Equally Well Victoria: 2nd Edition (2025)

Physical health framework for mental health services

OFFICIAL

Safer Care Victoria

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A word from Victoria's Chief Mental Health Nurse

I am proud to introduce the revised Equally Well Victoria: 2025 framework – a renewed commitment to improving the physical health outcomes of people living with mental illness across our state.

This framework reaffirms our collective responsibility to prioritise the physical health of people living with mental illness. It upholds the principles of Equally Well, which aim to improve quality of life by ensuring equal access to quality health care for all mental health consumers.

The 2025 update reflects the evolving needs of our communities and the importance of contemporary, inclusive care. It builds on the foundational work of previous versions and responds to the voices of consumers, carers, clinicians and communities who have called for more responsive, evidence-informed approaches.

This edition introduces several **new priority areas** that reflect current health challenges and equity considerations. These include **women's health**, **cancer screening**, **Aboriginal and Torres Strait Islander peoples' health**, and **young people**. Each new section has been carefully developed to ensure services are equipped to respond in ways that are culturally safe, trauma-informed and recovery-oriented.

I would like to extend my heartfelt thanks to Trudy Brown, whose tireless work, leadership and dedication have been instrumental in bringing this updated framework to life. Trudy's commitment to equity and excellence has helped shape a resource that will guide and inspire mental health services across Victoria.

I also thank the many contributors – including our working groups and community partners– for shaping this important work. Together, we are advancing a vision where every person accessing mental health services in Victoria receives care that supports their whole wellbeing.

Let us continue to walk alongside consumers, families and carers in creating a system that supports equally well outcomes for everyone.

Anna Love
Chief Mental Health Nurse

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Notes and acknowledgements

This updated Victorian Equally Well framework draws on several documents including the *National Equally Well 2024 report: 'Mortality of people using Australian Government-funded mental health services and prescription medications: Analysis of 2016 Census, death registry, MBS and PBS data'*. Other documents include the *National Safety and Quality Health Service Standards for Acute and Community Mental Health Services* and the Victorian Department of Health's *Strategic plan 2023–27*.

We thank the Victorian Equally Well Working Group and Community of Practice and the stakeholders who were involved in redeveloping this framework including:

- Albury Wodonga Health
- Alfred Health
- Austin Health
- Centre of Excellence in Eating Disorders
- Dental Health Services Victoria
- Eastern Health
- Goulburn Valley Health
- Melbourne Health
- Monash Health
- Northern Health
- Orygen Youth Health
- Pharmaceutical Society of Australia
- Western Health.

Acknowledgement of Country

Safer Care Victoria acknowledges the Traditional Owners who have lived and loved this country through the vastness of time. We honour the people of the many nations whose Country we stand on today.

We pay our respects to the Elders and ancestors who are the safekeepers and caretakers of the oldest living culture on the planet. For this is the bedrock of this place, our shared home and our special identity in the world and the source of shared pride as Australians.

This land always was, and always will be, Aboriginal land.

A note about language

There are several terms used in 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 term '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.

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. The 2024 Equally Well factsheet: *Unequally unwell* 'highlights the significantly higher mortality rates and potentially preventable deaths among people accessing Australian Government–funded mental health services. It underscores the urgent need for targeted solutions, especially for younger age groups and those in disadvantaged areas, to improve health outcomes and reduce premature mortality of people living with mental illness.' In Victoria the Department of Health's *Strategic plan 2023–27* bold plan and 'vision is that Victorians are the healthiest people in the world'. To achieve this, we need a framework that both highlights the needs of those with mental illness regarding their physical health and ways in which services can work to improve the physical health of those depending on them for care.

Purpose

- To provide mental health specialist services with a clear list of priority areas where the most can be achieved to improve physical health outcomes.
- To support mental health services to develop, implement and review policies, procedures and ways of working to help consumers make decisions to address their physical health.
- To enable mental health services to improve physical health care to improve outcomes.
- To ensure a consistent approach across the different jurisdictions in Victoria's mental health services.

Scope

This framework applies to all Victorian specialist mental health services across practice settings and age cohorts. It is intended to complement professional standards and related practice frameworks and comply with the Health Practitioner Regulation National Law regarding scope of practice for health practitioners. Best practice in health care is always changing based on new evidence, so this framework is best evidence at the time of publication. Although due diligence has been taken to include up-to-date references, the onus is on the reader to ensure best practice standards are met. Please seek guidance from the peak bodies listed if you believe information is outdated.

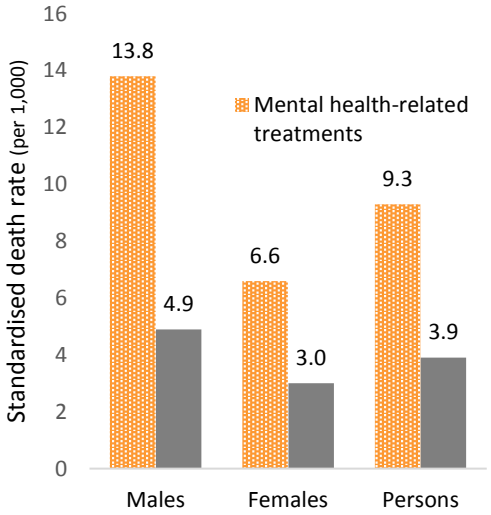
What we know about physical health

Several recent documents have highlighted the link between mental illness and poorer physical health outcomes. Although these issues are also in the general population, these documents highlight the overwhelming disparities that occur in people living with a mental illness. The following figures give an overview:

- Figures 1–3: Analysis of 2016 Census, death registry, Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) data details the excess deaths occurring in those with mental illness when compared with the general population.
- Figures 4–8: Unequally unwell: factsheet provides a snapshot of people who accessed mental health–related treatments and their mortality data.
- Figure 9: Chief Officer for Mental Health and Wellbeing Victoria annual report 2023–24

Figure 1: Standardised death rates of people aged 15 to 74

People (ages 15–74) who accessed mental health-related treatments had higher rates of premature mortality



- The linked dataset included 15.63 million people aged 15–74 years, of whom 3.46 million (22.2%) accessed mental health-related treatments.
- There were 58,650 total annual deaths of people aged 15–74 in Australia during the data collection period. Of this total, 28,912 **(49.3%)** were people who had accessed mental health-related treatments.
- People who accessed mental health-related treatments had a standardised death rate **2.4 times** greater than the **total** population (males 2.8, females 2.2 times).

FIGURE 1 Standardised death rates of people aged 15–74.

Sources: Analysis of 2016 Census, death registry, MBS and PBS data

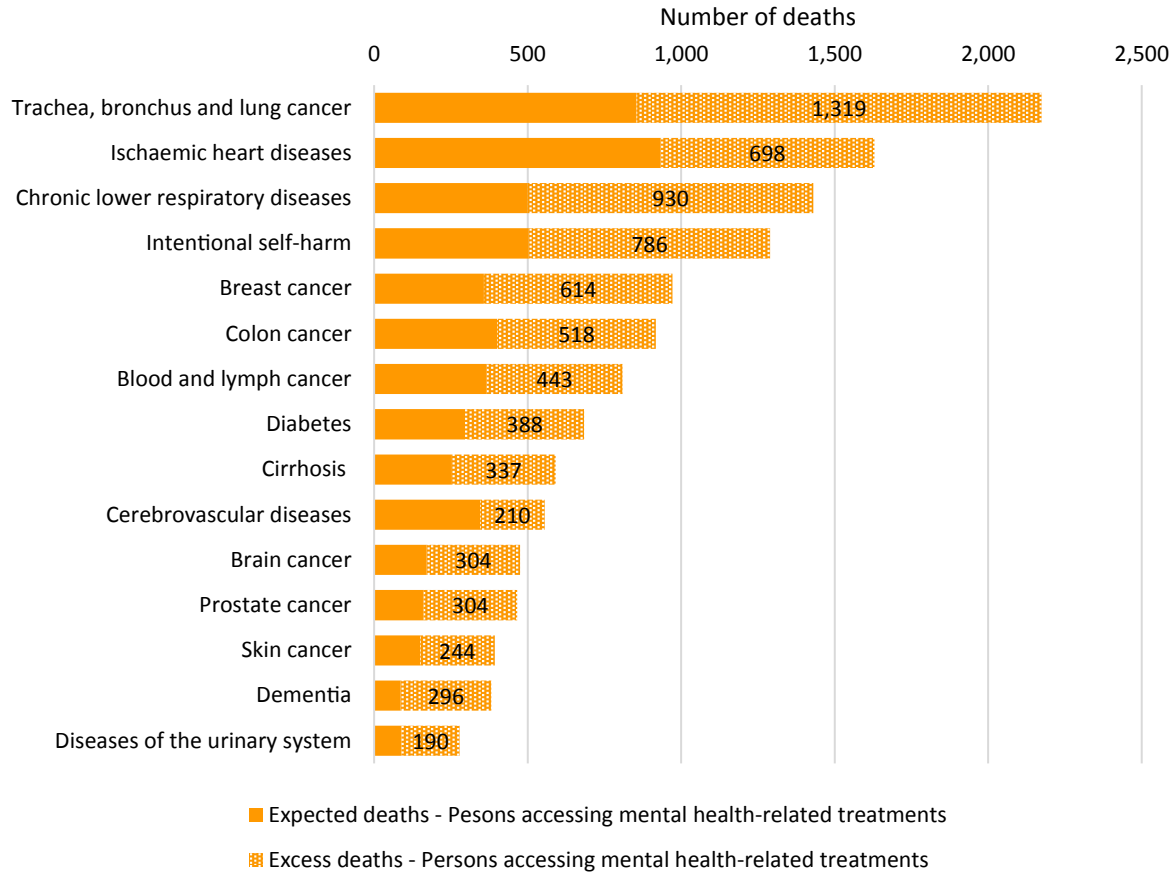
Figure 2: Excess annual deaths of people who accessed mental health treatment

Most deaths of people (15–74 years) with mental health conditions are excess deaths

Excess deaths are defined as the number of deaths in a particular section of the population above that expected, based on total population death rates. The OECD uses this measure to estimate potentially avoidable or excess deaths for population groups of interest.[3, 4]

The **excess** (potentially preventable) deaths of people (aged 15–74) who accessed mental health-related treatments comprised:

- a total of 16,658 excess annual deaths (46 per day)
- almost **three in five** (58%) of all deaths of people who accessed mental health-related treatments were **excess deaths**
- cancers were responsible for **24 excess deaths per day**[e]
- circulatory diseases were responsible for **4.4 excess deaths per day**.



Sources: Analysis of 2016 Census, death registry, MBS and PBS data

Standardised death rates by cause of death – ages 15–74

The comparative standardised death rates for the top 15 causes of death are presented in Figure 8. For every cause of death listed in Figure 8 (except transport accidents), the risk of death is over twice that of the total population. The standardised death rate ratios for breast cancer and lower respiratory disease were respectively 2.8 and 2.4 times higher than the total population. For some of the less common causes of death, such as dementia and diseases of the urinary system, the relative standardised death rate ratios were even higher.

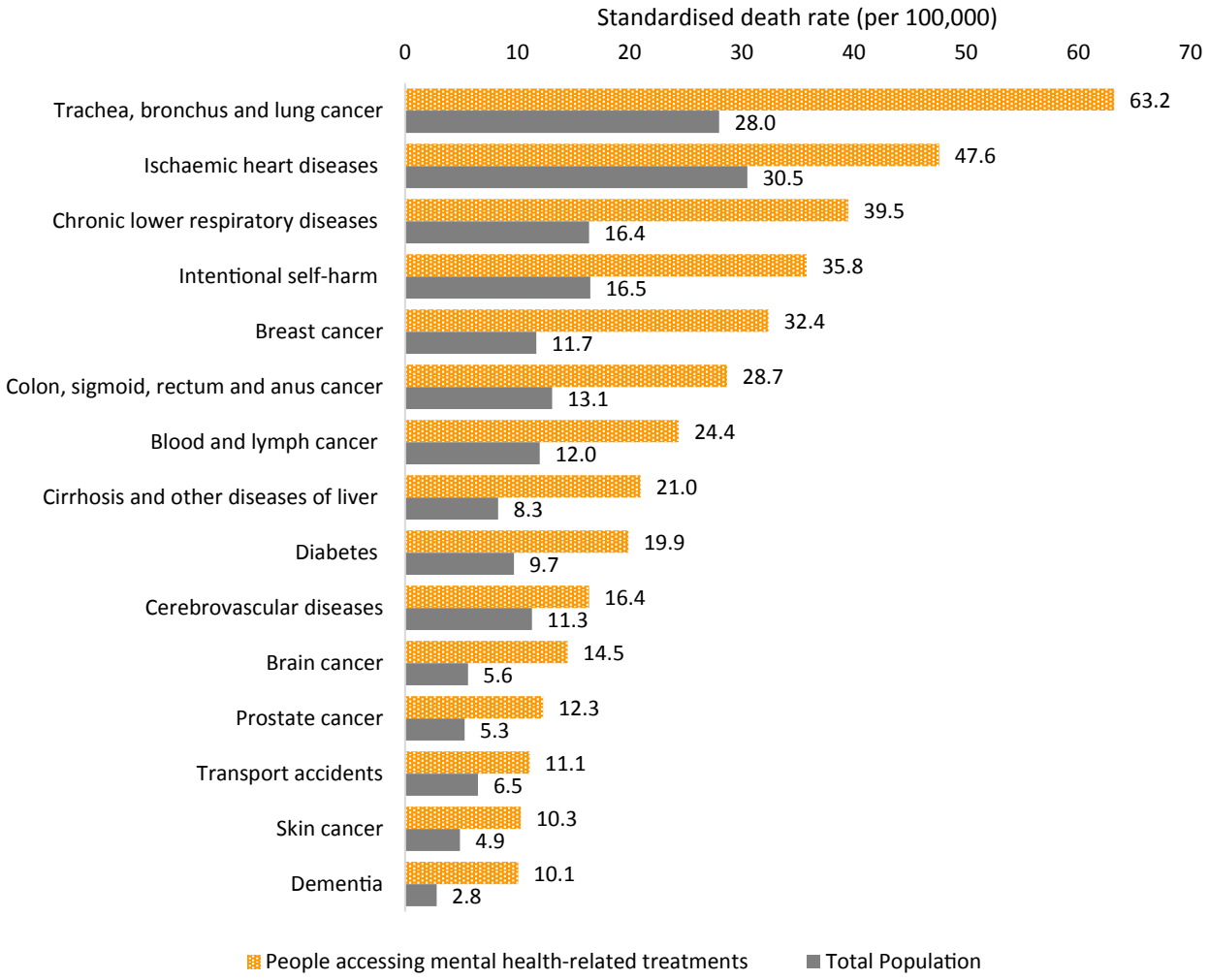
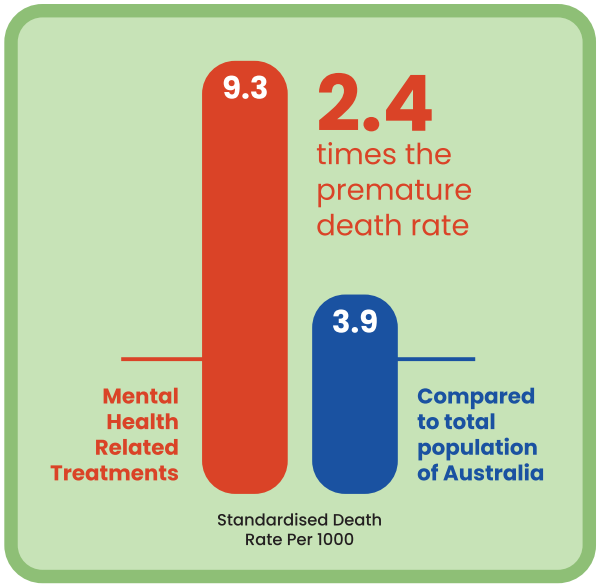


FIGURE 8 *Standardised death rates by major causes of death (ages 15–74).*

It is noteworthy that 56% (n=16,174) of all deaths of people accessing mental health treatments fall in the 'all other causes'[h] category. For reasons of figure scale, these are not presented in Figure 8, but are listed in Table 1. While each of the other causes of death accounted for fewer deaths than the 15 most common causes, the standardised death rate ratio for the 'all other causes' category (2.4) is equal to or greater than all the underlying causes listed in Figure 8, except breast cancer and cirrhosis of the liver.

Sources: Analysis of 2016 Census, death registry, MBS and PBS data

Figure 4: Snapshot of people who accessed mental health-related treatments

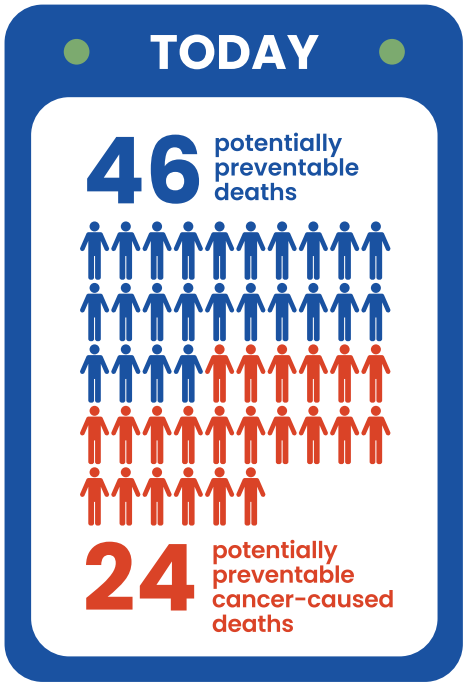


Source: Unequally unwell factsheet

Figure 5: Average reduced life expectancy

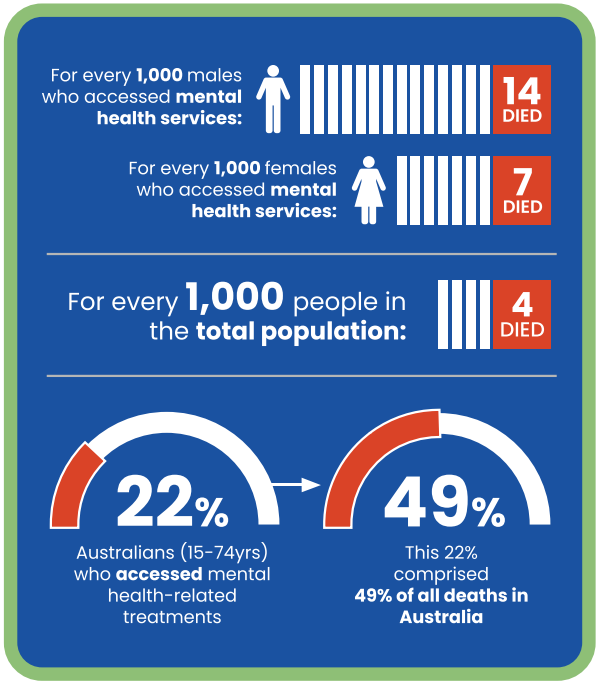
Source: Unequally unwell factsheet

Figure 6: Number of preventable deaths



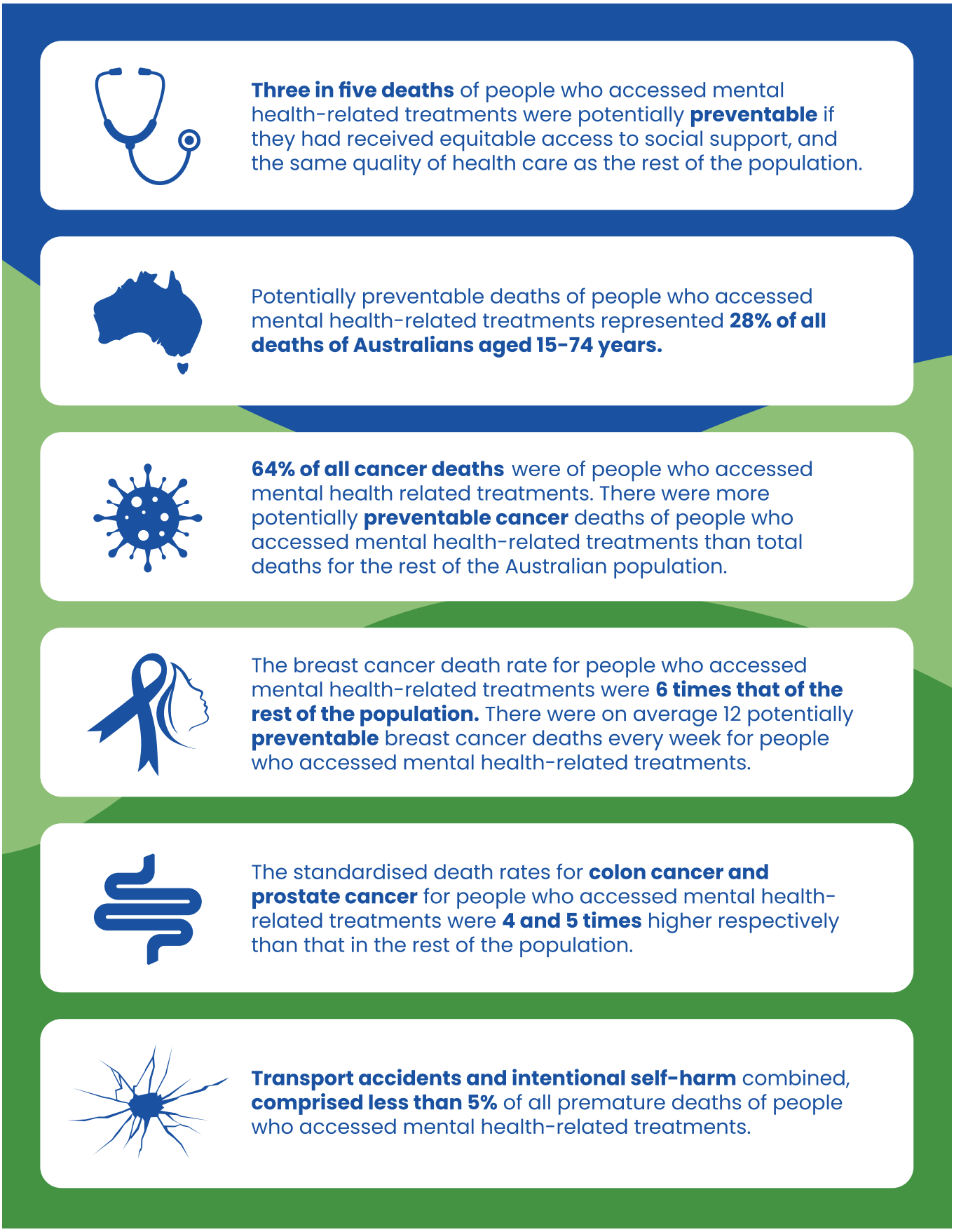
Source: Unequally unwell factsheet

Figure 7: People who accessed mental health services



Source: Unequally unwell factsheet

Figure 8: Cancer death facts



Source: Chief Officer for Mental Health and Wellbeing Victoria annual report 2023–24

Figure 9: Chief Officer for Mental Health and Wellbeing Victoria annual report 2023–2024

Domain 2: Victorians promote mental health for all ages and stages of life

Outcome 5: Victorians with mental illness have good physical health and wellbeing

The data analysis required to update the proportion of unique admitted clients who were discharged and used tobacco and the proportion of registered mental health clients with a type 2 diabetes diagnosis was not undertaken during 2024, therefore the results are unchanged from 2021–22, and date back to 2017–18.

