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Neuroscience Network

KEEPING THE BODY in MIND program

Keeping the Body in Mind(gardens) Digital Physical Health Resource Package

Prof Jackie Curtis
Executive Director
Mindgardens Neuroscience Network

Acknowledging the Traditional Owners of the land we meet on today

Black Dog Institute
NeuRA Discover. Conquer. Cure.
NSW GOVERNMENT Health South Eastern Sydney Local Health District
UNSW SYDNEY

Keeping the Body in Mind(gardens)

KEEPING THE BODY in MIND program

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2000-2004

File audit of metabolic screening rates

RaDiCaL program

2005-2010

Presentation at IEPA, Birmingham

FEP metabolic monitoring commencement

POWH Health Risk Screening Tool

Rainbow pilot

Creation of onsite gym

2011-2014

HETI Positive Cardiometabolic health resource

HeAL declaration

KBIM FEP pilot

KBIM expansion

KBIM translational research team

KoSiM round 1

2015-2019

KBIM FEP routine care

KoSiM round 2

Clozapine & Long acting injectable Clinic

KBIM adult program

yQUIT / KQIM

headspace Active

2020+

KBIM(X)

KBIM case management

KBIM Primary

KBIM Refugees

KBIM Vaccines

KBIM Food Security

Growth of the Landscape:

Clinical

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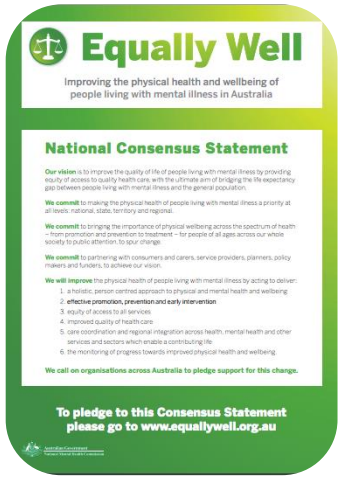
Evidence

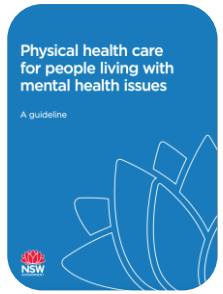
The Lancet Psychiatry Commission

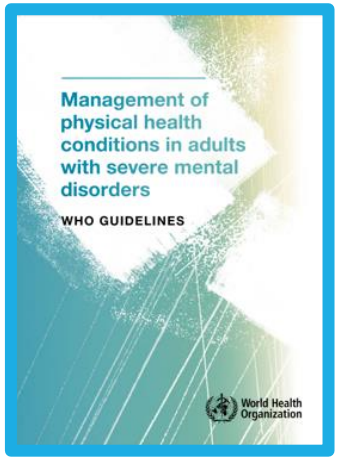
The *Lancet Psychiatry* Commission: a blueprint for protecting physical health in people with mental illness

Joseph Firth, Najma Siddiqi*, Ai Koyanagi*, Dan Siskind*, Simon Rosenbaum*, Cherrie Galletly*, Stephanie Allan, Constanza Caneo, Rebekah Carney, Andre F Carvalho, Mary Lou Chatterton, Christoph U Correll, Jackie Curtis, Fiona Gaughran, Adrian Heald, Erin Hoare, Sarah E Jackson, Steve Kisely, Karina Lovell, Mario Maj, Patrick D McGorry, Cathrine Mihalopoulos, Hannah Myles, Brian O'Donoghue, Toby Pillinger, Jerome Sarris, Felipe B Schuch, David Shiers, Lee Smith, Marco Solmi, Shuichi Suetani, Johanna Taylor, Scott B Teasdale, Graham Thornicroft, John Torous, Tim Usherwood, Davy Vancampfort, Nicola Veronese, Philip B Ward, Alison R Yung, Eoin Killackey†, Brendon Stubbs†

