Guideline

Physical Health Care for People Living with Mental Health Issues

Summary This Guideline details the role of NSW Health services to meet the physical health needs of people with mental health problems.

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Branch contact (02) 9461 7074

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Distributed to Ministry of Health, Public Health System, Divisions of General Practice, NSW Ambulance Service

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PHYSICAL HEALTH CARE FOR PEOPLE LIVING WITH MENTAL HEALTH ISSUES

GUIDELINE SUMMARY

NSW Health is committed to improving the physical health outcomes and reducing early mortality of people with a lived experience of mental health issues. Local Health Districts (Districts) and Specialty Health Networks (Networks) have a responsibility to provide equitable access to high quality, holistic, person-centred physical health care.

This Guideline builds upon the Fifth National Mental Health and Suicide Prevention Plan and the Equally Well Consensus Statement. It reinforces the expectations of NSW Health and the measures required to deliver a whole of health approach to reduce the physical health inequalities experienced by people with lived experience of mental health issues.

KEY PRINCIPLES

Improving and sustaining the physical health care of people with lived experience is the responsibility of all NSW Health mental health and non-mental health services.

All Services are to review their current policies, procedures and practices against the expectations stated in this Guideline. Local policies and protocols are to be developed to address any identified gaps.

The core expectations of this Guideline are;

- All services in contact with people with lived experience of mental health issues are to offer and support interventions to prevent physical illness and promote and sustain health.
- Mental health services are to complete routine physical health screening as an essential component of care.
- Mental health services are to deliver equitable and timely access to physical health assessment, intervention and review.
- Mental health services are to provide access to equitable, evidence-based interventions that target cardiometabolic and behavioural risk factors.
- Clinicians are to complete routine comprehensive assessment as part of an integrated physical and mental health care plan.
- Clinicians are to support, coordinate and document any additional assessments and/or investigations required.
- Clinicians are to offer routine medication assessment and optimisation to minimise risk and negative medication effects.
- Mental health services are to develop partnerships and pathways with key stakeholders to address identified physical health needs as part of an integrated care plan.

- Clinicians are to use a coordinated team approach to deliver high-quality holistic care.
- District and Networks are to deliver safe and effective physical health assessments, interventions and treatment. These are to support sustained health outcomes and health care experiences that matter to the people who receive them.

REVISION HISTORY

Version	Approved by	Amendment notes
April-2021 GL2021_006	NSW Health, Secretary	Revised to align with contemporary practice and strategic priorities.
GL2017_019	Deputy Secretary, Strategy and Resources	Revised with the involvement of consumers, carers and clinicians with aim to improve clarity in expectations as well as improve consumer focus. Clinical guidance on the physical observation for specific mental health settings has been revised and updated.
GL2009_007	Director-General	New Guidelines

ATTACHMENTS

1. Physical Health Care for People Living with Mental Health Issues: Guideline

Physical health care for people living with mental health issues

A guideline

NSW GOVERNMENT

NSW Ministry of Health
1 Reserve Road
ST LEONARDS NSW 2065
Tel. (02) 9391 9000
Fax. (02) 9391 9101
TTY. (02) 9391 9900
www.health.nsw.gov.au

Produced by: NSW Ministry of Health

The NSW Ministry for Health acknowledges the traditional custodians of the lands across NSW. We acknowledge that we live and work on Aboriginal lands. We pay our respects to Elders past and present and to all Aboriginal people.

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Further copies of this document can be downloaded from the NSW Health webpage
www.health.nsw.gov.au

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A note about language

These guidelines promote and demonstrate a culture of hope and optimism, consistent with the language of recovery. In this guide, the following terms are used to describe people who are currently living with mental health issues and are on their recovery journey;

- *people living with mental health issues* and
- *people with lived experience of mental health issues*

The terms *people with lived experience* and *people* are used as an abbreviation, in preference to consumers, clients or patients.

C*arers and families* is used for brevity and includes all the people who have some role in the support and recovery of a person with lived experience. This includes people with lived experience of caring for, supporting and/or just knowing people with lived experience, as friends, part of a family of origin or a family of choice, a kinship group, or a community.

This guideline acknowledges the contribution of the Lived Experience Framework's [1] use of respectful and inclusive language to describe people living with mental health issues.

Acknowledgements

The collaborators involved in the development of this document acknowledge the people of the many traditional countries and language groups of New South Wales on which health services are delivered. We acknowledge the wisdom of Elders past, present and emerging and pay respects to all Aboriginal communities of today.

We recognise and acknowledge the many people who have personal experience of mental health issues, as well as their carers and families . The contribution of the voices of people with lived experience is essential to delivering better outcomes for all people across New South Wales.

We acknowledge the following people who contributed to the development of this guideline:

Myu Arumuganathan, Ruth Baker, Ashley Brown, A/Prof Jackie Curtis, Andrew Davison, Irene Gallagher, Dr Claire Gaskin, Catherine Goodwin, Kristine Grainger, Hannah Halloran, Jonathan Harms, Joshua Harvey, Deborah Howe, Dr Rebecca Koncz, Peta Lucas, Janice Plain, Dr Kathleen Smith, Carmel Tebbutt, Tania Waitokia and Kerry West.

This document was also circulated for feedback with key stakeholders including; Local Health Districts, Speciality Health Networks, Ministry of Health Agencies, NSW Health Pillars, NSW Health Chief Allied Health Officer, Primary Health Networks, Royal Australian and New Zealand College of Psychiatrists, Royal Australian College of General Practitioners NSW & ACT, Nursing and Midwifery Office, Centre for Aboriginal Health, Mental Health Carers NSW (ARAFMI), BEING, Mental Health Coordinating Council, InsideOut Institute, Transcultural Mental Health Centre and Mental Health Consumer, Carer and Community Committee.

Message from the Minister

It is imperative that people living with mental health issues enjoy the same rights, opportunities and good physical health as the general population. However, when compared with the greater NSW community, people with mental health issues face poorer health outcomes, shorter lifespans and encounter stigma and discrimination more frequently.

The guideline reflects and supports equity of health care, with an emphasis on effective health promotion, routine screening and assessment, early intervention and timely access to evidence-based interventions.

While NSW Health already prioritises actions and initiatives that respond to and address the gaps in physical health care delivery, I believe this guideline will further drive sustainable and meaningful physical health outcomes for people living with mental health issues.

Hon. Bronwyn Taylor
Minister for Mental Health

Message from the Secretary

I am pleased to introduce *The Physical Health Care for People Living with Mental Health Issues* Guideline for NSW Health services. It builds upon the Fifth National Mental Health and Suicide Prevention Plan and the Equally Well Consensus Statement. It provides an important framework for actions that will improve physical health outcomes and reduce early mortality for people living with mental health issues in NSW.

