with consumers and carers to discuss physical health in the context of a recovery plan. This framework provides information to help mental health services and clinicians to think about how to tailor treatment and strategies to the realities of the daily lives of consumers.

We acknowledge that many Victorian mental health services are already working in this area and have established a range of initiatives to improve their response to the physical health needs of consumers. This framework will assist services to continue to improve their response to this challenge and establish a baseline to monitor our progress in this area.

We can do more to provide holistic and personalised care. And the help extends beyond biomedical screening, diagnosis and treatment. It is about each person's recovery journey and using collaborative recovery plans to enquire about the person's physical health, appreciating the complex interplay with mental illness and how this operates in the context of the person's life.

Consumers, families and supporters have the right to be informed and helped to take responsibility for treatment decisions affecting their physical health. The Office of the Chief Psychiatrist and Office of the Chief Mental Health Nurse are committed to working in partnership with Victorian services, consumers and carers to do better in this area. A significant first step is the creation of this framework.

Neil Coventry
Chief Psychiatrist

Anna Love
Chief Mental Health Nurse

'All mental health professionals (including peer workers) should receive role-appropriate physical health assessment training as part of ongoing mandatory training. Nurses working in mental health services are educationally prepared to carry out physical health checks' (Equally Well – National consensus statement 2016).

The above emphasises the shared responsibility all clinicians have in contributing to improving physical health outcomes while acknowledging the requirements for implementing discipline-specific scope of practice responsibilities regulated under the Health Practitioner Regulation National Law (s. 38(2)(b)), associated regulations and other legislation.

Mental health clinicians must be supported to practise within multidisciplinary teams. This environment enables a shared understanding of respective regulated scopes of practice and otherwise prescribed roles. This ensures people accessing services receive optimal health care including appropriate referrals to the health practitioner(s) (such as a registered nurse, nurse practitioner and/or medical staff) who have direct responsibility for undertaking physical health assessments and contributing to health improvement plans.

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Acknowledgements

This framework draws on a number of documents including the National Mental Health Commission's 'Equally well' consensus statement *Improving the physical health and wellbeing of people living with mental illness in Australia*, the *National Safety and Quality Health Service Standards* (second edition) and the National Health Services England's *Improving the physical health of people with mental health problems: Actions for mental health nurses 2016*. These and other related texts are listed under 'Resources' at the back of this document.

We wish to thank the expert reference group and the stakeholders who were involved in developing this framework including:

- Austin Health
- Forensicare
- La Trobe University
- Latrobe Regional Hospital
- Monash Health
- Neami National
- NorthWestern Mental Health
- Orygen Youth Health
- Plenty Valley Community Health
- Quit Victoria
- St Vincent's Hospital (Optimal Health)
- Star Health
- Tandem
- The Royal Australian and New Zealand College of Psychiatrists
- The University of Melbourne
- Turning Point Alcohol and Drug Centre
- VMIAC (Victorian Mental Illness Awareness Council).

VMIAC's perspective

As consumers, we live with knowing that we will die sooner and have poorer health. This is unacceptable. We are hopeful this new framework will help provide mental health consumers with health outcomes equal to other Victorians. We identify five areas that most contribute to inequality:

1. **Serious side effects from mental health treatments**

   Many psychiatric medications, particularly 'antipsychotic' drugs, have serious side effects that can cause new health problems, disability and even reduce life expectancy. 'Antipsychotic' medications carry the most serious risks, including metabolic and cardiovascular disease, movement symptoms, hormonal and sexual changes, cognitive and emotional changes, and many other health issues. Particular psychiatric prescribing practices, including high dosages and polypharmacy, carry even greater risks.

2. **Compulsory treatment and lack of informed consent**

   Many consumers are compelled to take risky medications under treatment orders, even when side effects are having a serious impact on their health. This takes away the opportunity for us to choose less risky treatment options such as talking therapies, peer support or reduced doses. Further, we know anecdotally that many clinicians don't tell us about risky side effects, out of concern that we'll choose to not take medication. Yet we deserve the chance to decide for ourselves if treatment benefits outweigh the risks of dying younger. This is not a decision to be made without consent for any citizen.

3. **Impacts of mental health problems and emotional distress**

   Mental health problems and emotional distress can themselves contribute to reduced physical health, like living with reduced motivation, having more important priorities (like housing), or needing to self-medicate because treatments are not helping.

4. **Discrimination in overall health care, particularly in diagnostic overshadowing**

   Too often, our physical health is ignored because health workers can't see beyond a diagnosis of mental illness. This is often called diagnostic overshadowing, but a more straightforward description is discrimination.

5. **Impacts of our disadvantaged socioeconomic status**

   Many people in our consumer community live with poverty, homelessness or unstable housing, isolation, stigma and discrimination. These disadvantages are barriers to physical health separate to our mental health or treatment experiences. Australians from disadvantaged backgrounds are more likely to have health problems and to smoke.

6. **Our hope, as consumers, is to see:**
    - changes to psychiatric prescribing practices including:
        - mandated information and education for consumers about the health risks of treatments
        - discontinuation of compulsory treatment if, or when, physical health impacts occur
        - new limits to compulsory treatment to prevent high doses and/or polypharmacy
    - increased access to safer treatments, like talking therapies
    - equitable access to health services that specialise in what we need, including access to physiotherapists, dietitians and health psychologists who offer specialist practice to respond to medication side effects, mental and emotional health impacts and socioeconomic factors
    - funding models that address socioeconomic disadvantage – many of us simply can't afford high-cost health foods, gym memberships, running shoes or nicotine replacement therapy, or even the gap to see a GP; we need access to affordable and inclusive services to screen for health conditions and to create opportunities for improved overall physical health
    - health practitioners who actively work with us to improve our health and life expectancy.

Maggie Toko
Chief Executive Officer

Oncology and orthopaedic health services often provide specialist physical health and rehab services and clinics because these treatments create these needs. Psychiatry also impacts on physical health – so where are our specialist physical health programs and clinics?

Tandem's perspective

Tandem welcomes the production of *Equally well in Victoria* as a statement of the Victorian Government's commitment to redressing the gap between mortality and morbidity rates in Victorians with diagnosed mental health issues compared with the rest of the population. Family and friends supporting these consumers have long been concerned about this issue and call for immediate action.

There are multiple factors currently impeding a focus on the physical health of consumers. Mental health services and their staff often seem to accept that consumers have compromised health due to negative lifestyle choices, and they have not seen addressing these concerns as in keeping with or as part of their roles.

Tandem is encouraged to see that some mental health services in Australia have run pilot programs including integrated and multifaceted programs with non-mental health staff, other health professionals and peer support workers to address the complex factors that affect physical health and wellbeing. Ideally, when designing and delivering new services in Victoria, drawing on the positive outcomes of such programs could lead to improved physical and mental health outcomes for mental health consumers and their families.

Family and friends have a valuable role in assisting to improve the physical health of consumers across the lifespan; however, this requires a very different service model from the one we currently have.

Tandem is pleased that *Equally well in Victoria* acknowledges and challenges the prejudice and lack of holistic care that has previously inhibited people with mental illness receiving respectful care. It will prove to be a useful document in guiding mental health staff about how they can respectfully engage with consumers, their family and friends, about their physical health goals, medications and care plans and about how to manage chronic illness. A partnership approach will almost certainly produce a better care plan and fit in with the broader recovery framework as laid out in the *Mental Health Act 2014* and *Victoria's 10-year mental health plan* (2015).

Tandem is pleased to work with the Office of the Chief Psychiatrist on the production of this framework. It is an important step in addressing the inequity in the physical health and wellbeing of consumers and their families.

We look forward to the implementation of this framework in Victoria and to a future where Victorians are equally well, regardless of their mental health status.

Marie Piu MAPS
Chief Executive Officer

A case for change:
a Victorian study of the interplay of mental illness on cardiovascular health from a consumer's perspective

The below was authored by Teresa Kelly[1] RN, MHN, PhD Candidate, Department of Nursing, School of Health Sciences, The University of Melbourne, and Professor Suresh Sundram, Unit Head, Adult Psychiatry, Monash Medical Centre, Department of Psychiatry, School of Clinical Sciences, Monash University. (Extract from themes and findings of Teresa Kelly - Victorian PhD Candidate thesis 2019).

Cardiovascular disease is the major cause of premature mortality in people who live with serious mental illness. All of us have been vexed by this tragedy of high morbidity and mortality rates, with people dying up to 20 years younger than the general population. The improvements in cardiovascular health in the general population that have resulted in substantial reductions in mortality have not benefited people who live with serious mental illness.

Extensive research has produced important biomedical knowledge of cardiovascular disease in mental illness populations. However, this knowledge has not translated into improvements in the cardiovascular health of people with serious mental illness.

To date, strategies have emphasised protocols to identify and respond to biomarkers of cardiovascular disease risk. Yet these have signally failed to impact this longstanding health inequality between those with and without mental illness. Understanding why this is so is the bedrock of our research questions and aims.

Using an interdisciplinary and multiperspective approach generated new knowledge of the complex interplay of mental illness on cardiovascular health; knowledge that places the person and their cardiovascular vulnerabilities in the context of a much broader narrative.

Understanding this identified four new perspectives. The **first** is that mental illness is a potent contributor to lived cardiovascular vulnerability. Mental illness switches on and sustains a constellation of factors that work together to generate and perpetuate cardiovascular disease risk. These factors include medication-related cardiometabolic disturbance, socioeconomic disadvantage, social isolation and illness identity formation. Once activated this complex array of factors interacts, resulting in mental illness and cardiovascular vulnerability becoming enmeshed. This creates profound disempowerment and powerlessness.

The **second** perspective is that there are multiple interpretations of heart and heart health. For many people hearts are the intersection of physical, mental, emotional and spiritual health. Acknowledging these diverse understandings of the human heart unlocks new ways of engaging people with their hearts and their heart health.

The **third** perspective is that even though cardiovascular vulnerability associated with mental illness is real, cardiovascular disease is not the inevitable consequence. That is, cardiometabolic risk factors such as those induced by prescribed psychotropic medication, lifestyle factors and social disadvantage are real and patterned into people's lives. But their stories also showed that improving cardiovascular health is possible. People care about their heart health. They demonstrated capacity for self-care, cultivated connection and belonging to self, others and their world, and found meaning and purpose in adversity and in everyday life. Some made and sustained heart-healthy lifestyle changes.

1 Teresa Kelly's PhD research project was supported by a NHMRC/National Heart Foundation Postgraduate Scholarship from the National Health and Medical Research Council, and the National Heart Foundation of Australia. Reimbursement of participants was supported by a NorthWestern Mental Health Seed Grant.

The **fourth** and ultimately most important perspective is that connection is key to transforming cardiovascular vulnerability into possibilities for improved cardiovascular health. Disconnection, isolation and powerlessness were powerful contributors to the emergence of interacting cardiovascular risk factors. However, overcoming disconnection, isolation and powerlessness enabled the emergence and interplay of protective factors. Connection, autonomy and empowerment gave rise to positive identities, self-agency and the desire and capacity for restorative heart-healthy lifestyle change.

Using an interdisciplinary and multiperspective exploratory approach generated a new narrative for understanding the cardiovascular risks associated with living with mental illness. This new narrative extends beyond the parameters of biomedical and biopsychosocial frames. It affirms mental illness to be a powerful contributor to lived cardiovascular vulnerability, generating an array of factors that individually and collectively initiate and power a cascade of interconnected cardiovascular risks.

'By drawing on peoples' stories of personal and lifestyle transformations, this new narrative points to connection as a critical driver for recovery and holistic heart health. Connection in this context includes connection and belonging to self, others, communities, nature, and the spiritual and existential realms. From this perspective, enabling heart health is not separate from recovery-oriented care; rather, it depends on it. Recovery facilitates the undoing of illness identities and the building of empowered and connected identities. This identity transformation enables the emergence and activation of the protective factors for cardiovascular disease'.

This new narrative shows that the psychosocial and subjectively defined determinants of cardiovascular disease are inextricably linked to identity, recovery and human flourishing. However, it also highlights a divide between recovery-oriented practice, supported decision making, trauma-informed care and the dominant problem-focused approaches to responding to cardiovascular risk in contemporary mental health care settings.

Addressing the cardiovascular inequalities experienced by people who live with serious mental illness calls for radical and transformational action. First, it requires a philosophical shift from an interventional biomedical model to a relational and integrated approach to holistic heart health. Second, it necessitates incorporation of foundational mental health practice principles such as recovery-oriented practice, trauma-informed care and supported decision making as core elements of practice models that aim to improve heart health. This then will provide the framework to introduce biomedical considerations and co-produced holistic and individualised approaches to improving heart health.

This whole of system transformation must be underpinned by human rights principles and a coproduction methodology. At its core, it will require:

1. **acknowledgement that personal understandings of the heart and heart health matter**
2. **activation of transformational qualities such as connection, autonomy and empowerment across a range of dimensions**
3. **commitment to building the capacity of clinicians and peer-workers for relational holistic evidence-based heart health improvement**
4. **commitment to building capacity of consumers and carers for evidence-based heart health self-care**
5. **foundational reappraisal of how effective interventions should be conceived, shaped and tested.**

About this document

People living with a mental illness have poorer physical health yet receive less and lower quality health care than the rest of the population. In 2016 the National Mental Health Commission released the *Equally well consensus statement: Improving the physical health and wellbeing of people living with mental illness in Australia*. The consensus statement calls for better collaboration and coordination between governments, professional bodies, social and community services and other leaders in mental health to make the physical health of people living with mental illness a national priority. The consensus statement ultimately aims to reduce the life expectancy gap that exists between people living with a mental illness and the general population.

Achieving this requires the ongoing commitment to foundational mental health practice principles such as recovery-oriented practice, trauma-informed care and supported decision making as core elements of practice models at both the organisation and clinician levels. This framework outlines how this can be achieved in Victorian specialist mental health services.

Purpose

- To support mental health services to make decisions about developing, implementing and reviewing policies, procedures and programs that help consumers to make decisions about addressing physical health issues.
- To enable services to provide a positive experience of care and improve outcomes for consumers, with the support of families and carers.
- To create a consistent approach to physical health care in Victorian specialist mental health services.

Scope

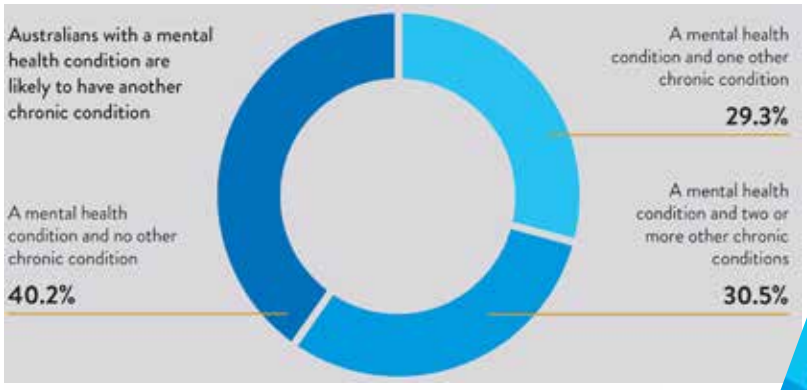
This framework applies to all Victorian specialist mental health services across different practice settings and all ages. The framework is intended to complement existing professional standards and related practice frameworks and adhere with the Health Practitioner Regulation National Law regarding scope of practice for health practitioners.