Current indicators for physical health are tobacco use (as a risk factor) and type 2 diabetes (as a preventable illness). Results this year have improved, but the data for this indicator draws on inpatient admission information for physical or mental ill health in registered consumers and is therefore a limited subset of consumers accessing mental health services.

Nonetheless there is a reduction in tobacco use, which is trending down. Tobacco smoking is Australia's leading cause of preventable death and disease. Some disadvantaged groups, including people with mental illness, have substantially higher smoking prevalence than the general population. Although this indicator is trending down, there is substantial room for improvement. The latest data estimated that 11.6% of Australian adults smoked daily in 2019, a rate that has halved since 1991 (25%).[15]

The proportion of registered clients with a type 2 diabetes diagnosis is slightly reduced this year, but the level has been fairly stable over the past 5 years at or around 10%. This is almost double the prevalence in the general population, which is estimated at 5.3%. The complications of diabetes can be severe and include heart disease, stroke, blindness, kidney disease, nerve damage and amputations.

Indicators for outcome 5

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
5.1 Proportion of unique admitted clients who were discharged and used tobacco	2021–22	38.2%	37.1%	36.5%	36.5%	32.7%
5.2 Proportion of registered mental health clients with a type 2 diabetes diagnosis	2021–22	9.8%	9.9%	10.0%	10.1%	9.3%

Outcome 6: Victorians with mental illness are supported to protect and promote health

Indicators yet to be developed.

Source: Chief Officer for Mental Health and Wellbeing Victoria annual report 2023–24

The Royal Australian and New Zealand College of Psychiatrists statement

Key facts

- Recent Australian and New Zealand Government health initiatives have identified the poor physical health and disparity in health outcomes experienced by people with mental illness compared with the general population as a priority.
- Mortality rates are higher in people with a mental illness than those in the general population, with this gap largely due to poor physical health, and this gap is widening.
- Many of these physical health conditions could be prevented or treated if appropriate services and treatments were accessible early in the person's care.
- Mental illness can overshadow the clinical awareness of many comorbid physical health risks, with symptoms of poor physical health being incorrectly attributed to symptoms of the person's mental illness.
- Psychiatrists play a key role in integrating mental and physical health care. As medical practitioners, psychiatrists are experts in diagnosing and managing complex mental health conditions. They are well placed to work collaboratively across healthcare settings to ensure symptoms of poor physical health are appropriately diagnosed, treated and monitored.

Key figures

The high rates of poor physical health in people with mental illness are similar in Australia and New Zealand.

A recent Australian report shows that people living with severe mental illness are:

- likely to die between 14 and 23 years earlier than the general population
- 6 times more likely to die from cardiovascular disease
- 4 times more likely to die from respiratory disease
- 5 times more likely to smoke.

(Source: National Mental Health Commission 2016)

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* (National Mental Health Commission 2016), many factors contribute to the poorer physical health experienced by people with mental illness. 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.

Overarching principles

The *Mental Health and Wellbeing Act 2022* lists 13 core mental health and wellbeing principles:

- **Dignity and autonomy principle** – The rights, dignity and autonomy of people living with mental illness or psychological distress are to be promoted and protected.
- **Diversity of care principle** – People living with mental illness or psychological distress are to be provided with access to a diverse mix of care and support services.
- **Least restrictive principle** – Mental health and wellbeing services are provided with the least possible restriction of a person's rights, dignity and autonomy with the aim of promoting their recovery and full participation in community life.
- **Supported decision-making principle** – People receiving mental health and wellbeing services (including those receiving compulsory treatment) are supported to make and participate in decisions about their assessment, treatment and recovery, with the views and preference of the person receiving mental health and wellbeing services to be given priority.
- **Family and carers principle** – Families, carers and supporters (including children) of people receiving mental health and wellbeing services are to be supported in their role in decisions about the person's assessment, treatment and recovery.
- **Lived experience principle** – The lived experience of a person with mental illness or psychological distress and their carers, families and supporters to be recognised and valued.
- **Health needs principle** – The medical and other health needs of people living with mental illness or psychological distress are to be identified and responded to.
- **Dignity of risk principle** – People receiving mental health and wellbeing services have the right to take reasonable risks to achieve personal growth, self-esteem and overall quality of life.
- **Wellbeing of young people principle** – The health, wellbeing and autonomy of children and young people receiving mental health and wellbeing services are to be promoted and supported.
- **Diversity principle** – The diverse needs and experiences of people receiving mental health and wellbeing services are to be actively considered, with services provided in a manner that is safe, sensitive and responsive.
- **Gender safety principle** – The specific safety needs or concerns that a person may have based on their gender are to be considered and services provided in a manner that is safe and responsive to these needs and concerns.
- **Cultural safety principle** – Mental health and wellbeing services are to be culturally safe and responsive to people of all racial, ethnic, faith based and cultural backgrounds – this includes provision of culturally safe and responsive mental health and wellbeing treatment and care to Aboriginal peoples that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices.
- **Wellbeing of dependants principle** – The needs, wellbeing and safety of children, young people and other dependents of people receiving mental health and wellbeing services are to be protected.

Domains

Consumer physical health needs

At the centre of the framework is identifying the person's needs through a holistic, collaborative process that engages the consumer, carers and clinicians.

The person'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 largely shaped 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 respond 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

This is an overarching domain that supports safety for all when engaging consumers about their physical health care. It includes the '4 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.

The framework

Every time a consumer engages with a mental health service there is 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).

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

The framework in action – organisational 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. There is an increasing body of good practice and evidence 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.

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:

- 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 in health practices
- implement key performance indicators to audit and track compliance across the healthcare setting with any physical health initiatives that are implemented.

Action area: Interprofessional leadership and culture

Organisational leaders must commit to the vision that 'People living with mental illness have the same life expectancy as the general population'. Leaders must 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 obligations 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.

Action area: Model of care

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 spelled out for each setting.

The model of care should respond to the individual needs and diversity of consumers in each setting and across all age groups. Sustaining safe and quality care for both mental and physical health needs across the service continuum depends 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.

Collaborative and recovery-focused: Collaborative practices, ensuring people can exercise optimal choice, personal agency and flexibility and recovery-focused practice, 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 (Department of Health 2011).

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 that the person:

- understands their condition
- is supported to make decisions
- sets goals
- follows their treatment plan
- tracks their symptoms
- is fully informed of their illness, the effects of their illness and medication
- maintains a healthy lifestyle.

Every mental health service has 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.

Action area: Comprehensive care

People living with 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 therefore less likely to be offered physical health interventions.

Evidence shows that people with a mental illness are significantly more likely to have a co-existing disease for which optimal management requires services from several 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 following their therapeutic care plan and could affect hospitalisation and survival rates.

Treatment burden for consumers with multiple chronic conditions can be assessed using validated tools that may help develop treatment strategies that are 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 can access the services they need, opportunities for early intervention, health promotion and improved health and care outcomes.

> 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.
>
> – Australian Commission on Safety and Quality in Health Care 2017

Implementing the framework – for clinicians

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 personalised 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 tailors treatment regimens to the realities of the daily lives of consumers. The approach aims to advance a consumer's goals for health, health care and life using effective care programs designed and implemented in a way 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 that incorporate the domains of 'collaborative planning and therapeutic interventions' and 'workforce considerations'.

Priority areas

Using a whole-of-health approach, the following 12 areas have been identified by consumers, carers and clinicians from the expert reference group involved in developing this framework as priority areas for action. Although listed here in number order, all priority areas are equally important.

- Priority area 1: Support to quit smoking or vaping
- Priority area 2: Improving metabolic health – nutrition and nourishment
- Priority area 3: Improving metabolic health – physical activity
- Priority area 4: Harm minimisation (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
- Priority area 9: Women's health
- Priority area 10: Cancer screening
- Priority area 11: Aboriginal and Torres Strait Islander peoples' health
- Priority area 12: Young people.

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 12 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 regarding the needs and care of people and developing their care plans
- developing a care plan for each person based on the need to address their physical health
- considering the will, preferences and goals that the person considers the most important areas to address, accounting for 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.

Physical health and family violence

This document aligns with the Family Violence Multi-Agency Risk Assessment and Management (MARAM) framework. Readers will notice references 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 should be familiar with the person's current (lack of) safety before discussing physical health. If family violence was not identified and is picked up during conversations, the person's safety is paramount. A family violence risk assessment needs to be undertaken.

Discussing physical health may need to take a backstep, or it might offer 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 service.

Remember that mostly women, children and young people experience family violence, but also older people and people in same-sex relationships.

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

Collaborative planning

- Use a person-centred approach to assess the person'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 person's fears and anxieties.
- Use an appropriate physical assessment tool (examples in the appendix).

Formalise the plan

- Work with the person 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 support.
- With the person's consent, work with other health professionals to promote equal access to all appropriate healthcare services.
- Agree what will be in the care plan and give the person a copy.

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 health professionals as appropriate.
- Make sure the person receives treatment for their physical health problems.
- Use the activities to achieve change outlined under each action area.
- Continually encourage people to take care of their physical health.

Evaluate

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

Priority area 1: Support to quit smoking or vaping

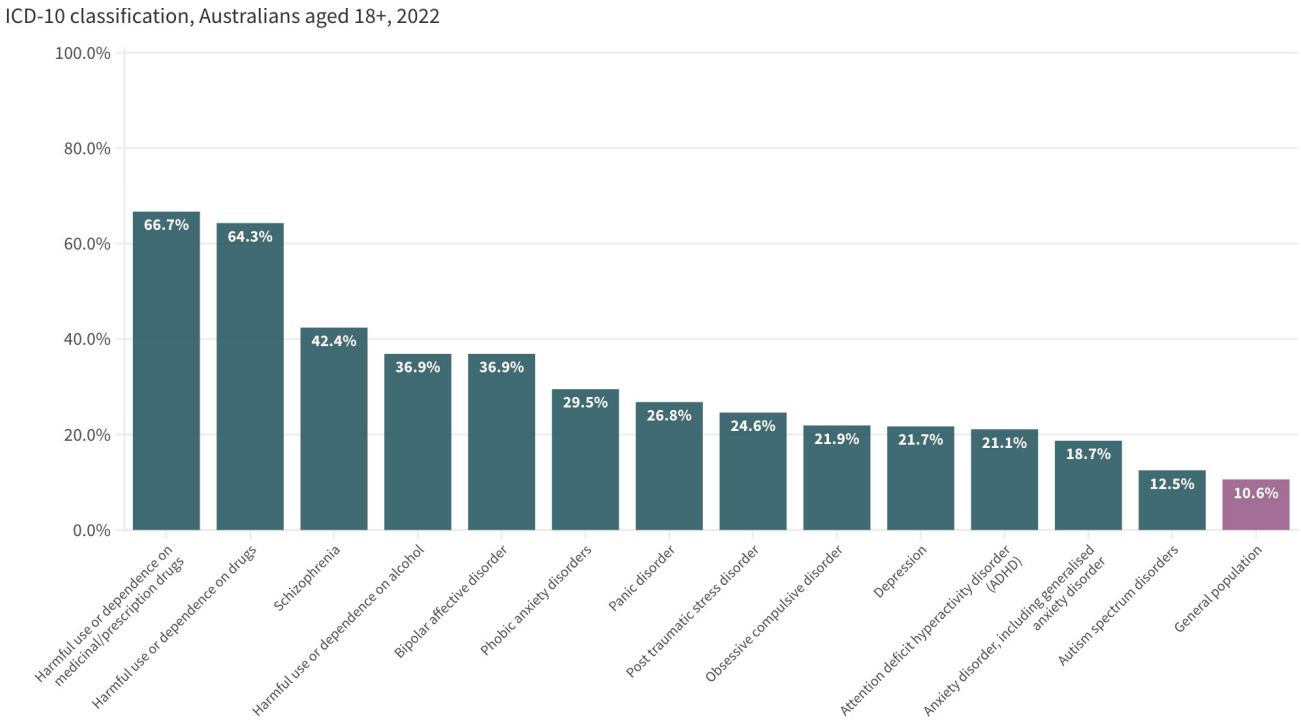
Evidence

Cigarettes

High smoking rates among people with a mental illness contribute to higher levels of tobacco-caused morbidity and mortality. Smoking rates in the general population sit at around 14%. However, for those with a schizophrenia related condition, it sits at 62% (Greenhalgh and Scollo 2022) (Figure 10).

High rates of morbidity and mortality for those with a mental illness is linked to smoking-related illnesses such as cardiovascular disease, respiratory disease, diabetes and cancer. People with mental illness who smoke are far more likely to die from their smoking than from their psychiatric condition. People with a mental illness and mental health workers often perceive smoking to be helpful in relieving or managing psychiatric symptoms (for example, smoking helps manage anxiety and agitation). However, recent evidence suggests that the reverse is true; people who quit smoking may experience improvements in their mental health and quality of life (the anxiety and agitation may be caused by nicotine withdrawal) (Greenhalgh and Scollo 2022). Smokers with mental illness who quit report lower levels of psychological distress and mental health symptoms than those who continue to smoke (Greenhalgh and Scollo 2022). Quitting smoking has been found to have a similar-sized effect to taking antidepressants on improving mental health.

Figure 10: Prevalence of daily smoking by mental disorder (%)



Source: Australian Bureau of Statistics Table Builder, using data from the National Health Survey 2022

Source: Greenhalgh and Scollo 2022

Vapes

There may be less motivation to quit vaping because of a perception that vaping is 'safer' than smoking due to no combustion occurring in the product and fewer chemicals being present (Royal Australian College of General Practitioners 2025). Vaping may be an initial harm reduction strategy for those deciding to think about reducing or ceasing cigarette smoking. Vaping may pose fewer health risks than smoking, but it is not risk-free (Royal Australian College of General Practitioners 2025). There are numerous shorter term potential adverse health effects of vaping, including: acute lung injury; mouth and airway irritation; cough; nausea; dizziness and headache. The extent of longer term health risks and effect on chronic health conditions are yet to be determined and may take decades to emerge. Other risks include the risk of poisoning through nicotine liquid touching skin or ingestion, and there is risk of injury such as burns due to the e-cigarette or vaping device catching fire or exploding (Royal Australian College of General Practitioners 2025).

Understanding the consumer's perspective or journey

- Asking consumers if they smoke or vape is an important part of physical health assessment.
- Use positive language. Do not make people feel bad about their smoking/vaping; do not blame. Be curious about a person's smoking.
- Walk beside the person on their journey. Engage in a supported decision-making conversation.
- Ask if the person would like to discuss it or receive information or assistance with quitting smoking/vaping.
- Explore the relationship people have with their smoking/vaping, what it means to the person and how it is helpful (for example, to reduce stress, social connection). Ask questions such as, 'What's good about your smoking/vaping? ' and 'What's not so good about it?'
- Ask about trigger points for smoking or vaping and what changes might be possible (reducing smoking/vaping, having more control of their smoking/vaping), or just begin the discussion. Again, be curious and ask about their perspective.

A common misperception is that people with a mental illness do not want to quit, which can lead to a lack of encouragement and support to do so. A study of mental health centres found that the most common barrier to staff implementing smoking/vaping cessation treatment was a perceived lack of consumer interest in quitting (Greenhalgh and Scollo, 2022). Although the co-presence of mental illness can make quit attempts more challenging and less successful, there is motivation to quit. Greenhalgh and Scollo, (2022) found consumers recruited from outpatient and inpatient psychiatric settings suggest they are just as likely as the overall population to want to quit smoking/vaping.

Links to recovery goals

Explore how smoking or vaping 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 quit smoking/vaping, improve breathing and overall health).

When the consumer is ready to reduce or quit

- Follow the 3-step brief intervention model (refer to AAH box below).
- Explore how smoking/vaping might relate to the person's mental health experiences (Is it meeting a need that could be addressed another way?).
- Consider 'motivational interviewing' or other evidence-based strategies and techniques.
- Calculate the amount of money saved by not smoking/vaping 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.
- Advise that the best way to quit smoking or vaping is with a combination of support and medication. Help is available to help them through the process.
- Adopt a team approach and work 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/vaping cessation services to plan and deliver community-based support for people living with mental health issues and to support those transitioning from inpatient to community services.
- Support people who experience smoking/vaping withdrawal symptoms.

The Ask, Advise, Help (AAH) model

This model can be used by individual health, community and social service professionals in their everyday interactions with patients, clients and consumers. It can also be used to guide systems change in these settings.

- **Ask** about smoking status and document this.
- **Advise** all people who smoke to quit in a clear, non-confrontational, personalised way, and advise about the best way to quit.
- **Help** by offering referral to behavioural intervention through Quitline (13 7848), and help clients to access smoking cessation pharmacotherapy, such as nicotine replacement therapy (NRT).

Reasons to offer consumers who smoke or vape a referral to the Victorian Quitline 137848

Accessible recovery-oriented multi-session smoking/vaping 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 consumer to offer the free callback service that includes:

- counselling to help build motivation, identify smoking/vaping triggers and build skills to manage triggers including mood management strategies that can help with stopping smoking/vaping, smoking/vaping 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 medication side effects (refer to 'Considerations for prescribers' below).

When the consumer is not ready to reduce or quit

- Respect the person's preferences if they do not want to discuss their smoking/vaping. 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/vaping 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 and consider working from a harm reduction perspective. Build the capability of the workforce by ensuring motivational interviewing is included in training and learning packages.
- Develop the skills and confidence to administer nicotine replacement therapy.
- Develop trauma-informed care skills and skills in assessing for family violence (MARAM).
- Consider the person's environment, family and social groups — everyone around them may smoke/vape.
- Support and lead activities and policies in services to become completely smoke-free.
- Become familiar with Quit Victoria's smoking cessation program.
- Create Interprofessional education and learning programs about smoking/vaping cessation.
- Consider access to a Smokerlyzer so consumers who are reducing or stopping smoking have an objective measure of carbon monoxide and each time will see a reduction in the level. This can be a strong motivator.