At our core, NSW Health strives to deliver value-based healthcare, which means delivering outcomes that matter to patients, while ensuring positive experiences for those receiving or providing care. Value-based healthcare encourages broad collaboration and offers strong benefits in both service delivery and health care.

This guideline is built on the principles of person-centred, recovery-oriented and collaborative care. The actions outlined within, aim to support people living with mental health issues to lead physically healthy lives while contributing positively to their communities.

Elizabeth Koff
Secretary, NSW Health

Purpose of this guideline

NSW Health is committed to improving the physical health of all people with a lived experience of mental health issues. A value-based health care service ensures safe and effective treatments by delivering outcomes and experiences that matter to the people who receive them.

Local Health Districts (districts) and Specialty Health Networks (networks) have a responsibility to provide equitable access to high-quality, holistic, person-centred physical health care.[2-4] Districts and networks can support people with lived experience to achieve positive health outcomes by addressing physical health risks and conditions, and supporting health promotion and prevention.

This guideline:

- outlines the measures that NSW Health will take to improve physical health,
- clarifies expectations of districts and networks to provide physical health care for people living with mental health issues,
- provides service managers and clinicians in districts and networks with actions to meet the requirements
- is supported by resources and tools for implementation, at www.health.nsw.gov.au/mentalhealth/professionals/pages/resources.aspx.

The five sections of this guideline can be read together or independently. Service and unit managers and clinicians are expected to refer to this document as they focus on areas for improvement. While defining actions for improvement, this guide provides districts and networks the flexibility to implement measures according to the local population and context.

People at risk of acute illness

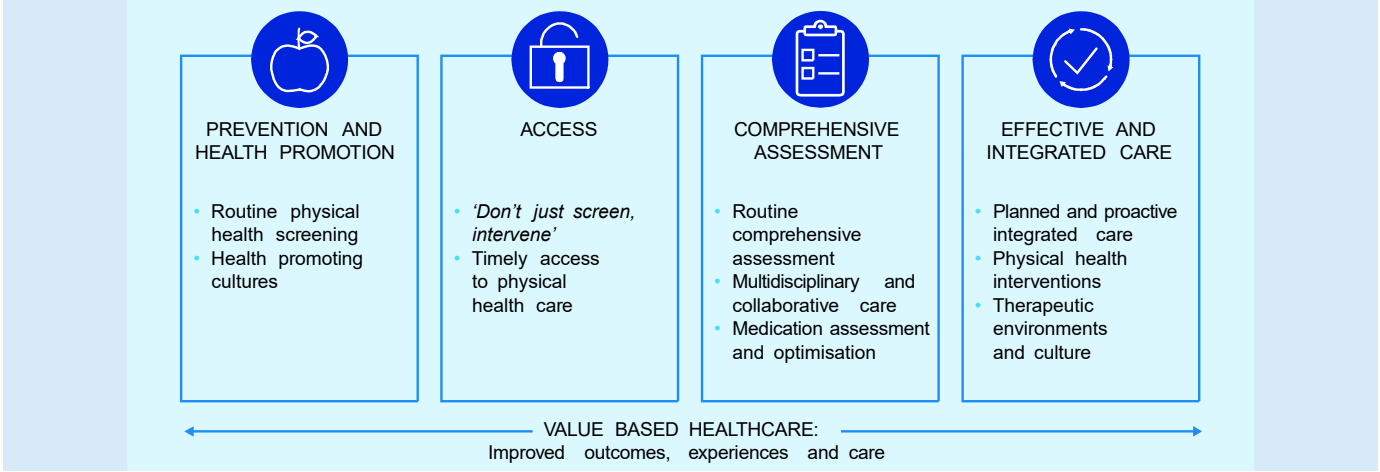
The *Physical Health Care for People Living with Mental Health Issues* guideline does not address the specific needs of people who present as medically unstable or with deteriorating health. For example; people with eating disorders can be at high risk of medical complications and may present in more acute and urgent stages of physical ill-health.

It is also important to ensure adequate screening and investigation for people living with mental health issues who require acute sedation. In these cases, it is important to follow local policies, procedures and guidelines. Clinicians may be required to order or perform additional actions or investigations (such as baseline ECG) in order to appropriately manage the concern.

People who present with eating disorders may also present with cognitive impairment, psychiatric conditions, suicidal ideation and/or deliberate self-harm5,6. Guidelines outlining best practice assessment and treatment of eating disorders in NSW include:

- NSW Eating Disorders Toolkit [5]
- Guidelines for the Inpatient Management of Adult Eating Disorders in General Medical and Psychiatric Settings in NSW [7]
- Guidelines for the Development of a Service Plan for Eating Disorders within Your Local Health District [8]
- NSW Service Plan for People with Eating Disorders 2021-2025 [9]

Figure 1. NSW Health actions to improve physical health for people living with mental health issues