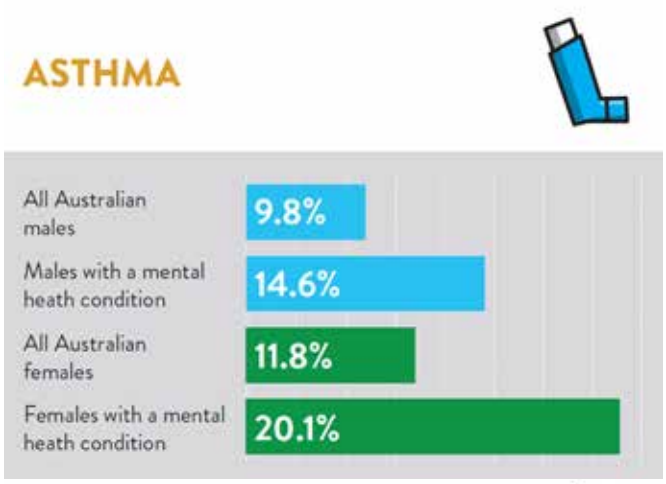
What we know about physical health

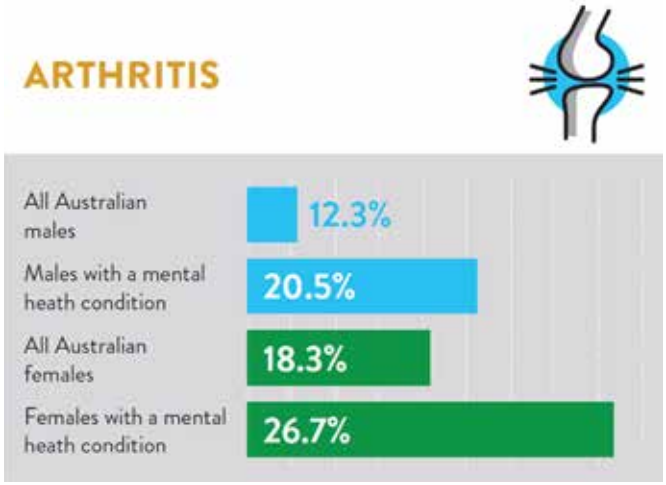
A number of documents released recently in Australia highlight the interlinked issues associated with mental health and physical health. These issues exist across the general population, as well as for people living with a severe mental illness.

- Figure 1, *Australia's mental and physical health tracker,* describes Australia's performance in tackling the higher risk factors and incidence of preventable chronic physical disease among people with mental health conditions.
- Figure 2, the *Equally well consensus statement,* outlines a number of physical health conditions and their impact on people living with mental illness at the national level.
- Figure 3, *Victoria's mental health services annual report 2016–17,* provides an overview of the information available on physical health issues for people with severe mental illness. This includes data on various aspects of our services and system, including aggregated data on emergency departments and area mental health services.

Figure 1: Facts and figures on physical and mental health

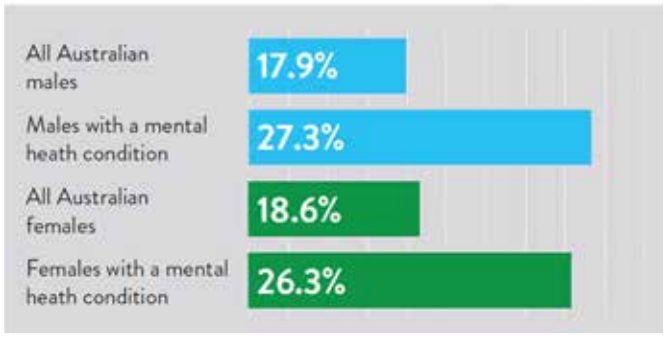






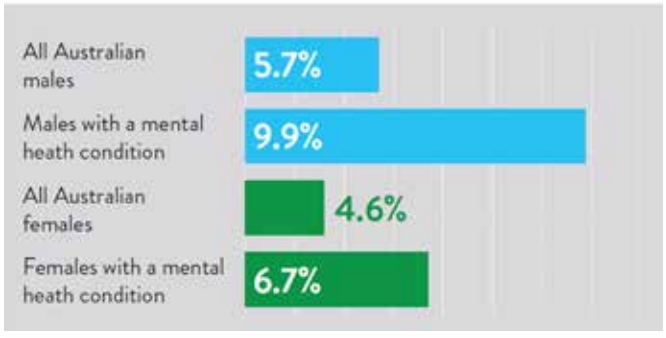
Australia's mental health and physical health tracker: Harris B, Duggan M, batterham P, Bartlem K, Clinton-Mcharg T, Dunbar J, Fehily C, Lawrence D, Morgan M, Rosenbaum S. 2018 Australia's mental health and physical health tracker, Australian Health Policy Collaboration, August 2018

CIRCULATORY SYSTEM DISEASE



BACK PROBLEMS

DIABETES



CANCER

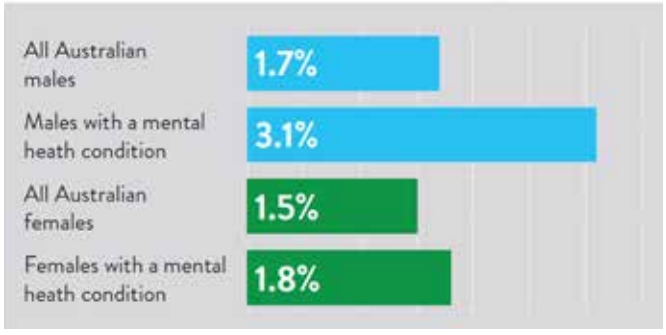
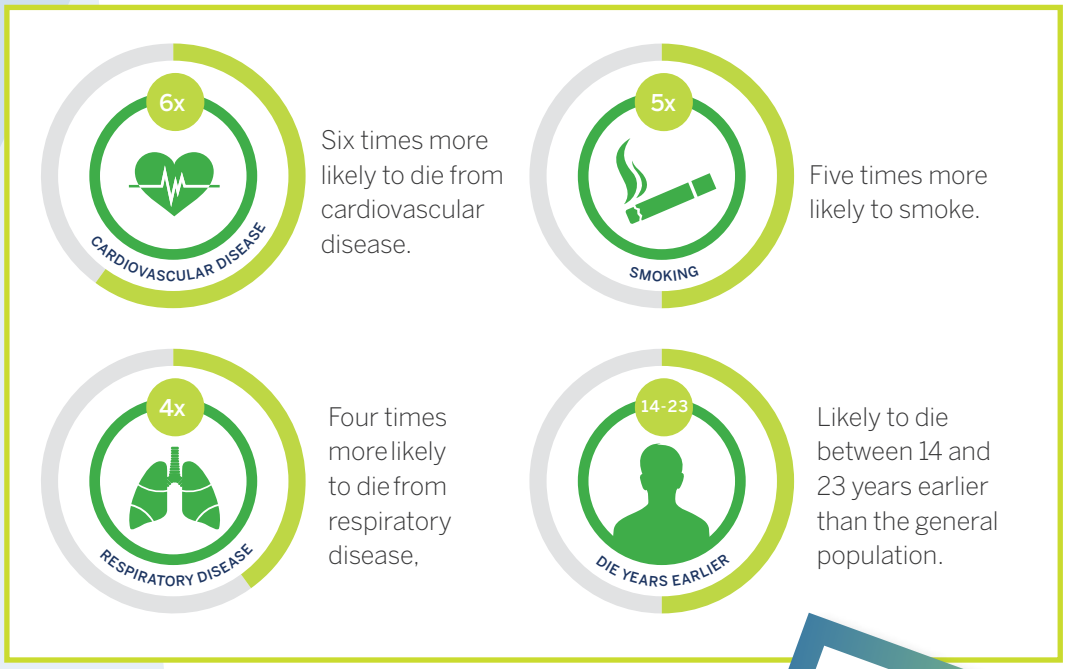


Figure 2: Statistics from the *Equally well consensus statement*



Equally Well – National Mental Health Commission. Equally Well Consensus, Statement: Improving the physical health and wellbeing of people living with mental illness in Australia. Sydney NMHC, 2016.

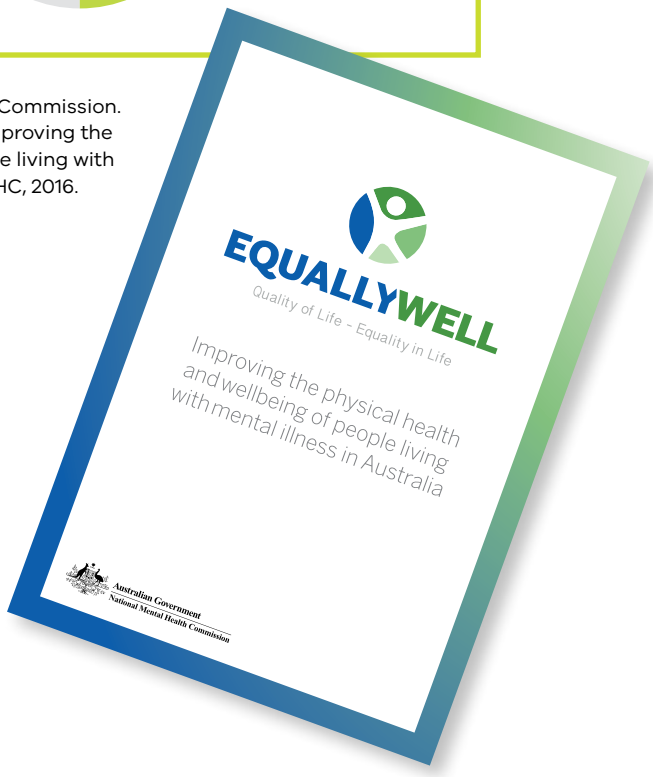


Figure 3: Statisitics from *Victoria's mental health services annual report 2016–17*

10.6%

Type 2 diabetes

The total of registered adult mental health clients with a recorded diagnosis of type 2 diabetes during 2015–16 was almost double at 10.6 per cent compared with 6 per cent of the Victorian adult population.

3.1 x

Emergency department admissions

- Victorians with a mental health condition were 3.1 times more likely to be admitted to hospital for a chronic ambulatory care sensitive condition and 6.7 times more likely to be readmitted within 28 days.
- 3 per cent of public hospital admissions and 4 per cent of people using emergency departments were Victorian mental health clients admitted for physical health conditions, although they represent less than 1 per cent of the general population.

50%↑

Life expectancy

The crude death rate for registered mental health consumers in 2015 was nearly 50 per cent higher than for other Victorians.

33.4%

Smoking

33.4 per cent of registered clients of Victorian public mental health services who were hospitalised were smokers.

39%↑

Cost

The cost of mental health patients admitted to public hospitals for physical conditions is 39 per cent higher than for an average inpatient stay and 77 per cent higher for an emergency department attendance.

Social determinants of health and mental illness

Good mental health is integral to human health and wellbeing. A person's mental health and many common mental disorders are shaped by various social, economic and physical environments operating at different stages of life. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk. In terms of physical health for mental health consumers, as outlined in the *Equally well consensus statement*, many factors contribute to the poorer physical health experienced by people with mental illness (Figure 4). These factors include:

- intergenerational trauma
- stigma and discrimination
- exposure to violence and abuse
- unemployment
- inadequate housing
- poor access to services
- poverty
- low income
- social exclusion
- lack of education
- poor-quality care.

Figure 4: Interrelated dynamic elements affecting people's physical health

Adapted from: NHS England 2016, Improving the physical health of people with mental health problems: Actions for mental health nurses, Department of Health, London.

The framework

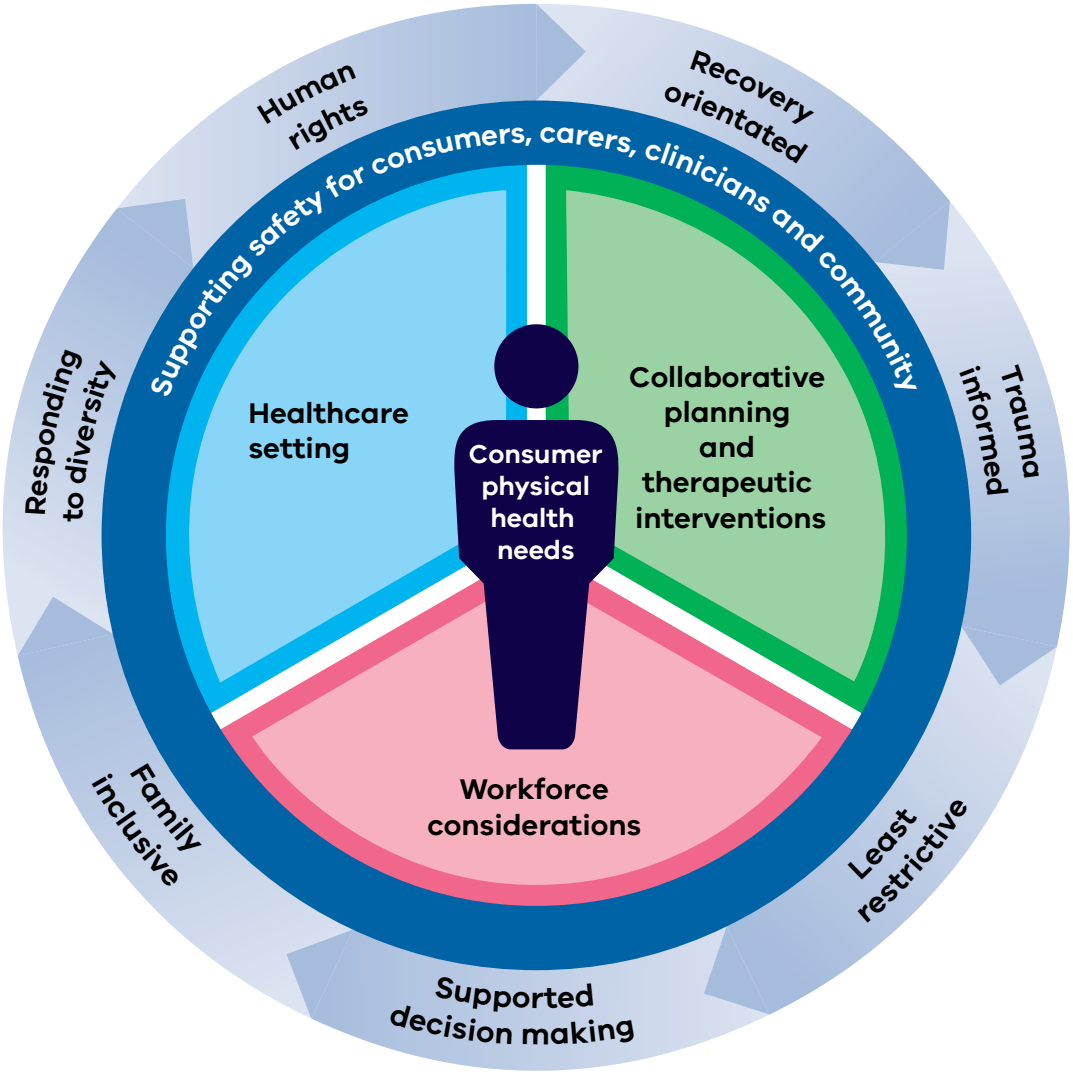
The framework

Every time a consumer engages with a mental health service it provides an opportunity for clinicians to work together to understand physical health issues and how they impact on recovery goals and to offer help and support to address them. This includes working with the consumer's family, carers and support community to better understand their health needs and goals, and this applies across service settings (inpatient and community).

Equally well in Victoria places consumers at the centre of making decisions about their physical health. The framework describes five interconnected clinical practice domains that are underpinned by seven core practice principles that support physical health care in Victorian specialist mental health services (Figure 5).

The framework describes the necessary elements at the organisation and clinical practice levels to guide implementation of physical health in a consistent way across Victoria.

Figure 5: Equally well in Victoria – clinical practice domains and principles



Domains and principles

Services providers must give regard to the principles and provisions of the *Mental Health Act 2014* (Vic) when delivering mental health care.

Principles

Equally well in Victoria is underpinned by a commitment to the following principles.

Recovery-oriented: *The Framework for recovery-oriented practice* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Framework-for-Recovery-oriented-Practice> should underpin the practice of all Victorian mental health services. The framework outlines the core principles, key capabilities and practices required for mental health services to operate in ways that optimally support people's recovery efforts. Clinicians will provide a recovery-oriented service with the aim of supporting individuals to define and work towards their personal goals, which includes their values, preferences and desires regarding their physical health. This will be done with a clear understanding of the challenges associated with their mental illness.