- Review QUIT online training for mental health professionals <https://www.quit.org.au/training-and-resources-mental-health-services>
- Peer led interventions – peer health coaches and peer-led smoking cessation programs are highly effective and valued. Programs that are co-designed with consumers value and respond to peoples lived experience of smoking cessation and mental health.

Quit Victoria has suggested several strategies that mental health services could implement to reduce smoking-related harms, including:

- routinely asking consumers about their smoking/vaping and recording responses
- referring consumers and staff to Quitline, a doctor or a local quit smoking/vaping program
- establishing or reviewing a smokefree policy
- encouraging staff to complete further training in smoking/vaping cessation
- displaying posters and print resources
- referring staff and consumers to the Quit website <http://www.quit.org.au/> for information on services and smoking care medications.

Considerations for prescribers

Nicotine replacement therapy (NRT) is a medication-assisted treatment that helps people quit smoking or vaping by providing a controlled dose of nicotine without the harmful chemicals found in cigarettes. NRT comes in various forms including patches, mist, lozenges and gum. NRT can be purchased from most pharmacies, supermarkets or online. Discounted nicotine patches are available on the PBS via prescription.

As per the Royal Australian College of General Practitioner (RACGP) guidelines (2025):

- Higher levels of dependence in people with mental illness may need more intensive treatment (such as higher doses of NRT, closer follow-up and monitoring).
- Varenicline is safe and effective for smoking cessation in people with stable mental illness or a history of mental illness. Both varenicline and bupropion can be used in people with significant mental illness. A large randomised control trial <https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/supporting-smoking-cessation/smoking-cessation-for-high-prevalence-groups> showed no increase in neuropsychiatric adverse events linked to varenicline or bupropion relative to a nicotine patch or placebo.
- Nicotine does not interact with psychiatric medications directly. However, the tar in tobacco smoke induces certain liver enzyme activity (cytochrome P450 1A2 [CYP1A2]), which increases the metabolism of certain medications, including some psychotropic drugs. Those who smoke cigarettes may therefore require larger doses with these medications. For more information, refer to the Australian Prescriber website <https://australianprescriber.tg.org.au/articles/smoking-and-drug-interactions.html>.
- In the event of cigarette smoking reduction or cessation, consider reducing the dose of drugs that are metabolised by the CYP1A2 pathway, assessing therapeutic drug levels where appropriate and monitoring for toxic side effects (sedation, blood count).

Health promotion messages for consumers, carers and supporters

- Stopping smoking/vaping is one of the best things you can do to improve your physical health.
- Cutting down smoking/vaping can have significant financial benefits, and it may make it easier to quit.
- The most effective way to quit is to combine NRT 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.
- If you are concerned about how nicotine withdrawal might affect your mental health, Quitline can help track how you're feeling while you try to stop smoking/vaping.
- Your doctor can prescribe 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. Speak with your doctor before making any changes.

Health promotion messages for mental health professionals

- Smoking is the leading cause of preventable death in people with mental illness.
- Smoking/vaping can be addressed while treating mood, substance use and other conditions, and stopping for 6 weeks or more can improve mood and other outcomes.
- While many consumers receiving care in an acute inpatient mental health setting express dissatisfaction with being detained in a smoke-free environment, there is a high uptake of smoking/vaping cessation interventions when offered.
- Routinely offering a 3-step brief intervention to consumers, regardless of their level of interest in stopping smoking/vaping, can trigger a quit attempt.
- It is safe for consumers to use NRT, varenicline and bupropion, all of which improve the chances of quit success among people with mental illness. It is also safe for a consumer to use these if they are still smoking. Using NRT while still smoking can help to cut down on the pathway to quitting.
- Supporting people to quit smoking/vaping 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.
- Being aware of consistently applying a smoke-free policy can be helpful to avoid mixed messages and can be important in reducing experiencing feelings of confusion and punishment for consumers.

Considerations for older people

- Lifelong habits take time to change – start small by highlighting the benefits of quitting or cutting down.
- Implement a detailed smoking/vaping history screen for all consumers.
- Residential services: ensure visual aids describing replacement therapies are in areas where consumers can see them.
- Have the clinical team, including the person's GP, discuss the benefits of not smoking/vaping with the consumer.
- Conduct regular physical health reviews to monitor for the adverse effects of smoking and ensure routine testing is conducted for all consumers.

Priority area 2: Improving metabolic health – nutrition and eating behaviour

Evidence

Good metabolic health can reduce the risk of metabolic syndrome. Risk factors for metabolic syndrome include high blood pressure, raised glucose levels, larger waist size and abnormal cholesterol levels. Having metabolic syndrome increases the risk of diabetes, cardiovascular disease and cancer. Good metabolic health reduces the risk of these diseases.

Previous focus on weight and measuring body mass index as indicators of health have led to issues with weight stigma and body image. There has been a shift towards weight-inclusive health care that recognises the natural diversity of body shapes and sizes and understands that health cannot be measured by weight alone. Through encouraging health-promoting behaviours such as eating nutrient-dense foods, health markers may be improved, irrespective of weight changes. Relevant objective physiological measures that may be used to monitor metabolic health and outcomes of interventions include blood glucose levels, HbA1c, total cholesterol, HDL cholesterol, LDL cholesterol, triglycerides, blood pressure, inflammatory markers or a cardiovascular risk calculator. The focus should be on enhancing health and wellbeing rather than weight change.

(Source: Levinson et al. 2024)

Understanding the consumer's perspective or journey

- Use positive recovery-focused language. Discuss the person's wellbeing goals, how they feel about their dietary pattern, eating behaviour and impact on physical and mental health, function, self-esteem and identity. Explore the consumer's readiness for change.
- Walk beside the person on their journey. Engage in a supported decision-making conversation, and draw on what has worked well or not so well for them before.
- Ask about their nutrition goals or explore how nutrition might be linked to other recovery goals. Gently explore what their views are, what they would like to do, what is important to them at that 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, does someone else do the cooking and shopping? If medication is impacting their function, explore the relationship between nutrition and its effect on their physical and mental health wellbeing.
- Gently explore how a person's socioeconomic status impacts on their food choices (for example, how much income they have for groceries). Assess for food insecurity – you may be able to link the person with supports such as food hampers to increase their access to food.

Links to recovery goals

Include nutritional health in discussions and when developing recovery goals.

Consider the person's living situation: Who in the household contributes to and manages food-related housekeeping activities; what resources (for example, culinary and food-related housekeeping skill set; kitchen, food preparation and storage facilities; proximity and access to food supply; financial resources) does the person have?

Explore the relationship between nutrition and eating behaviour for inclusion in recovery goals. For example, a consumer may have goals to increase their meal preparation skills such as confidence, variety of meals they can prepare, increased capacity to manage their food budget, or even thinking about how they can use values to develop food recovery goals so eating and feeding aligns. For example, if someone values kindness and connection, maybe they want to

prepare a meal for friends; if someone values the environment, maybe they want to reduce their food waste; if someone values curiosity or adventure, maybe they want to explore cooking different cuisines.

When the consumer is ready to make changes

- Ask the person about their physical health goals in the short, medium and long term – what changes would they 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 allied health, nursing and medical teams to develop a holistic care plan with the consumer based on their strengths and preferences.
- Work with counsellors, psychologists and social workers (as available) to explore the interactions between social factors and physical health and wellbeing.
- Work with dietitians, occupational therapists and other allied health professionals to develop a holistic care plan.
- Consider the impact that food choices can play on improving mood and reducing depression.
- Disordered eating may present in many forms and may not be obvious. What is the person's self-perception of body image? Have they experienced disordered eating and what does this mean for them? Screen for disordered eating: either use a tool endorsed by your organisation or consider the Inside Out Institute Screener <https://insideoutinstitute.org.au/screener/>, which can be completed online. Consider using the Reach Out and Recover resource <https://reachoutandrecover.com.au/> to explore eating and body shape concerns.
- With consent, jointly decide on appropriate health measurements to monitor (for example, diabetes or metabolic syndrome parameters). Ensure care plans are individualised to their needs, address their health goals and promote physical health. Examples of ways to monitor metabolic syndrome are listed in an article by Waterreus and Laugharne (2009) <https://www.mja.com.au/system/files/issues/190_04_160209/wat10895_fm.pdf>.
- Refer people to relevant supportive lifestyle programs, ideally 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. Think of this as social prescribing because it may also assist in other areas of mental wellbeing: meaningful, purposeful, engagement.
- Work with partners such as dietitians, wards, teams and catering departments to increase access to healthier food choices in mental health care settings.
- Dietitians are experts in food and nutrition and provide care, both individualised and group, in a recovery-oriented and strengths-focused way. When appropriate, consider a referral to a dietitian for more individualised care.
- Include family/carers/supports (with consent and where able) in discussions on nutrition and eating behaviour.
- If appropriate, conduct a nutrition risk assessment (an example is the St Andrew's Healthcare Nutrition Screening Instrument SANSI tool <https://onlinelibrary.wiley.com/action/downloadSupplement?doi=10.1111%2Fj.1365–2850.2011.01848.x&file=JPM_1848_sm_appendixS1.doc>).

When the consumer is not ready to make changes

- 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 different headspace or situation.
- There is always an opportunity to address this in the future. Revisit this priority.

Workforce considerations

- Build motivational interviewing skills.
- Develop weight-inclusive and eating disorder–safe practice to avoid stigma and discrimination, promoting acceptance and respect for body size diversity.
- Ask permission for health measurements including blood pressure, blood tests, weight and waist circumference (consider trauma-informed care and use strategies to reduce discomfort – for example, blind measurements). Explain why you are taking health measurements (for example, to assess metabolic health and to understand nutrition status).
- Become familiar with nutrition and lifestyle programs and services and referral pathways.
- Create interprofessional education and learning programs about healthy eating and learn about nutrition.
- 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 higher weight may already experience stigma and discrimination, and any 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 to acknowledge that these are common issues for many mental health consumers. Clinicians should also acknowledge that some people work hard to maintain health, and bodies naturally exist in a broadly diverse spectrum. 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 with weight, general shape or size but are reviewed in the context of function and improving metabolic health/markers.

Considerations for prescribers

- Pharmacists, nurse practitioners, psychiatrists and GPs have specialist knowledge of psychiatric medicines and their effects including how they contribute to improvements in their mental health and the potential effect on metabolic health. They are trained to monitor and explore the effects of the medication, so have these conversations with consumers to optimise medicine choice, taking into consideration consumer preferences. If medication is contributing to changes in metabolism, food choices and contributing to hunger, offer to review their physical health and their prescriptions.
- It is important to note that antipsychotic medicines don't simply increase weight, they alter insulin sensitivity, they alter insulin secretion and they affect lipid metabolism (including storage and mobilisation).
- Metabolic issues associated with antipsychotic medicines is complex and is a red flag (if not a diagnostic criteria) for prediabetes.
- In the event of antipsychotic associated weight gain, metformin is an effective pharmacological agent to slow weight gain followed by adding aripiprazole (if the causative agent cannot be changed). Prescribers should consider both agents by when antipsychotic-associated weight gain is evident (Dayabandara et al. 2017).
- Use caution when prescribing medications that help with weight loss. This should be done in conjunction with someone who is trained in these medications.

Health promotion nutrition messages for consumers, carers and supporters

- The *Australian guide to healthy eating* includes information about how much and what types of food we need to eat to maintain a healthy body.
- Aim to eat a variety of food from all food groups – wholegrain bread and cereals, vegetables, fruit, dairy (or dairy alternatives), lean meat, oily fish or plant proteins (for example, lentils, chickpeas, beans, tofu) and healthy fats such as extra virgin olive oil, avocado, nuts and seeds.
- Try to increase your fruit and vegetable intake; they are a rich source of vitamins, minerals, gut healthy fibre and antioxidants. Try to 'eat the rainbow' – different-coloured fruit and vegetables have different health benefits. Nutritious and affordable options can include canned and frozen varieties.

- Choose wholegrains where you can so you don't miss out on all the extra nutrients and fibre contained in those extra layers (for example, brown rice, brown and grainy breads, wholemeal pasta, rolled oats).
- If you eat a lot of red meat, consider swapping to include other nutritious proteins including plant proteins (such as tofu, tempeh, chickpeas, lentils and beans) and aiming for 2 to 3 serves of oily fish per week (such as salmon, mackerel, canned sardines). Oily fish is one of the best sources of omega 3s, which are an important type of fat that can reduce risk of heart disease and can help with inflammation.
- Try to include some probiotics to support your gut health. You can get probiotics from foods such as yoghurt, kefir, sauerkraut, kimchi, tempeh and kombucha. Don't forget to eat lots of fibre-rich foods to feed the healthy gut bacteria.
- Try to eat regular and balanced meals that have carbohydrate, protein, heart healthy fats and produce (fruit or vegetables) to help meet your nutrition requirements and support you with feeling full and satisfied. Don't forget to add flavour to improve enjoyment at meals.
- Try to reduce sugary and fizzy drinks.
- Where possible, use your hunger and fullness body cues to make decisions about how much to eat. Take a mindful pause before eating and reflect on your reason for eating. Are you physically hungry, having a craving, trying to cope with uncomfortable feelings or something else? Think about whether you sometimes use food as comfort, such as when you are upset, angry or stressed. Explore other ways to cope with these feelings and consider seeking professional support such as a psychologist or dietitian.
- Small changes to eating can help improve vitality and health. These changes should be things that you can maintain as part of your everyday life – that way you'll build confidence in your ability to manage your health in a way that works for you.
- Avoid 'crash' dieting (fad diets, restrictive eating) because these are not evidence-based approaches. If you want to make changes, request a referral to a dietitian who can support you with healthy eating.
- Try to put time aside each week for flexible meal planning so you have an idea of how you're going to feed yourself. Don't forget to have some quick, easy and nutritious options for when you might not feel up to cooking.

Considerations for older people

Consider the specific differences in malnutrition risk for older people.

- With permission, request and record baseline metabolic measurements on admission to community and aged care services and repeat every 6 to 12 months.
- Consider sarcopenia. The loss of muscle mass and strength that occurs with ageing and weight loss can be detrimental, especially when there is an increased risk of falls.
- All meals provided by residential aged care services are nutritious and comply with recommended dietary standards for this age group.
- Consider a dietitian referral when there are concerns for high malnutrition risk, wound healing, multiple complex allergies and so on. Ensure referrals are followed up.
- Educate families and friends who visit the aged care facility with food and drink about any special nutritional requirements and food texture modifications as clinically indicated.

Priority area 3: Improving metabolic health – physical activity

Evidence

High levels of sedentary behaviour and low levels of physical activity are key modifiable risk factors that contribute to poor metabolic health outcomes for those with mental ill health. Consumers face considerable barriers to starting and maintaining movement activities such as mental health symptoms (amotivation, avolition), sedation from medication and poor access to resources and services designed to increase physical activity.

Mental health service users are entitled to quality, evidence-based care to address their physical health needs, including access to physical activity providers and services. Individual lifestyle modification strategies can be achievable and sustainable with the right approach. There is an increasing body of evidence on the efficacy of physical activity interventions for both physical and mental health outcomes for people experiencing mental illness.

(Source: Lederman et al. 2016)

Understanding the consumer's perspective or journey

- Understanding a consumer's perspective can help clinicians to encourage an increase in physical activity. There are many factors to consider, including values and preferences, current and past physical activity, opportunities to be active, the capabilities of the person and any barriers or limiting factors.
- It is also important to consider a consumer's readiness to change as well as their perceived motivation levels before engaging in planning for physical activity and exercise.
- Physical activity should be viewed as an enjoyable form of self-care. Society has shifted this perspective by framing exercise and physical activity as something that should be difficult, done in large amounts and used mainly as a tool for weight loss. These societal challenges can lead to negative views and beliefs and even traumatic events related to physical activity and exercise. This can often be related to feelings of poor body image and living in a larger body.
- It is important to approach discussions with trauma-informed conversations. Recognise that a person's relationship with physical activity could have been impacted by negative beliefs, as explored above.
- Take a 'weight neutral' approach to help reframe increased physical activity rates. Clinicians should encourage exercise and physical activity being used for the various mental and physical health benefits but not for changes in bodyweight.
- Clinicians should be conscious of not contributing to low self-esteem or a low sense of self-efficacy when having these conversations with consumers. Weight stigma is prevalent in current social norms. Consumers living in larger bodies will have been subject to this. Any 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 in these conversations that clinicians avoid making assumptions or judgements 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 various reasons including ability and physical health.

Links to recovery goals

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

Explore common consumer goals and try to fit in where physical activity sits with these. If the goals are sedentary (study, desk job), discuss ways to incorporate movement into lifestyle. It does not have to be a formal activity; it could be active transport or using a standing desk. Look at opportunities in daily life to incorporate physical activity (such as walking instead of driving short distances). Discuss physical activity in the context of the person's daily routine where possible. Acknowledge that the benefits are specific to the person rather than to others.

Focus on linking physical activity and time outdoors (sun, green space, leaving the home), building self-efficacy, relaxation/meditation time, finding a sense of achievement through mastery or achieving something regularly, and having less or reducing pain. 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 taking part in kid's 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 starting psychotropic medication?
  - On average, how many hours are spent sitting or lying down?
  - Alternatively, the SIMPAQ (Simple Physical Activity Questionnaire) <https://www.unsw.edu.au/medicine-health/our-schools/clinical-medicine/research-impact/research-groups/psychiatry-mental-health-neuroscience/simpaq> is a validated assessment tool for people with mental illness (Rosenbaum et al. 2020).
- Ask the person if they experience any side effects (sedation, muscular fatigue, movement disorders) from their medication and, if so, how this affects their activity levels.
- If the person experiences sedation, ask the psychiatrist and/or pharmacist to review the dosage and the time of day the medicines are taken to minimise the impact on physical activity. Work with the person to develop strategies to increase activity.
- Ask the person if their mental 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?
- Explore barriers and enablers to physical activity or exercise such as finances, time, caring responsibilities or lack of motivation. Problem-solve with the consumer and educate on what physical activity can include (exercise at home or in a park; it is not just about going to the gym).
- Routinely ask if there are any health problems that get in the way of activity (for example, joint pain, diabetes, foot issues, balance and mobility, asthma, respiratory issues). If so, ensure these barriers are addressed through appropriate referrals.
- Encourage people to engage in small increases in their physical activity levels. Look at incorporating physical activity in most days, adding in strength training and reducing the amount of time sitting or lying down.
- Provide information about the benefits of actively maintaining their personal fitness level and how it can enhance all aspects of quality of life. Request support to assess the fitness of people and develop meaningful care plans.

- Work with local partners and other agencies to ensure consumers have access to leisure centres, gyms and sports facilities. Are there movement or walking groups in the local area? Refer to these services as part of social prescribing – meaningful, purposeful engagement.
- Explore other 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 medication for asthma or 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 and exercise physiologists can 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 health, offer to come back to it when they are in a different headspace or situation.
- There is always an opportunity to address this in the future.

Workforce considerations

- Become familiar with information about local physical activity programs and services.
- Create interprofessional education and learning programs about programs and services in your area.
- Physical activity is everyone's responsibility, and it is evidence-based treatment (social workers, dietitians, nurses etc. can walk with consumers). Exercise is medicine. It helps prevent, treat and manage many forms of mental and physical illness. Everyone has a role to discuss movement and physical health. Everyone has the responsibility to link the consumer with the right professional at the right time.

Considerations for prescribers

- Psychiatrists and GPs can explore whether medicines can be optimised for a range of conditions that may affect physical health – for example, reviewing asthma and rheumatoid arthritis medication.
- Review psychotropic medicines and their side effects, such as metabolic syndrome and sedation, to ensure their impacts on physical activity are minimised.
- Consider administration timing of medications known to increase sedation to reduce the impact on daily activities or consider extended-release medications when available as another way to decrease sedation.
- If a chronic physical illness is present, consider referring to the appropriate health professional (such as an exercise physiologist or physiotherapist) as different medications impact exercise capacity and safety.

Health promotion messages for consumers, carers and supporters

- Exercise is evidence-based treatment to improve mental health. Physical activity improves mental health and can form part of a holistic treatment plan.
- Exercise can prevent muscle loss and keep your metabolic rate ticking over at a healthy level.
- Some people feel too busy or too tired to exercise regularly, but exercise will increase your energy levels and help you to feel less tired. Exercise doesn't have to be overly strenuous, even moderate amounts of physical activity of about 30 minutes a day can speed up your metabolic rate.
- 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. If you are uncertain about how to get started, speak to your GP and ask for a referral to an exercise physiologist or physiotherapist.
- Moderate-intensity exercise (walking, gardening, cycling and even mowing the lawn) improves mental and physical health.
- Exercise is not always about weight loss. Increasing fitness levels and strength is more important and can occur independently of weight loss.
- Different modes of activity can deliver different treatment effects – for example, walking when compared with weight training when compared with yoga. Finding something you enjoy is most important.
- Saying something like 'something is better than nothing' around exercise (the Australian guidelines on exercise have a good message here). Even 5 minutes of moderate-intensity exercise can establish great benefits for both mental and physical health.
- The best mode of exercise is what you enjoy. Benefits on mental and/or physical health can occur regardless of the mode of exercise you choose.
- Refer to the Australian physical activity guidelines for all Australians <https://www.health.gov.au/topics/physical-activity-and-exercise/physical-activity-and-exercise-guidelines-for-all-australians/for-adults-18-to-64-years>.