Introduction

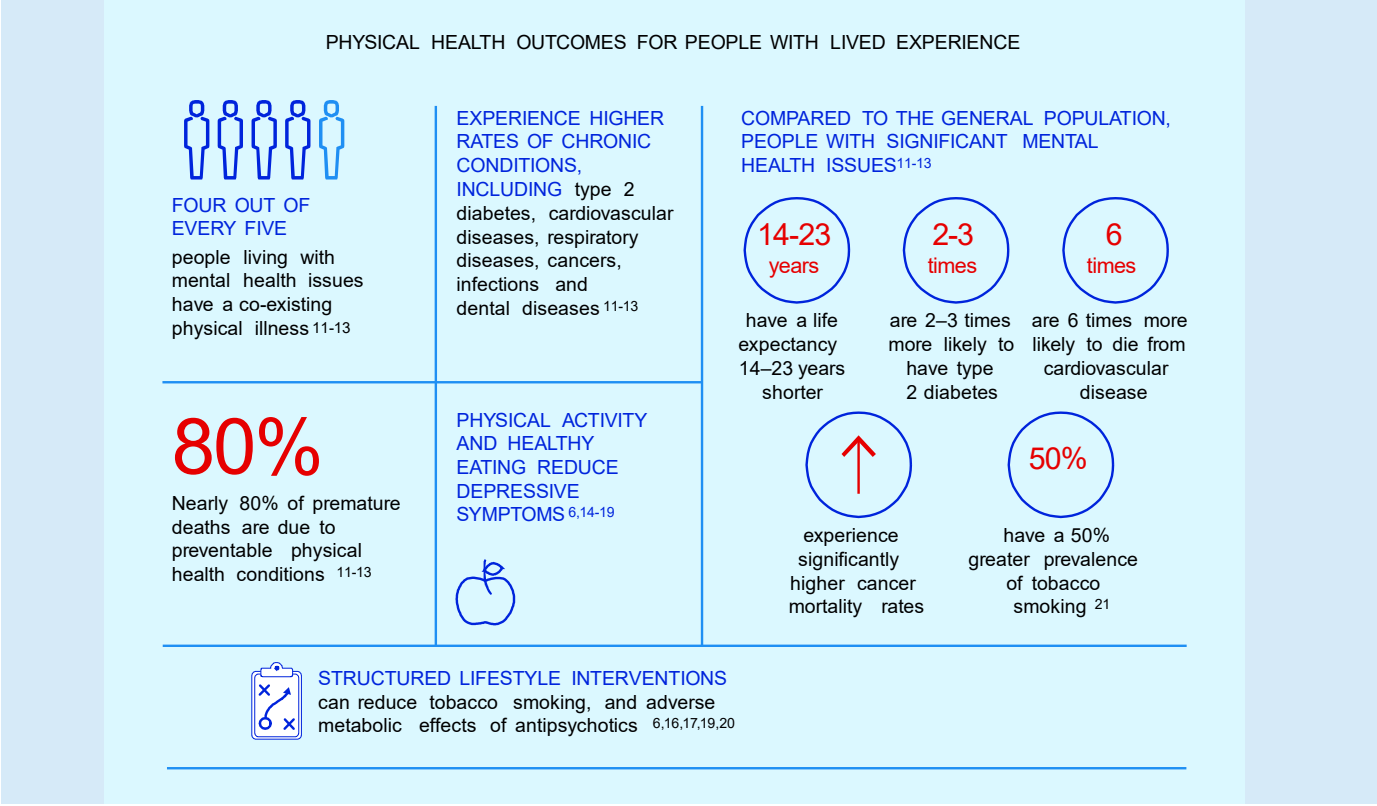
People living with mental health issues will be supported to lead active and contributing lives. [10-12]

People with lived experience of mental health issues should enjoy the same rights, opportunities and health as the general population. However, when compared with the rest of the NSW community, people living with mental health issues face poorer physical health outcomes, shorter lifespans and more frequent experiences of stigma and discrimination. For people with lived experience, leading an active and contributing life may require support and partnership from carers and families, and services.

In July 2017, the National Mental Health Commission released the *Equally Well* national consensus statement. [11] *Equally Well* called for a national commitment to improve the physical health of people with lived experience, and to minimise the gap between their health outcomes and life expectancy and those of the rest of the population.

Districts and networks have a responsibility to work alongside people with lived experience of mental health issues to improve their physical health outcomes and quality of life.

Figure 2. People with lived experience of mental health issues



Considerations for specific populations

Some populations in NSW experience discrimination, stigma and disadvantage; these groups also experience mental health issues at higher rates than the general population. People in these groups may also find it challenging to access health care, and may experience more significant physical health impacts associated with mental health issues.

Examples of specific populations which should be considered as part of service planning include people who are:

- Aboriginal
- child and adolescents
- older persons
- presenting to mental health services for the first time
- from culturally and linguistically diverse backgrounds
- part of the lesbian, gay, bisexual, transgender, queer, intersex, asexual, and/or related (LGBTQIA+) communities
- in rural and remote areas
- experiencing early psychosis
- in the criminal justice system
- experiencing housing instability or homelessness
- living with intellectual disability and/or other disability.

NSW Health is committed to addressing disadvantage and to improving the experience of care and health outcomes for people who are also in these populations. Districts and networks should ensure that services and programs are tailored to meet the needs of people in these groups.

Culturally safe environments

Cultural safety sits on a continuum from cultural awareness to cultural sensitivity, cultural competency and cultural safety. Cultural safety requires health care organisations to inspect their practices and practitioners to reflect on their own cultural identity and the impact this has on their practice. [23] Culturally safe environments are achieved when service users deem a service to be safe. To have a positive impact on health outcomes and life expectancy for people with lived experience, services are to facilitate treatment that is both early and culturally appropriate. [24]

The principles and approaches that underpin good mental health service provision in NSW can be translated to physical health care. Systems and services require approaches that are person centered, person-directed, trauma informed and recovery oriented.

A recovery oriented approach recognises the inherent value of lived experience and that every recovery journey is unique. Recovery oriented principles are embedded in the policies and standards across NSW mental health services. [4]

Clinicians can provide recovery-oriented physical health care by supporting individuals to define and progress towards their physical health goals, while taking into account their personal values, preferences and desires. [12]

Trauma informed care is when all aspects of a service acknowledge the prevalence of trauma throughout society, and in particular for people who access mental health services. It incorporates principles of safety, choice, collaboration, trust and empowerment. [22]

Clinicians deliver trauma informed care with an awareness and consideration of the dynamics of trauma and how it effects an individual's life, health and engagement with services.

1. Prevention and health promotion

People with lived experience must be supported to nurture their health and prevent illness.

All district and network services that have contact with people with lived experience of mental health issues will play an active role in preventing illness and promoting a healthy lifestyle.

A range of individual health-related factors, daily living conditions and the broader environment or context in which people live influence health. [25] Social determinants of health (e.g. social history, housing, poverty, biopsychosocial risks, isolation, exclusion and stigma, employment and education, access to appropriate and affordable primary health care) can significantly impact on mental and physical health. [12,26,27] Clinicians should be aware of the impact of social determinants on the ability of people to take steps to improve their health. A coordinated team approach can help to support people with lived experience to access physical health care and health-promoting services. Effective promotion, prevention and early intervention activities help to prevent the onset or development of illness, lower disease severity or duration and reduce its impact. [11.]

District and network services will also provide routine and opportunistic physical health screening and treatment. Services will empower and support people to make informed choices, to address their modifiable health risk factors and advocate for their own health.