Trauma-informed: An understanding of, and responsiveness to, the impact of trauma that emphasises physical, psychological and emotional safety, and practices that ensure a universal precaution approach. Trauma-informed services understand the profound neurological, biological, psychological and social effects of trauma and violence on the individual and appreciate the high prevalence of traumatic experiences in people who receive mental health services.[2] A trauma-informed approach is based on the recognition that many behaviours and responses (often seen as symptoms) expressed by people are directly related to traumatic experiences. Services take an active role in preventing re-traumatisation.

2 Mueser KT, Goodman LB, Trumbetta SL, et al. 1998, 'Trauma and posttraumatic stress disorder in severe mental illness', Journal of Consulting and Clinical Psychology, 66(3): 493–499.

Human rights: Rights are protected by the Mental Health Act and the Charter of Human Rights and Responsibilities Act 2006. Services are obligated to protect human rights, which includes knowing, understanding and applying human rights perspectives and protections in their work. Service providers must ensure all necessary steps to support effective communication of rights are undertaken and documented, including providing patients' rights handbooks and giving repeated explanations over time.

Supported decision making: Every service provider has an obligation to enable and support all consumers to make or participate in decisions about their treatment and to determine their individual path to recovery. Legal mechanisms in the Act that enable supported decision making include a presumption of capacity, advance statements, nominated persons and the right to seek a second psychiatric opinion.

Family-inclusive: Identification and acknowledgment of the role of families and carers is vital in supporting recovery. Families and carers can play an important role in reinforcing healthy lifestyle practices, supporting consumers with health behaviours and healthcare appointments. Family-inclusive practice refers to a range of actions and activities that directly involve members of the consumer's social network in their treatment support. This includes being involved in assessments, education and decisions around referrals and appointments. Consideration of the views and support needs of families and carers, including children, can enable broader health outcomes.

Responding to diversity: As an integral part of their practice, mental health clinicians must recognise, respect and respond to the diverse needs, values and circumstances of each person. This includes their gender, family circumstances, culture, language, religion, sexual and gender identity, age and disability.

Least restrictive: The aims and objectives of the Act set out the principles of care in the least restrictive environment consistent with the effective provision of treatment and care. These aims serve as a foundation for all professionals working with people who have a mental illness or disorder. Any restrictions on a person's human rights or interference with a person's rights, privacy, dignity and self-respect will be kept to the minimum necessary to provide treatment and care.

Domains

Consumer physical health needs: At the centre of the framework is the holistic identification of the person's needs through a collaborative process that engages the consumer, carers and clinicians.

The individual's physical health needs are identified and addressed by the consumer, with the support of clinicians and carers. Mental health and many common mental disorders are shaped to a great extent by the social, economic and physical environments in which people live. Social inequalities are associated with increased risk of many common mental disorders. It's important to understand how the social determinants of health impact on each consumer's life.

Collaborative planning and therapeutic interventions: The planning process is consultative and collaborative to engage and understand the consumer's perspective/journey related to physical health and physical illness. The planning will consider the links to personal recovery goals and will be responsive to the consumer's readiness to make changes to physical health issues, respecting their wills and preferences. Collaboration recognises that families, carers and the person's unique support community have valuable knowledge and insights about the consumer. They often hold resources that can assist in supporting recovery.

Healthcare setting: Services can co-design the necessary policies and practices to support the clinicians, consumers and carers with the physical health goals established in recovery plans. The approach to integrating physical health into practices within the service include a focus on an interprofessional model of care that incorporates effective governance and leadership across all mental health settings. Referral pathways to appropriate physical health specialists and programs (within or outside the service) should be established.

Workforce considerations: Consider the resources, skills and experience necessary to meet the consumer's needs, maintain safety and enhance therapeutic engagement. Supporting physical health requires a range of skills including specialist skills, appropriate resourcing and interprofessional input. Workforce considerations occur along a continuum that begins with identifying and engaging with people early about their health needs and goals.

Supporting safety: An overarching domain that supports safety for all when engaging consumers about their physical health care. This domain includes the 'four Cs' – consumer, carer, clinician and community. Promoting safety and wellbeing for all is an iterative and continuous process that considers the consumer's needs and safety issues, the communal and environmental risks and the safety requirements of staff.

Family Violence Multi-Agency Risk Assessment and Management Framework

The new Multi-Agency Risk Assessment and Management Framework[3] (MARAM) has been developed as part of the Royal Commission into Family Violence recommendations. The MARAM aims to increase the safety of all Victorians by ensuring that identification, assessment and management of family violence (FV) risk is shared by organisations across the state.

Mental Health Services are in the process of implementing the MARAM framework and once available will use the MARAM assessment tools for FV assessments. If a FV assessment is undertaken, mental health clinicians will most likely utilise the brief or intermediate assessment. They may also have access to a comprehensive assessment, undertaken by a Family Violence Specialist. FV may have not been assessed and may become apparent during conversations about physical health.

All Government Departments need to align policies with the MARAM. Equally, all organisations prescribed under MARAM (including Clinical Mental Health Services) are also required to bring their policies into alignment.

This physical health framework has been aligned with the MARAM and the reader will notice references to the MARAM throughout the document.

3 State Government of Victoria 2018, Family violence multi-agency risk assessment and management framework. A shared responsibility for assessing and managing family violence risk. Melbourne.

The framework in action at the organisation level

The framework in action at the organisation level

This framework describes the need for mental health services to place consumers at the centre of the design, implementation and evaluation of physical health care for consumers. There is an increasing body of good practice and evidence available to support specialist mental health services in designing integrated physical and mental health care. This framework outlines the importance of integrating healthcare settings, collaborative planning and therapeutic engagement and workforce considerations in addressing consumer physical health needs. The healthcare setting domainis explored in detail in this section.

Healthcare setting

To embed integrated physical and mental health care in specialist mental health services, clinical leaders and organisational managers must embrace co-design principles to establish (Figure 6):

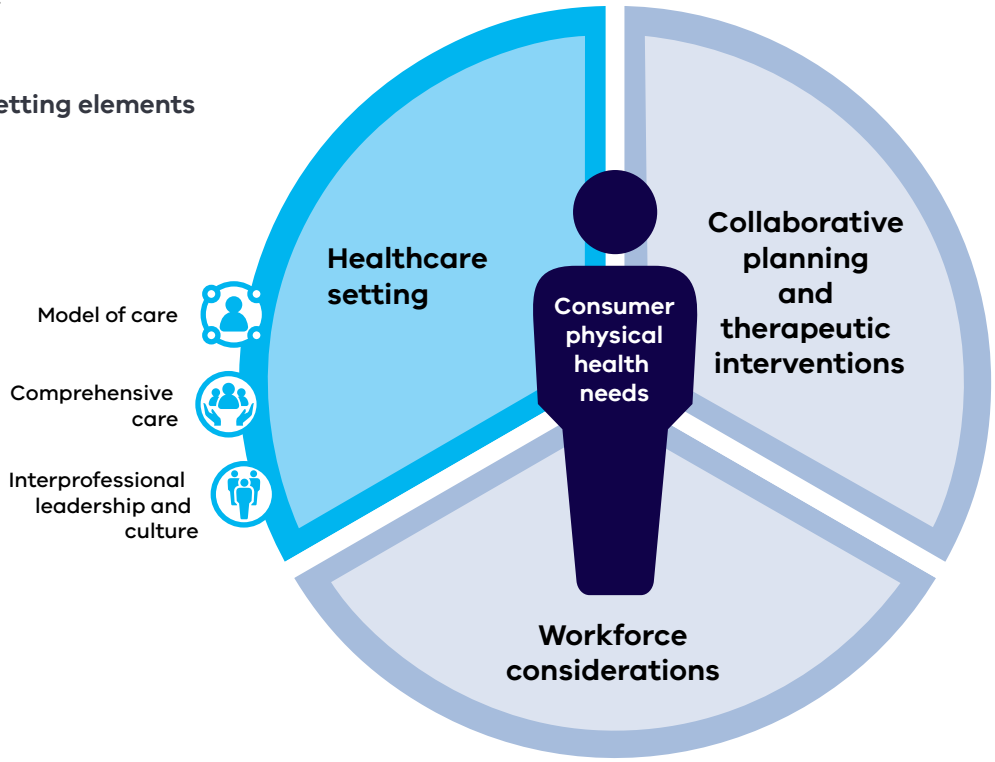
- interprofessional leadership and culture
- model of care
- comprehensive care.

Preparation

Undertake an organisational assessment to:

- understand current or previous practices and initiatives in improving the physical health of consumers across the different specialist mental health consumer pathways or service continuums
- identify the likely physical health risk profiles of consumers in each setting
- identify opportunities for partnering with consumers and carers in identifying physical health interventions in each setting
- understand interprofessional workforce capabilities related to physical health care and competencies for engaging with consumers in addressing physical health
- understand the way data is used to inform practice and monitor progress
- understand the engagement of consumers and carers at all levels of operations and governance to support learnings, feedback and quality improvement of health practices.

Figure 6: Healthcare setting elements



Action area: Interprofessional leadership and culture

Healthcare setting

Leadership demonstrates a commitment to the vision that 'People living with mental illness have the same life expectancy as the general population'. Leaders motivate the workforce, consumers and carers and broader health partners to align activities throughout the organisation.

Core to any leadership role is accountability. Accountability means that leaders have clear responsibilities and accountabilities within the organisation's governance structures in relation to the framework.

The roles and responsibilities of effective leadership should be clear and understood when developing and implementing strategies to improve the physical health outcomes for mental health consumers.

Detailed actions on comprehensive care are available at Appendix 3.

'High-quality health care requires clinicians and consumers to be engaged.

Culture doesn't just happen; it is purposeful. A strong organisational culture is required to support leaders and staff to create and maintain high-quality care. The culture should be one of fairness, respectfulness and transparency. It should be based on principles of natural justice, innovation, learning from errors and accountability for decisions and behaviours.' [4]

4 Safer Care Victoria 2017, Delivering high-quality healthcare: Victorian clinical governance framework, State of Victoria, Melbourne

Action area: Model of care

Healthcare setting

This describes a model of care for routine delivery of, and engagement with, consumers and carers in:

- primary prevention of avoidable harm
- early identification of, and intervention in, the interactions between mental illness, medication, psychotherapy and other treatment and physical health risk factors
- comprehensive care
- ensuring access to physical health services is articulated for each setting.

The model of care should be responsive to the individual needs and diversity of consumers within each setting and across all age groups. The sustainable delivery of safe and quality care for both mental and physical health needs across the service continuum is dependent on having the right service delivery structure with associated interprofessional workforce roles, practice tools and resources and effective partnerships with consumers. Key features of evidenced approaches in physical health care include the following components.

Collaborative and recovery-focused: Collaborative practices, ensuring that people are able to exercise optimal choice, personal agency and flexibility and recovery-focused practice'[5] are well aligned and evidenced as effective in supporting physical health self-management. Models would include how the principles of recovery are enacted in supporting decisions about physical health in delivering health care.

Self-management: Supporting people to self-manage can result in significant physical health outcome gains such as improved symptom management. Self-management is a key element in contemporary optimal integrated chronic disease management. Key elements of self-management are the person: understanding their condition; being supported in making decisions; setting goals; following the treatment plan; monitoring their symptoms; being fully informed of their illness, the effects of their illness and medication; and having a healthy lifestyle.

- Every mental health service will have processes and information resources that support consumers to make choices about their physical health, build health literacy and enhance self-management skills.
- Strategies must be in place to support a skilled, competent and proactive interprofessional workforce in effective, evidence-based mental and physical health practice.

Important note: The principle of self-management does not take away from the responsibility of clinicians, or from the impact of disadvantaged socioeconomic status:

- Consumers cannot manage their physical health without all the relevant information. Clinicians have a responsibility to ensure consumers are fully informed of health risks and their options.
- Many consumers come from extreme socioeconomic disadvantage and will face many practical barriers to self-management of physical health (for example, Medicare gap fees, gym costs and the cost of healthy food).

Detailed actions on comprehensive care are available at Appendix 3.

5 Department of Health 2011, Framework for recovery-oriented practice, State of Victoria, Melbourne

Action area: Comprehensive care

Healthcare setting

People living with a mental illness are less likely to be screened for physical health conditions (for example, cholesterol) and lifestyle risk factors than other members of the community. They are consequently less likely to be offered physical health interventions.

The evidence shows that people with a mental illness are significantly more likely to have a co-existing disease whose optimal management requires services from a number of healthcare providers.

There are complex, bi-directional interactions between mental illness and physical illness. Mental illness can challenge a person's capacity to implement lifestyle behaviours, to engage with physical healthcare providers and to self-manage health conditions.

Burden of treatment: In the minimally disruptive medicine approach, the burden of treatment represents the challenges associated with everything consumers do to care for themselves – for example, visits to the doctor, medical tests, treatment management and lifestyle changes.

Consumers with chronic conditions find it difficult to integrate everything asked of them by their healthcare providers in their everyday life (between work, family life and other obligations). Treatment burden is associated, independently of illness, with adherence to therapeutic care and could affect hospitalisation and survival rates.

Treatment burden for consumers exhibiting multiple chronic conditions can be assessed using validated tools that may help develop treatment strategies that are both efficient and acceptable for consumers.

Improving the physical health as well as the psychological and social recovery of people living with mental illness requires comprehensive care delivered seamlessly across physical and mental health services. For people with complex needs, poor coordination of care increases the risk of poor health outcomes.

Comprehensive care will ensure people living with mental illness have access to the services they need, opportunities for early intervention, health promotion and improved health and care outcomes.

Detailed actions on comprehensive care are available at Appendix 3.

'Comprehensive care – that is, coordinated delivery of the Interprofessional health care required or requested by a patient. This care is aligned with the patient's expressed goals of care and healthcare needs, considers the effect of the patient's health issues on their life and wellbeing, and is clinically appropriate.'[6]

6 Australian Commission on Safety and Quality in Health Care 2017, National Safety and Quality Health Service Standards, 2nd edn. ACSQHC, Sydney

THE Multi-Agency Risk Assessment and Management Framework (MARAM)

The MARAM framework outlines organisational responsibilities for risk assessment and management and the necessary processes needed to support staff.

Publication of this physical health framework is likely to precede organisational policy alignment with MARAM. Such alignment will more clearly outline organisational and staff responsibilities for assessing family violence risk.

Organisational responsibilities include ensuring staff understand the nature and dynamics of family violence and that they have the necessary training to identify and assess family violence. Responsibilities also include ensuring staff have access to adequate supervision and secondary consultation to undertake family violence assessments and contribute to the new information sharing schemes (as authorised by legislation). Staff need to be supported to actively contribute to coordinated risk management.

For an outline of organisational responsibilities see page 45 in the MARAM framework.

Implementing the framework – for clinicians

Implementing the framework – for clinicians

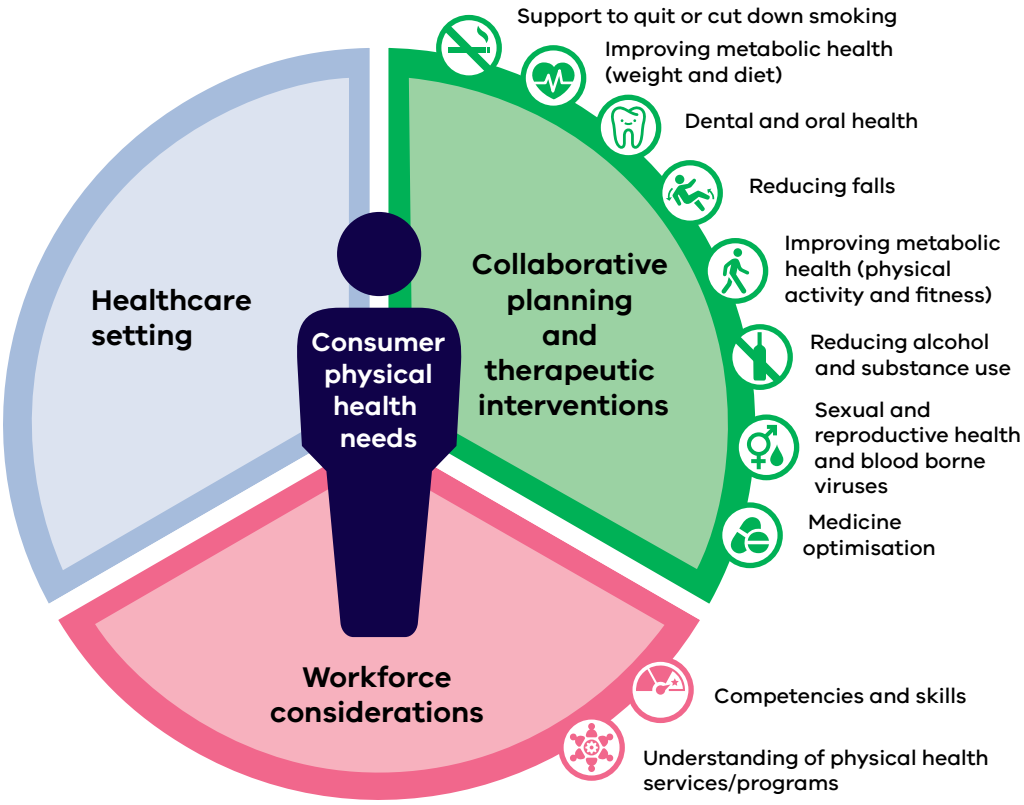
As described in the case for change, addressing physical health inequalities among people who live with serious mental illness requires a radical approach to engagement and care planning for clinicians.