Additional benefits associated with increased physical activity levels

Physical benefits	Mental benefits	Quality-of-life benefits
• Reduces the risk of developing bowel cancer • 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	• Reduces feelings of depression and anxiety • Provides a greater resistance to stress, anxiety and fatigue • Helps to relax and feel less tense • Improves self-image • Increases productivity at work • Reduces cravings for alcohol and other drugs • Improves cognition including memory, attention and concentration • Improves motivation	• 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

Physical benefits	Mental benefits	Quality-of-life benefits
• Helps reduce blood pressure in people with high blood pressure • Increases muscle strength • Slows the loss of muscle mass		• Increases strength in older adults and reduces the likelihood of falling • Increases stamina, strength and flexibility • Improves the efficiency of the heart and lungs

Considerations for older people

- Conduct a physical health assessment including a mobility assessment for all consumers to inform individual daily physical activity programs.
- Obtain GP, exercise physiology 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 risk injury.
- Arrange exercise physiology and physiotherapy referrals for consumers with mobility issues to ensure their baseline functioning is maintained for as long as possible.
- Aged care services can provide daily physical activity programs for all consumers.
- Maintain mobility for bedridden or chair-bound consumers, with referrals to a physiotherapist recommended.

Priority area 4: Harm minimisation (alcohol and substance use)

Part A: Alcohol use

Evidence

People with a mental health condition were more likely to drink alcohol at risk levels compared with people without a mental illness. Risky drinking is defined as consuming more than 10 standard drinks per week on average or having more than 4 standard drinks in a single day at least once per month over the last 12 months. It has also been reported that 37% of people with a mental illness state they drink alcohol at risky levels. Those with mental illness are also more likely to consume alcohol in ways that puts their physical health at risk (Australian Institute of Health and Welfare 2024b).

The relationship between alcohol use and mental illness is bi-directional. Many consumers with a mental disorder are also diagnosed with an alcohol use disorder and vice versa. Dual diagnosis is common. Common antecedents include social determinants of health and adverse childhood events (National Institute on Drug Abuse 2020).

The principles of patient-centred care and shared decision-making are now understood to be essential for effectively treating alcohol problems. This entails providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring patient values guide all clinical decisions. People with comorbid alcohol use and mental disorders should be offered treatment for both disorders as part of routine care (Haber and Riordan 2021).

Understanding the consumer's perspective or journey

- Understand the role of alcohol in a person's life and develop strategies based on this. Alcohol 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 alcohol of choice, amount and the range of reasons for use.
- Adopt a non-judgemental approach and use available tools to gauge use and its impact.
- If alcohol is viewed by the consumer as helpful, ask how it is helpful to the person and how its use affects their mental illness, their day-to-day life and psychosocial aspects.
- Respect consumers' autonomy and choice around their use and readiness and openness for change.

Links to recovery goals

Explore how using alcohol impedes recovery goals. This may include relationships, work, independence, finances, housing and physical and mental health goals.

Explore and understand the connection to support structures that may assist in addressing alcohol use. Is there a significant other who engages in the alcohol use activities?

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

When the consumer is ready to address alcohol use

- Use the 'stages of change' model (example at Figure 12).
- Adopt an interprofessional collaborative approach. Pharmacists and nurses, for example, can provide advice on the interactions between alcohol and prescribed medicines. Nurses, social workers and other allied health professionals can explore the interplay between psychosocial factors and dependency or addiction to alcohol.
- Assess alcohol use as a core component of the person's mental health assessment.

- Screen everyone aged 16 or older for alcohol use disorders, using a validated tool, and offer appropriate interventions (examples in the appendix).
- Offer verbal and written information about the effects of alcohol on physical and mental health and the way in which they may interact with prescribed medications.
- Offer information about local services and self-help/mutual aid groups – for example, Alcoholics Anonymous or SMART Recovery.
- If the person is not ready to stop alcohol, offer information and treatment options that can help reduce the harms associated with use – for example, prescribing thiamine and naltrexone.
- Follow evidence-based protocols to safely assess and initiate substitute prescribing or detox (alcohol, benzodiazepines).
- Work with alcohol use services to develop referral pathways and treatment options that are accessible and tailored to the needs of different people with mental health problems. Offer advocacy as needed.
- Know how to manage physical emergencies associated with alcohol use – for example, withdrawal seizures, delirium tremens and Wernicke's encephalopathy.
- Support the person to access specialist alcohol services including withdrawal rehabilitation services. This may be by phoning the service on behalf of the consumer (with their consent).
- 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 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. Lived experience workers can discuss and share similar experiences and explore reasons for use and reasons for change.

When the consumer is not yet ready to address alcohol use

- Respect the person's preferences. Engage in a supported decision-making conversation.
- If appropriate, provide information about safety issues associated with alcohol 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 a person's life, ensure the safety of the victim-survivor (and risk regarding alcohol use). If working with a perpetrator of family violence, assess for increased risk to the victim-survivor (consult with specialist services).
- If a person is not ready to address this aspect of health, offer to come back to it when they are in a different headspace or situation.
- There is always an opportunity to address this in the future. Keep track of the stages of change.

Workforce considerations

- Build motivational interviewing skills and consider working from a harm reduction perspective. Enhance the capability of the workforce by ensuring motivational interviewing is included in training and learning packages.
- Learn trauma-informed care skills and skills in assessing family violence (MARAM).
- Develop harm minimisation approaches.
- Understand the stages of change model.
- Become aware of the range of effects of alcohol use.
- Get familiar with information about alcohol use programs and services.
- Create interprofessional education and learning programs about programs and services in your area, including lived experience.
- Link in with the following training providers and establish links with your service:
  - VAADA <https://www.vaada.org.au/>
  - Turning Point <https://www.turningpoint.org.au/>
  - Cracks in the ice <https://cracksintheice.org.au/>.

Considerations for prescribers

There are several options for treating alcohol use disorder. There are considerations for acute withdrawal and other recommendations for longer term treatment.

Acute withdrawal

- Benzodiazepines are currently recommended for acute alcohol withdrawal. The use of benzodiazepines is indicated for short-term use to reduce the severity and duration of alcohol withdrawal. However, the evidence to support the use of benzodiazepines in relapse prevention is very limited, with no recognised evidence of efficacy (Haber and Morley 2016).
- Thiamine is also recommended for all people undergoing alcohol withdrawal for preventing thiamine deficiency and Wernicke-Korsakoff syndrome (Haber and Riordan 2021).

Longer term treatment

- Acamprosate (Campral) is recommended to help maintain abstinence from alcohol. It is thought to reduce drinking by modulating brain GABA and glutamate function, which is implicated in withdrawal symptoms. It reaches desired levels in the brain after 1 to 2 weeks.
- Naltrexone is recommended to prevent relapse to heavy drinking. It is an opioid receptor antagonist that reduces levels of dopamine (the major reward neurotransmitter in the brain) and reduces alcohol intake.
- Disulfiram is only recommended in close supervision settings where patients are motivated for abstinence. It primarily works by inhibiting the action of aldehyde dehydrogenase, the enzyme involved in the second step in the metabolism of alcohol, that converts acetaldehyde to acetate. This leads to the accumulation of acetaldehyde following consumption of alcohol while on disulfiram. The resulting symptoms are unpleasant including flushing, dizziness, nausea and vomiting, irregular heartbeat, breathlessness and headaches. Disulfiram acts as a deterrent to drinking because the patient expects to experience these negative consequences.
- Some evidence for off-label therapies baclofen and topiramate exists, but their side effects are complex, and neither should be a first-line medication.

(Source: Haber and Riordan 2021)

Research states that less than 3% of people with alcohol dependence in Australia are being dispensed these medicines. Of those 3% less than 25% received the recommended 3 months of treatment (Haber and Morley 2016).

Health promotion messages for consumers, carers and supporters

- Alcohol is detrimental to our physical and mental health and is the sixth leading cause of disease in Australia.
- When alcohol use is reduced, your body starts to function better (the heart, the liver, sleep), you can save money, gain social stability and take part in new activities.
- Alcohol use disorder is a serious health issue and can lead to serious consequences for both you and those around you.
- There are different options available to help treat alcohol use disorders.

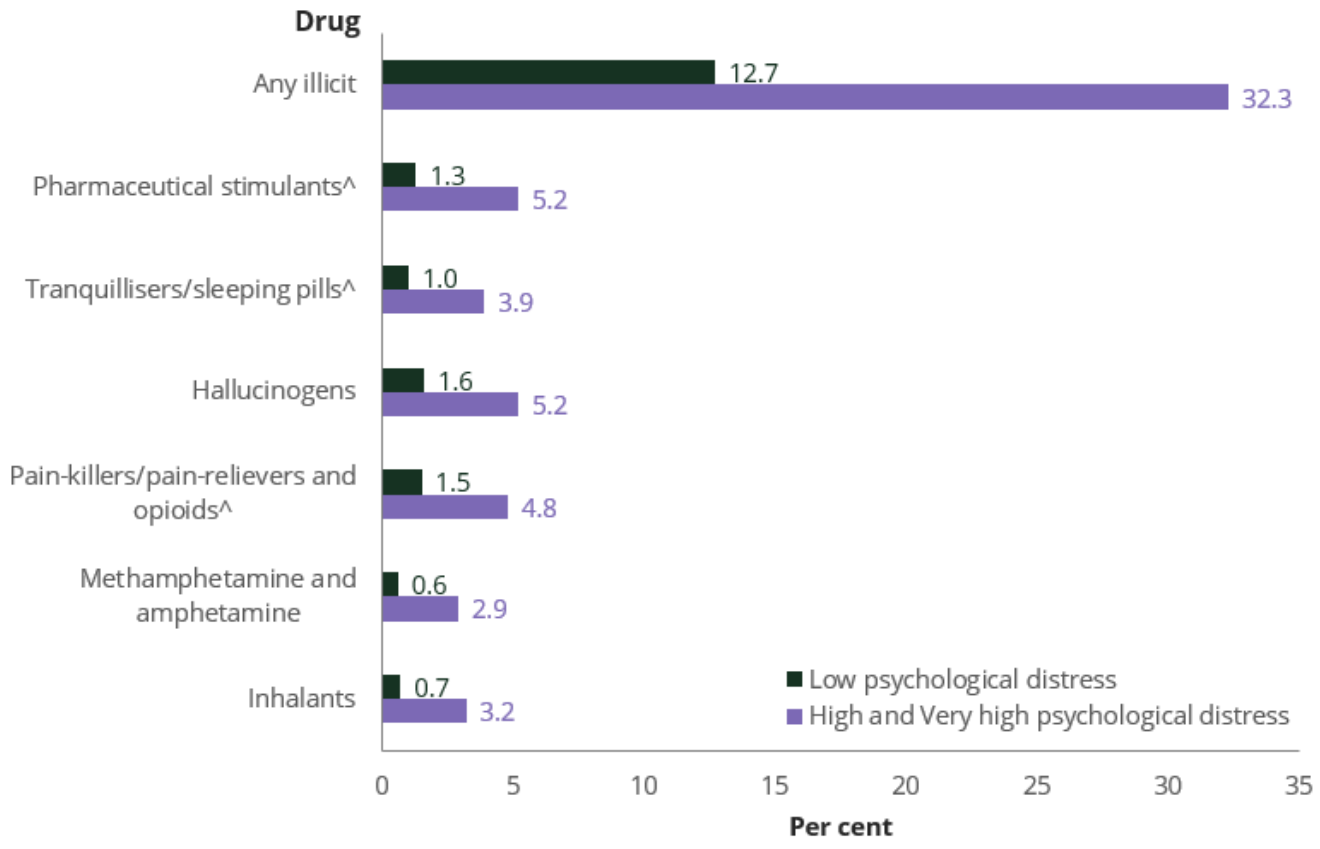
Part B: Substance use

Evidence

There are known relationships between mental illness and substance use. A mental illness may make a person more likely to use drugs – for example, for short-term relief from their symptoms – while other people may have drug problems that trigger the first symptoms of mental illness. Some drugs cause drug-induced psychosis, which is usually brief. However, if someone has a predisposition to a psychotic illness such as schizophrenia, illicit drugs may trigger the first episode in what can be a chronic mental illness (SANE Australia 2017). Drug use can interact with mental illness in ways that create serious adverse effects on many areas of functioning, including work, relationships, health and safety.

Illicit drug use is more common among people with a mental health condition. In 2022–23, people with a mental health condition were more likely to have used illicit drugs in the previous 12 months than people without a mental health condition (Figure 11). Around 1 in 4 (29%) people who report having a mental health condition have used illicit drugs, compared with 1 in 6 people (15.9%) without a mental health condition. Recent use of all illicit drugs was higher among people who had been diagnosed or treated for a mental health condition than those who had not (Australian Institute of Health and Welfare 2024b).

Figure 11: Recent use of select illicit drugs by diagnosis or treatment for a mental health condition, people aged 18 or older, 2022–23



Source: Australian Institute of Health and Welfare 2024

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. Focus on harm reduction strategies to reduce risk.
- Explore their substance(s) of choice and the reasons for use. Adopt a non-judgemental approach and use available tools to gauge use and its impact.
- Ask the person how drugs help them and how their use affects their mental illness, their day-to-day life and psychosocial aspects.
- Often substance use occurs as a way to 'self-medicate', and getting appropriate mental health services and treatment involved will show the consumer another way that is supported and not criminalised.

Links to recovery goals

Explore how using substances impedes recovery goals. This may include relationships, work, independence, financial, housing and 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 substance use is present.

When the consumer is ready to address substance use

- Use the 'stages of change' model for substance use (Figure 12). Be aware that there are higher risks related to overdose in the relapse stage. Educate on reducing this risk.
- Adopt an interprofessional collaborative approach. Pharmacists and nurses, for example, can provide advice on the interactions between substances and prescribed medicines. Nurses, social workers and other allied health professionals can explore the interplay between psychosocial factors and dependency/addiction to substances.
- Assess substance use as a core component of the person's mental health assessment.
- Screen everyone aged 16 or older for substance use, 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, Narcotics 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 starting with a lower dose after periods of abstinence (such as release from hospital or prison).
- Follow evidence-based protocols to safely assess and initiate substitute prescribing or detox (opioids, GHB/GBL, benzodiazepines).
- Work with substance use services to develop referral pathways and treatment options that are accessible and tailored to the needs of different people with mental health problems. Offer advocacy as needed.
- Know how to manage physical emergencies associated with substance use – for example, opiate overdose.
- Be aware of new drugs and changing patterns of substance use – for example, 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 drug services including withdrawal rehabilitation services. This may be by phoning the service on behalf of the consumer (with consent).
- 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 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 address substance use

- Respect the person's preferences. Engage in a supported decision-making conversation.
- Consider harm minimisation strategies.
- 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 a person's life, ensure the safety of the victim-survivor (and risk regarding substance use). If working with a perpetrator of family violence, assess for increased risk to the 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

- Build motivational interviewing skills and consider working from a harm reduction perspective. Enhance the capability of the workforce by ensuring motivational interviewing is included in training and learning packages.
- Learn trauma-informed care skills and skills in assessing family violence (MARAM).
- Develop harm minimisation approaches.
- Understand the stages of change model.
- Become aware of the range of illicit substances people might use.
- Get familiar with information about substance use programs and services.
- Create interprofessional education and learning programs about programs and services in your area, including lived experience.
- Be aware of the increased risk of overdose related to reduced tolerance on discharge from an inpatient or prison setting. Plan approaches to target those at risk.
- Develop links with training organisations listed in the alcohol use section for further education for clinicians.

Considerations for prescribers

There are several options to consider for treating opioid use disorder:

- Buprenorphine can be used for detoxification and maintenance of abstinence (also available as a long-acting injectable).
- Methadone can be used for maintaining abstinence.
- Naltrexone blocks opioid receptors to reduce cravings.
- Prescribe naloxone for those at risk of overdose.

There are research trials currently underway for treating cannabis use disorder and stimulant use disorder, but these treatments are not currently available for routine use in Australia.

Health promotion messages for consumers, carers and supporters

- When substance use is reduced, the body starts to function better (the heart, the brain, sleep), you can save money, gain social stability and take part 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 person and those around them as well as the broader community. Examples of harm reduction initiatives include:
  - needle and syringe programs
  - safe injecting room
  - opioid pharmacotherapy treatment
  - peer education programs.

For Both Part A and Part B: Matching alcohol and other drug interventions to the stages of change

Pre-contemplation

- Build trust.
- Avoid confrontation.
- Explore other issues.
- Provide information and harm reduction tips.
- Encourage self-monitoring and personalise the risk.

Contemplation

- Validate any lack of readiness.
- Build motivation and confidence in the person's ability to change.
- Employ 'motivational interviewing' techniques.

Preparation

- Identify obstacles and assist in problem solving.
- Goal setting – take small steps.
- Identify support systems.

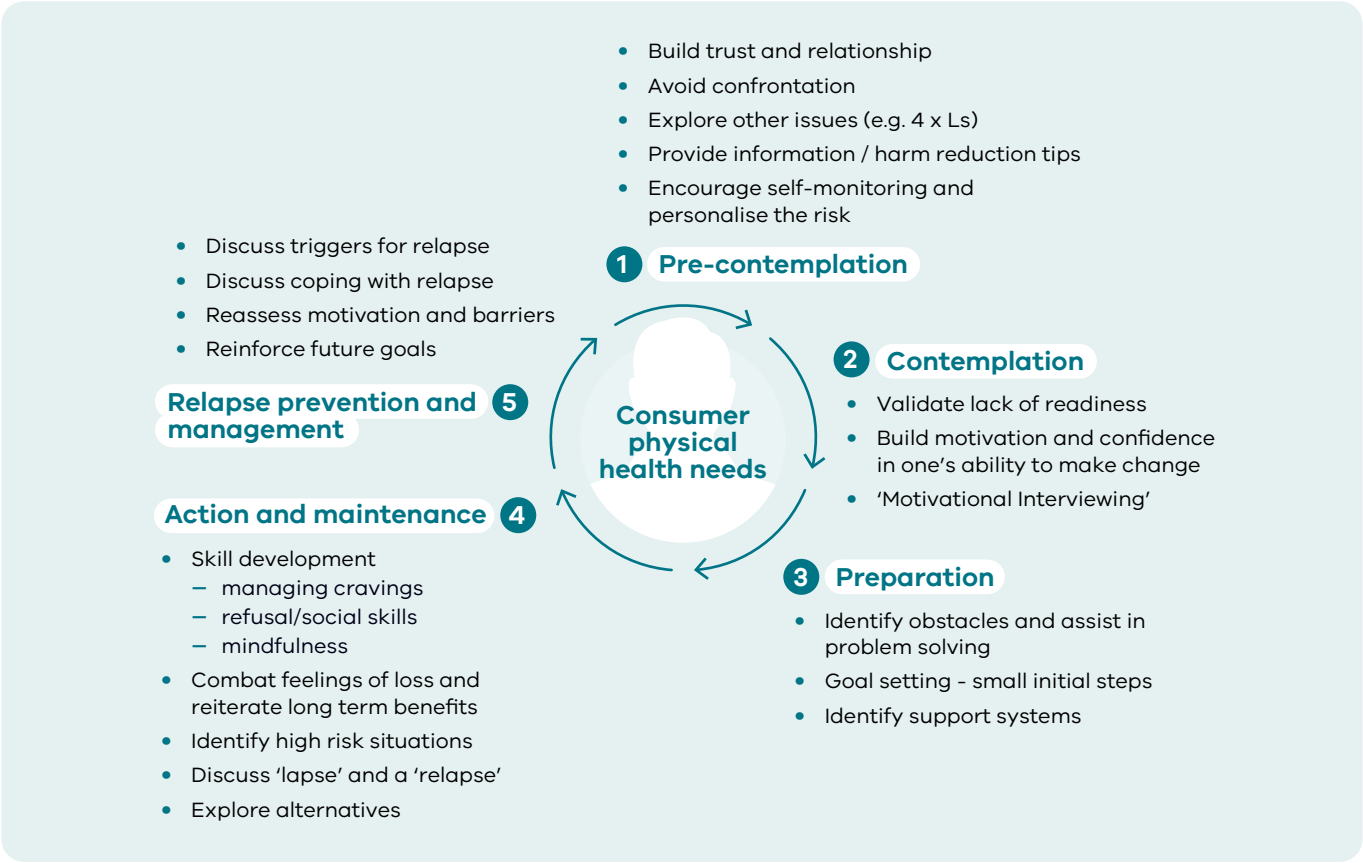
Action and maintenance

- Skill development
  - managing cravings
  - refusal / social skills
  - mindfulness.
- Combat feelings of loss and reiterate the long-term benefits.
- Identify high-risk situations.
- Discuss 'lapse' and a 'relapse'.
- Explore alternatives.