Routine physical health screening

Physical health screening for prevention and health promotion focuses on screening for cardiometabolic risk, in order to actively reduce risk, prevent illness and promote health. It aims to identify people at risk of negative physical health outcomes, identify if further assessment is warranted, and support care plan development. [28]

Physical health screening is an essential component of care across all inpatient and community care settings as soon as is feasible;

- within 24 hours of admission to acute services
- within 1 month of admission to community care

If a person is too distressed, is unable to participate, or refuses physical assessment, this should be documented in the health record and the assessment completed at the next earliest opportunity. Community mental health services should collaborate with primary care to complete physical health screening. Physical health screening involves the person with lived experience where possible and will include the following (see Table 1). [29]

Table 1. Minimum standards for physical health screening

		Inpatient care	Community care	Notes for specific populations and settings
Cardiometabolic screening	Lifestyle factors			
	Smoking	✓	✓	Within 24 hours in acute services
	Healthy eating / malnutrition / hydration	✓	✓	Within 1 month of admission to community care Review as part of metabolic monitoring
	Physical activity	✓	✓	
	Weight / abdominal obesity			
	Weight and height, body mass index [30]	✓	✓	Within 24 hours in acute services, then weekly Within 1 month of admission to community care, then monthly
	Waist circumference	✓	✓	Once stable, review as part of metabolic monitoring
	Blood pressure		✓	Within 24 hours in acute services Within 1 month of admission to community care Review as part of metabolic monitoring
	Glucose regulation			
	FPG – fasting plasma glucose or	✓	Community services collaborate with general practice or ACCHS*	Within 24 hours in acute services
	RPG – random plasma glucose	✓		Within 1 month of admission to community care Review 3 to 6-monthly for people on antipsychotics and 6-mon for >65 yo or Aboriginal people >30 yo
	HbA1c – haemoglobin A1c	✓		Complete if a person has confirmed diabetes and testing not completed within the last 3 months. If a person does not have confirmed diabetes diagnosis, complete once per year only.
	Fasting blood lipids			
	Total cholesterol	✓	Community services collaborate with general practice or ACCHS	Within 24 hours in acute services
	LDL – low density lipoprotein	✓		Within 1 month of admission to community care
	HDL – high density lipoprotein	✓		Review 6-monthly for people on antipsychotics or >65 yo or Aboriginal people >30 yo [26]
	Triglycerides	✓		
Polypharmacy		✓	✓	Within 24 hours in acute services Within 1 month of admission to community care
Substance use		✓	✓	Within 24 hours in acute services Within 1 month admission to community care
Blood borne viruses (Hep C, HIV, Hep B)		✓	Community services collaborate with general practice or ACCHS	Within 24 hours in acute services Within 1 month of admission to community care Review 6- to 12-monthly for people who use intravenous drugs
Oral health		✓	✓	Within 24 hours in acute services Within 1 month of admission to community care
Sleep (obstructive sleep apnoea and hypopnea)		✓	✓	12-monthly for people on antipsychotics and for people with BMI>25kg/m [2]
Falls		✓	✓	Within 24 hours in acute services Within 1 month of admission to community care

This table outlines minimum expectations. Where possible, monitoring should occur at baseline (prior to medication initiation). Frequency of review is dependent on abnormalities identified and/or changes to medication. Clinicians should consider pathology currency to avoid unnecessary testing. Screening and outcomes are to be recorded using the NSW Health Mental Health Clinical Documentation Guidelines (GL2014_002) [41] *ACCHS – Aboriginal Community Controlled Health Service

Clinicians are to discuss screening with the person with lived experience to support informed choice and self-determination. Once the screening is complete, clinicians can then collaborate with the individual to identify health priorities, discuss the risks and benefits of various treatment options (e.g. medication, evidence-based lifestyle intervention) and decide on appropriate referral pathways (e.g. GP, specialist medical and allied health services). Where appropriate, the clinician can provide brief intervention within their scope of practice.

Screening and agreed interventions should include critical people who will support the individual to enact the plan (e.g. carers and families, GP and community providers).

As part of physical health screening, practitioners may identify that the person has also experienced intimate partner violence, family violence, sexual abuse or trauma. In this instance, care will require particular sensitivity and support. Services should respond in line with current NSW Health policy. [27]

Physical health screening must:

- be a standard component of integrated physical and mental health care
- be simple to implement
- identify health risk factors and highlight opportunities for change
- trigger follow-up assessment, referrals and support as appropriate
- provide an early opportunity to intervene and improve physical health outcomes. [6,11,29]

ACTION AREAS

Routine physical health screening

- Embed policies and processes for routine and opportunistic physical health screening of people with lived experience, across whole of health care.
- Identify and implement a screening tool that includes flags for referral to appropriate medical and allied health services.
- Ensure staff are trained to conduct and interpret physical health screening.
- Routinely screen people prescribed antipsychotic medications (particularly Clozapine and Olanzapine) for cardiometabolic risk factors (including diet and physical activity) for early detection and intervention. People on antipsychotics require a comprehensive assessment at 3-monthly intervals for the first 12 months and every 6 months thereafter.
- Proactively link people with primary care services (e.g. GP) and develop models of shared care
- Work collaboratively with general practice (with consent) to share information, develop goals of care and provide multidisciplinary team support for the person with lived experience.
- Provide information, education and ongoing review to those who screen as low risk to encourage maintenance of good health.
- Refer people who are identified as at risk for assessment and physical health interventions.
- Implement processes for regular multidisciplinary review or recall (minimum 3-monthly) to monitor health, facilitate access to treatment and prevent deterioration. This may involve shared care with primary care services where appropriate.

Health-promoting interventions promote positive physical health outcomes

- Empower people with lived experience to actively engage in choice and decision-making to select priority goals and referrals to other services (e.g. implement the 5A's behaviour change model).
- Monitor and manage lifestyle interventions (e.g. healthy food and drink, physical activity), in line with current evidence-based guidelines.
- Ensure inpatient and residential services include physical activity programs and facilities.
- Provide opportunities for physical activity in inpatient units and access to evidence-based interventions (e.g. exercise physiologists, physiotherapists).
- Promote physical activity by implementing local partnerships and agreements that link people in the community with local service providers (e.g. walking programs, gyms, sport and recreation facilities and groups) and evidence-based lifestyle interventions (e.g. Get Healthy NSW, allied health referral).

- Support healthy eating and hydration in inpatient and residential settings by ensuring access to evidence-based interventions (e.g. dietitians, speech pathologists) and healthy food options. [31]
- Promote healthy eating and hydration by referring to dietetic services, promoting local food access and food security programs, supporting access to group education programs, and providing emotional and psychological support to improve health behaviours.
- Promote healthy weight and body image by discussing potential medication effects, providing healthy lifestyle support (e.g. Get Healthy NSW, referral to dietetic and exercise physiology services) and managing weight-specific negative effects of medication.
- Engage young people, or people experiencing first episode psychosis, in prevention and early intervention activities by identifying age-appropriate services, discussing potential medication effects, encouraging a reduction in substance misuse and promoting risk reduction practices to prevent transmission of sexually transmissible infections (STI) and blood borne viruses.
- Support engagement in preventative and early detection activities, such as; sexual safety (contraception, STI), UV/sun safety, national cancer screening programs (melanoma, cervical, bowel, breast, prostate), and immunisation programs (flu, cervical and hepatitis).
- Provide referral pathways and education for oral health promotion, prevention and treatment services.
- Reduce smoking rates through brief interventions, primary care (including ACCHSs), tailored evidence based support (e.g. tobacco cessation specialist, Quitline, pharmacotherapy) and advice from community or hospital pharmacist.
- Promote substance harm minimisation through brief interventions, primary care and referral to drug and alcohol programs, and dual diagnosis services.
- Reduce polypharmacy and negative medication effects by systematically requesting a medication assessment and review in conjunction with prescribing physician, nursing staff and pharmacy. [32]
- Refer people to relevant services (e.g. housing) where social determinants impact on their physical and mental health.
- Ensure a variety of referral pathways, resources and programs that are suitable to meet the needs of all specific populations.
- Actively advocate for and support co-designed, co-produced and co-led health-promoting education/ services.