It is radical because it asks clinicians to transform the conditions necessary for engaging in discussion and treatment of physical health for people with serious mental illness from an interventional biomedical approach to a person-centred, integrated approach to holistic health. It asks clinicians to work in partnership with consumers to explore the connection of physical, mental, emotional and spiritual health. Through this engagement, clinicians, consumers and carers can use biomedical considerations to co-design a holistic and individualised approach to improving physical health issues.

This has similarities with the 'minimally disruptive medicine' approach to care in chronic illness. Minimally disruptive medicine is a concept that seeks to tailor treatment regimens to the realities of the daily lives of consumers. The approach seeks to advance a consumer's goals for health, health care and life using effective care programs designed and implemented in a manner that respects the capacity of consumers and carers and minimises the burden of treatment (the 'healthcare footprint') that the care program imposes on their lives.

The aim of clinicians is to work with consumers to instil confidence that physical health issues can be managed and improved. This can be achieved by developing care plans incorporating the domains of 'collaborative planning and therapeutic interventions' and 'workforce considerations' (Figure 7).

Figure 7: Integrating the 'collaborative planning and therapeutic interventions' and 'workforce considerations' domains



Priority areas

Using a whole-of-health approach, the following eight areas have been identified by consumers, carers and clinicians within the expert reference group involved in developing this framework as priority areas for action.

Priority area 1: Support to quit or reduce smoking
Priority area 2: Improving metabolic health (weight and diet)
Priority area 3: Improving metabolic health (physical activity and fitness)
Priority area 4: Reducing alcohol and substance use
Priority area 5: Sexual and reproductive health and blood borne viruses
Priority area 6: Medicine optimisation
Priority area 7: Dental and oral health
Priority area 8: Reducing falls.

Clinical approach to care planning and management

Clinicians have a unique opportunity to engage therapeutically, assess and offer options to address physical health needs by:

- reviewing the eight priority areas identified in this resource
- considering the social determinants of health with every consumer engagement, particularly when assessing, referring, delivering and facilitating psychosocial, psychological and physical interventions
- following the relevant guidelines for each priority area
- considering the activities to achieve change for each priority area in relation to the needs and care of individuals and the development of their care plans
- developing a care plan for each individual based on their identified need to address their physical health
- considering the individual's will, preferences and goals that the person considers the most important areas to address, taking into account their support needs for managing complex comorbidities (look for opportunities to engage families, carers and others in supporting change)
- using the stages of care planning: 'collaborative planning', 'formalise plan', 'therapeutic engagement' and 'evaluate' as a cycle to achieve improvements in each consumer's physical health and wellbeing (Figure 8).

Physical health and family violence

This document has been aligned with the new Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM). The reader will notice reference to the MARAM throughout this document. While some physical violence is obvious (bruises, breaks), other violence and its impact is less obvious.

  - If a family violence assessment has been undertaken, clinicians ought to be familiar with the person's current (lack of) safety prior to discussing physical health. If family violence was not identified and is identified during conversations, the person's safety is paramount. A family violence risk assessment needs to be undertaken. Discussion of physical health may need to take a back-step, or it might provide an ideal opportunity for support. If needed, seek support or secondary consultation from clinicians trained in family violence assessment or from a Family Violence Specialist Services for support.
  - Remember that mostly women, children and young people experience family violence, however, also elderly people and people in same-sex relationships experience such violence.

Figure 8: Care planning – exploring the potential for individual change and improving physical health

Collaborative planning

- Use a person centred approach to assess the individual's current physical health
- Listen to the person, their preferences and concerns
- Identify what is important to the person, how they live their life and what they want to change
- Acknowledge and address the individual's fears and anxieties
- Use an appropriate physical assessment tool.

Formalise plan

- Work with the individual to create a shared care plan for improving their physical health and wellbeing
- Identify key goals and aspirations, set dates and times that are realistic and manageable for achieving measurable outcomes
- Identify local health, social care and/or voluntary services that can provide particular types of support
- With the person's consent, work in partnership with other healthcare professionals to promote equal access to all appropriate healthcare
- Agree what will be in the care plan and give a copy to the individual.

Evaluate

- Monitor and review progress with the individual and refine and adjust care plans if necessary
- Discuss and record outcomes of specific actions and interventions with the individual
- Gather evidence on the impact of any changes, for example by repeating assessment tool measures
- Review priorities and action areas and negotiate with the individual to update their care plan
- Repeat the care planning cycle.

Therapeutic engagement

- Work in a person centred, integrated, holistic way to implement the plan of care
- With the person's consent, involve carers and other healthcare professionals if appropriate
- Make sure the individual receives treatment for their physical health problems
- Use the activities to achieve change outlined under each action area
- Continually encourage individuals to take care of their physical health.

Modified from: NHS England 2016, Improving the physical health of people with mental health problems: Actions for mental health nurses, Department of Health, London.

Priority area: Support to quit or reduce smoking

Collaborative planning and therapeutic interventions

Understanding the consumer's perspective or journey

- Asking consumers if they smoke is an important part of physical health assessment.
- Use positive language. Do not make people feel bad about their smoking; do not blame.
- Walk beside the person on their journey. Engage in a supported decision-making conversation.
- Identify if the person would like to discuss it or receive information/assistance with smoking reduction/cessation.
- Explore the relationship people have with their smoking, what it means to the person and how it is helpful (for example, to reduces stress, social connection).
- Ask about trigger points and what might be possible (reducing smoking, having more control of their smoking) or just begin the discussion.

Links to recovery goals

Explore how smoking affects the consumer's recovery goals. For example, its effect on finances, managing fear and frustrations, lifestyle aspirations (activity and exercise), socialising and health (desire to reduce/quit smoking, improve breathing and overall health).

When the consumer is ready to quit or reduce smoking

- Follow the three-step brief intervention model (see practice tips section next page).
- Adopt a team approach and work collaboratively with pharmacists, doctors, Quitline, counsellors and other allied health professionals to ensure consumers receive brief advice that links them to both pharmacological support and a multi-session behavioural intervention.
- Engage with Quitline and other local smoking cessation services to plan and deliver community-based support for people living with mental health problems and to support those transitioning from inpatient to community services.
- Explore how smoking might relate to the person's mental health experiences (Is it meeting a need that could be addressed another way?).
- Advise people that the best way to quit/reduce smoking is with a combination of support and medication and that help is available.
- Calculate the amount of money saved by not smoking and ask how it might be spent. Seek permission to provide psychoeducation about improved mental health following nicotine withdrawal, improved physical health and reduction in medications affected by tobacco, and explore lifestyle aspirations (activity and exercise) and social impacts.
- Support people who experience smoking withdrawal symptoms.
- Support health service policies on smoke-free environments.
- Consider 'motivational interviewing' or other evidence-based strategies and techniques.

Practice tips: three-step brief intervention model

1. Ask all clients: 'Do you smoke (tobacco or anything else)?'

2. Advise: Seek permission to give advice about smoking and how it might be interacting with the presenting condition: 'Stopping smoking improves mental health and wellbeing.'

3. Help: Make an enthusiastic offer of help – provide self-help material and advice regarding pharmacotherapy and offer a multi-session behavioural intervention such as a referral to Quitline **<https://www.quit.org.au/referral-form/>** or to a stop smoking specialist.

Reasons to offer consumers who smoke a referral to the Victorian Quitline 137 848

Accessible recovery-oriented multi-session smoking cessation and reduction support is available for consumers from 8 am to 8 pm Monday to Friday. Your referral <https://www.quit.org.au/referral-form> will initiate a call from Quitline to your client to offer the free callback service that includes:

- counselling to help build motivation, identify smoking triggers and build skills to manage triggers including mood management strategies that can dually help with stopping smoking, smoking refusal skills, instituting rewards to reduce feelings of deprivation and assistance to use cessation pharmacotherapy
- monitoring of nicotine withdrawal symptoms, many of which overlap with mental health symptoms such as depression, anxiety and anger/irritability – this helps to distinguish temporary withdrawal symptoms from a flare up of mental illness and linking consumers with their key clinician if a flare up occurs
- monitoring of medication side effects. Smoking cessation can increase the blood levels and hence side effects of some psychotropic medications (for example, clozapine, olanzapine and fluvoxamine) and of caffeine and alcohol. Consumers are referred to their treating doctor to discuss possible medication dose reduction. You will receive feedback on your client's use of the service and smoking behaviour following a referral.

When the consumer is not yet ready to quit or reduce smoking

- Respect the person's preferences if they do not want to discuss their smoking. Engage in a supported decision-making conversation.
- Offer to come back to this aspect of their physical health when they are ready.
- Explain that it is standard practice to routinely be asked about smoking status in future appointments and they will be invited to engage in conversation (if they choose to do so).
- Indicate that you are happy to keep the conversation open.

Workforce considerations

- Develop motivational interviewing skills.
- Develop the skills and confidence to administer nicotine replacement therapy.
- Develop trauma-informed care skills and skills in assessing for family violence (MARAM).
- Support and lead activities within services to become completely smoke-free.
- Familiarisation with Quit Victoria smoking cessation program.
- Create Interprofessional education and learning programs about smoking cessation.

Health promotion messages for consumers, carers and supporters

- The most effective way to quit is to combine nicotine replacement therapy or a stop smoking medication to help manage cravings with a multi-session behavioural coaching program, such as Quitline, to help manage triggers to smoke.
- Stopping smoking is one of the best things you can do to improve your physical health.
- Cutting down smoking can have significant financial benefits and it may make it easier to quit.
- If you are concerned about how nicotine withdrawal might affect your mental health, Quitline can help track how you are feeling while you try to stop smoking.
- Your doctor can provide you with a prescription to get very low cost nicotine patches or may suggest a medication to help manage nicotine withdrawal symptoms.
- Some medications for mental health become more effective once people stop smoking. This means you may experience medication side effects when you stop smoking and may need your dose reduced. See your doctor before making any changes.

Health promotion messages for mental health professionals

- Smoking is the leading cause of preventable death in people living with mental illness.
- Smoking can be addressed while treating mood, substance use and other conditions, and cessation of six weeks or more can improve mood and other outcomes.
- While many inpatients express dissatisfaction regarding being detained in a smoke-free environment, there is a high uptake of smoking cessation interventions when offered.
- Routinely offering a three-step brief intervention to consumers, regardless of their level of interest in stopping smoking, can trigger a quit attempt.
- It is safe for consumers to use nicotine replacement therapy, varenicline and bupropion, all of which improve the chances of quit success among people with mental illness.
- Supporting people to quit smoking is one of the most cost-effective healthcare interventions.
- Telephone smoking cessation interventions are just as effective as face-to-face interventions for people living with mental illness.

Youth mental health services considerations

- Involve parents where developmentally appropriate.
- Share clinical responsibility among all medical, nursing and allied health staff.
- Initiate a smoking policy for inpatient units including the use of nicotine replacement therapy in the under 18 age group.

65+ Aged care services considerations

- Lifelong habits take time to change – start small by highlighting the benefits of quitting or cutting down.
- Implement a detailed smoking history screen for all consumers.
- Residential services: ensure no-smoking policies and visual aids describing replacement therapies are positioned in areas where consumers can see them.
- Have the clinical team, including the person's GP, discuss the benefits of not smoking with the consumer.
- Conduct regular physical health reviews to monitor for the adverse affects of smoking and ensure routine testing is conducted for all consumers.

Priority area: Improving metabolic health (weight and diet)

Collaborative planning and therapeutic interventions

Understanding the consumer's perspective or journey

- Use positive language. Explore body image, how the person feels about their weight, their self-esteem (and how important it is to them), their identity and whether they would like to do something about it.
- Walk beside the person on their journey. Engage in a supported decision-making conversation.
- Ask about what weight goals they might have, what their views are, what they would like to do, what is important to them at the moment and what is possible given their living situation – for example, do they live at home, do they have family support, do they live in a share house that will affect what can be done. If medication is making them put on weight, explore the relationship between their weight and its effect on their mental health recovery.

Clinicians should be conscious of not contributing to low self-esteem or a low sense of self-efficacy when having these sensitive conversations with consumers. Many consumers with obesity will already be judging themselves harshly, and even a gentle conversation about these issues may have a negative emotional impact – particularly during an admission when the person may already have heightened sensitivity.

It is imperative that these conversations are non-blaming and begin by acknowledging that these are common issues for many mental health consumers. Clinicians should also acknowledge that some people work really hard to maintain health, with ideal diets and exercise, but are still unable to lose weight. Given the high prevalence of eating disorders as a co-occurring issue for consumers, it is important that conversations about healthy bodies are not linked only with weight.

Links to recovery goals

Explore the relationship between weight and diet with metabolic health for inclusion in recovery goals. Are weight or dietary habits getting in the way of socialising (eating out), getting a job, spending time with family, meeting someone?

Are there cultural aspects that influence eating habits (living with family or with someone else who does the cooking/ shopping)?

Is being able to buy and prepare healthy food a recovery goal? Are there circumstances beyond the immediate such as where the person lives (share house, a place with no cooking facilities and so on) affecting this recovery goal?

When the consumer is ready to make changes to weight and diet

- Ask the person about their physical health goals in the short, medium and long term – what changes they would like to see? Using a strengths-based approach explore what they know, what has worked and how would they proceed.
- Adopt an interprofessional team approach that incorporates using nurses or nurse practitioners to explore the effects of medicines on physical health and wellbeing. Collaborate with counsellors, psychologists and social workers (as available) to explore the interactions between social factors and physical health and wellbeing. Collaborate with dietitians, physiotherapists and other allied health professionals to develop a holistic care plan.
- Nurses will routinely undertake a physical health assessment.
- Routinely ask about the impact of medication and mental and emotional experiences on diet (for example, food cravings or a reduced appetite, and the impact of stress on appetite).
- Explore psychological links between food, emotions and behaviours. What is the person's self-perception of body image? Have they experienced disordered eating and what does this mean for them?
- Routinely ask about how a person's socioeconomic status impacts on their diet (for example, how much income they have for groceries).
- With consent, monitor the weight of individuals using a standard measurement such as BMI/girth and weight.
- Ensure care plans focus on the individual's needs and address their nutrition and weight management.
- Offer advice on how to live with cravings or suppressed appetite or eating that's related to mental or emotional distress.
- Offer advice on eating a healthy balanced diet, healthy food choices, meal preparation, eating habits and how to interpret food labels.
- Provide support to people seeking to limit consumption of energy-dense food and drinks prepared outside the home, particularly 'fast' or 'takeaway' foods.
- Refer people to lifestyle weight management programs, ideally programs customised to people with mental health issues. This should be offered as routine care for anyone prescribed antipsychotic medicines. If your service has these programs, invite and support access and participation.
- Work in conjunction with other partners such as dietitians and catering departments to increase access to healthier food choices within mental health care settings.
- Nurse practitioners, pharmacists, psychiatrists and GPs have specialist knowledge of psychiatric medicines and their contribution to weight gain and are trained to have these conversations with consumers to optimise medicine choice, taking into consideration consumer preferences. If medication is contributing to weight gain, offer to review their prescriptions.