Relapse prevention and management

- Discuss what is working well.
- Discuss triggers for relapse.
- Discuss coping with relapse.
- Reassess motivation and barriers.
- Reinforce future goals.

Figure 12: Stages of change model



Modified from Insight <www.insight.qld.edu.au>

Considerations for older people

- 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.

Priority area 5: Sexual and reproductive health and blood-borne viruses

Evidence

The World Health Organization (2006) defines sexual and reproductive health 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.

This section concerns sexual wellbeing and identity, gender identity, contraception, sexually transmissible infections (STIs) and 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 through tattooing. Hepatitis B can be transmitted both sexually and through needle-sharing (including needle-stick incidents). HIV and hepatitis C are highly stigmatised. A person's BBV status does not need to be raised unless it is relevant to their experience of mental health issues (anxiety, depression, for instance) or it is associated with an increased risk of acquiring a BBV. Note, that if a person has a BBV, providing this information to a clinician should not be required unless it impacts on the care they receive.

Understanding the consumer's perspective or journey

Sexual and reproductive health and 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, consider 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 person, how this affects identity, roles and self. Explore details such as sexual identity, sexual functioning, vulnerabilities, reproductive history, aspirations and knowledge of 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 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, apply a family violence lens. Anyone can experience family violence, but it is predominately perpetrated by men against women and children. One in 5 women has experienced sexual violence, and during pregnancy and shortly after birth is one of the high-risk times for women and their children. Women with mental illness experience higher rates of violence than women without mental illness. 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 the possibility of BBVs, 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:

- 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
- assessing and managing family violence.

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

- Be aware of the stigma associated with activities such as injecting drug use related to BBV transmission.
- Inform the consumer that they are welcome to discuss their concerns at any time.
- Consider giving written information to the person with the contact details of relevant support services (outlined below).
- Take a non-judgemental approach, understanding the impact of your own attitudes and those of others, and treat people with privacy, dignity and discretion.
- 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.
- Refer to specialist services.

Reproductive health

Refer to specialist sexual and reproductive health services such as Sexual Health Victoria, the Melbourne Sexual Health Centre, specialist GPs and LGBTIQA+ inclusive services.

Otherwise, doctors and nurses in the mental health program can do the following:

- Seek consent to discuss reproductive health. Ask about short-, medium-, and long-term goals.
- Ask about: (a) the impacts of medication and mental health 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 (refer to the cancer screening priority area for more information).

Sexual identity

Health practitioners who have undertaken specific education and training can do the following:

- 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.
- 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 can do the following:

- 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 about 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 can do the following:

- Raise awareness that all people who are sexually active need to protect themselves against STIs and have an annual STI screen. Give information about what tests will be required, how they can be taken and the importance of being immunised against human papillomavirus 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, often with an 8- or 12-week course of medication, and that mental illness is not a barrier to accessing treatment. A person who has received treatment to cure hepatitis C in the past is eligible for re-treatment if they are exposed to hepatitis C in the future.
- Refer consumers who have hepatitis B to a specialist service for treatment and management of their viral hepatitis.
- 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.

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.
- Indicate you are happy to keep the conversation open if they change their mind.

Workforce considerations

- Build 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>

Considerations for prescribers

- Consider if your consumer requires immunisations for hepatitis B.
- Look at immunisations for HPV in young people who may not have received them.
- Information on screening and treating STIs is available through the Australian STI therapeutic guidelines <https://sti.guidelines.org.au/>.
- The 'how effective is my contraception' diagram <https://www.shinesa.org.au/media/2016/04/Efficacy-of-contraception-methods.pdf> is a great tool to use with consumers to look at different contraception options and what may be suitable for them.
- Treating hepatitis C is important to prevent long-term implications. Prescribers should look at how they can expand their scope into this practice to improve outcomes for consumers with hepatitis C.

Training providers for prescribers:

- ASHM – peak organisation for health workers and medical professionals who work in HIV, BBVs and sexual and reproductive health.
- Sexual Health Victoria – provides education and training to clinicians.
- Melbourne Sexual Health Centre – focuses on STIs and BBVs, specialises in HIV, PEP and PrEP, and how to take a sexual history.

Health promotion messages for clinicians

New hepatitis C treatments are now available for all adults with a Medicare card. They are very different from previous treatment because they:

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

Health promotion messages for consumers, carers and supporters

- There is a large range of contraceptive options available. Please seek support or advice on which option is best for you and your needs.
- You can increase your understanding and awareness of STIs. It is important that you are regularly checked for STIs if you are at risk. Many STIs don't have any symptoms.
- There is a lot of information available on pregnancy choices. If you are thinking of pregnancy, then please discuss this with a health professional to give both mother and baby the best start in life.
- There are a lot of services and support available (local and national services) for sexual identity, STIs and treatment. Ask your healthcare provider for information on these services if this is something you want help with.

Considerations for older people

- 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.

Priority area 6: Medicine optimisation

Evidence

Evidence from the literature shows many difficulties that people with mental health conditions may face in using medicines, including:

- inappropriate therapeutic selection
- lack of recognition of side effects of the medicines
- lack of understanding and appreciation of the impact of side effects on daily life
- monitoring of metabolic side effects in consumers on continuing antipsychotic medication being inconsistent and limited
- lack of monitoring, reviewing and deprescribing psychotropics when they are no longer indicated
- frequent changes in therapy
- lack of documentation of past therapeutic failures and outcomes
- lack of information on using medicines safely
- difficulty in complying with medicine regimens and inadequate information sharing and communication at transitions of care
- the lack of access to mental health services and pharmacists with limited expertise – services see benefits with cross-liaison and joint initiatives between pharmacy and mental health services
- lack of informed consent regarding medicines for mental health conditions as stipulated in the Mental Health and Wellbeing Act.

(Source: Pharmaceutical Society of Australia 2023)

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.
- Medicines optimisation looks at the value that medicines deliver, making sure they are clinically effective and cost-effective. It is about ensuring people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team.
- People should be involved in all aspects of their assessment, treatment and recovery and should be supported in making and taking part in decisions, even when those decisions include a degree of risk (refer to the Mental Health and Wellbeing 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. Consumers and carers should receive consistent messages and information about their medicines.
- 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 it's only one strategy and may not be the main focus.

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

- Explore what the person thinks would help. What are their goals and what has worked for them before? The consumer should feel confident enough to share openly their experiences of taking or not taking medicines, their views about what medicines mean to them, and how medicines impact on their daily life such as discussing potential side effects.
- 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 stopped due to unacceptable side effects. It is also important to know when a medicine started because some psychotropic medicines can take 2 to 4 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, as are shared health records such as My Health Record and Safescripts. A thorough and accurate medication history and medication reconciliation is critical, particularly at transitions of care such as admission, transfer or discharge.
- 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 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 with the pharmacist to ensure the person's medication list is current and accurate. Ensure medication changes are clearly and accurately documented and communicated to the person, their carers and their other healthcare providers.
- 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 line with relevant guidelines. Ensure adequate follow-up is in place and that it is clear who will be responsible for physical health monitoring. 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 referrals are in place for treating or managing cardiometabolic side effects such as hypertension, dyslipidaemia, diabetes or weight gain.
- 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 the side effects are intolerable. Consider switching medications to an alternative where appropriate and seek the advice and expertise of a pharmacist on when and how to safely switch medications. 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

- Engage in a supported decision-making conversation.
- Provide up-to-date information about medications. Discuss alternatives, 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 stop 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 Beyond Blue, 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

- Become familiar with information about pharmacists and doctors who can help with medication management.
- Ensure oversight and monitoring for inappropriate high doses and/or polypharmacy through pharmacy-led psychotropic stewardship programs.
- Adopt a multidisciplinary team approach that has clear lines of responsibility that place consumers at the centre of decision-making.
- Develop policies, procedures and guidelines to support clinicians in medication-related decision-making and promote judicious, evidence-based use of psychotropic medicines.
- Workforce capability to manage complex comorbidities – mental health staff may lack skills, training and confidence in treating or managing physical conditions. Create interprofessional education and learning programs about medication side effects and referral services in your hospital and local area.
- Use data and digital information from electronic medical records to design and implement psychotropic decision support tools and alerts for clinicians in the clinical software applications. Embed the use of digital tools and dashboards for tracking physical health and medication use.
- Ensure effective communication about a person's medicines at any transition of care is managed appropriately. Obtain consent to communicate a person's current medicines regimen; this communication should include health professionals who are normally part of the person's care team (GP, pharmacist, psychologist) and should occur even if changes to medicines have not occurred, or if changes are unrelated to treatment of a mental health condition.

- Also consider reducing the use of chemical restraint <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/treatments-and-interventions/restrictive-interventions> as per the Mental Health and Wellbeing Act.

Considerations for prescribers

- Consider polypharmacy. Be aware of all prescribers involved in the consumer's care and prescriptions being provided.
- Liaise with pharmacists to get a clearer picture of all the medications the consumer is currently taking and potential for interactions.
- Always use the lowest effective dose.
- Aim for one medication from each class of drugs.
- Avoid treating an adverse effect of one drug with another drug – keep it simple. Review and rationalise medications regularly. In scenarios where treating side effects of a medicine is lower risk than ceasing the offending medicine, ensure the person has enough information about the options to make an informed decision.
- Consider withdrawal and deprescribing of medications where appropriate.
- Consider drug interactions and metabolic status – some consumers may be more sensitive or susceptible to medication side effects.
- Implement strategies or interventions to help address adverse impacts of psychotropics such as routine monitoring and management of metabolic and physical health parameters. Employ therapeutic drug monitoring – for example, plasma drug level monitoring of psychotropic medications such as lithium and clozapine levels.
- Consider pharmacogenetic testing when there's repeated nonresponses (efficacy) and/or adverse effects (tolerability) to psychotropic medicines so medication regimens can be optimised and tailored.

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 that includes peer support and community assistance alongside counselling and a range of other supports.
- It is important to know that medicines will vary in the time it takes to be effective. During this time side effects may be more troublesome. Side effects are real but usually subside (this can take 2 to 4 weeks). If the side effects are not tolerable, you should feel safe speaking about them and should not have your concerns set aside in the hope that they will settle in time.
- It is important to discuss any concerns you have about a medicine's effects with a doctor, pharmacist or mental health nurse practitioner because maybe changes will 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 differing 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 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.

Considerations for older people

- Consider non-medication or non-pharmacological strategies or alternatives first.
- Assess the current prescribed pharmacotherapy including any over-the-counter medications that the person may be using.
- 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. Simplify medication regimens where possible.
- Be mindful when prescribing sedating medications and the effect these may have on mobility, increased risk of falls and risk of delirium (if family violence or elder abuse is indicated or has been assessed, consider the impact of sedation on the person's safety).
- There is increased risk of polypharmacy in older people. Monitor, review and deprescribe medications where appropriate.
- With consent, include carers in discussions about medicines use and therapeutic decisions. While carers may not contribute to a decision, their understanding about the purpose, benefits and side effects of a medicine can be important for future supportive needs of the person being treated.
- Monsh University developed a guideline for people with dementia <https://www.monash.edu/mips/themes/medicine-safety/major-projects-clinical-trials/clinical-practice-guidelines-for-the-appropriate-use-of-psychotropic-medications>. The guideline is used to assess the appropriateness of psychotropics in older people regardless of dementia, due to the nature of the side effects, especially falls risks.

Priority area 7: Dental and oral health

Evidence

There is a strong and consistent association between socioeconomic status (income, occupation and educational level) and the prevalence and severity of oral diseases and conditions. Across the life course, oral diseases and conditions disproportionately affect vulnerable people, often including:

- those experiencing financial hardship
- people with disability including severe mental illness
- older people living alone or in residential care
- refugees and asylum seekers
- people in prison or living in remote and rural communities
- people from minority and other socially marginalised groups.

High out-of-pocket health expenditure is often associated with oral health care, resulting in people not able to receive timely care when needed (World Health Organization 2024).

Understanding the consumer's perspective or journey

- Explore personal feelings about the consumer's oral health and how this affects their self-esteem and impacts on their day-to-day life.
- Poor oral health may have a negative impact on overall health and wellbeing. This can be affected by limited access to dental service providers and affordable oral health care. Oral health may also be a low priority if there are other more pressing health and social care issues.
- Explore how the consumer feels about oral health issues and if they want support to seek the care they need.
- Refer to Dental Health Services Victoria health promotional messages for oral health.

(Source: Pham et al. 2025)

Links to recovery goals

Explore how oral health issues impact on the person's recovery goals for mental health. This might include socialising, establishing healthy behaviours, self-esteem, going out in public and their ability to eat and drink well.

When the consumer is ready to discuss dental and oral health

- Be aware that some medications (prescription and non-prescription) can cause dry mouth and that dental infections can contribute to cognitive impairment and delirium. Severe dental pain can manifest as aggressive behaviour.
- Include an oral health risk assessment including dry mouth when undertaking health assessments and, where appropriate, dental referral.
- Ensure consumers have access to a dental service provider and that they attend regular dental check-ups at the intervals their dental practitioner recommends.
- Promote drinking tap water, preferably fluoridated, as the drink of choice.
- Ensure consumers have access to appropriate oral hygiene products such as a toothbrush, fluoride toothpaste and interdental cleaning aids.
- Encourage brushing twice a day using fluoride toothpaste and the use of interdental cleaning aids.
- Encourage people to limit sugary foods and drinks, especially before bedtime.
- Encourage people to stop smoking or using tobacco products and provide support services (for example, health professionals and the QUIT helpline <https://www.quit.org.au/>).

- Some people have dental anxiety or social phobias. Be aware that some who have survived sexual violence may find dental check-ups particularly triggering.
- Registered clients of mental health services are eligible for Victorian public oral health care and may have priority access and are offered the next available dental appointment for general care. For enquires, phone Dental Health Services Victoria on (03) 9341 1000 or 1800 833 039 (country callers). Visit the Dental Health Services Victoria 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 shared decision-making.
- If appropriate, provide information supporting oral health care and how to access oral health care.
- If a family violence assessment has been undertaken, consider that a person's apprehensiveness to see a dental practitioner might be linked to an experience of violence (recent or in past) or another dental anxiety or social phobias.

Workforce considerations

- Become familiar with information about dental referral pathways.
- Create interprofessional education and learning programs about oral health and dental service providers in your local area.

Health promotion messages for consumers, carers and supporters

- Oral health is essential to overall health and wellbeing.
- Fluoridated tap water is the best drink for oral health. Excess sugar consumption can lead to tooth decay and gum disease. Try to limit food and drinks containing sugars (for example, soft drink, fruit juices, cordial, sports drinks, energy drinks and hot drinks sweetened with sugar or honey).
- For people aged 6 years or older, brush your teeth twice a day using fluoride toothpaste to prevent tooth decay. Clean between teeth daily. After brushing spit out the toothpaste, but don't rinse.
- If you have difficulty cleaning your teeth, please let your healthcare provider know so you can be supported based on your individual needs.
- Wear a custom-made mouthguard for all sports and training where there is a risk of mouth injury.
- Everyone has different oral health needs. Speak with your dental practitioner about how often you need a check-up.
- Smoking, vaping and using tobacco products are harmful to oral health. If you use these products, try to quit. Quitting reduces the risk of developing gum disease, mouth infections and mouth cancer. Speak to a health professional or contact Quitline on 13 78 48 for support.
- Drinking alcohol is harmful to oral health and increases your risk of mouth cancer. The less you drink, the lower your risk of harm from alcohol.

Considerations for older people

- Arrange and encourage regular reviews of dental health for all aged care consumers – poor dental hygiene or poor denture care can affect appetite and the ability to eat.
- For consumers who are in aged care facilities, oral hygiene is a daily activity to be carried out with as much assistance as required for each consumer/resident. Developing an oral health care plan (including routinely planned dental checks-ups) and the assistance of trained staff will support consumers with their oral hygiene.
- Plan regular dental checks for each consumer/resident.

Priority area 8: Reducing falls

Evidence

Falls are a major safety and quality risk in health services. In mental health services, there are added risks related to the side effects of psychotropic medication, including sedation and postural hypotension.

Falls prevention and harm minimisation plans based on best practice and evidence can improve consumer outcomes. These can include strategies such as monitoring a consumer's lying and standing blood pressures and providing education about sitting up between lying and standing (Australian Commission on Safety and Quality in Health Care 2009).

Falls are the leading cause of hospitalised injuries and injury deaths among older Australians, making up 77% of all injury hospitalisations and 71% of injury deaths in this age group. Australians aged 65 or older are 8 times as likely to be hospitalised and 68 times as likely to die from a fall than those aged 15 to 64 (Australian Institute of Health and Welfare 2022).

Understanding the consumer's perspective or journey

- Falls prevention is an ongoing challenge for people with mental illness accessing a service. 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, psychotropic medications (and their adverse reactions) and substance use/misuse.
  - 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 family violence is indicated or has been assessed, consider the 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.
- Falls can have a significant negative impact on a person's confidence, leading to the person limiting physical activity over time, which then becomes a significant risk factor for further falls alongside deterioration in mental and physical wellbeing generally. A fall can often be a real trigger event for an older person who was previously relatively independent and engaged.

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.

Recovery goals are a way to operationalise what it means to be living a valued and meaningful life. At times recovery goals can feel very future-oriented and people can sometimes struggle to see how these apply (especially to older consumers) – linking these to what it means for a consumer to be living a valued and meaningful life can help orient recovery goals to services.

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, occupational therapy, alcohol and other drug services (if falls are linked to substance use) – and encourage the person to engage with prescribed interventions such as wearing glasses, inserting their hearing aid and using walking aids appropriately.
- Working closely with a physio and occupational therapist alongside psychology can be helpful here. Community services can support the older person to remain active and engaged.
- Refer to a clinical and/or health psychologist to address loss of confidence following a fall as this may lead to consumers limiting physical activity, leading to greater risk of falls of time (if not addressed).
- Ensure consumers 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.
- Review substance use/misuse and offer management as appropriate.
- Ensure minimising falls is an integral part of the organisation's improvement agenda.
- Assess any risk related to family violence and offer management as appropriate.
- 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 ready to discuss falls management

- Respect the person's preferences. Engage in a supported decision-making conversation.
- Assess any risk related to family violence and offer management as appropriate.
- If appropriate, provide information about osteoporosis, support equipment and available services.

Workforce considerations

- Become familiar with your organisation's falls strategy.
- Many organisations will have a falls screening tool in place. Ensure clinicians are familiar with this tool and that it is used as required. Have quality audits in place and ensure tools are promoted.
- Ensure clinicians undertake regular education in falls management.
- Consider referrals to occupational therapists, physiotherapists, exercise physiologists, alcohol and other drug and family violence specialists to conduct appropriate assessments for those at increased risk of falls.

Considerations for prescribers

- Some medications have adverse effects on balance, blood pressure and sedation levels. Clinicians can help to identify these medications and help to reduce the risk of falling. Discuss the potential culprits with pharmacists and work on appropriate management strategies to address this.
- Consider how polypharmacy and interactions can increase the risk of falls in some people.

Health promotion messages for consumers, carers and supporters

- Clinicians, consumers and their families can help with fall prevention programs.
- Slips, trips and falls can happen to anyone, but they are more common and more significant as we get older because we are more likely to injure ourselves. People often dismiss falls as 'part of getting older' or 'just not concentrating', but they are often a warning sign that something is not right, so it is important to discuss any fall with your doctor (Department of Health and Ageing 2011).

Other considerations for older people

- Conduct falls risk assessments for all aged care consumers in the community (home assessments) and in residential facilities.
- Use appropriate mobility aids and home safety aids for consumers who live in their own home with limited in-home support such as family, a spouse or external supports.
- Keep sedating medications to a minimum to prevent falls secondary to the effects of these preparations.
- Ensure adequate foot care and regular examination by a podiatrist.
- Assess footwear for comfort, fit and appropriateness to minimise risk of falls and potential damage to feet.