Services reinforce a health-promoting culture through policy and procedure

- Support and create a health-promoting environment that enhances physical health for staff (e.g. healthy workplace policies, [33] supporting healthy eating and physical activity).
- Empower staff and people with lived experience to actively contribute and guide decision-making about services by incorporating co-design principles as part of service development and quality improvement practices.
- Support services to embed practices of health promotion and disease prevention with early detection of risk factors and symptoms.
- Invest in staff training to upskill workforce to implement techniques which support good health (e.g. brief interventions, motivational interviewing, cultural safety, physical health screening, teach-back, stages of change models).
- Model healthy behaviours (e.g. by implementing smoke-free campuses, promoting healthy food and drinks, improving healthy food and drink options in vending machines, choosing appropriate social activities and offering positive reinforcement of behaviour change). [34]

2. Access and intervention

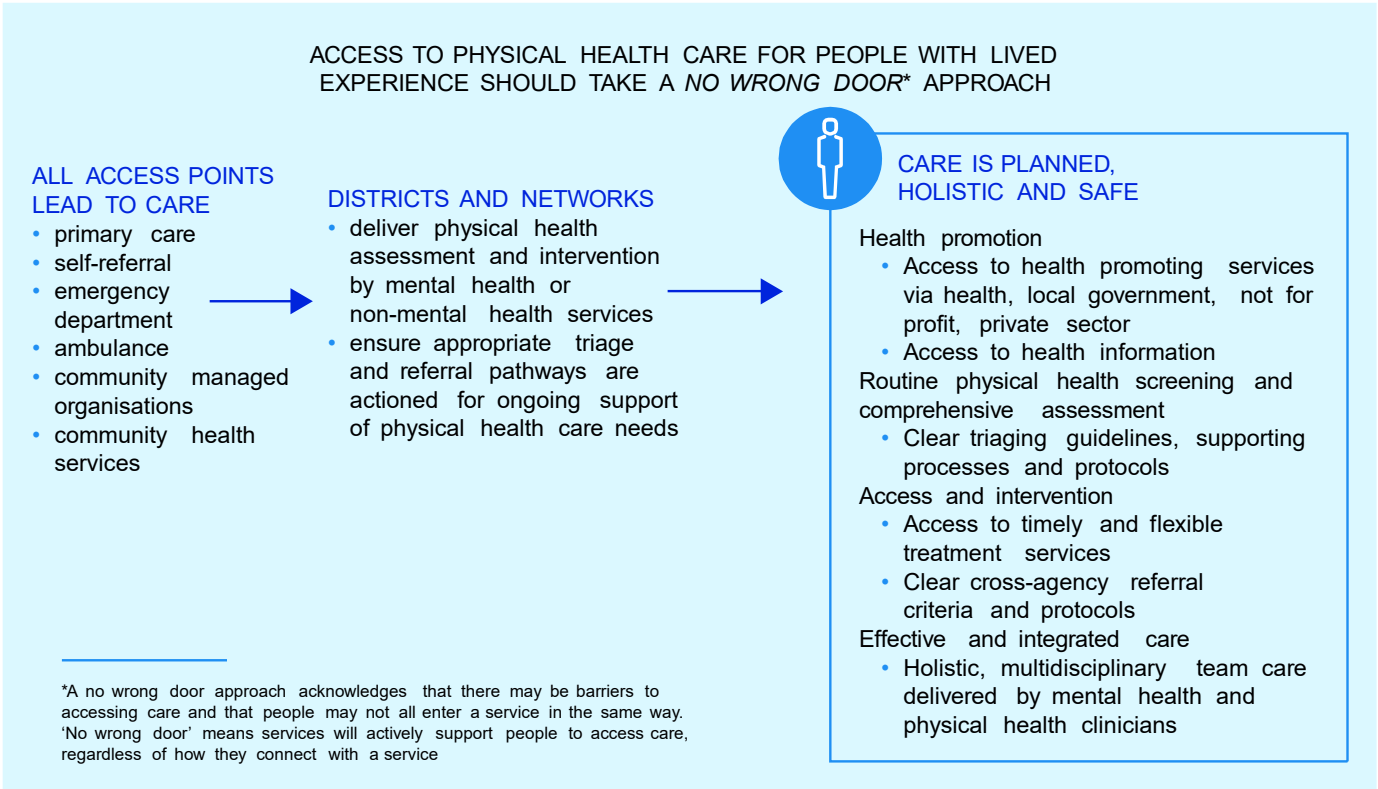
Districts and networks will ensure equitable and timely access to physical health care for people with lived experience of mental health issues.

People with lived experience receive fewer interventions for physical health needs than the general population. Health services and staff may misinterpret physical symptoms as part of the person's mental illness and hence focus on crisis management. [35]. Services are to use a range of strategies to identify and treat physical health needs early, and support people to self-manage physical health risks and behaviours.

Local referral pathways and networks are required for appropriate assessment, management and treatment of physical health. Services should include GP, medical specialists (endocrinologists, cardiologists, psychiatrists), nurses, diabetes educators, dentists, allied health professionals (dietitians, exercise physiologists, occupational therapists, pharmacists, physiotherapists, podiatrists, speech pathologists), dual diagnosis services, and mental health professionals.

Flexible service delivery options support a person with lived experience to engage with physical health care services at the right time. Home visiting, co-located, virtual and telehealth services for physical health interventions may also support improved access.

Figure 3. Access to physical care



"Don't just screen: intervene"

Physical health screening is a form of secondary prevention and supports risk management, illness prevention, health promotion and treatment. However, screening alone is not sufficient to improve physical health outcomes and reduce excess mortalities. [36] All cardiometabolic and behavioural risk factors identified through screening should be treated; intervention can lead to significant improvements in physical and mental health outcomes. [15] The Positive Cardiometabolic Health algorithm [37] provides a model for screening, further assessment and offers first-line intervention pathways for people with lived experience.