When the consumer is not yet ready to make changes to weight and diet

- Respect the person's preferences. Engage in a supported decision-making conversation.
- Metabolic health is a lifelong challenge for everyone. If a person is not ready to address this aspect of physical health, offer to come back to it when they are in a better space or situation.
- There is always an opportunity to address this in the future. Revisit this priority.

Workforce considerations

- Develop motivational interviewing skills.
- Develop trauma-informed care skills and skills in assessing for family violence (MARAM).
- Become familiar with information about healthy eating and weight management programs and services.

Health promotion messages for consumers, carers and supporters

- Eat a wide variety of food from all food groups. Check that you eat from the following food groups every day: wholegrain bread and cereals, vegetables, fruit, milk and dairy, and meat, fish or legumes. Where possible, choose low-fat varieties.
- Increase your fruit and vegetable intake, particularly vegetables, as most are low in calories and contain fibre, which helps you feel full.
- Reduce your intake of foods that are high in added fat, sugar and salt. Make soft drinks, lollies and snack foods an occasional 'extra'.
- Try to balance an 'extra' food with extra exercise. The more energy you burn, the more treats you can afford to have. Remember, you should only add extra foods after you have covered your nutrient needs with choices from the healthier food groups.
- Cut down on saturated fats and alcohol.
- Replace sugary drinks with water.
- Avoid using food for comfort, such as when you are upset, angry or stressed. Explore other healthy ways to cope with these feelings.
- The Australian guide to healthy eating (Figure 9) includes information about how much and what types of food you need to eat to maintain a healthy weight.
- Eating a balanced, nutritious diet. Being physically active is the best way to stay healthy and help reduce your risk of disease.
- To maintain a stable weight, your energy (kilojoule) intake needs to equal the energy you use. If you use more energy than you consume, you will lose weight. On the other hand, if you eat more than you use, you will gain weight.
- Eating well can contribute to improved mental health (there are links between diet and depression).
- The sensible answer to losing excess body fat is to make small healthy changes to your eating and exercise habits. These changes should be things that you can maintain as part of your lifestyle – that way you will lose weight and keep it off.
- Create interprofessional education and learning programs about healthy eating and learn about weight management programs and services in your area.

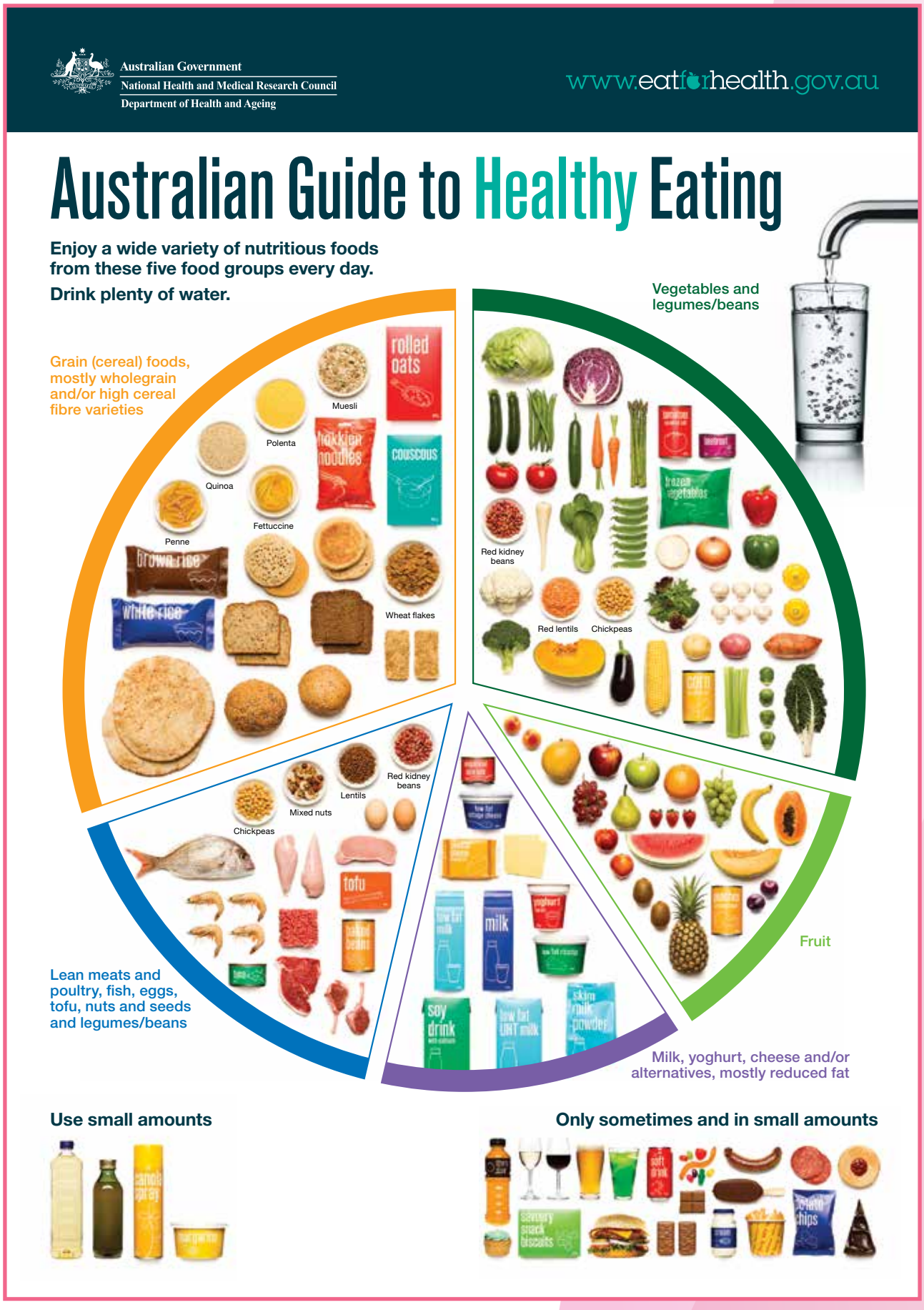
Youth mental health services considerations

- Explore family beliefs of healthy weight and diet.
- Recognise the developmental challenges of adolescence in navigating towards a healthy body image.
- Identify any potential child protective concerns of neglect or other family violence related issues (has a family violence assessment been done?).

65+ Aged care services considerations

- Ensure baseline metabolic measurements are recorded at admission to community and aged care services and are repeated at recommended intervals.
- All meals provided by residential aged care services are nutritious and comply with recommended dietary standards for this age group.
- Dietician referrals for all consumers requiring special diets.
- Families and friends who visit the aged care facility with food are educated about nutritional options.
- Aged care services are to provide daily exercise programs for all consumers.
- Maintain mobility for bedridden or chair bound consumers with referrals to physiotherapist recommended.

Figure 9: The Australian guide to healthy eating



Healthy eating: Australian Guide to Healthy Eating.
Source: National Health and Medical Research Council

Priority area: Improving metabolic health (physical activity and fitness)

Collaborative planning and therapeutic interventions

Understanding the consumer's perspective or journey

What value does the person give to activity? What do they feel is important? Do they feel they have the ability to engage in activities? Do they have gym wear? How might they build activity into routines? How could they introduce activity with a graded approach over time? How will physical activity fit in with their daily routine? Think about different sorts of activity such as walking and housework.

Clinicians should be conscious of not contributing to low self-esteem or a low sense of self-efficacy when having these conversations with consumers. Many consumers with obesity will already be judging themselves harshly, and even a gentle conversation about these issues may have a negative emotional impact – particularly during an admission when the person already has a heightened sensitivity.

It is imperative that these conversations are non-blaming and begin by acknowledging that reduced physical activity is a common issue for many mental health consumers. Clinicians should also acknowledge that, for some people, incorporating physical activity into their lives can be difficult for all sorts of reason including ability and physical health.

Links to recovery goals

Assess the person's recovery goals and the impact reduced physical activity and fitness has on those goals.

If the goals are sedentary (study, desk job), put in context the importance of exercise and movement.

Highlight any opportunities that exist in daily life to turn activity into exercise (such as walking instead of driving short distances). Discuss physical activity and improving fitness levels in the context of the person's daily routine where possible.

Highlight ways in which improving physical activity will enable the person to achieve their recovery goals – for example, achieving independence (to do their own shopping, walking the dog) and participating in kids activities.

Physical activity also promotes social inclusion and connection.

When the consumer is ready to address physical activity

- Seek consent to have a conversation about physical health.
- Ask the person about their goals in the short, medium and long term.
- Include an assessment of the person's physical activity levels when undertaking a physical assessment:
  - On average how many days a week do you engage in moderate to vigorous physical activity like a brisk walk?
  - On those days, on average, how many minutes do you engage in physical activity at this level?
  - Has this changed since you developed your mental health condition or since commencing psychotropic medication?
- Ask the person if they experience any sedation from their medication, and if so, how this affects their activity levels.
- If the person experiences sedation, ask the pharmacist to review the dosage and the time of day that the medicines are taken with the consumer to minimise the impact on physical activity. Work with the person to develop strategies to increase activity.
- Ask the person if their mental or emotional health affects their activity levels. If so, work with the person to develop strategies to increase activity.
- Ask the person about their relationship with exercise. Do they feel compelled to exercise or overexercise even when they are sick? Does this worry them?
- Routinely ask about how the person's socioeconomic status affects their activity level (for example: Does money ever get in the way of exercise?).
- Routinely ask if there are any health problems that get in the way of activity (for example, obesity can often cause knee or back pain that can make activity difficult). If so, ensure these barriers are addressed through appropriate referrals.
- Encourage individuals to engage in the recommended 150 minutes of physical activity each week.
- Use the physical activity benefits guide when discussing physical activity with individuals to assess their ability and suitability for increasing physical activity.
- Provide information about the benefits of actively maintaining their personal fitness level and how it can enhance all aspects of quality of life. Request additional support to assess the fitness of individuals and develop meaningful care plans.
- Work with local partners and other agencies to ensure service users have access to leisure centres, gyms and sports facilities.
- Explore ways that physical activity can be integrated into existing lifestyles and personal preferences as much as possible. Examples include parking further from a train station when commuting, walking with friends, using a free exercise video (for example, via YouTube) in their own home, taking a pet for a walk twice daily instead of once daily and perhaps for slightly longer walks. Small, positive changes can be easier to integrate and maintain than expecting someone to attend a gym for the first time.
- Adopt an interprofessional team approach. Pharmacists, psychiatrists and GPs can explore whether medicines can be optimised for a range of conditions that may affect physical health – for example, reviewing asthma medication, reviewing medication for rheumatoid arthritis. Review psychotropic medicines and their side effects, such as weight gain and sedation, to ensure their impact on physical health are minimised. Physiotherapists can also ensure physical activity plans are tailored to factor in pre-existing physical limitations. Social workers and other allied health professionals can review the impact of psychosocial factors on physical activity.

When the consumer is not yet ready to address physical activity

Respect the person's preferences. Engage in a supported decision-making conversation.

If a person is not ready to address this aspect of physical health, offer to come back to it when they are in a better space or situation.

There is always an opportunity to address this in the future.

Workforce considerations

- Develop motivational interviewing skills.
- Develop trauma-informed care skills and skills in assessing for family violence (MARAM).
- Become familiar with information about local physical activity programs and services.
- Create interprofessional education and learning programs about programs and services in your area.

Health promotion messages for consumers, carers and supporters

- Physical exercise can improve mental and emotional states. Physical activity improves mental health as well, and can form part of a holistic treatment plan.
- Exercise prevents muscle loss, so it is important to exercise when you are losing weight. Exercise will protect your muscles and keep your metabolic rate ticking over at a healthy level.
- The number of people who are overweight and obese is increasing every year. This is because we have become more sedentary (inactive). For most of us, physical activity is no longer a natural part of our lifestyle, so it must be consciously included into our daily schedule.
- Some people feel too busy or too tired to exercise regularly, but exercise will actually increase your energy levels and help you to feel less tired. Exercise does not have to be overly strenuous, even moderate amounts of physical activity of about 30 minutes a day can speed up your metabolic rate and help weight loss.
- The amount of energy you 'burn up' depends on your age, your gender and your activity levels. Young people burn more energy than older people. Men burn more energy than women. More physically active people burn more energy than less active people.
- The best approach to increasing the level of physical activity in your life is to take it slowly. You can increase your activity levels by simply increasing movement throughout the day. The human body is designed for movement and any physical activity brings benefits.
- Moderate intensity exercise – walking, gardening, cycling and even mowing the lawn – has been shown to help reduce body fat.

Additional benefits associated with increased fitness levels

Physical benefits

- Reduces the risk of developing bowel cancer
- Promotes the loss of excess body weight
- Assists in controlling healthy body weight
- Reduces the risk of heart attack
- Helps build and maintain healthy bones, muscles and joints
- Reduces the risk of dying prematurely
- Reduces the risk of dying from heart disease
- Reduces the risk of developing diabetes
- Reduces the risk of developing high blood pressure
- Helps reduce blood pressure in individuals with high blood pressure
- Increases muscle strength
- Slows the loss of muscle mass

Mental benefits

- Improves self-image
- Reduces feelings of depression and anxiety
- Helps control appetite
- Provides a greater resistance to stress, anxiety and fatigue
- Helps you to relax and feel less tense
- Increases productivity at work

Quality-of-life benefits

- Improves the ability to fall asleep quickly and sleep soundly
- Promotes a longer, healthier life
- Improves mobility and balance
- Reduces joint and muscle pain
- Increases energy levels and capacity for physical work and leisure activities
- Lowers the risk of falls and serious injuries like hip fractures
- Improves coordination, balance and reflexes
- Increases strength in older adults and reduces the likelihood of falling
- Increases stamina, strength and flexibility
- Improves the efficiency of the heart and lungs

Youth mental health services considerations

- Involve parents in brainstorming family activities that promote physical fitness.
- Identify group sports or peer-related physical activities for motivation.

65+ Aged care services considerations

- Conduct a physical health assessment including a mobility assessment for all consumers to enable individual daily exercise programs to be developed.
- Obtain GP and physiotherapy input for special needs consumers – those with osteoporosis, cardiac problems, peripheral neuropathy and so on – to ensure programs are not too vigorous to cause injury.
- Arrange physiotherapy referrals for consumers who have identified mobility issues to ensure their baseline functioning is maintained for as long as possible.

Priority area: Reducing alcohol and substance use

Collaborative planning and therapeutic interventions

Understanding the consumer's perspective or journey

- Understand the role of substances in a person's life and develop strategies based on this. Substance use is a complex issue and occurs for a range of reasons.
- Walk beside the person on their journey. Engage in a supported decision-making conversation.
- Explore their substance(s) of choice and the range of reasons for use. Adopt a non-judgemental approach and use available tools to gauge use and its impact.

If it is viewed as helpful to use, ask how it is helpful to the person and how its use affects their mental illness, their day-to-day life and psychosocial aspects.

Links to recovery goals

Explore how using alcohol and other substances impedes recovery goals. This may include relationship, work, independence, financial, housing, physical and mental health goals.

Explore/understand the link to support structures that may assist in addressing substance use. Is there a significant other who engages in the same substance use activities?

If family violence assessment has been done, check if alcohol or substance use is present.