Guidelines







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Health
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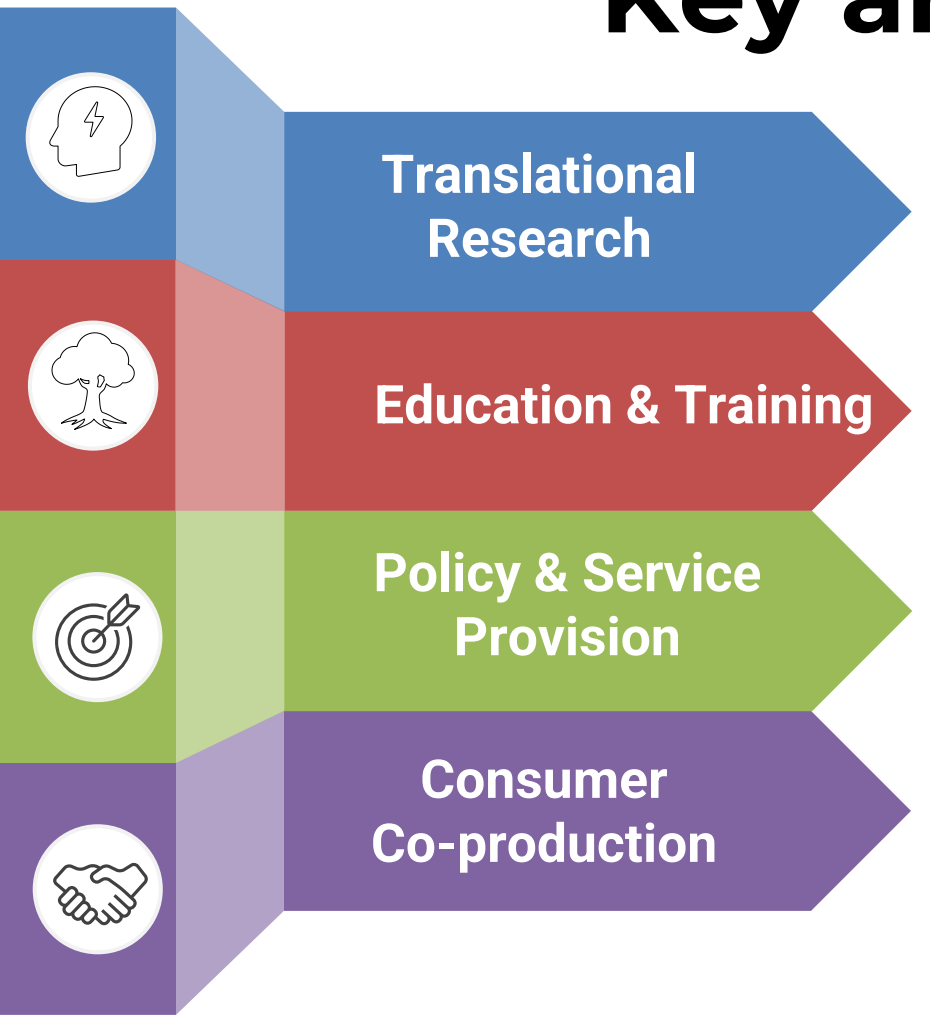
Translational Research Hub:

Key areas of influence



Research & Implementation

Designing, implementing, and consulting research projects with the aim to efficiently translate results to consumers and service providers.

Education & Training

Supporting research development and knowledge translation at all levels – students, consumers, clinicians and established researchers.

Policy & Service Provision

Contributing to policy design and resource development for local health providers through to government and international agencies.

Consumer Co-production

Engaging with the experts of mental illness – those with lived experience to design research projects and new service models for future best practice.

2023

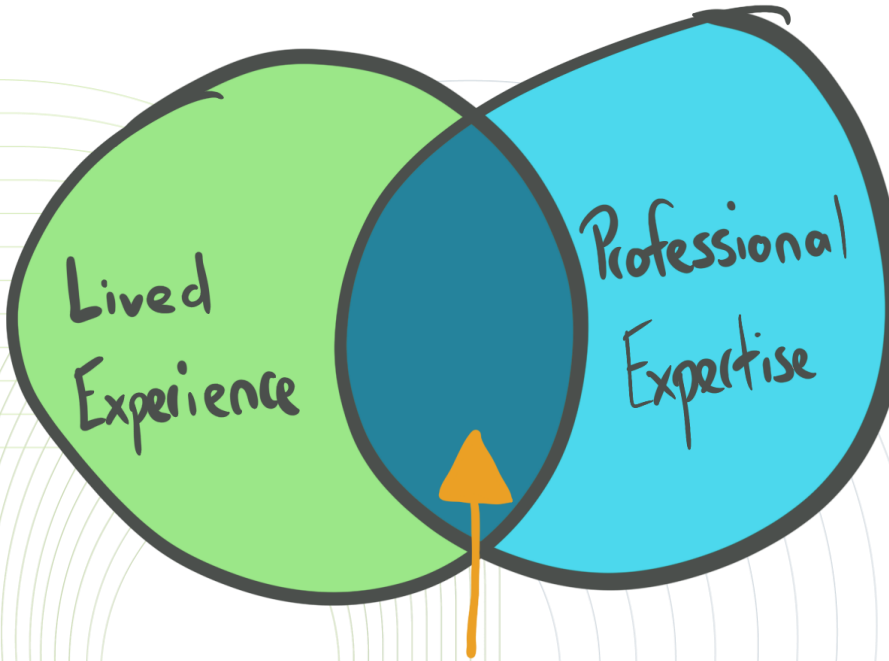
Resource Package

- Co-designed process
- Digitalise and updated KBIM resources
- Consumer and clinician resources
- Funded by MHC of NSW