Districts and networks should develop treatment pathways for specialist medical and allied health services. Collaboration at a local level between health, primary health networks, local government, non-profit and private sector organisations will also improve access to local health services. People with lived experience of complex mental health issues may require more supports (e.g. care coordinator, peer worker) to remove barriers to engagement and to enable participation in a health-promoting program. Health-promoting services must also be acceptable, appropriate, accessible and available to the person with lived experience.

Figure 4. Evidence-based interventions

Interventions that promote physical health and prevent illness include: [36]

- tobacco smoking
- sedentary behaviour
- substance misuse
- nutrient poor food choices
- polypharmacy and medication side effects
- risky sexual behaviour

- nutrition and healthy eating
- physical activity
- sexual health
- dental and oral health

Timely access to treatment

Timely (early and appropriate) access to care is facilitated by:

- early and routine screening processes
- comprehensive assessment
- timely and well-planned referrals.

For people experiencing psychosis, antipsychotics:

- are the most effective evidence-based treatments for stabilising mental health
- may cause negative medication effects that can significantly impact on physical health.

Prescribers will:

- discuss effects and potential cardiometabolic risks with all people who begin treatment with antipsychotic medications (in particular for Clozapine and Olanzapine), and strategies to mitigate these
- enable active choice-making by providing information about alternative medications, where available
- discuss negative medication effects on health behaviours (e.g. increased appetite, increased thirst, sedation).
- provide referral to specialist medical and allied health services for ongoing treatment that can support the management of any negative effects and improve physical health outcomes.

Clozapine initiation, monitoring, management and cessation requires particular rigour and extra precautions due to cardiometabolic effects. [38,39]

ACTION AREAS

Timely access to appropriate, well-planned, and coordinated treatment

- Include people with lived experience in all stages of care to encourage active engagement and ownership.
- Empower consumers, carers and families and staff to manage their own physical and mental health by addressing gaps in health literacy.
- Establish agreements on service criteria and priorities, referral, communication and care planning processed and tools within districts and networks, external organisations and partners.
- Develop a local 'map' of physical health services and referral pathways (e.g specialist medical and allied health) to support and enhance physical health. Consider district and network services, NDIS service providers and Chronic Disease Management Plan under Medicare Benefits Schedule (requires GP referral).
- Identify and address gaps in physical health care services for people with lived experience with local services, implement local processes for information-sharing and communicating with general practice.
- Partner/liaise with local community-based resources (e.g. leisure centres, food access programs) to enable people to access health-promoting services and activities in their local community.
- Regularly monitor and evaluate access to, and experiences and outcomes of, care.
- Promote access to developmentally appropriate and accessible self-help and digital interventions (e.g. Head to Health, Get Healthy NSW).
- Support engagement in practices that lead to improved outcomes (e.g. the diabetes annual cycle of care).
- Link Aboriginal people to their local ACCHS or Aboriginal Primary Health Care. Partner with ACCHSs and Aboriginal communities to plan, design, resource and deliver mental health services, with a focus on prevention and early intervention.
- Link people with preferred, culturally appropriate and sensitive providers (e.g multicultural, refugee and asylum seeker health services). Partner with multicultural health services and culturally and linguistically diverse communities to plan, design, resource and deliver mental health services, with a focus on prevention and early intervention.
- Refer people who identify as sexually diverse to LGBTQIA+ health services and/or services that deliver LGBTQIA+ inclusive practice. Partner with LGBTQIA+ health services and LGBTQIA+ communities to plan, design, resource and deliver mental health services, with a focus on prevention and early intervention.
- Monitor progress toward providing culturally safe environments, in partnership with people with lived experience and their carers and families. [40]
- Ensure appropriate access to interpreter services.

3. Comprehensive assessment

Comprehensive assessment is a routine component of care, regardless of the service's point of entry. Comprehensive assessment forms an essential part of an integrated physical and mental health plan and is to be completed and documented in a timely manner.

Comprehensive assessment provides an opportunity to:

- explore and discuss health risks and or/ conditions identified through screening process
- identify and diagnose mental and physical health conditions
- identify additional physical health risk factors
- identify developing and existing medical conditions
- seek input from the broader multidisciplinary team with regards to assessment and treatment planning
- order or coordinate and document further investigations
- work in partnership to offer options, treatments and referrals for physical health treatments.

In inpatient settings, comprehensive assessment should be completed and documented on the admission of a person with lived experience. In community care settings, assessments should be completed and documented as soon as possible after admission.

If a person is too distressed, is unable to participate, or refuses physical assessment, this should be documented in the health record and the assessment completed at the earliest opportunity.

Comprehensive assessment is a standard component of care

Districts and networks are responsible for ensuring all people with lived experience have a current comprehensive assessment that is documented in the health record. [2,41] Annual reviews should be conducted, unless there is indication for earlier review in line with current guidelines (e.g. in the presence of developing or existing medical conditions, or in the case of deteriorating health). Comprehensive assessments require awareness of, and provision of, culturally responsive and trauma-informed care. [42]

Comprehensive, multidisciplinary assessment includes:

- collecting relevant personal history, as it relates to mental and physical health (including substance use, sexual and/or reproductive health, oral health, sleep hygiene), current and previous medical history (including blood borne viruses), family health history, social history, personal supports and support services (including GP, NDIS, NGO's)
- observations (blood pressure, pulse, respiratory rate)
- physical health screen (including cardiometabolic risk, if not already done in the relevant time frame) and national population based screening activities (including early detection and prevention cancer and immunisation programs)
- physical examination (including but not limited to respiratory, cardiovascular, gastrointestinal and neurological systems)
- identifying strengths (physical, cognitive, social, psychological)
- assessing liver function, renal function and vitamin D, B12 and folate status
- assessing medications and medication effects
- identifying health risks (including underweight/ malnutrition) and developing or existing medical conditions
- psychological assessment.

Assessments of older people (>65 yo) with lived experience must also:

- include a falls risk assessment
- consider delirium in new presentations and relapse of established illness
- consider frailty, polypharmacy, continence, constipation, UTIs, cognition, skin status and dysphagia
- consider the possibility of elder abuse and/or financial abuse from family member/s or close supporters.

Assessments of Aboriginal people must also;

- take into consideration specific historical, cultural, spiritual and social issues
- consider the increased risk profile of individuals at younger age (e.g delirium screening for Aboriginal people over 45 years [43])
- focus on primary health care; including prevention strategies
- incorporate recommendations, targets and services specific to Aboriginal communities.