When the consumer is ready to reduce/ eliminate substance use

- Use the 'stages of change' model for substance use (see Figure 10).
- Adopt an interprofessional collaborative approach. Pharmacists and nurses, for example, can provide advice on the interactions between alcohol, substances and prescribed medicines. Nurses, social workers and other allied health professionals can explore the interplay between psychosocial factors and dependency/ addiction to alcohol and other drugs.
- Assess alcohol and drug use as a core component of the person's mental health assessment.
- Screen everyone aged 16 or over for alcohol use disorders, using a validated tool, and offer appropriate interventions.
- Offer verbal and written information about the effects of substances on physical and mental health and the way in which they may interact with prescribed medications.
- Offer information about local substance use services and self-help/mutual aid groups, for example, Alcoholics Anonymous.
- If the person is not ready to stop using, offer information and treatment options that can help reduce the harms associated with use, for example, using a needle exchange or prescribing thiamine.
- Follow evidence-based protocols to safely assess and initiate substitute prescribing or detox (alcohol, opioids, GHB/GBL, benzodiazepines).
- Work in partnership with substance use services to develop referral pathways and treatment options that are accessible and tailored to the needs of different individuals with mental health problems. Offer advocacy as needed.
- Know how to manage physical emergencies associated with substance use, for example, withdrawal seizures, delirium tremens, Wernicke's encephalopathy and opiate overdose.
- Be aware of new drugs and changing patterns of substance use, for example, new psychoactive substances and drugs used in chemsex.
- Ensure people assessed as having co-existing alcohol and drug use problems are referred to services to address both areas of need.
- Support the person to access specialist alcohol and other drug services including withdrawal rehabilitation services. This may be by phoning the service on behalf of the consumer.
- As described in the stages of change model, there may be relapse events. During this change process, most people will experience relapse. Relapses can be important for learning and helping the person to become stronger in their resolve to change. Alternatively relapses can be a trigger for giving up in the quest for change. The key to recovering from a relapse is to review the quit attempt up to that point, identify personal strengths and weaknesses, and develop a plan to resolve those weaknesses to solve similar problems the next time they occur.

When the consumer is not yet ready to reduce/eliminate substance use

- Respect the person's preferences. Engage in a supported decision-making conversation.
- If appropriate, provide information about safety issues associated with substance use – for example, falling, passing out or other personal safety issues that might arise when using (being assaulted, robbed and so on). If family violence is present in person's life, ensure safety of victim survivor (and risk regarding substance use), if working with perpetrator of family violence, assess for increased risk to victim survivor (consult with specialist services).
- If a person is not ready to address this aspect of physical health, offer to come back to it when they are in a better space or situation.
- There is always an opportunity to address this in the future. Keep track of the stages of change.

Workforce considerations

- Develop motivational interviewing skills.
- Develop trauma-informed care skills and skills in assessing for family violence (MARAM).
- Develop harm minimisation approaches.
- Understand the stages of change model.
- Become familiar with the range of effects of alcohol use and the range of illicit substances people might use.
- Familiarisation with information about substance use programs and services.
- Create Interprofessional education and learning programs about programs and services in your area.

Health promotion messages for consumers, carers and supporters

- When alcohol and other drug use is reduced, the body starts to function better (the heart, the liver, sleep), you can save money, gain social stability and participate in new activities.
- For people who use illicit drugs or use pharmaceutical drugs, stopping is not simple. Harm reduction is about finding ways to reduce the negative impacts of ongoing use. Harm reduction initiatives are targeted at people who continue their drug use despite the negative consequences, which can include overdose, relationship breakdown, isolation, ongoing health issues, unemployment and involvement in the criminal justice system. Harm reduction strategies are evidence-based public health approaches and specifically focus on providing benefit to the individual and those around them as well as the broader community. Examples of harm reduction initiatives include:
  - needle and syringe programs
  - opioid pharmacotherapy treatment
  - peer education programs.

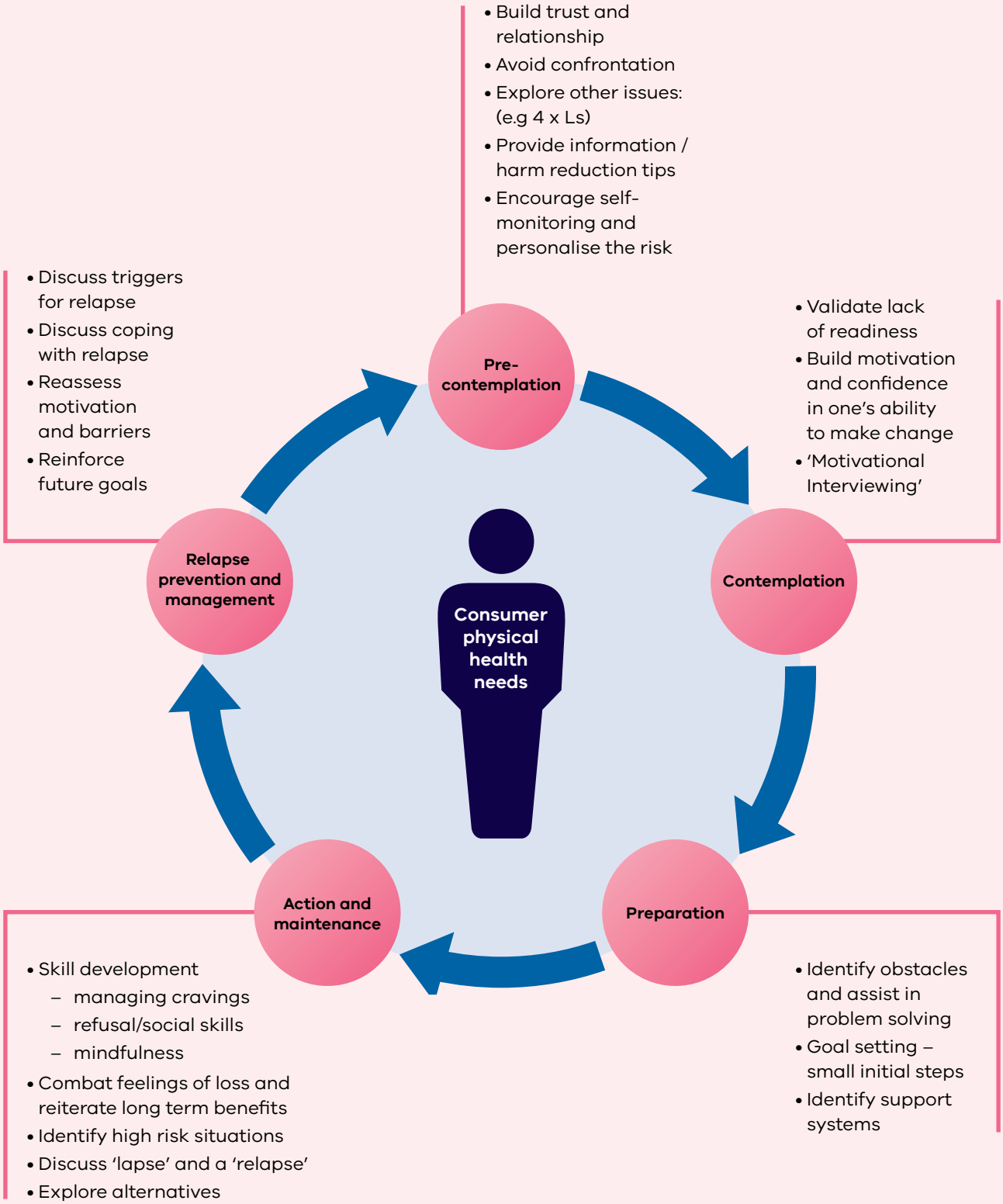
Youth mental health services considerations

- Recognise experimentation is a normal developmental task of adolescence.
- Acknowledge but not condone substance use. Engage in open dialogue and take an opportunistic harm minimisation approach.
- Weigh up the confidentiality of the young person against the duty of care to inform their parents.

65+ Aged care services considerations

- Conduct an assessment, screening and substance use history for each new referral to the service.
- Provide education and support about the harms of continued use specific to this population.
- Monitor withdrawal in consumers who may not be able to communicate their previous substance use.

Figure 10: Matching alcohol and other drug interventions to the stages of change



Modified from Insight Centre for AOD Training and Workforce Development <www.insight.qld.edu.au>

Priority area: Sexual and reproductive health and blood borne viruses

Collaborative planning and therapeutic interventions

Understanding the consumer's perspective or journey

This section concerns sexual well-being and identity, gender identity, contraception, sexually-transmitted infections (STIs) and gender-linked cancers. It also concerns blood-borne viruses (BBVs). Human Immunodeficiency Virus (HIV) is transmitted most commonly through sexual contact. Hepatitis C is not. It is transmitted usually by needle-sharing (including needle-stick incidents) and occasionally tattooing. Hepatitis B can be transmitted both sexually and through needle-sharing (including needle-stick incidents). HIV and Hepatitis C are highly stigmatised.

Sexual and reproductive health and blood-borne viruses (BBVs) is a specialist area of health care that requires maximum sensitivity and specialist expertise. If the person has disclosed to the mental health clinician an issue related to this priority, consideration should be given to the following:

- Understand what aspect of sexual and reproductive health and BBVs are important and relevant for the person.
- Be respectful of the person's need for privacy. Explore what is important to the individual, how this affects identity, roles and self. Explore details such as sexual identity, sexual functioning, vulnerabilities, reproductive history, aspirations and knowledge of sexually transmissible infections (STIs) and BBVs and stigma or shame a person may feel around these topics.
- Be aware that some people have complex issues relating to sexual and reproductive health, which may make these discussions very sensitive (some people who have experienced sexual assault, often also a feature of family violence, can find it harder to talk about sexual and reproductive health)
- Current and/or previous sexual abuse can cause or exacerbate mental health problems and mental illness, therefore using a trauma-informed care and practice approach is recommended.

When discussing sexual and reproductive health and BBVs, a family violence lens needs to be applied. Anyone can experience family violence, but it is predominately perpetrated by men against women and children. One in five women has experienced sexual violence, and during pregnancy and shortly after birth is one of the high-risk times for women and their children to experience intimate partner violence. Women with mental illness experience higher rates of violence than women without mental illness. Please refer to the *Chief Psychiatrist's guideline and practice resource: family violence* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/family-violence-guideline-practice-resource> for further guidance and the MARAM framework https://www.vic.gov.au/information-sharing-schemes-and-the-maram-framework.

Often people have never had a conversation about their sexual health, and permission needs to be sought to do so.

Links to recovery goals

Explore what the recovery goals are for the consumer. They may be broad and relate to the following categories:

- assessing and managing family violence
- treating STIs and BBVs
- preventing STIs and BBVs through harm minimisation and immunisation
- sexual and gender identity
- sexual function and managing their mental health
- family planning and reproductive aspirations and/or pregnancy choices.

When the consumer is ready to address sexual and reproductive health and blood-borne viruses

- Be aware that sexual violence may have been a part of, or still exist, in the person's journey and, as such, a conversation about sexual and reproductive health might be triggering. Also, it may not be culturally appropriate to discuss sexual and reproductive health with a particular gender/person. Assess the level of comfort for the person to have the conversation and respect their personal preferences and boundaries. A consultation with a colleague of a different gender can be offered and/or referral to a specialist sexual, reproductive, BBV or culturally appropriate service. Be mindful that the willingness for someone to discuss sexual/reproductive health and BBVs can vary during the person's contact with your service.
- Be aware of the stigma associated with activities such as injecting drug use related to BBV transmission.
- Consider giving written information to the person with the contact details of relevant support services and inform them that they are welcome to discuss concerns at any time.
- Take a non-judgemental approach, understanding the impact of your own attitudes and those of others, and treat people with privacy, dignity and discretion.

Refer to specialist services.

Reproductive health

Refer to specialist sexual and reproductive health services such as Family Planning Victoria, the Melbourne Sexual Health Centre, specialist GPs and LGBTI-inclusive services.

Otherwise, doctors and nurses within the mental health program may:

- Seek consent to discuss reproductive health. Ask about short-, medium- and long-term goals.
- Ask about: (a) the impacts of medication and mental and emotional experiences on sexual and reproductive health; (b) socioeconomic impacts on their sexual and reproductive health such as affording contraceptive or IVF; (c) screening for STIs and BBVs; and (d) getting their immunisations assessed and brought up to date as part of planning a pregnancy.
- Actively support women with pre-existing mental health problems to reduce the risk of unintended pregnancies, for example, by providing guidance and information about contraception, particularly the more effective long-acting methods, as well as supporting their access to family planning services.
- Consider mentioning the availability of newer, less triggering sexual health screenings such as self-administered pap smears for eligible people.

Sexual identity

Health practitioners who have undertaken specific education and training may:

- Seek consent to have a conversation about sex, 'sexuality/sexual orientation' and 'gender'. Language is important when discussing gender identity, expression, biological sex and sexual orientation.
- Become informed and understand the differences between various terms before engaging in a discussion on the topic. Links to resources to help with this are located at the end of this resource.
- Offer information about sex, sexuality/sexual orientation, gender and the specialist services where appropriate support can be offered.

Sexual dysfunction

Health practitioners who have undertaken specific education and training may:

- Ask about sexual dysfunction and the effects of psychotropic medication on sexual function and libido.
- Routinely provide information about sexual and reproductive health risks for consumers, and the potential reasons for these risks. Include information about ways that psychotropic medicine can affect sexual health (for example, hormonal impacts including menstrual cycle and breast changes, decreased libido, impaired arousal and impaired orgasm).
- Provide information on specialised sexual health services and offer support for people to attend these services.

Sexually transmissible infections, blood-borne viruses and immunisation

Health practitioners who have undertaken specific education and training may:

- Have resources available for consumers that provide information on STI/BBV transmission risks, STI/BBV fact sheets, prevention (for example, consistent condom use), regular testing, harm minimisation, immunisation and specialist sexual health services.
- Raise awareness that all people who are sexually active need to protect themselves against STIs and have an STI screen. Give information about what tests will be required, how they can be taken and the importance of being immunised against Human Papilloma Virus and Hepatitis A and B.
- Discuss risk factors for transmitting BBVs and harm minimisation strategies for people who are injecting drugs, including getting vaccinated against Hepatitis B.
- Raise awareness that Hepatitis C is now easily curable with an 8-12-week course of medication.
- Refer consumers who have Hepatitis B or C to a specialist service for treatment and management of their condition.

When the consumer is not yet ready to address sexual and reproductive health

- Respect the person's preferences. Engage in a supported decision-making conversation.
- Be mindful of changes in the person's life and relationships. Where appropriate, use these changes as opportunities (age changes, relationship changes, diagnosis of an STI) to discuss sexual and reproductive health.

Workforce considerations

- Develop motivational interviewing skills.
- Develop trauma-informed care skills and skills in assessing for family violence (MARAM).
- Become familiar with information about sexual and reproductive health programs and services.
- Create interprofessional education and learning programs about sexual and reproductive health services in your area.
- Consult the *Language guide for trans and gender diverse inclusion* <https://www.acon.org.au/wp-content/uploads/2017/11/External_Language-Guide-17396_print_V12A.pdf>.

Health promotion messages for clinicians

New hepatitis C treatments are now available for all adults in Australia who hold a Medicare card (Figure 11). They are very different from previous treatments because they:

- cure around 95 per cent of people who take them
- are effective for people who have liver cirrhosis
- have minimal side effects
- are taken for just 8-12 weeks (in most cases)
- involve daily tablets (no injections).

Screening – There are various screening services for men and women in relation to sexual health such as Breast Screen Victoria and Prostate screening. Screening is an aspect of all consumer health that can be encouraged by clinicians for consumers of all ages and stages of life.

There are various ways to increase screening participation at your practice or pharmacy.

Health promotion messages for consumers, carers and supporters

- Sexual health is defined as 'a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.'
- Provide information, awareness and understanding of the full range of contraceptive options. Increase understanding and awareness of STIs.
- Promote accurate impartial information on pregnancy choices. Promote pregnancy planning to give both mother and baby the best start in life.
- Increase awareness of services and support (local and national services) for sexual identity, STIs and treatment.