Priority area 9: Women's health

Evidence

Women in Victoria have one of the highest life expectancies in the world. Historically, medical studies have excluded female participants and research data have been collected from males and generalised to females. This gender gap in medical research results in real-life disadvantages for female patients. This systematic bias has been incorporated into the system, and the implications of this include gendered health inequities. For example, the Victorian Enquiry into Women's Pain has highlighted that, for too long, women's pain (associated with conditions like endometriosis, pelvic pain and migraines) has been missed and dismissed. We are now listening to women's experiences and paying attention to their needs. We are also expanding access to women's health services and boosting our research and data collection. To bridge the gap in women's health care, the department is leading a program of work with increased budget investments to change the way women's health issues are diagnosed, understood and treated (Department of Health 2024).

Any references to a woman, women or girls are intended to include anyone who may experience similar health issues or gender-based discrepancies in care. This includes those assigned female at birth and anyone who identifies as a woman, though they may have a different sex at birth (Department of Health 2025).

Understanding the consumer's perspective or journey

- Women and girls make up more than half of our population, yet their health has been overlooked, underdiagnosed and/or misdiagnosed for too long. Women often experience barriers when trying to access the services they need to support their physical and mental health.
- Be aware that women have often been dismissed regarding pain or concerns about their bodies. The symptoms women experience secondary to physical health issues, often including significant and ongoing pain, are frequently misdiagnosed as symptoms of mental health issues. This has implications for the mental health workforce who are frequently working as representatives of the system that has dismissed these women's concerns and are now working to engage these same women in services.
- Walk beside the woman on their journey. Engage in supported decision-making conversations.
- Ask about what health goals they may have or explore any issues they may be having related to health in a woman's body.

Links to recovery goals

Explore what the recovery goals are for the consumer. Consider the impact of symptoms (including significant and ongoing pain) on a person in terms of accessing socially valued roles (vocational, educational, family) and how having these symptoms dismissed can impact on recovery.

Recovery goals may be broad and related to the following categories and examples:

- Fertility – the goal may incorporate any or all of the following types of fertility at some point in a woman's journey: contraception, pregnancy, termination and menopause. What does recovery mean for the consumer in relation to their fertility?
- Pain control – polycystic ovary syndrome, endometriosis, menstrual cycle. In this category, recovery goals may incorporate being a mother or pursuing a particular career. Issues with fertility and/or pain may impact on the ability to pursue these recovery goals.

- Continence – the recovery goals may be doing voluntary work in the community, going to the shops or attending sporting fixtures with kids. The point is to explore what the implications of continence (not knowing if there are going to be public toilets, worrying that you smell, not having financial resources for incontinence pads) is having on the ability to aspire to or work towards these recovery goals.

When the consumer is ready to make changes to women's health

- Ask the woman about her physical health goals in the short, medium and long term – what changes would they like to see in relation to women's health? Using a strengths-based approach, explore what they know, what has worked and how they would like to proceed.
- Does the woman have any concerns about women's health issues? If so, consider referrals to your local women's health service <https://www.health.vic.gov.au/womens-health-and-wellbeing-program/about-the-program>.
- Offer support with women's healthcare advice and system navigation.
- For discussions around contraception, refer to Priority area 5.
- For discussions around breast and cervical screening, refer to Priority area 10.

When the consumer is not yet ready to make changes to women's health

- Respect the woman's preferences. Engage in supported decision-making conversations.
- Women's health is a lifelong challenge for all women. If a woman is not ready to address this aspect of health, offer to come back to it when they are in a different space or situation.
- There is always an opportunity to address this in the future. Revisit this priority when the consumer is ready.

Workforce considerations

- Develop trauma-informed care skills and skills in assessing for family violence (MARAM).
- Become familiar with women-specific services in your area.
- Create interprofessional education and learning programs about programs and services in your area.
- Clinicians need to hold in mind the implications on a woman of physical symptoms being dismissed, missed, misdiagnosed, etc. This may have been occurring for someone since adolescence, which is such a key developmental stage for figuring out who you are and what is available to you in terms of socially valued roles. This connects to trauma-informed care skills and operationalises them in the context of this priority area.
- Historically health services have not responded well to symptoms and problems associated with women's health. Organisations need to address this and make services better.

Considerations for prescribers

- Is there training you could consider to address women's specific issues such as contraception or pain management?
- Consider how menopause or perimenopause and its symptoms could be interacting with the consumer's mental health symptoms and review how hormone therapy could potentially play a role in treatment.

Health promotion messages for consumers, carers and supporters

Let your health service know if you have concerns about women's health. Even if these have been dismissed (or worse) in the past, health services now have a better understanding of women's health and should be able to support you. Every woman deserves access to care regardless of their background or circumstances.

Considerations for older people

- Document any concerns the consumer may have regarding women's health issues as part of a holistic assessment.
- Provide opportunities for the woman to discuss their issues and needs.
- Post menopause may present different issues for women (such as osteoporosis). Ensure these are considered as part of a holistic physical assessment.
- There is potential for assumptions to be made that disregard or minimise women-specific health issues as women age. Ensure this is considered when planning care for older women.

Priority area 10: Cancer screening

Evidence

Analysis of the 2016 Census, death registry, MBS and PBS data shows that those who access treatment for mental illness have more than double the risk of the general population of dying from cancer. The highest rates are for lung cancer, followed closely by breast cancer and then bowel cancer. Risk factors for cancers also disproportionally link to those with mental illness (for example, increased risk of breast cancer from raised prolactin levels caused by psychotropic medications; increased risk of lung cancer related to increased numbers of smokers) (Roberts et al. 2024a).

There are various cancer screening services available in Victoria such as bowel, breast, cervical, lung and prostate (Figure 13 has one example). Cancer screening is an aspect of physical health that clinicians can encourage for consumers of all ages and stages of life. There are various ways to increase screening participation at your practice.

The Australian cancer plan aligns with the Equally Well Consensus Statement and supports co-designed and tailored information to better support people living with a mental illness and cancer (Cancer Australia 2025).

Figure 13: The bowel cancer at-home test kit

Source: Cancer Council Victoria website

Understanding the consumer's perspective or journey

- Cancer screening is an important tool in the early detection and treatment of cancer.
- There are many barriers that prevent people from taking part in cancer screening. These may be due to not knowing about the different screening options available, misinformation about when to attend for screening or limited health literacy.
- Explore how the consumer feels about cancer screening. There is often fear associated with the unknown.
- Often, when there is a delay in screening, people will feel they may have missed something or they may be fearful of what could be found. The fear that they have left it too late may further delay screening opportunities.

Links to recovery goals

When we take consumers on a journey towards improving their physical health they may be motivated to address cancer screening.

Explore how cancer screening can be part of the consumer's recovery goals. Often completing something that has been playing on someone's mind (such as screening) can be positive to motivate them to address other aspects of their physical health.

When the consumer is ready to participate in cancer screening

Assist or offer to assist the consumer to make appointment with services (such as their GP or BreastScreen Victoria). Provide the relevant information on screening as listed here:

- **Breast cancer screening:**
  - Men and women can both get breast cancer, but it is more common in women.
  - People are encouraged to become familiar with the normal look and feel of their breasts at different times of the month. Looking in the mirror regularly is a good way to learn the normal shape of your breasts. There's no right or wrong way to feel your breasts; some people might find it easier in the shower/bath, lying in bed or while getting dressed. Remember to check all the breast tissue and to feel near the surface and deeper into the breast.
  - Breast changes to look out for include:
    - → a new lump or lumpiness, especially if it's only in one breast
    - → a change in the shape or size of your breast
    - → a change to the nipple, such as crusting, ulceration, redness or recent inversion
    - → a nipple discharge that occurs without squeezing
    - → a change in the skin of your breast such as redness or dimpling
    - → an unusual pain that doesn't go away.
  - Nine out of 10 breast changes aren't due to cancer, but it's important to see a doctor to be sure.
  - Women aged 50 to 74 are also encouraged to have a mammogram every 2 years.
  - Consumers can self-refer to screen at BreastScreen Victoria by calling 13 20 50 or by booking an appointment online <https://www.breastscreen.org.au/>. Note: If you have a specific breast problem such as a breast lump, the BreastScreen program isn't suitable. It's recommended to see a doctor who will organise any tests needed to diagnose the problem.
- **Bowel screening:**
  - Up to 90% of bowel cancers can be successfully treated if they are found early.
  - People aged 45 to 74 can bowel screen every 2 years.
  - The bowel screening test looks for traces of blood in poo that is invisible to the human eye and can be a sign of bowel cancer. The test requires you to collect small samples from 2 separate poos.
  - Eligible people aged 45 to 49 will be able to join the Program by requesting their first bowel screening kit online <www.ncsr.gov.au/boweltest> or by calling the National Cancer Screening Register on 1800 627 701. All eligible people aged 45 to 74 can also ask their doctor about getting a free test kit.
  - Your next test kit will automatically be mailed every 2 years after your last screening test is completed.

- **Cervical screening:**
  - Cervical cancer is one of the most preventable cancers and can be successfully treated if detected early.
  - The Cervical Screening Test looks for HPV (human papillomavirus), which causes almost all cases of cervical cancer. HPV is a common STI that is spread by genital skin-to-skin contact and can affect people of any gender or sexuality. HPV is common (about 80% of sexually active adults will have an HPV infection at some point in their life). HPV usually causes no symptoms and goes away by itself. However, if your body cannot clear an HPV infection, it can cause cell changes that can, if left untreated, become cervical cancer.
  - Under the National Cervical Screening Program, women and people with a cervix aged 25 to 74 who have ever been sexually active are recommended to have a Cervical Screening Test every 5 years.
  - You can choose how you have your next Cervical Screening Test. You can have it done by a doctor or specially trained nurse or you can self-collect your test using a small swab. Both options are equally as accurate at detecting HPV. You can choose which option is right for you.
  - You can book a cervical screen at a doctor's clinic and most community health centres, women's health centres or at some Aboriginal health services.
- **Lung cancer screening:**
  - Involves 2-yearly low-dose computed tomography (LDCT) scans for those eligible. Eligibility criteria: aged between 50 and 70 years, show no signs or symptoms of lung cancer (asymptomatic), have a history of at least 30 pack-years of cigarette smoking and either still smoking or quit within the past 10 years.
  - A healthcare provider checks eligibility. If eligible and the consumer agrees, a referral is made to a radiology provider for an LDCT scan.
  - Once results are available, there may be a need for a referral to a respiratory health specialist <https://www.health.gov.au/our-work/nlcsp> or if there are no issues the consumer will be invited to scan again in 2 years.
- **Prostate screening:**
  - The current PSA testing guidelines do not recommend routine testing of all men of a certain age group, but they do support the appropriate use of PSA testing.
  - For men who decide to be tested, the recommendations are:
    - → If you are aged 50 to 69 with no family history of prostate cancer, it is recommended that you have a PSA blood test every 2 years. If you have a family history of prostate cancer, discuss earlier testing with your doctor. They may advise you to have a PSA blood test every 2 years starting from age 40 to 45. This will depend on family history.
  - If you are worried, or if you have any symptoms, speak to your GP or call the Cancer Council on 13 11 20 to speak with a cancer nurse.
  - See your doctor if:
    - → you need to wee (urinate) a lot
    - → you have trouble weeing, or it hurts to wee
    - → wee dribbles out at the start or end of doing a wee
    - → it hurts to ejaculate
    - → you have blood in your wee or semen
    - → your back, hips or pelvis hurt
    - → other people in your family have had prostate, breast or ovarian cancer.

When the consumer is not ready to participate in cancer screening

- Respect the person's preferences. Engage in a supported decision-making conversation.
- If appropriate, provide information about cancer screening services appropriate for their gender, age and smoking status for them to go through later.
- If a person is not ready to address this aspect of physical health, offer to come back to it when they are in a different headspace or situation.
- There is always an opportunity to address this in the future.

Workforce considerations

- Have a list of places where cancer screening can be completed in your area.
- Create interprofessional education and learning programs about cancer screening.

Considerations for prescribers

- Consider NRT discussions for those eligible for lung cancer screening who continue to smoke.
- Check HPV immunisation status and offer the HPV vaccine for eligible people.

Health promotion messages for consumers, carers and supporters

- Cancer screening is a simple way to reduce your risk of poorer outcomes with cancer.
- Cancer screening is provided free to eligible participants.
- Cervical screening and breast screening can be provided in trauma-informed ways to reduce the risk of pain or discomfort.

Considerations for older people

Cancer screening services stop between the ages of 70 and 74. This is because as a screening service they often detect cancer or even changes that occur before they become cancer. The overall benefits of screening, such as detecting cancer earlier when it's potentially easier to treat, outweigh the likelihood of harms in younger adults. However, the harms increase as people age. Screening tests usually pick up slower growing cancers. The potential is that cancers that are detected by screening may not have caused any symptoms or concerns for another 15 or so years. Therefore, interventions for those aged over 75 is not likely to improve outcomes but may cause harm.

Priority area 11: Aboriginal and Torres Strait Islander peoples' health

Legislative Framework and Statement of Recognition

The Mental Health and Wellbeing Act is the key Victorian legislation covering mental health and wellbeing treatment and support. The Act includes a Statement of Recognition and an acknowledgement of Victoria's treaty process (at s 14). The Act took effect in 2023 and established commitments to Aboriginal and Torres Strait Islander peoples' self-determination and cultural safety in Victorian health legislation for the first time.

The Act includes a cultural safety principle (s 27), which requires that mental health and wellbeing services are to be culturally safe and responsive to people of all racial, ethnic, faith-based and cultural backgrounds. The principle means that mental health services are required to ensure:

- regard is given to Aboriginal and Torres Strait Islander peoples' culture and identity, including connections to family and kinship, community, Country and waters
- treatment and care for Aboriginal and Torres Strait Islander peoples is, to the extent that it is practicable and appropriate to do so, decided and provided having regard to the views of Elders, traditional healers and Aboriginal and Torres Strait Islander mental health workers.

The Equally Well framework aims to further embed consistent practices that ensure compliance with the Act and its aspirational objectives for the mental health system. One key inclusion in the Act is the Statement of Recognition (s 13).

Statement of Recognition

'(1) The Parliament recognises that Aboriginal and Torres Strait Islander peoples' people in Victoria are First Nations people of Australia and acknowledges their enduring connection to Country, kin, land and culture.

(2) The Parliament acknowledges the following—

(a) that Aboriginal self-determination serves as a foundational principle to improve mental health and wellbeing outcomes of Aboriginal and Torres Strait Islander people in Victoria;

(b) the lasting impact of laws, practices and policies on the mental health and wellbeing outcomes of Aboriginal and Torres Strait Islander people since colonisation and enduring to this day;

(c) cultural dislocation, oppression, intergenerational trauma, lack of healing, systemic racism, institutionalised inequality and the loss of land, lore and language continue to harm the mental health and wellbeing of Aboriginal and Torres Strait Islander people in Victoria today;

(d) the strength of Aboriginal and Torres Strait Islander people, culture, kinship and communities in the face of historical and ongoing injustices;

(e) Aboriginal and Torres Strait Islander people's ongoing connection to culture, community and Country and the importance of this connection for the mental health and wellbeing of Aboriginal and Torres Strait Islander people in Victoria.

(3) It is the intention of Parliament that the mental health system recognises, respects and supports the distinct cultural rights of Aboriginal and Torres Strait Islander people and their right to receive culturally safe holistic mental health and wellbeing services throughout Victoria.

(4) The Parliament supports initiatives which address the ongoing mental health inequalities experienced by Aboriginal and Torres Strait Islander people in Victoria.

(5) The Parliament recognises the essential role of Aboriginal and Torres Strait Islander peoples' community-controlled health organisations in

meeting the mental health and wellbeing and care needs of Aboriginal people in Victoria.

(6) The Parliament supports the development of future reforms which further Aboriginal and Torres Strait Islander peoples' self-determination within mental health and wellbeing services in Victoria.'

National Aboriginal and Torres Strait Islander health plan

Historically, healthcare policy in Australia has focused on the medical treatment and management of illness and conditions. However, there is now a greater focus on targeting action towards the historical, social, political, cultural and environmental factors that influence health. This is closely aligned with Aboriginal and Torres Strait Islander concepts of holistic, social and emotional health and wellbeing.

The *National Aboriginal and Torres Strait Islander health plan 2021–2031* emphasises that trauma-aware and healing-informed approaches must be embedded in prevention programs, policies and services. Such approaches are about creating supportive environments that enable and empower Aboriginal and Torres Strait Islander peoples, families and communities to take control of their own health, wellbeing and healing, and are strongly grounded in Aboriginal and Torres Strait Islander traditions, values and cultures.

Stolen Generations

Between 1910 and the 1970s, as many as 1 in 3 Aboriginal and Torres Strait Islander children were forcibly removed from their families under Australian Government policies of assimilation. The intergenerational impact on the lives and wellbeing of Aboriginal and Torres Strait Islander peoples has been lasting and devastating, including the disconnection from culture, language, Country, identity and community.

Racism

Aboriginal and Torres Strait Islander peoples' experiences of racism have a direct impact on their health and wellbeing outcomes. At the societal level, racism can debilitate confidence and self-worth. Following the Voice referendum in 2023, there was a 52% increase in Aboriginal and Torres Strait Islander mental health presentations at emergency departments.

At the service level, Aboriginal peoples who experience racism are less likely to access health services and seek care. Experiences of racism can include derogatory comments, stereotyping, assumptions about lifestyle choices and receiving suboptimal treatment. At the health level, this can result in misdiagnoses, dismissal of symptoms and missed opportunities for preventative care. Racism also contributes to a higher rate of Aboriginal peoples leaving against medical advice or discharging themselves from care.

Cultural safety

Cultural safety is about how care is provided, rather than what care is provided. It requires practitioners to deliver safe, accessible and responsive health care that is free of racism by:

- recognising and responding to the power imbalance between practitioners and patients
- reflecting on their knowledge, skills, attitudes, practising behaviours and conscious and unconscious biases
- addressing negative patient experiences with meaningful and systemic change.

Embedding cultural safety is necessary to ensure Aboriginal peoples can safely access health services and experience better outcomes when they do. Cultural safety needs to be self-determined at the local level by Aboriginal people, families and communities.

Ongoing work to improve cultural safety across the health system is underway, and all services and practitioners are expected to include this in their practice under s 27 of the Mental Health Act and following Yoorrook Justice Commission commitments. This includes amending policies, guidelines and training requirements at the national, state and local levels, and national reporting of available data on cultural safety.

(Source: Department of Health 2021)

Evidence

The health gap

Although there have been improvements in a range of health and social indicators for Aboriginal peoples, substantial disparities remain in many health outcomes between Aboriginal and non-Aboriginal Australians. This is referred to as the 'health gap'.

Australian Institute of Health and Welfare analysis of Australian Bureau of Statistics health survey data from 2017 to 2019 estimated that just under 3 in 10 (29%) Aboriginal adults aged 18 to 64 self-identified as being in 'good health', using a composite measure based on a number of survey questions, compared with 51% of non-Aboriginal Australians. After accounting for the differences in average age, sex, marital status, remoteness and state/territory between Aboriginal and non-Aboriginal survey respondents, the health gap between Aboriginal and non-Aboriginal was 24.0 percentage points – an improvement from 26.9 percentage points in 2011–13.

Analysis of data for 2017–19 showed that an estimated 35% of the health gap was explained by social determinants, and a further 30% by selected health risk factors.

Around 35% of the gap was left unexplained by this analysis. This unexplained component of the health gap reflects that the available data sources do not provide a complete picture of the differences in health between Aboriginal peoples and non-Aboriginal Australians. These factors may include access to affordable and culturally appropriate health care services, connection to Country and language, and effects of structural disadvantage and racism.

(Source: Australian Institute of Health and Welfare 2024a)

Health disparities

Approximately 45% of Aboriginal people are daily smokers – a prevalence rate almost 3 times that of non-Aboriginal Australians. Tobacco smoking accounts for 23% of the health gap between Aboriginal peoples and non-Aboriginal Australians (RACGP 2024).

The Victorian Cancer Council (2023) has determined that Aboriginal Victorians are 2.8 times more likely to die from cancer than non-Aboriginal Victorians.

The importance of self-identification in health data collection

Self-identification as an Aboriginal and/or Torres Strait Islander person in health settings is critical to ensuring people are visible in data used for service planning, funding allocation and evaluation. Accurate identification supports health services and governments to:

- monitor health disparities and improve equity in outcomes
- ensure culturally appropriate services are delivered where they are most needed
- track progress on Closing the Gap targets and other national and state-level strategies
- recognise and respond to the unique health needs of Aboriginal peoples.