Optimise psychiatric medications

Psychiatric medications can have a significant and negative impact on physical health, resulting in additional health issues, disability and reduced life expectancy. [12] Clinicians are to:

- identify current medications
- highlight medication effects and polypharmacy (polypharmacy triggers a medication review)
- implement strategies to minimise risks and negative medication effects

ACTION AREAS

Comprehensive assessment is part of routine care

- Develop clear responsibilities for undertaking comprehensive assessments, dependent on local staffing arrangements and scope of practice.
- Develop protocols, procedures and tools to implement and record physical health assessments.
- Assess at admission (or at the earliest opportunity if the person is unable to give consent or declines).
- Ensure screening tools link to relevant assessments and interventions for managing identified risk
- Collaborate with general practice, with consent of the person with lived experience.
- Support access to multidisciplinary assessments (e.g. dietitians, exercise physiologists as appropriate).
- Implement processes for regular multidisciplinary review or recall
- Document findings in the health record in a timely manner. [44]

Medication assessment and optimisation [32]

- Develop and follow clear protocols for review of medicines. Inpatient prescribing should be monitored and reviewed in morbidity and mortality meetings.
- Complete and document a baseline comprehensive assessment before commencing anti-psychotic medication.
- Inform people on antipsychotics of potential negative effects associated with proposed or current medications including providing written education materials in plain language.
- Work with people living with mental health issues to identify, monitor and manage their psychotropic medications (antidepressants, anxiolytics, mood stabilisers/anticonvulsants, antipsychotics) and potential medication effects.
- Engage the multidisciplinary team to support evidence-based strategies to minimise negative medication effects and promote physical health. This team approach may include nurses, pharmacists, physicians, psychiatrists, dietitians, exercise physiologists, nurse practitioners and peer workers.
- Review antipsychotic medications that may contribute to cardiometabolic risk (consider ethnicity and family history). Modify as necessary (e.g. reducing the dosage, changing medications or introducing pharmacological agents to control negative medication effects [6]).

4. Effective and integrated care

Identified physical health needs are addressed in partnership with the person with lived experience across population health, primary care, acute, non-acute and community services.

The Strategic Framework for Integrating Care outlines NSW's vision, approach and anticipated outcomes of integration across the continuum of care.[45] General practice is often the primary point of contact for people with lived experience in the community. This is particularly true for people in rural, remote and regional areas.

Providing integrated, high-quality physical care for people with lived experience:

- improves their quality of life
- improves their ability to engage in effective self-management
- improves symptoms and experiences of health
- reduces hospital admissions
- reduces costs to the health system. [46]

High-quality holistic care for people living with mental health issues requires a coordinated team approach, often across discipline, specialty, service, organisation and sectoral boundaries.

> "A first step in reducing physical health disparities for people with mental illness is the adoption, translation and routine provision of evidence-based lifestyle interventions as a standard component of mental health care. [6]"
>
> Firth J et al., 2019

Physical health needs are addressed as a priority

Services are to address physical health needs, developing and existing disease, and medication efficacy by working in partnership with consumers, carers and families to prioritise, plan and take action to improve health.[47]

People with lived experience should have access to multidisciplinary team care to address their physical health needs. Evidence supports interventions that actively target modifiable health risk factors (e.g. healthy eating and physical activity, diabetes prevention and control, cardiometabolic-related morbidity). [6] Strengths-based approaches empower people with lived experience to plan their goals collaboratively with their service providers, carers and families. Making explicit links between physical and mental health can support people to engage in active decision-making and to prioritise, plan and act on their physical health goals. An integrated physical and mental health care plan is essential to reinforcing the commitment to physical health care and supports the regular review and progression of goals and actions.

When a person with lived experience is issued with an involuntary treatment order this poses a potential challenge in terms of balancing the personal rights, the need to reduce harm to self and others, and the need for treatment. [48] Involuntary treatment should aim to restore a person's decision-making capacity. [48,49]

Care navigation may also be challenging for people with lived experience of mental health issues. Districts and networks should ensure that people with lived experience are referred to, and are supported to access, necessary treatments.

ACTION AREAS

Physical health interventions

- Encourage full involvement and consent of the person in the creation of their care plan, to empower the person to self-advocate, to increase their confidence and ultimately to achieve self-determination and self-management.
- Ensure physical health interventions are based on currently available evidence (refer to *Prevention and Health Promotion*)
- Ensure medical interventions treat prevalent physical health issues (e.g. metabolic disorders, hypertension, cardiovascular and respiratory disease, dental disease, infection, health risk factors).
- Deliver medical, allied health and pharmaceutical interventions based on best available evidence.

Inpatient and residential therapeutic environments

- Offer a purposeful and predictable therapeutic program delivered by a multi-disciplinary team on an extended-hours basis[51].
- Identify any acute or chronic physical health concerns and refer to appropriate medical or allied health service
- Provide opportunities to maintain and increase mobility, physical activity and function.
- Encourage activities and recreational choices that are engaging and varied, and suit the interests of people with lived experience.
- Provide opportunities to stay connected to their support network.
- Provide appealing and healthy, culturally appropriate food choices to maintain and improve nutrition. [31]
- Support NSW health promotion policies such as; Healthy Choices in Health Facilities (to reduce consumption of sugar sweetened beverages) and Smoke-free Health Care (supporting provision of Nicotine Replacement Therapy).
- Assist and supervise mealtimes (e.g. modified diets and fluids if required to reduce choking risk).
- Educate about oral hygiene and equipment.
- Assist with enhancing physical health literacy.

Planned and proactive integrated care

- Actively support people with lived experience to identify and reduce physical health risk (refer to *Prevention and Health Promotion*).
- Ensure all staff are trained in delivering physical health screening and assessment
- Develop care teams and referral pathways to provide physical health services.
- Work collaboratively with general practice (with consent) to share information, develop goals of care and provide multidisciplinary team support for the person with lived experience.
- Provide timely access to appropriate physical health services (refer to *Physical Health Interventions*).
- Ensure effective care coordination through the use of tools for referral, goal-setting, communication, transfers of care, discharge and follow-up.
- Integrate physical and mental health plans and include physical health information in discharge summaries from mental health services.
- Support people living with mental health issues to access care by removing barriers to participation, providing flexible service delivery models (e.g. telehealth) and providing follow-up and care coordination support as required.
- Ensure that people with lived experience have access to care navigation support, Aboriginal health and Aboriginal mental health clinicians, care coordinators, cultural workers and peer workers to support engagement in care.
- Implement local systems, structures and processes that support the recognition, response and appropriate management of the physiological and mental state deterioration of patients. [50]

5. Value-based care: improving value, quality and monitoring progress

Value-based health care ensures safe and effective treatments, by delivering outcomes and experiences that matter to the people who receive them.