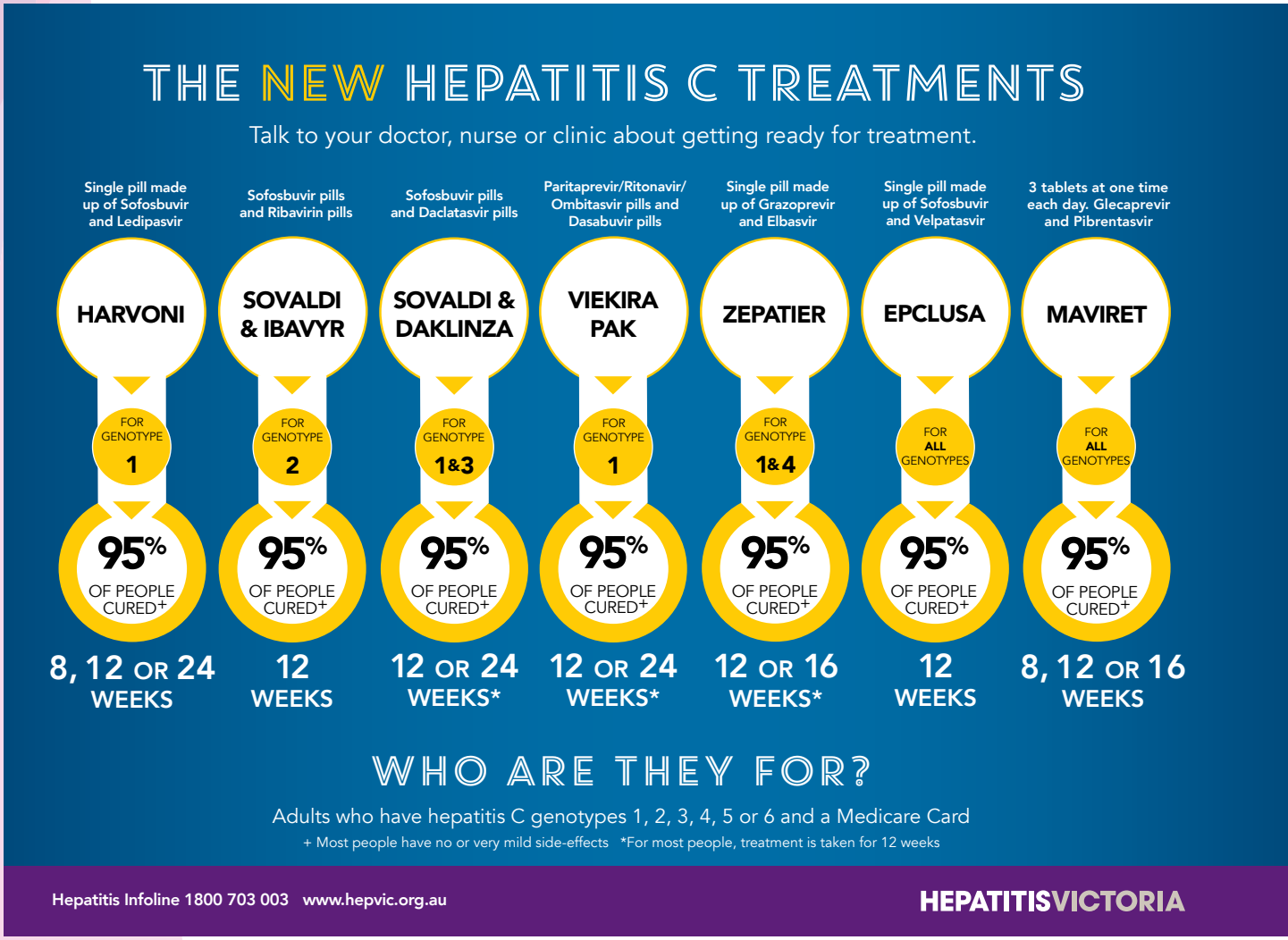
Youth mental health services considerations

- Consider if the young person is a competent minor and clearly document this in their clinical file.
- Consider if risky sexual behaviour is related to:
  - impulsive experimentation of adolescence
  - financing comorbid substance abuse
  - undiagnosed Axis 1 affective or psychotic disorder
  - past or present sexual trauma or childhood sexual abuse.
- Liaise with stakeholders – GPs, paediatricians, youth drug and alcohol workers, child protection practitioners and sexual health nurses.

65+ Aged care services considerations

- Document current and past sexual health including childhood sexual abuse as part of a holistic assessment.
- Provide opportunities for consumers to discuss their sexuality and sexual health needs, remembering that some consumers experience sexual disinhibition.
- Physical comorbidities may impair sexual function in older adults, so take a sensitive approach when discussing sex with the person, their spouse or their family.

Figure 11: New hepatitis C treatments



Hep C – The new hepatitis c treatments.
Reproduced with permission from Hepatitis Victoria, Brunswick 2019

Priority area: Medicine optimisation

Collaborative planning and therapeutic interventions

Understanding the consumer's perspective or journey

To optimise medicines, we first need to understand the person's values and beliefs about their medicines and the role they play in their mental health and wellbeing. These values and beliefs can vary depending on the person's age, gender and culture. Other factors that inform the person's beliefs around their medicines include the relationship they have with their interprofessional mental health care team, past experiences of medicine use, the complexity of their medication regimen and whether they consider possible side effects to their medicines as acceptable.

People should be involved in all aspects of their assessment, treatment and recovery and should be supported in making and participating in decisions, even when those decisions include a degree of risk (refer to the Mental Health Act). This includes decisions around their medication regimen.

Being supported in making decisions about their medication involves an understanding of the impacts that medicines have on their mental health, physical health and their lifestyle. As such, people need to be provided with both verbal and written information about their medicines and have an opportunity to discuss their choices, preferences and any concerns.

People will vary in the degree to which they want to be involved in making decisions about their medication; this may be influenced by their capacity to be involved in those decisions at any given time.

Links to recovery goals

Explore how the use of medication impacts on the person's recovery goals. Medication may enhance their capacity to achieve recovery goals, but its only one strategy and may not be the main focus.

When the consumer is ready to address medicine issues and side effects

The doctor or nurse will:

- Explore what the person thinks would help. What are their goals and what has worked for them before?
- Adopt an interprofessional collaborative approach to medicine optimisation throughout the person's journey from admission through to discharge from the mental health service.
- Taking a medication history can be challenging if a person is acutely unwell on admission. It is important to take the best possible medication history to ensure there is an accurate and up-to-date record of the medicines, doses and indications. It is important to know what medicines the person has found helpful and which were unhelpful or perhaps ceased due to unacceptable side effects. It is also important to know when a medicine commenced, as some psychotropic medicines can take two to four weeks to be effective. The community pharmacist, GP, family members and carers are all important sources of information for obtaining and checking the medication history.
- Understand the indication for all medicines being taken, including medicines used for both mental and physical health and wellbeing. Be aware of the balance between benefits and risks to the person, including side effects that negatively affect the person's physical health, such as sedation and weight gain. Be aware also of interactions with alcohol, illicit drugs, over-the counter treatments and alternative medicines.
- Ensure that medicines that are used topically are included (inhalers, creams, eye drops, hormone patches), as well as Chinese, herbal and other alternative medicines. Any of these prescribed or alternative medicines have the potential to interact with newly prescribed medicines or may otherwise affect physical activity. Take note of any depot injections the person may be prescribed and check when the next dose is due.
- Where pharmacy services are available, work collaboratively with the pharmacist to ensure the person's medication list is current and accurate.
- Provide information to consumers and their carers to ensure they know the therapeutic use, dose, side effects, precautions and contraindications to prescribed medicines, especially when medicines are newly prescribed. The pharmacist can assist in providing written information. This may include thinking about how to support children and young carers with questions about medications.
- Monitor the impact of all medicines, particularly antipsychotic and other psychotropic medicines, in accordance with relevant guidelines. Where pharmacy services are available discuss possible side effects with the pharmacist.
- Regularly ask consumers if they experience any side effects with their medicines. Use approved side effect rating scales as available and take appropriate actions as required – for example, discussions with the prescriber or pharmacist.
- Ensure prevention and controls of infection measures are maintained to safeguard service users.
- Advocate on behalf of the consumer for medicines to be changed or stopped if there is little or no perceived benefits or the side effects are intolerable. Consider the role of medicines in falls and seek the advice of a pharmacist where appropriate.

When the consumer is not yet ready to address medicine issues or side effects

The doctor or nurse will:

- Engage in a supported decision-making conversation.
- Provide up-to-date information about medications. Provide objective feedback and invite the person to comment.
- People are more likely to take their medication if they are meaningfully engaged and informed of the reason for taking the medication and its possible side effects, and if they are involved in making decisions about their medication regimen.
- When a person forgets to take their medication or chooses to cease their medication abruptly, they may be at risk of becoming mentally unwell; for example, they may experience a relapse in schizophrenia, bipolar disorder, depression or anxiety. It is therefore important to inform the person of these risks in a non-judgemental way.
- If the person believes their medication is not working or causing unacceptable side effects, suggest that they discuss this with the prescriber. It may be possible to improve the person's wellbeing by changing the dose, changing the medication or taking the medication at a different time of day.
- When a person does not want to discuss any aspect of their medication use, it is important to ensure they at least know how to access medication information when they are ready. Some sources of written medicine information include:
  - locally developed medicines information leaflets
  - information from reputable online sources such as beyondblue, the Black Dog Institute, SANE Australia, Choice, medication.org and NPS MedicineWise consumer medicines information.
- Offer the consumer other options for discussing medication with someone outside the mental health service – for example, with a community pharmacist or GP.

Workforce considerations

- Develop motivational interviewing skills.
- Become familiar with information about pharmacists and doctors who can help with medication management.
- Create interprofessional education and learning programs about medication side effects and referral services in your hospital and local area.

Health promotion messages for consumers, carers and supporters

- It is important to remember that medications can be an effective part of a broader approach to treatment including peer support and community assistance alongside counselling and a range of other supports.
- It is important to know that some medicines may take two to four weeks to be effective and that during this time side effects may be more troublesome. It is possible that the person may become more tolerant to some side effects, such as sedation, with continued use.
- It is important to discuss any concerns about a medicine's effects with a doctor, pharmacist or mental health nurse practitioner because there may be changes that can be made to reduce unwanted side effects and improve the therapeutic benefits of the medication.
- Stopping psychotropic medications is best done slowly and with the support of a health practitioner.
- Most mental health or psychotropic medications have side effects. The most common ones are headaches, weight gain, dizziness, dry mouth, muscle spasms/cramps, nausea, loss of sex drive, constipation, sleepiness or problems sleeping. Discuss all side effects with a doctor, pharmacist, your nurse or nurse practitioner including weighing the pros and cons of treatment, and what options are available to provide the best possible quality of life.
- Minimise the use of excessive medication doses and polypharmacy because these can both be associated with greater physical health risks. Polypharmacy refers to concurrent use of multiple medications in a single patient. Please note that while polypharmacy has a negative connotation (implying an inappropriate or irrational use of multiple medications), it can sometimes be an effective clinical intervention.

Youth mental health services considerations

- Work collaboratively with the young person and their parents regarding dosing times and the timing of dose titration and medication changes, taking into consideration the potential impact on school and peer relationships.
- Be aware of the psychodynamic representation of medication being an external locus of control with all the projected desperation, hopes and wishes and the risks associated at a crucial time for social emotional development and identity formation (simply put, know what and who are we treating and what other hard conversations need to be had).
- Avoid polypharmacy and simplify to a single prescriber where possible.

65+ Aged care services considerations

- Assess the current prescribed pharmacotherapy including any over-the-counter medications that the person may be utilising.
- Return any unused or expired medications to a pharmacy.
- Assess each consumer for their ability to use medication self-administration aids such as blister packs and Webster packs.
- Be mindful when prescribing sedating medications and the effect these may have on mobility and increased risk of falls (if family violence/elder abuse is indicated or has been assessed, consider impact of sedation on person's safety).

Priority area:
Dental and oral health

Collaborative planning and therapeutic interventions

Understanding the consumer's perspective or journey

Explore personal feelings about the consumer's dental and oral health and how this affects their self-esteem and impacts on their day-to-day life.

Poor dental health may have a negative impact on health and wellbeing. This can be affected by lack of access to services or lack of funds, so there may be a financial disincentive. This may also be low on the person's priority list if there are other more pressing physical health issues.

Explore how the person feels about dental and oral health issues and if they want to do something about it.

Links to recovery goals

Explore how dental health issues impact on the person's recovery goals. This might include socialising, self-esteem, going out in public and eating a balance diet

When the consumer is ready to discuss dental and oral health

- Be aware that some people who have been victims of sexual violence may find dental exams particularly triggering.
- Include an assessment of a person's dental and oral health, including dry mouth, when undertaking physical health assessments.
- Be aware that some medication can cause dry mouth and that dental infection can contribute to cognitive impairment and delirium.
- Ensure consumers have access to a dental practice and that they attend for check-ups at the intervals their dentist recommends.
- Ensure consumers have access to appropriate oral hygiene equipment such as a toothbrush, fluoride toothpaste and interdental cleaning aids.
- Encourage brushing twice a day using a fluoride toothpaste and the use of dental floss and mouthwash.
- Encourage people to chew sugar-free gum to stimulate saliva to help neutralise acids – especially for people who are unlikely to carry out routine oral hygiene.
- Encourage people to eat less sugary foods and drinks, especially before bedtime.
- Encourage people to stop smoking.
- Registered clients of mental health services are eligible for public dental services and may also have priority access to public dental care. For general enquires, phone Dental Health Services Victoria on (03) 9341 1000 or 1800 833 039 (country callers). Visit the Dental Health Services website <https://www.dhsv.org.au/>.

When the consumer is not yet ready to discuss dental and oral health

- Respect the person's preferences. Engage in a supported decision-making conversation.
- If appropriate, provide information about dental care and how to access dental services. If family violence assessment has been undertaken, consider apprehensiveness to see dentist might be linked to violence experience (recent or in past).

Workforce considerations

- Develop motivational interviewing skills.
- Become familiar with information about oral and dental health management.
- Create interprofessional education and learning programs about oral and dental health services in your local area.

Health promotion messages for consumers, carers and supporters

- Dental care is important because it can help to prevent tooth decay and gum disease while improving overall health.
- Brush last thing at night and at one other time during the day with a fluoride toothpaste.
- Reduce the amount and how often you have sugary foods and drinks. Plain tap water is the best drink for your teeth.
- Choose healthy snacks between meals such as fruit, vegetables, nuts, reduced salt crackers and reduced fat dairy foods such as plain yoghurt and cheese.
- Eating disorders can cause permanent dental and oral health problems. Dental erosion is a common sign in people with eating disorders. If you have an eating disorder, look for information about rinsing your mouth and discuss an oral care plan with your dentist or health professional.

Youth mental health services considerations

- Structure behavioural interventions either through direct parent work or refer consumers to family services to work alongside parents in the home.
- Identify any potential child protective concerns of neglect.

65+ Aged care services considerations

- Arrange and encourage regular reviews of dental health for all aged care consumers – poor dental hygiene or poor denture care can affect appetite and their ability to eat.
- For consumers who are in aged care facilities, dental hygiene is a daily activity to be carried out with as much assistance as required for each consumer/resident.
- Routinely plan regular dental checks for each consumer/resident.

Priority area: Reducing falls

Collaborative planning and therapeutic interventions

Understanding the consumer's perspective or journey

- Falls prevention is an ongoing challenge for people with mental illness accessing a service for a number of reasons. A person may not be aware of the risk of falling until it happens.
- Explore personal feelings about mobility and balance. Explore whether there are factors that might increase the risk of falling. These factors can be intrinsic, extrinsic, situational or a combination.
  - Intrinsic factors include impaired cognition and psychotropic medications (and their adverse reactions).
  - Extrinsic factors (environmental factors) include a lack of support equipment (such as side rails for when consumers are getting into and out of bed, walkers and canes) and lifting devices. If (past) family violence is indicated or has been assessed, consider person's safety (unexplained falls?).
  - Situational factors (factors related to activities) occur when consumers are attempting to perform more than one task at a time, or are distracted.

Links to recovery goals

Explore how mobility, balance and the risk of falling impact on the person's recovery goals.

Where relevant, discuss what it is like to be unsteady and lack confidence with movement and how that may prevent the person from being active and social.