Importantly, self-identification empowers Aboriginal peoples to assert their identity and access targeted supports. Services have a responsibility to create culturally safe environments where people feel confident and respected when asked to identify.

All practitioners need to ensure they ask every person for their Aboriginal status at intake, and throughout their treatment. Due to past experiences of racism in the health sector, many Aboriginal peoples may not feel comfortable identifying until they feel culturally safe within a service or care team. It is important to note that Aboriginality is not tied to skin tone, and clinicians must not assume a person's identity.

Social and emotional wellbeing

Aboriginal peoples understand health and wellbeing as an integrated and holistic experience, which is impacted by cultural, social, political and historical determinants (Figure 14).

Using this, mental health support and recovery needs to prioritise the impact of culture as a protective factor. It also must look at the broader context of colonisation and the ongoing personal and structural racism that negatively effects Aboriginal peoples.

Figure 14: Social and emotional wellbeing

SEWB Diagram adapted from Gee et al., (2014)

Adapted from Gee et al. 2014

An Aboriginal person's priorities around their physical health and wellbeing can vary depending on factors including the person's age, gender, education, lived experience and exposure to trauma.

Understanding the consumer's perspective or journey

- Aboriginal peoples 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 (Mental Health and Wellbeing Act). This includes decisions around their own physical health care and needs.
- Treatment and care must be appropriate for, and consistent with, the cultural and spiritual beliefs and practices of a person living with mental illness or psychological distress. Regard is to be given to Aboriginal peoples' unique culture and identity, including connections to family and kinship, community, Country and waters (Mental Health and Wellbeing Act). Community-led decision-making is important and should consider the role of Elders or cultural mentors in supporting health decisions and ongoing care.
- Other factors that inform the person's beliefs around their physical health include the relationship they have with their interprofessional mental health care team, past experiences of health care, the complexity of

their physical health issues and their current capacity to prioritise physical health. Past experiences of health care can include those of other community members, emphasising the need to ensure all service provision is culturally safe and accessible.

- Being supported in decisions about their physical health needs involves an understanding of the additional cultural and social determinants of health and wellbeing. Information should be shared in an accessible way with the consumer and their care team. Services should develop formal partnerships with local Aboriginal Community Controlled Organisations (ACCOs) and Aboriginal-led organisations to support long-term care.
- As with many consumers, Aboriginal peoples will vary in the degree to which they want to be involved in making decisions about their physical health. This may be influenced by their capacity to be involved in those decisions at any given time, how culturally safe they feel in the service, and their support system. Ensuring a person is connected with their community and has tangible cultural connections will benefit their ongoing care.

Links to recovery goals

Formalised partnerships with ACCOs will support ongoing, culturally appropriate care that addresses long-term recovery goals. Explore how Aboriginal peoples' physical health impacts on their recovery goals. Addressing their physical health needs may be one way to enhance their capacity to achieve recovery goals, but it is only one strategy and may not be the focus.

Consider those with links to the Stolen Generations and whether they are looking to connect with family (if they were removed) or to find family who were removed. Link-Up Victoria <https://linkupvictoria.org.au/> can assist with this journey in a trauma-informed way.

Reconnection to culture, family and Country is often a key recovery goal in itself. Clinicians having a thorough understanding of local ACCOs and community groups can support appropriate referrals and build professional relationships.

Not every Aboriginal person will feel comfortable accessing their local ACCO due to conflicts of interest within families or previous experiences. Self-determination requires multiple culturally safe options, meaning all mainstream services need to be able to provide appropriate care.

When the Aboriginal person is ready to address their physical health needs

- Explore what the person thinks will help. What are their physical health goals and what has worked for them before?
- Adopt an interprofessional collaborative approach to the person's physical health needs by engaging with the appropriate physical health care provider for that person.
- Formalised ACCO partnerships can support this, as well as ensuring clinicians understand the breadth of services available in their area.
- Continue with recovery planning, keeping in mind the Social and Emotional Wellbeing framework and cultural safety training.

When the Aboriginal person is not yet ready to address their physical health needs

- Engage in a supported decision-making conversation.
- Consider using Social and Emotional Wellbeing frameworks to emphasise the importance of physical health. People are more likely to engage in physical health conversations if there are specific reasons for the discussion, and if they are involved in making decisions about their physical health care plan.
- When a person does not want to discuss any aspect of their physical health, it is important to ensure they at least know how to access physical health information when they are ready. Resources of written physical health information for Aboriginal people can be located through the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) <https://www.vaccho.org.au/community-health/>.

Workforce considerations

- All services should prioritise recruitment of Aboriginal health liaison officers to provide culturally safe support internally, as well as developing formalised partnerships with local ACCOs and Aboriginal-led organisations.
- The Minister for Health has committed to mandating ongoing and Aboriginal-led cultural safety training for all public and community health service staff and providers through the Cabinet-endorsed Aboriginal Health and Wellbeing Partnership Forum action plan 2023–2025 and in Yoorrook Justice Commission hearings.
- VACCHO's training is endorsed and used across various sectors in Victoria. For instance, the Department of Families, Fairness and Housing has embedded mandatory Aboriginal cultural safety training into its People and culture strategy, particularly for child protection staff. This initiative includes programs for all staff and leadership, aligning with recommendations from the Yoorrook for Justice report.
- Create interprofessional education and learning programs about Aboriginal health disparities and referral services in your hospital and local area. Ensure these are regularly updated and reviewed by Aboriginal health liaison officers or an Aboriginal community counterpart.

Considerations for prescribers

- Prescribers should ensure all Aboriginal consumers are registered for Closing the Gap, which provides concession rates for Aboriginal peoples not eligible for concession cards.

Health promotion messages for consumers, carer and supporters

- **Clinicians are not being asked to provide cultural care.** Cultural safety does not require non-Aboriginal staff to take part in Aboriginal cultural customs. Instead, it asks that all staff hold respect and knowledge of Aboriginal ways of knowing, being and doing, and can support consumers to access the appropriate care.
- **Social and emotional wellbeing is more than mental health.** Encourage a holistic view of wellbeing that includes kinship, culture, identity and healing from past and ongoing trauma.
- **Connection to culture, community and Country is healing.** Supporting access to cultural practices, language and time on Country can strengthen wellbeing and identity, and is a protective factor against poor health outcomes.
- **Healing is not linear.** Recognise that mental, physical and emotional wellbeing are interconnected, and that healing may involve family, community, cultural connection and professional support.
- **Self-determination supports better health.** Empowering people to make informed choices about their health and care is central to improving outcomes and restoring autonomy.
- **Spiritual wellbeing matters.** Recognise the importance of spirituality in healing and recovery – this may involve Elders, cultural healing practitioners or cultural ceremonies.
- **Aboriginal-led services are culturally safe spaces**. Encourage use of Aboriginal Community Controlled Health Organisations, which are built on trust, cultural safety and community leadership.
- **Respect for mob diversity**. Acknowledge that not all Aboriginal people share the same health beliefs, cultural practices or preferences for care – tailor support accordingly.
- **Deadly choices are strong choices**. Promote campaigns like Deadly Choices, which empower people to take control of their health through culturally relevant messaging on diet, exercise and screening.
- **Nutrition and movement are part of cultural wellbeing**. Promote bush foods, traditional movement and community sport as culturally connected ways to support physical health.

Other focus points

- It is important to remember cultural dislocation, oppression, intergenerational trauma, lack of healing, systemic racism, institutionalised inequality and the loss of land, lore and language continue to harm the mental health and wellbeing of Aboriginal peoples.
- Services' smoke-free policies need to reference culturally sensitive smoking cessation practices specific to Aboriginal peoples. The RACGP Supporting smoking cessation guidelines (2021) include recommendations specific to Aboriginal

populations to support services to provide culturally sensitive support.

- QUIT Victoria has dedicated Aboriginal Quitline specialists who can assist a person with short-term cessation and quit options.

Considerations for older people

Older Aboriginal peoples and communities are less likely to access aged care services than all other non-Aboriginal demographics. This is despite older Aboriginal peoples having the highest comorbidities and rates of early-onset dementia across all older demographics in Australia.

To improve access for Aboriginal peoples, the aged care system must better embed holistic, community-centred, trauma-aware and healing-informed models of care. This includes ensuring on site access to wraparound services and supports, which requires:

- aged care services working in partnership with ACCOs for better accessibility to services.
- expanding the reach of ACCOs to deliver more services in communities.

Aboriginal Elders have unique cultural, social and historical experiences that must be respected and understood in aged care settings. Services should ensure the following considerations are embedded in practice.

Cultural safety

Ensure aged care environments are culturally safe, inclusive and welcoming.

Staff should complete ongoing Aboriginal cultural safety training, supported by local ACCOs.

Include culturally appropriate food, language, art and spiritual practices in service design.

Stolen Generations and trauma-informed care

Many Elders are survivors of the Stolen Generations. Aged care services must adopt trauma-informed approaches that prioritise choice, transparency and respect.

Avoid practices that may trigger trauma such as forced isolation, disempowerment or culturally inappropriate procedures.

Connection to Country and culture

Support opportunities for connection to Country, including access to on-Country aged care or visits back to community.

Create space for cultural connection through Community-led yarning circles, Elder-led events or taking part in cultural days (NAIDOC Week, Sorry Day).

Family and kinship involvement

Aboriginal decision-making is often collective. Care planning must include consultation with family, kin and trusted community members.

Respect cultural protocols regarding Eldership, gender roles and caregiving responsibilities.

Communication and language

Use clear, plain language or interpreters as needed.

End-of-life and spiritual care

Provide culturally sensitive palliative care that honours spiritual beliefs and cultural protocols around death and dying.

Support advance care planning that involves trusted family or Elders and respects the person's cultural identity and wishes.

Aboriginal workforce inclusion

Employ Aboriginal staff in roles such as care coordinators, liaison officers and support workers to strengthen cultural trust and communication.

Support pathways into aged care careers for Aboriginal people through traineeships and mentoring.

Access and outreach

Partner with ACCOs to build trust and awareness of aged care services.

Address access barriers by providing outreach support, transport assistance and localised service delivery where possible.

(Source: Department of Health 2021)

Priority area 12: Young people

Evidence

The onset of mental ill-health often occurs between the ages of 12 and 25 years and can also bring risks in identity development and poor physical health outcomes, including sexual and oral health (refer to previous priority areas). Mental health concerns often become the biggest focus without considering their effects on a young person's physical and sexual health.

The challenges of working with young people with mental health difficulties are many and varied. One of the key challenges is making sure each young person receives holistic care – care that responds to both their physical and mental health needs. This is extremely important because physical and mental health are interconnected – one affects the other. We need to be mindful that a young person's physical health needs, including lifestyle factors, contribute to their cardiometabolic health, sexual health and oral health.

For many young people, the physical aspects of health are closely related to appearance and performance rather than health per se. Young people may focus on short-term implications of positive health behaviours rather than being motivated by long-term benefits on their health. This can result in young people being more likely than other age groups to experiment and take risks, particularly in relation to alcohol, other substance use and sexual behaviour.

Risk-taking behaviours can have long-term effects on both physical and mental health. An important part of the role of mental health clinicians is to work with young people in a way that protects their overall health and wellbeing now and in the future. Mental health clinicians are well placed to perform this role, harnessing aspects of mental health training in working with young people in a way that's not patronising, not expecting too much of them too quickly, and uses the principles of harm-minimisation.

(Source: Orygen 2016)

More young people are using e-cigarettes/vapes

Electronic cigarettes/e-cigarettes or vapes (referred to collectively as 'e-cigarettes') are personal vaping devices where users inhale aerosol rather than smoke. The inhaled aerosol usually contains flavourings and a range of toxic chemicals and may contain nicotine as well (Department of Health and Aged Care 2023).

In 2022–23, around half (49%) of people aged 18 to 24 in Australia reported having used an e-cigarette at least once in their lifetime, the highest of all age groups. This was almost double the 26% of people who had done so in 2019.

People aged 25 to 29 were the next most likely to have used e-cigarettes in their lifetime, with 41% having done so (double the proportion who had done so in 2019).

In 2019, only 9.6% of people aged 14 to 17 in Australia had ever used e-cigarettes; this percentage had nearly tripled by 2022–23, to 28%.

(Source: Australian Institute of Health and Welfare 2024c)

More young people are at risk of sexually transmitted infections

In 2020, among young people aged 15 to 24:

- There were nearly 5 times as many notifications of chlamydia as other STIs (37,500 compared with 7,700 for gonorrhoea and 871 for syphilis).
- Chlamydia was around twice as common in females as males (23,900 notifications compared with 13,500).
- Gonorrhoea and syphilis were more common in males than females (4,200 notifications compared with 3,500 for gonorrhoea and 546 compared with 324 for syphilis).

There were around twice as many notifications of each STI in 20 to 24-year-olds as in 15 to 19-year-olds:

- 24,800 compared with 12,700 for chlamydia
- 5,300 compared with 2,300 for gonorrhoea
- 589 compared with 282 for syphilis
- among 15–19 year olds, chlamydia and gonorrhoea were more common in females than males (for chlamydia, 9,200 notifications compared with 3,500; for gonorrhoea, 1,300 compared with 986).

(Source: Australian Institute of Health and Welfare 2021)

Understanding the consumer's perspective or journey

- Discussing physical health is the first important step in understanding and assessing the cardiometabolic and sexual health issues that young people with mental ill-health may be facing or are at risk of developing.
- It is important to assess cardiometabolic health and sexual health as part of the overall engagement and assessment process, and from the beginning of an episode of care.
- Discussing these issues as a normal and expected part of health care will help young people feel more comfortable discussing these issues throughout their care.
- The general principles of assessment and engagement apply to talking with young people about their physical health.
- A genuine, non-judgemental and empathic approach will help the young person to feel at ease and open up about any concerns they have.

Links to recovery goals

Explore how this young person is working towards independence. There are considerations that can also be worked through such as: Do they have their own Medicare card? Do they have a regular GP?

When the young consumer is ready to address their physical health needs

A shared decision-making model is an important step. The clinician and consumer should work together to make healthcare decisions that are best for the consumer. The young person is more likely to be actively engaged if they have been part of the process.

Targeting smoking/vaping cessation

- Share clinical responsibility among all medical, nursing and allied health staff.
- Ensure a smoking policy exists for youth services (inpatient, residential and community) that includes the using NRT in the under 18 age group.

Increased risk of weight gain for the younger population starting treatment

- Explore family beliefs on nutrition and nourishment.
- Recognise the developmental challenges of adolescence in navigating a healthy body image. Conversations about making changes to nutrition and physical activity should, where possible, adopt a weight-neutral approach.
- Identify any potential child protective concerns of neglect or other family violence–related issues (Has a family violence assessment been done?). Consider malnourishment and food insecurity.
- Explore media literacy – education and awareness around the influence of social media and potential impact on body image.
- Awareness of the impact of peer relationships and structured activities that focus on an ideal body image such as formalised dance classes or an athletic physique.

Physical activity

- Involve parents in brainstorming family activities that promote physical activity.
- Identify group sports or peer-related physical programs for motivation that are free or low cost.

Substance use

- Recognise experimentation is a normal developmental task of adolescence.
- Acknowledge but do not condone substance use. Engage in open dialogue and take an opportunistic harm minimisation approach that for some young people may involve discussions about accessing intranasal naloxone.
- Weigh up the confidentiality of the young person against the duty of care to inform their parents.

Sexual health

- Consider if the young person is a competent minor and clearly document this in their file.
- Consider if risky sexual behaviour is related to:
  - impulsive experimentation of adolescence – exploration of gender or sexual identity, sexual curiosity and exploration where education and awareness of risk is the key missing component
  - lack of information / health literacy around sexual health or not perceiving behaviour as risky
  - financing comorbid substance abuse
  - undiagnosed Axis 1 affective or psychotic disorder
  - past or present sexual trauma (for example, sexual assault, intimate partner violence) or childhood sexual abuse.
- With the young person's consent as appropriate, liaise with stakeholders such as GPs, paediatricians, youth drug and alcohol workers, child protection practitioners, sexual health clinics and sexual health nurses.
- Promote safer sex practices including sexual consent, the use of condoms and contraception to prevent STIs and unwanted pregnancy.
- Normalise STI screening for all young people who are sexually active even if not deemed to be 'high risk'.
- Consider whether MPox vaccination is indicated and can be offered to young person, also pre-exposure prophylaxis for HIV for young people at higher risk.
- Respecting and acknowledging young people's sexual orientation and gender by using preferred names and pronouns. This helps to establish rapport and develop trust.

Medication optimisation

- Work with the young person and their parents regarding dosing times and the timing of dose titration and medication changes, considering 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 irrational polypharmacy and simplify to a single prescriber where possible.
- Apply special consideration to new consumers who are naive about antipsychotics to have education about differing effects and adverse impacts.

Dental

- Provide education and information about financially accessible dental care programs.
- 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.

Cancer screening

- Encourage HPV vaccines.
- Encourage sun protection and regular skin checks.

When the young person is not yet ready to address their physical health needs

- Respect the young person's preferences.
- Education is an important aspect of holistic health care. Although the young person may not yet be ready to address their physical health needs, they may be open to listening about what different services are available. Provide the young person with information that they may be able to refer to later.
- Let them know you are happy to have this conversation again when they are ready to.

Workforce considerations

- Provide regular training for the mental health workforce on physical health issues for the young person and ways that clinicians can improve outcomes.
- Make a list of young person–specific physical health providers in your area that mental health clinicians can refer to or engage with for advice. This list should be regularly updated.

Consideration for prescribers

- Young people are more at risk for medication-induced weight gain. Consider the choice of medication and the early use of metformin in conjunction with antipsychotics.

Health promotion messages for consumers, carers and supporters

- Screening your physical health early and providing interventions is important to prevent or address any issues.
- There are physical, physiological and hormonal changes that occur during your normal development.
- Be aware that mental ill-health can have an impact on your physical and sexual health.
- Educate yourself and others on the impact psychotropic medications can have on physical health.
- Be mindful of the impact of physical health issues on your mental health.
- Modifiable lifestyle factors can positively impact your overall physical health.
- Learn about what early intervention services can offer regarding your physical health.
- There are strategies to assist your physical health monitoring and intervention.
- If you are over 15 years of age you are eligible to get your own Medicare card. This allows you to see a doctor for STI/BBV testing and receive scripts without your parents having to provide consent. Be aware also that young people can get STI testing without parental consent if you are a mature minor even if you are on your parents' Medicare card. Having your own card provides more assurance of confidentiality and may be helpful in promoting independence, but GPs can elect to not have prescriptions or test results added to the young person's My Health Record as well.

(Source: Orygen Youth Health 2016)

Other priorities to note

Sleep apnoea

Consumers with mental illness are at higher risk for sleep apnoea due to multiple factors (for example, higher weight, smoking rates, excess sedation from medications). Focus on early diagnosis and exploring treatment options. The cost of equipment to manage sleep apnoea may be a barrier for many consumers, but this can be explored through NDIS funding or alternatives as appropriate. Screening and referral pathways can be accessed through the Victorian Government <https://www.health.vic.gov.au/statewide-referral-criteria/obstructive-sleep-apnoea>.

Culturally and linguistically diverse communities

The experience of culturally and linguistically diverse consumers differs from other consumers with mental illness, and they face further barriers to receiving appropriate physical health care (for example, language, Medicare access, lack of awareness of the Australian health system). Ethnic Communities' Council of Victoria (ECCV) <https://eccv.org.au/mental-health-system-reform-in-victoria/> is the peak body for ethnic and multicultural organisations and can be approached for support and training in this area.

LGBTIQA+ people

Just over one in 20 adult Victorians openly identifies as being LGBTIQA+. They face high levels of discrimination, stigma and exclusion. This leads to poorer physical, economic, social and mental health outcomes than other Victorians. Research has shown that LGBTIQA+ Australians are at a higher risk of poor mental health. The only acceptable scenario for Victoria is that there is no distinction among people who are or are not LGBTIQA+. Healthcare does not discriminate (Department of Health 2024).

Thorne Harbour Health <https://thorneharbour.org/> is Australia's oldest LGBTIQA+ health organisation and Victoria's largest, formed in 1983. Thorne Harbour Health delivers community-led and culturally appropriate services that improve the health and wellbeing of LGBTIQA+ people living throughout Victoria and beyond. It provides peer-to-peer and professional expertise in services and programs delivered by staff and volunteers and in partnership with other organisations.

Young people 0–11

The wellbeing, physical and mental health of children from birth through late childhood (0–11 years) is shaped by a complex interplay of social, cultural, biological and environmental factors. Biological factors such as genetic predispositions and neurodevelopmental variations significantly influence emotional regulation, cognitive development and physical health. These intersect with social and environmental influences to shape overall wellbeing (Rutter 2012).