In NSW, value-based health care means continually striving to deliver health care that improves:

- health outcomes that matter to patients
- experiences of receiving care
- experiences of providing care
- effectiveness and efficiency of care

This requires services to collect and evaluate the outcomes and experiences of all people receiving care and use this information to make decisions about services and practices. Principles and values of collaboration and co-design should be embedded in all interventions.

Services should embed measures of processes, outcomes and experiences of care to determine if proactive interventions are having an impact on patient safety and quality. [3] Services also need to ensure that they meet the expectations and experiences of the individual receiving care. [52] Patient Reported Measures (PRMs) and Clinician Rated Measures should be incorporated as meaningful, practical and patient-centred metrics that capture outcomes and experiences of care. Measuring, collecting, analysing and reporting on experience and outcome data will be a part of quality improvement processes and systems that actively involve people with lived experience.

Building a system prepared for measuring environments, processes, outcomes and experiences of care [53] requires:

- acceptable tools, quality measures, protocols, governance structures and infrastructure to collect, analyse and report information
- a workforce with the skills and capabilities to implement and make meaningful conclusions from data
- a culture and systems that support quality improvement
- strong relationships with people with lived experience, their carers and families to collaborate to improve service quality.

Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) are used to help services understand what matters most to people who experience health care. Services should use individual level measures (such as those listed below) to inform and facilitate change at a service and organisational level.

- Mental Health Outcomes and Assessment Tools (MH-OAT) Data Collection Tools
- Your Experience of Service (YES) survey, eYES
- Physical and mental health outcome measures (e.g. HONOS)
- Person reported experience and outcome measures (PREMS and PROMS)
- Mental health literacy and self-efficacy scales

ACTION AREAS

Services monitor progress and identify opportunities for further improvement

- Include people with lived experience on leadership and governance committees, to support safe, transparent and high-quality care.
- Co-design services with people with lived experience (refer to *Prevention and Health Promotion*).
- Proactively obtain and analyse data to improve services and quality of care.
- Partner with other organisations to explore innovative models and approaches to care, improve efficiencies and improve experiences and physical health outcomes for people with lived experience.

Reducing inequities

- Co-design with people with lived experience, their carers and families, and people from specific populations to identify, address and evaluate the factors and strategies that impact on service access and equity.
- Work in partnership with Aboriginal people with lived experience to co-design service models that use Aboriginal health workforces to engage people using the service, across the system.
- Develop strong partnerships with ACCHSs, multicultural, refugee and justice health services and other organisations associated with specific populations.

Workforce has the relevant skills, knowledge and experience to deliver high-quality care

- Invest in training and research to support health and partner organisations to provide appropriate physical health screening, assessment and intervention to priority populations (e.g. cultural safety training, motivational interviewing, physical health screening, trauma-informed care).
- Ensure partner organisations examine opportunities for resource-sharing and creative models or approaches to care that build continuity of care and improved physical health care for people with lived experience.
- Co-design physical health care with people with lived experience, their carers and families, to reveal the factors that impact on service access and equity, leading to improved access to and experiences of care.

Glossary

Aboriginal Community Controlled Health Services (ACCHSs)	Provide a range of primary health services targeted for Aboriginal people and their communities, with funding by NSW Health and the Australian Government. [24]
Allied Health Professionals	A diverse group of individual professions, in most instances university qualified professionals, who work in a health-care team with specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses. NSW Health recognises 23 professions, listed on www.health.nsw.gov.au/workforce/alliedhealth/Pages/default.aspx
Biopsychosocial approach	Acknowledges the role of biological, psychological and social factors in mental health and considers these factors in prevention, assessment and treatment.
Cardiometabolic risk	Genetic, environmental, personal and medical factors, and illness-related behaviours, associated with the development of metabolic and cardiovascular disease. [54]
Clinician	A clinician is a general term used to encompass all health care professionals who work with patients. It includes physicians, nurses, dentists and allied health professionals.
Contributing life	Although it has varied meaning for different people, living a contributing life can mean living with purpose, having secure social connections, enjoying good health and wellbeing, sheltering in a safe home, participating in families, and communities and taking advantage of opportunities for education, training and employment. [5]
Malnutrition	Includes undernutrition (wasting, stunting, underweight), inadequate vitamins or minerals, overweight, obesity, and resulting diet-related non-communicable diseases. [55]
Metabolic syndrome (MetS)	A cluster of cardiovascular risk factors including insulin resistance, hypertension, central obesity and dyslipidaemia, which result in significantly increased risk of cardiovascular disease and mortality.
Multidisciplinary team	Involves care provided by a range of professionals and commonly includes medical, nursing and allied health professionals. Multidisciplinary teams in this context also include workers in health and community-managed organisations (e.g. peer workers, Aboriginal health and mental health clinicians, health coaches).
Negative medication effects	Antipsychotics are the most effective evidence-based treatment for psychosis. However, they have significant negative effects. Negative medication effects include adverse drug reactions, side effects and drug interactions.
Physical health	Relates to the physical body and includes impacts on bodily functions and structures, and a person's ability to engage in a range of activities and participate in community life.
Polypharmacy	Psychiatric polypharmacy refers to combination therapy with two or more psychotropic medicines. [52] It has been associated with an increased side effect burden, high-dose prescribing, increased hospitalisation and length of stay rates and increased mortality. [48]
Primary care	Often associated with general practice and general practitioners but can also include care by nursing, allied health, midwives, pharmacists, dentists and Aboriginal health and mental health clinicians.
Recovery	People with lived experience or distress being able to create and live a meaningful and contributing life in a community of choice with or without the presence of illness. [47]
Recovery-oriented practice	Mental health care that: • recognises and embraces the possibilities for recovery and wellbeing created by the inherent strength and capacity of all people experiencing illness • maximises self-determination and self-management of mental health and wellbeing • assists families to understand the challenges and opportunities arising from their family member's experiences.
Recovery plan	Recovery-oriented care plans that are developed via a process of empowering people with lived experience to identify their own goals and strategies for recovery. [4]
Self-management	Recognises the ability of individuals to manage their health and wellbeing, with support. Supporting people to self-manage can result in significant physical health gains, such as improved symptom management. [7]
Trauma-informed care	A strengths-based approach that: • recognises trauma and its prevalence • understands the neurological, biological, psychological and social effects of trauma and interpersonal violence • acknowledges the prevalence of these experiences in people with lived experience • emphasises physical, psychological and emotional safety for both service providers and survivors. [21]

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