When the consumer is ready to discuss falls management

- Adopt an interprofessional approach with the person, and offer older people or those judged to be at risk a multifactorial falls risk assessment.
- Ensure referrals are made to appropriate services as required – for example, nurse consultants, optometry/ ophthalmology, physiotherapy and occupational therapy – and encourage the person to engage with prescribed interventions such as wearing spectacles, inserting their hearing aid and using walking aids appropriately.
- Ensure service users have appropriate footwear – check their shoes for secure fit, a non-slip sole and no trailing laces.
- Review medication that can increase the risk of falls or request a medical and/or pharmacist review.
- Ensure minimising falls is an integral part of the organisation's improvement agenda.
- Work with facilities staff to create a safer environment.
- Encourage people to be physically active, use walking aids as prescribed and, where appropriate, engage in exercise programs to improve posture and balance.
- Offer a referral for a home assessment to be undertaken.

When the consumer is not yet ready to discuss falls management

- Respect the person's preferences. Engage in a supported decision-making conversation.

If appropriate, provide information about osteoporosis, support equipment and available services.

Workforce considerations

- Develop motivational interviewing skills.
- Become familiar with information about falls prevention and falls management.
- Create interprofessional education and learning programs about falls prevention and management health services in your local area.

Health promotion messages for consumers, carers and supporters

- Clinicians, consumers and their families can help with fall prevention programs.
- Some medications potentially have adverse effects on balance, and clinicians can help to identify them and help to reduce the risk of falling.

Youth mental health services considerations

- Liaise with treating paediatrician and other medical specialists as well as schools for young people with medical co-morbidities or physical disability.

65+ Aged care services considerations

- Falls risk assessments to conducted for all aged care consumers in the community (home assessments) and in residential facilities.
- Appropriate mobility aids and home safety aids are to be utilised for consumers who reside in their own home with limited in home support such as family /spouse/ external supports.
- Sedating medications to be kept to a minimum to prevent falls secondary to the effects of these preparations.
- Adequate care of feet and regular examination by a podiatrist.
- Footwear to be assessed for comfort, fit and appropriateness to minimise risk of falls and potential damage to the feet

Developing measures for physical health

To monitor progress and drive service improvement, performance indicators linked to desired outcomes should be meaningful, practical and measureable.

As highlighted at the start of this document, in Victoria there are established measures (albeit not consistently captured across services) for a number of physical health elements, including smoking status, type 2 diabetes, death age and admissions and readmission rates to emergency departments.

Further to these measures, the YES Survey includes questions regarding experience of physical health care during episodes of care in mental health services. The surveys are completed on a voluntary basis and therefore cannot be relied upon to provide a comprehensive measure of consumer experience.

Opportunities for *Equally well in Victoria*

This framework provides a platform for establishing measures of physical health interventions offered to consumers, including the eight priority areas.

Local interventions

At a local level, the measures for physical health interventions will be derived from the National Safety and Quality Health Service Standards (second edition), which has a number of standards that apply to mental health services on physical health including:

5. Comprehensive Care Standard

8. Recognising and Responding to Acute Deterioration Standard.

These standards are further clarified in the accompanying document, *Map of the National Safety and Quality Health Service Standards (second edition) with the National Standards for Mental Health Services* (November 2018).

Organisational interventions

At the organisation level, the measures for physical health interventions will be derived from skills and competencies related to physical health for interprofessional teams, governance arrangements and models of care and compliance with scopes of practice as prescribed under National law, associated regulations and other legislation. The World Health Organization's *Guidelines on management of physical health conditions in adults with severe mental disorders* outline a number of outcome measures, which can inform practice at the organisation level.

Indicators of compliance with this framework can include the proportion of selected clinical records that include:

- reference to physical health care in the authorised psychiatrist's initial clinical assessment
- evidence of subsequent discussion(s) between the authorised psychiatrist, nurses (or other relevant staff) and the consumer regarding physical health care goals and their association with recovery goals
- evidence of discussions about physical health care with families, carers and support people
- evidence that treatment and recovery plans were handed to the consumer (and any accompanying person) including agreed goals and physical health measures (for any or all priority areas in this document)
- evidence of referral to relevant services for physical health care (for example, a GP, community service or dentist), provision of promotional material and instructions to follow-up with a consumer throughout contact with the service (inpatient, subacute and community settings).

Consumer interventions

At the consumer level, the measures for physical health interventions will be derived from care plans, recovery plans and case notes describing physical health care. These will include referrals to physical health services.

Appendix 1: Actions – leadership and culture

Domain	Actions
Collaborative planning and therapeutic interventions	**Implement mechanisms for co-design of:** • physical health policy/procedures • physical health interventions, programs, practice tools and resources • consumer information resources that are age and diversity appropriate – refer to *Co-production: Putting principles into practice in mental health contexts*.[7] **Review and quality assurance** • Integrate continuous improvement in safe and quality care for both mental and physical health needs into organisational quality improvement systems, including governance and reporting structures, to effectively monitor and improve physical health performance. • Set policies that assign clear accountability for planning, monitoring and improving the quality of physical health strategies.
Healthcare setting	**Develop a culture that prioritises improving physical health** • Board and executive leadership develops, and visibly engages in communicating, a clear vision for improving the physical health of mental health service consumers. • Mental health service leadership creates a supportive, transparent culture where the consumers are viewed holistically and where mental and physical health needs are seen together. **Set priorities and strategic directions for improving physical health.** **Establish and regularly review physical health policies and procedures that:** • are specific to mental health services • include mandatory bare minimum practices, processes and reporting • are integrated with existing organisational policy-related structures, procedures, processes and guidelines • promote use of physical activity facilities • develop physical health programs and facilities customised to the needs of mental health consumers • promote nutritionally appropriate diets, taking account of the effects of mental health experiences and medication side effects (which may increase or decrease appetite. **Systems** • Address systems, policies, practices, service delivery and human resource models and environments in integrated responses.
Workforce considerations	**Establish effective and accountable workforce roles, designations and scope of practice in physical health service delivery structures and systems. Outline these in position descriptions, duty statements or employment contracts.** **Options could include:** • staff with specific portfolio/specialist positions • inclusion in the case management role • access to exercise physiologists, a dietitian, nurses/nurse practitioners, physiotherapy, podiatry, health psychology and occupational therapy services with specialist understanding of the needs of mental health consumers • consumer preferences for choice of practitioner (for example, the gender of the practitioner considering the impact of trauma on some examinations).

7 Roper C, Grey F, Cadogan E 2018, Co-production: Putting principles into practice in mental health contexts, The University of Melbourne, Melbourne

Appendix 2: Actions – model of care

Domain	Actions
Collaborative planning and therapeutic interventions	**Develop policies, practices and procedures and utilise tools and resources that:** • support consumers to make informed choices and be active partners in planning and monitoring their lifestyle and physical health • define consumers' rights and informed consent with respect to physical health interventions • articulate the roles and responsibilities of mental health services and clinicians in physical health care and support • define the roles and responsibilities of clinicians when obtaining consent • are responsive to consumer preferences, gender, ethnicity, English proficiency and age • support the presence of carers/families/nominated person/support network in physical health (including medication) planning, with the consumer's consent. **Provide, and support consumers to understand and interpret, information (for example, verbal and written, age-appropriate, languages) on:** • the relative risks of developing a physical illness, screening protocols and medication side effects • lifestyle risk factors (exercise, diet, tobacco smoking, cholesterol, dental, medication effects, alcohol and illicit drug use, sexual) • the benefits of a healthy lifestyle • voluntary screening protocols for diabetes, cardiovascular disease, obesity, respiratory disease, osteoporosis and dental health • access to a GP and primary care services • accessing lifestyle and chronic disease supports from expert organisations (for example, Quitline and Diabetes Australia). **Identify or develop age- and diversity-appropriate tools and resources to support self-management and lifestyle changes. These could include:** • a consumer diary to assist in self-checking and monitoring physical health • a carer handbook that includes information on health, smoking, risk factors and the benefits of making lifestyle changes. **Review and quality assurance** • Design performance measures and benchmark organisational physical health key performance indicators (KPIs) such as the percentage of consumers with a health care plan and the percentage of physical health assessments/reviews undertaken at defined points in the consumer journey (admission, discharge), • Provide planned and systematic feedback on the experience of consumers, carers and the workforce – for example, experience surveys as part of the discharge process and exit interviews with peer workers, families, carers and other supports.

Domain	Actions
Healthcare setting	**Programs** • Establish programs to maintain and improve physical health. • Implement lifestyle risk factor education, health coaching, motivation and support. • Support access to healthy lifestyle activities. • Introduce prevention activities (for example, annual flu vaccinations). **Facilities** • Establish and maintain dedicated controlled physical spaces for physical examinations and medical treatment. When designing or redeveloping care environments, consideration should also be given to privacy and the impact of trauma and feelings of discomfort consumers can experience when engaging in physical examinations and medical treatments. • Establish and maintain age-appropriate access, with clear directions to physical activity facilities and resources within inpatient services. Providing physical activity facilities within mental health service settings promotes a positive structure and opportunities for consumers to focus on their physical health and to safely access healthy lifestyle activities. **Systems** • Establish physical health as a required inclusion in clinical health records including: – integrating systematic documentation of the following into clinical health records: physical assessments and plans, monitoring and reviews, physical effects of medication, informed choices – ensuring health record design allows for systematic audits of the contents against KPIs – working towards including physical health assessments and monitoring in a personalised eHealth record. • Ensure health record design allows for the systematic inclusion of information about: – how the service's procedures align with clinical guidelines – clinical handover information procedures, a handover/discharge checklist and minimum datasets that include information on physical health assessments and physical health plans – medication effects. • Develop procedures, protocols and policies that: – enable KPIs to be reported to the mental health service's quality and safety governance leaders – establish and maintain information and research systems to monitor KPIs – utilise safety and quality systems to ensure monitoring of medication practice, outcomes and risk. • Ensure safety and quality systems include requirements to support timely and appropriate recognition of, and response to. acute physical deterioration including: – a policy for inpatient/outpatient observations – workforce training in identifying and responding to deterioration – regular audits to ensure basic essential equipment (for example, scales, thermometer, BP monitor) are onsite and functional.

Domain	Actions
Workforce considerations	**Evidence-based and recovery-oriented care** • Ensure the model of care for service delivery for the best available evidence-based physical health interventions and programs delivers: prevention and promotion; screening and early intervention; comprehensive care; and self-management interventions and programs as part of the routine interaction of clinicians with consumers and carers regarding physical health issues. • Implement policies and procedures for discipline specific screening (physical health check, lifestyle assessment) and physical health planning at identified points along the consumer pathway/continuum. Physical health plans should be developed annually and reviewed six-monthly (minimum) subject to consumer consent. • Implement evidenced-based clinical guidelines and associated policies and procedures for: – medications (medication specific and complex medication regimens) that: > consider physical health effects in planning and managing the risks associated with medication prescribing and management > identify a process for side-effects monitoring with consumers > activate guidelines and processes for physical health interventions indicated by medication use – general and targeted monitoring and review of key physical health markers (weight gain, seizures) that: > support recognition of deterioration > include guidelines for medication side-effect management > include markers and processes for triggering a review and/or medical emergency response > include an escalation pathway and process for responding to deterioration triggers. • Identify local diversity groups and, within the model of care and across settings, establish appropriate evidence-based physical health interventions and programs for: – **age:** people over 65 years, children and adolescents – **diversity:** Aboriginal and Torres Strait Islander people, consumers from culturally diverse backgrounds, LGBTI people – **specialty:** pregnant women, people with intellectual disabilities, prisoners, the homeless. • Develop effective workforce education and training: – Establish and maintain training and development systems that ensure the workforce can provide services aligned to Health Practitioners prescribed scope of practice and has appropriate skills, qualifications, experience and ongoing support in age and diversity responsive physical health literacy and health interventions and the physical health effects of medications. – Establish and maintain clinical leadership and mentoring practice.

Appendix 3: Actions – comprehensive care

Domain	Actions
Collaborative planning and therapeutic interventions	**Partner with consumers to review information collection and management policies and procedures to ensure they:** • support effective information flow and practice within the health organisation, the mental health service and with other health providers • operate in accordance with consumer consent • support routine offers to send copies of reports to health professionals involved in a consumer's care. **Review and quality assurance** • Measure performance in developing and regularly reviewing care plans. • Use data to inform development and monitor sustainability of pathways with community providers.
Healthcare setting	**Process** • Establish processes and protocols that ensure equity of access to physical health services across the broader health organisation. • Establish collaborative relationships and well-defined referral, comprehensive care and information-sharing pathways with local health services and resources (general practice, community health chronic disease management) and/or specialist services (for example, endocrinology). **Systems** **Ensure the model of care includes systems for:** • comprehensive care planning that includes individual choice and focuses on required interventions • establishing workforce roles and responsibilities in collaborative teams • establishing partnerships to develop programs that are accessible and integrate mental health and physical health care • consistent and effective referral pathways. **Ensure documentation of physical health assessment and planning is integrated in consumer care plans including:** • ensuring medical record contains information on the consumer's current GP and if consumer does not have a GP requirement to offer to arrange for the person to get a GP and an initial apt (for example, at a community health service or GP surgery) • transferring a written copy of a consumer's current mental health care plan (including medication) to their GP • transferring relevant information, with consent, to any health professionals involved in a consumer's care • routinely providing copies of any transferred information to the consumer • routinely supporting the consumer to share information with their family, carer or support networks.

Domain	Actions
Workforce considerations	**Screening capability** Health Practitioners who have undertaken specific education and training will: • Implement screening tools and processes for diabetes, cardiovascular disease, obesity, respiratory disease, osteoporosis, alcohol and drug issues, smoking and dental health with defined referral pathways. • These screening tools and processes should be age and service point appropriate and based on the best available evidence. • Processes should include responsibilities for proactive liaison and advocacy for prioritising access to physical health services for further assessment and intervention. **Communication** • Ensure there is a procedure for updating a consumer's current GP details in the service's records. • Implement processes for referral and, if required, proactive liaison and advocacy for prioritising access to the following services for assessment and intervention in accordance with clinical guideline assessment triggers: GP, diabetes educator, dietitian, nurse practitioners, pathology, dental, sleep clinic, imaging services (echocardiograms and ECGs), occupational therapists (for healthy lifestyle programs), cardiologist, alcohol and drug and sexual health services. **System knowledge** **People with a serious mental illness are a designated priority group for many public health services. Allied health services funded via the Medicare Benefits Scheme (MBS) are also available through GPs. Staff should be across:** • brief intervention referrals (for example, Quitline) • programs to maintain and improve physical health within the mental health service setting • strategies to ensure appointments are attended or rescheduled. **Provide clinicians with ready access to:** • local integrated care pathways (for example, through Health Pathways – a free, web-based portal with relevant and evidence-based information on assessing and managing common clinical conditions including referral guidance available through Primary Health Networks) • directories of local services for referral and/or provision of information to consumers carers/families (for example, the local community health service for access to free/affordable dental/podiatry/physio/dietitian services) **Implement annual physical health training that is co-designed and co-produced with consumers, carers and clinicians.**

Resources

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EQUALLYWELL

Improving the physical health and wellbeing of people living with mental illness in Australia

National Consensus Statement

Our vision is to improve the quality of life of people living with mental illness by providing equity of access to quality health care, with the ultimate aim of bridging the life expectancy gap between people living with mental illness and the general population.

We commit to making the physical health of people living with mental illness a priority at all levels: national, state, territory and regional.

We commit to bringing the importance of physical wellbeing across the spectrum of health – from promotion and prevention to treatment – for people of all ages across our whole society to public attention, to spur change.

We commit to partnering with consumers and carers, service providers, planners, policy makers and funders, to achieve our vision.

We will improve the physical health of people living with mental illness by acting to deliver:

1. a holistic, person centred approach to physical and mental health and wellbeing
2. effective promotion, prevention and early intervention
3. equity of access to all services
4. improved quality of health care
5. care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life
6. the monitoring of progress towards improved physical health and wellbeing.

We call on organisations across Australia to pledge support for this change.

To pledge to this Consensus Statement please go to www.equallywell.org.au

Australian Government
National Mental Health Commission

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