Attachment relationships with carers form through babyhood and intertwine with physical experience as the baby's need to be fed and cared for are met across the early years. A secure attachment (Ainsworth 1979) provides the emotional foundation for exploration, social engagement and developing personal agency. Without this, the ability to regulate emotions, explore and learn may be affected. Children may experience heightened anxiety or dysregulation straining caregiver–child relationships and impairing the development of trust and secure bonds (Champagne 2015).

Functional difficulties such as unresolved issues with early feeding, picky eating and soiling are entwined with aspects of a child's physical health, diet, relational and environmental factors. Failure to thrive and behaviours associated with

disordered eating can be present in the 0 to 11 age group. Early nutritional issues like iron deficiency can impair both physical growth and emotional regulation impacting a child's capacity to engage meaningfully with their environment and relationships (Galloway and Farquhar 2019).

Physical activity is a protective factor in mental health and wellbeing, and for children this is an important aspect of their development. Where developmental differences are present, everyday activities such as writing in a classroom, playing in the school yard or community sport activities can create unmeetable demands shaping a child's developing sense of identity. Difficulty with processing sensory experiences may also lead to emotional distress, social withdrawal and difficulties in peer interactions

Practice examples

General practitioners in community settings

- GPs are embedded in the service and provide opportunistic access for consumers receiving treatment from the service.
- GP roles are structured so they provide a diverse range of services including:
  - direct clinical contact with patients, targeting the most vulnerable patients who haven't been able to engage with community GPs (GPs provide holistic care, addressing complex biopsychosocial presentations, emergency care, chronic conditions, preventative care and liaison with specialist staff)
  - providing secondary consultation, capacity building, advice on building practice guidelines with best practice, supporting with screening and linking with community GPs
  - education and support to staff
  - research.
- GPs are adaptive and can work within the system that is available (for example, they do not require specialist software, dedicated administrative staff or practice nurses).
- There are many ways that GPs can support psychiatric patients with their holistic healthcare needs, and Eastern Health's Embedded GP Service <https://www.easternhealth.org.au/mental-health-3/> is one example of how this can work well.

Nurse practitioners – inpatient

Inpatient nurse practitioners can work autonomously to address physical health needs. With specific parameters and areas to target, nurse practitioners can expand their scope of practice to target gaps in service. Examples include performing cervical screening, diabetes management, STI screening and treatment, hepatitis C treatment, contraception (including Implanon insertion and removal), metabolic monitoring and treatment. This helps provide a more holistic approach to inpatient care and ensures physical health is prioritised even when mental illness requires acute treatment.

Nurse practitioners – community

A nurse practitioner in the community can again work autonomously to address physical health needs such as those in the Equally Well framework. The nurse practitioner can work with consumers who are at risk and intervene with specialised physical health care that is evidence-based and cost-effective. Nurse practitioners can offer a higher level of skill and experience and can be instrumental in developing strategies, frameworks, linkages and potentially conducting research.

Physical health nurses

Physical health nurses can provide secondary consultation, as well as training and resources for healthcare teams. A physical health nurse can also engage with consumers to work in a flexible way to assist with screening, referral pathways and system navigation. Suitable candidates should have experience working with consumers with mental illness (nurses in GP clinics may still be suitable). Enrolled nurses fit well into these roles and can be responsible for the hands-on work in teams (such as taking measurements, completing screening tools with consumers and organising appointments with other physical health services). Registered nurses offer a good skill set in this area and can work autonomously in developing the roles (they can also become nurse immunisers to administer vaccinations within the health service specifically targeting mental health consumers).

Other health professionals

Consider employing **exercise physiologists and dietitians**. This could be done either through direct employment or through a contract with local community health services. Most community health services employ or have access to exercise physiologists, dietitians and other allied health professionals. Discuss arranging access to those services through an agreement.

Consider the role of **pharmacists** in providing primary, secondary and tertiary consultation. Pharmacists can help address many of the Equally Well priority areas and are a great resource for prescribers when expanding into physical health areas.

Ways to start

Physical health committee: Establishing a committee to elevate physical health in mental health services is a great way to start. Having people in the room focused on physical health outcomes will help with momentum. This committee can explore what is already being done in relation to Equally Well and work on filling any gaps. Having a variety of disciplines and management levels in the room will ensure a good balance between clinical and budget considerations.

Champions/drivers: Leaders at any level can be called on to drive change in physical health care in mental health settings. Appointing champions to lead and monitor specific physical health tools or processes can help to cement changes in services.

Clinical nurse specialists: Employing CNS roles specifically focused on physical health can help in implementing physical health policies and processes. Train CNSs to lead services such as wound care, diabetes care and metabolic monitoring.

Immunisation nurses: Many services are working towards having nurse immunisers. Nurse immunisers can assist with targeting both staff and consumers with flu vaccinations. They can also assist with hepatitis B vaccinations (for at-risk populations), HPV (for under 25s) and catch-up vaccines if patients are at risk of missing childhood vaccines.

Policy development: Embrace co-design principles to establish a model of care to address physical health gaps in service. Review what is already in place to address physical health and develop policies to help the service to better meet the physical health needs of mental health consumers.

Screening tools: Implement standardised vital sign monitoring plans for consumers in specific circumstances:

- starting on clozapine
- starting on other medications with significant side effects such as postural hypotension, cardiac disorders or metabolic effects.

The organisation should also set key performance indicators for any screening tools that are adopted. These tools can then be audited, and the service can work towards increasing compliance.

Local service training programs: Services can develop their own training programs or look to other organisations for support if they are already established in these areas. Consider specific training on the following:

- MARAM training
- Equally Well training targeting the priority areas and delivered by experts in the areas (such as QUIT, cultural safety, sexual health, cancer screening, metabolic monitoring).

Linking in with and developing relationships with other services

- Partner with community health services such as dental, allied health (dietitian, exercise physiology), gyms and sexual health centres.
- Engage with colleagues in Primary Health Networks.

Consider developing a capability framework

- Health services can self-evaluate and check where they are standing (just starting -> advanced).
- Create a tool for self-assessment to ensure holistic care is taking place across the service.
- Organise a one-stop shop to link to services and referrals for staff.
- Link to other frameworks (for example, Safewards).

Consider what can be done in the emergency department

Think about what assessments are undertaken in the emergency department during a mental health presentation and if any of these incorporate (or can be slightly adjusted to incorporate) physical health aspects.

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).

Resources

ASHM: Provide resources, training and education for health professionals on HIV, BBV and sexual and reproductive health: https://ashm.org.au/

Cancer Council Victoria: The leading cancer charity, working with, and for, the community across all cancers and for all people. CCV provides cancer information as well as education and training for health professionals: https://www.cancervic.org.au/

Dietitians Australia: The leading voice in nutrition and dietetics offering advice on how diet and nutrition can improve health and wellbeing: https://dietitiansaustralia.org.au/diet-and-nutrition-health-advice

GPEx: A training provider that offers continuing professional development to meet the needs of the primary care system: https://gpex.com.au/

Melbourne Sexual Health Centre: Provides clinical services as well as a range of education and training opportunities: https://www.mshc.org.au/

Orygen: The lead in youth mental health offering continuing professional development online for mental health clinicians: https://orygen.org.au/Training/Resources/Physical-and-sexual-health/Clinical-practice-points/Physical-mental-health

Primary Health Networks (PHNs): Independent organisations working to streamline health services – particularly for those at risk of poor health outcomes – and to better coordinate care so people receive the right care, in the right place, at the right time: https://www.health.gov.au/our-work/phn/your-local-PHN/Vic-PHNs

QUIT: The leading not-for-profit organisation supporting people to quit smoking and vaping. QUIT also provides resources, education and training for clinicians who are supporting others who quit: https://www.quit.org.au/

Sexual Health Victoria: Provides clinical services and is also the leading provider of reproductive and sexual health education and training in Victoria: https://shvic.org.au/

Thorne Harbour Health: A community-controlled health organisation that delivers community-led and culturally appropriate health and wellbeing programs to the LGBTIQA+ community. Thorne provides general health care for LGBTIQA+ community members as well as specialist medical care for people living with HIV and expert sexual health screening and treatment: https://thorneharbour.org/

VAADA: Victoria's peak body representing alcohol and other drug services. VAADA's website contains information on services as well as education and training opportunities: https://www.vaada.org.au/

VACCHO: The peak body for Aboriginal health and wellbeing in Victoria, with a membership of 34 community-controlled organisations: https://www.vaccho.org.au/members/

First Peoples' Health and Wellbeing is another Aboriginal-led service: https://www.fphw.org.au/

Victorian Virtual Emergency Department (VVED): A public health service that treats non-life-threatening emergencies. For healthcare providers the VVED can offer on-demand consultations, enabling providers to call VVED while the patient is still at their facility or residence, and to have a direct consultation with an emergency physician. The VVED can also provide a pathway for referrals to primary health care providers for patients who have had an emergency telehealth consult and require follow-up: https://www.vved.org.au/

Women's health resources: https://whise.org.au/resources/

References

Ainsworth MDS (1979) Mother–baby attachment. *American Psychologist*, 34(10): 932–937.

(Australian Commission on Safety and Quality in Health Care 2009).

Australian Commission on Safety and Quality in Health Care (2017) *National Safety and Quality Health Service Standards, 2nd edn*, Australian Commission on Safety and Quality in Health Care, Sydney. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-safety-and-quality-health-service-standards-second-edition

Australian Commission on Safety and Quality in Health Care (2019) NSQHS – standards user guide for acute and community mental health services: *Falls prevention*, Australian Government, Canberra. https://www.safetyandquality.gov.au/our-work/comprehensive-care/related-topics/falls-prevention

Australian Institute of Health and Welfare (2021) *Australia's youth: infectious diseases*, Australian Government, Canberra. https://www.aihw.gov.au/reports/children-youth/infectious-diseases

Australian Institute of Health and Welfare (2022) *Falls in older Australians 2019–20: hospitalisations and deaths among people aged 65 and over*, Australian Government, Canberra. https://www.aihw.gov.au/reports/injury/falls-in-older-australians–2019–20-hospitalisation/contents/summary

Australian Institute of Health and Welfare (2024a) *Determinants of health for First Nations people*, Australian Government, Canberra. https://www.aihw.gov.au/reports/australias-health/social-determinants-and-indigenous-health

Australian Institute of Health and Welfare (2024b) *Mental health and use of alcohol, tobacco, e-cigarettes and other drugs*, Australian Government, Canberra. https://www.aihw.gov.au/reports/mental-health/mental-health-alcohol-drugs

Australian Institute of Health and Welfare (2024c) *National Drug Strategy Household Survey 2022–2023: Young people's use of vapes and e-cigarettes*, Australian Government, Canberra. https://www.aihw.gov.au/reports/smoking/young-peoples-vapes-e-cigarettes

Cancer Australia (2025) *Australian cancer plan – people living with a mental illness*, Australian Government, Canberra. https://www.australiancancerplan.gov.au/populations/people-living-with-a-mental-illness

Cancer Council Victoria (2023) *Cancer in Victoria*, CCV, Melbourne. https://www.cancervic.org.au/research/vcr/cancer-in-victoria–2023

Cancer Council Victoria (n.d.) *Cancer screening and early detection*, CCV, Melbourne. https://www.cancervic.org.au/cancer-information/screening

Champagne T (2015) Sensory processing and attachment: a framework for understanding early relational dynamics. *Journal of Child and Family Studies*, 24(3):711–722. https://doi.org/10.1007/s10826-014-9923-3

Dayabandara M, Hanwella R, Ratnatunga S, Seneviratne S, Suraweera C and de Silva VA (2017) Antipsychotic-associated weight gain: management strategies and impact on treatment adherence. *Neuropsychiatric Disease and Treatment*, 13, 2231–2241.

Department of Health (2011) *Framework for recovery-orientated practice*, Mental Health, Drugs and Regions Division, Victorian Government, Melbourne. https://www.vgls.vic.gov.au/client/en_AU/search/asset/1269305/0

Department of Health (2021) *National Aboriginal and Torres Strait Islander health plan 2021–2031*, Commonwealth of Australia, Canberra. Publications Number: DT0002195 https://www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-health-plan–2021–2031?language=en

Department of Health (2024) *Strategic plan 2023–27: 2024 update*, Victorian Government, Melbourne. https://www.health.vic.gov.au/our-strategic-plan–2023–27

Department of Health (2025) *Chief Officer for Mental Health and Wellbeing annual report 2023–2024*, Victorian Government, Melbourne. https://www.health.vic.gov.au/publications/victorias-mental-health-services-annual-report

Department of Health (2025) *Inquiry into Women's Pain*, Victorian Government, Melbourne. https://www.health.vic.gov.au/inquiry-into-womens-pain

Department of Health and Aged Care (2023) *About e-cigarettes*, Australian Government, Canberra. https://www.health.gov.au/topics/smoking-vaping-and-tobacco/about-vaping

Department of Health and Ageing (2011) *Don't fall for it, falls can be prevented*, Australian Government, Canberra. https://www.health.gov.au/sites/default/files/documents/2021/04/don-t-fall-for-it-falls-can-be-prevented.pdf

Family Safety Victoria (2018) *Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM)*, Victorian Government, Melbourne. https://www.vic.gov.au/sites/default/files/2019-01/Family%20violence%20multi-agency%20risk%20assessment%20and%20management%20framework.pdf

Galloway T and Farquhar M (2019) Feeding difficulties and growth failure in early childhood: a multidisciplinary approach. *Journal of Paediatric Health Care*, 33(6):629–638. https://doi.org/10.1016/j.pedhc.2019.07.002

Gee G, Dudgeon P, Schultz C, Hart A and Kelly K (2014) *Aboriginal and Torres Strait Islander social and emotional wellbeing*. In: Dudgeon P, Milroy H and Walker R (eds). Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. 2nd edn, Australian Government, Canberra, pp. 55–68.

Greenhalgh EM and Scollo MM (2022) 9A.3 People with substance use and mental disorders. In Greenhalgh, EM, Scollo, MM and Winstanley, MH [editors]. Tobacco in Australia: facts and issues, Cancer Council Victoria, Melbourne. https://www.tobaccoinaustralia.org.au/chapter-9-disadvantage/in-depth/9a-3-people-with-substance-use-and-mental-disorders

Haber PS and Morley KC (2016) The impact of alcohol pharmacotherapies on public health in Australia is limited by low prescribing rates. *Public Health Research and Practice*, 26(4):e2641643. https://dx.doi.org/10.17061/phrp2641643

Haber PS, Riordan BC (2021) *Guidelines for the treatment of alcohol problems (4th edn)*, Specialty of Addiction Medicine, Faculty of Medicine and Health, The University of Sydney. https://alcoholtreatmentguidelines.com.au/pdf/guidelines-for-the-treatment-of-alcohol-problems.pdf

Lederman O, Grainger K, Stanton R, Douglas A, Gould K, Perram A, et al. (2016) Consensus Statement on the role of accredited exercise physiologists within the treatment of mental disorders: a guide for mental health professionals. *Exercise Sports Science Australia*, 24(4):347–351.

Levinson JA, Clifford D, Laing EM, Harris CL, Slagel N, Squires ND, et al. (2024) Weight-inclusive approaches to nutrition and dietetics: a needed paradigm shift. *Journal of Nutrition Education and Behaviour*, 56(12):923–930.

Mental Health and Wellbeing Act 2022 (Victoria): https://www.legislation.vic.gov.au/as-made/acts/mental-health-and-wellbeing-act–2022

National Institute on Drug Abuse (2020) *Common comorbidities with substance use disorders research report*. US Department of Health and Human Services. https://www.ncbi.nlm.nih.gov/books/NBK571451/

National Mental Health Commission (2016) *Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia*, NHMC, Sydney. https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf

Orygen (2016) *Clinical practice in youth mental health: Screening and intervening for physical and sexual health*. Orygen, The National Centre of Excellence in Youth Mental Health. https://www.orygen.org.au/Training/Resources/Physical-and-sexual-health/Clinical-practice-points/physical-and-sexual-health/physical_and_sexual_health_CPP

Pham S, Evans K, Patel K, Gallagher F, Nguyen TM (2025) Dental Health Services Victoria health promotion messages for oral health: a modified Delphi study. *Health Promotion Journal of Australia*, 36(1):e941. https://doi.org/10.1002/hpja.941

Pharmaceutical Society of Australia (2023) *Medicine safety: mental health care*, PSA, Canberra.

Roberts R, Wong A, Lawrence D, Lawn S and Johnson C (2024a) *Mortality of people using Australian Government-funded mental health services and prescription medications: analysis of 2016 Census, death registry, MBS and PBS data*. Charles Sturt University, Bathurst. https://www.equallywell.org.au/wp-content/uploads/2025/03/Full-Report-Mortality-of-people-using-Government-funded-mental-health-services-May–2024.pdf

Roberts R, Wong A, Lawrence D, Lawn S and Johnson C (2024b) *Unequally Unwell: Shorter life expectancies, reduced life opportunities. Summary report: Mortality of people using Australian Government-funded mental health treatments. Analysis of 2016 Census, death registry, MBS and PBS data*. Charles Sturt University, Bathurst, ISBN Print – 978-1-86-467451-4 Electronic – 978-1-86- 467452-1. https://doi.org/10.17605/OSF.IO/Q5CXJ

Rosenbaum S, Morell R, Abdel-Baki A, Ahmadpanah M, Anilkumar TV, Baie L, et al. (2020) Assessing physical activity in people with mental illness: 23-country reliability and validity of the simple physical activity questionnaire (SIMPAQ). *BMC Psychiatry,* 20, 108. https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-020–2473-0

Royal Australian College of General Practitioners (RACGP) (2025) *Supporting smoking cessation: a guide for health professionals*, RACGP, East Melbourne. https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/supporting-smoking-cessation

Royal Australian College of General Practitioners (RACGP) (2024) *Supporting smoking cessation for high prevalence groups: a guide for health professionals*, RACGP, East Melbourne. https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/supporting-smoking-cessation/smoking-cessation-for-high-prevalence-groups

Rutter M (2012) Achievements and challenges in the biology of developmental psychopathology. *Development and Psychopathology*, 24(3):883–890. https://doi.org/10.1017/S095457941200049X

SANE Australia (2017) *Cannabis and psychosis*, SANE Australia, Melbourne. https://www.sane.org/information-and-resources/facts-and-guides/cannabis-and-psychotic-illness#factsheet

The Royal Australian and New Zealand College of Psychiatrists (2017) *Physical health clinical guideline*, RANZCP, Melbourne. https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/physical-health

Waterreus AJ and Laugharne JDE (2009) Screening for the metabolic syndrome in patients receiving antipsychotic treatment: a proposed algorithm. *Medical Journal of Australia*, 190:185–189.

World Health Organization (2006) *Defining sexual health: Report of a technical consultation on sexual health*, 28–31 January 2002, WHO, Geneva.

World Health Organization (2024) *Global strategy and action plan on oral health 2023–2030*, WHO, Geneva. https://www.who.int/publications/i/item/9789240090538

Appendix: Examples of assessment tools and guides

Alcohol and Other Drugs Victorian Assessment Tools – intake and assessment tools available: https://www.health.vic.gov.au/aod-treatment-services/intake-process-and-tools

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) – manual for use in primary care (can be adapted for use across mental health services): https://iris.who.int/server/api/core/bitstreams/d38b0238-268a-495f-8139-4b69bb12b7ad/content

Alcohol Use Disorders Identification Test (AUDIT) – simple and effective method of screening for unhealthy alcohol use: https://auditscreen.org/

Antipsychotic Monitoring Tool – suitable for use in metabolic monitoring: https://resources.amh.net.au/public/antipsychotic-monitoring-tool.pdf

Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK): https://www.health.gov.au/resources/apps-and-tools/the-australian-type-2-diabetes-risk-assessment-tool-ausdrisk

Cardiometabolic Health Resource – early intervention framework: https://www.mindgardens.org.au/wp-content/uploads/2023/07/Adult-Positive-Cardiometabolic-Health-Resource-KBIM-Resources–2023.pdf

Cardiovascular Risk Assessment Calculator – use this tool to assess a person's 5-year cardiovascular disease risk: https://www.cvdcheck.org.au/

Falls Risk Assessment Tool: https://www.health.vic.gov.au/publications/falls-risk-assessment-tool-frat

Health Improvement Profile – a one-page form to access a user's physical health needs. Adapted from the UK model to meet Australian public mental health service standards: https://onlinelibrary.wiley.com/doi/abs/10.1111/jpm.12616

Nutrition Screening Assessment – St Andrew's Healthcare Nutrition Screening Instrument (SANSI): https://www.elft.nhs.uk/sites/default/files/2022-12/elft_nutrition_screening_tool.docx

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