Access the guide and complete list of references online either by scanning the QR code or by visiting **mindgardens.org.au/KBIMResources**

Resource Development

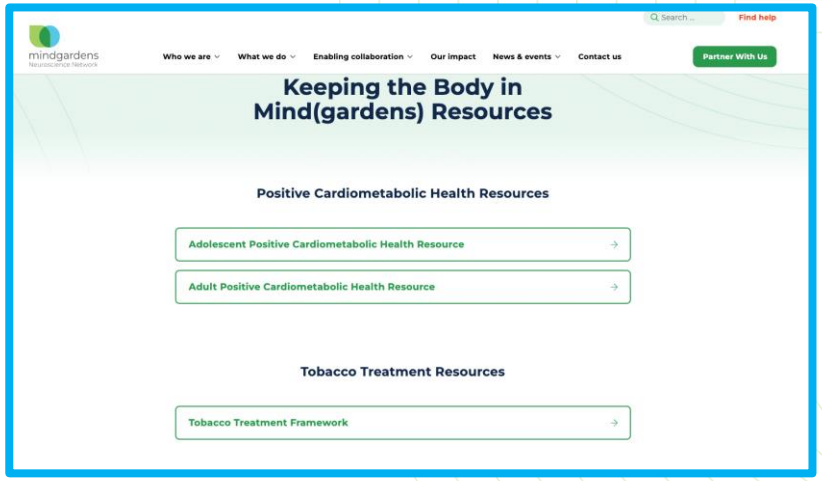
- Steering groups for the three health frameworks with national and international experts, and lived experience representatives
- Co-design workshops for the modules
- User testing and feedback
- Lived experience editing and review of the modules
- Digitalised version → additional information to help guide clinical decision making.



Health Resource Frameworks

Three clinical frameworks to guide clinical decision making

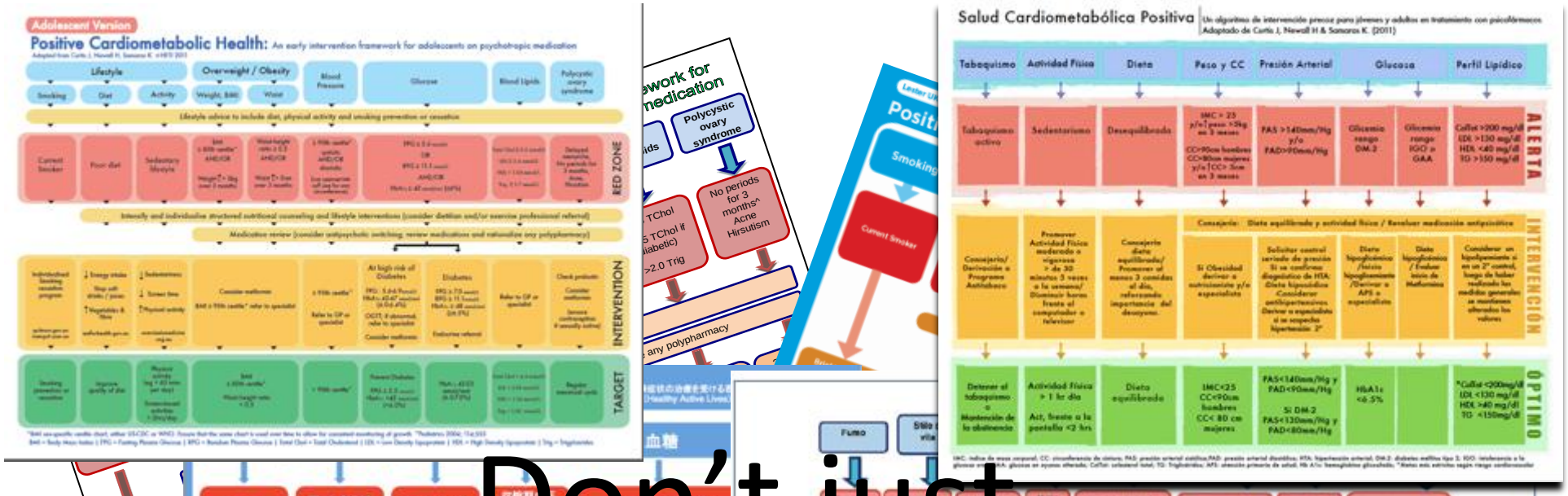
- Adult Positive Cardiometabolic Health Resource
- Adolescent Positive Cardiometabolic Health Resource
- Tobacco Treatment Framework



Positive Cardiometabolic Health Resource

- Fully revised & updated version of the 2011 HETI algorithm that has been adapted in nine countries across the world, and adolescent resource update

Don’t Just Screen, Intervene!



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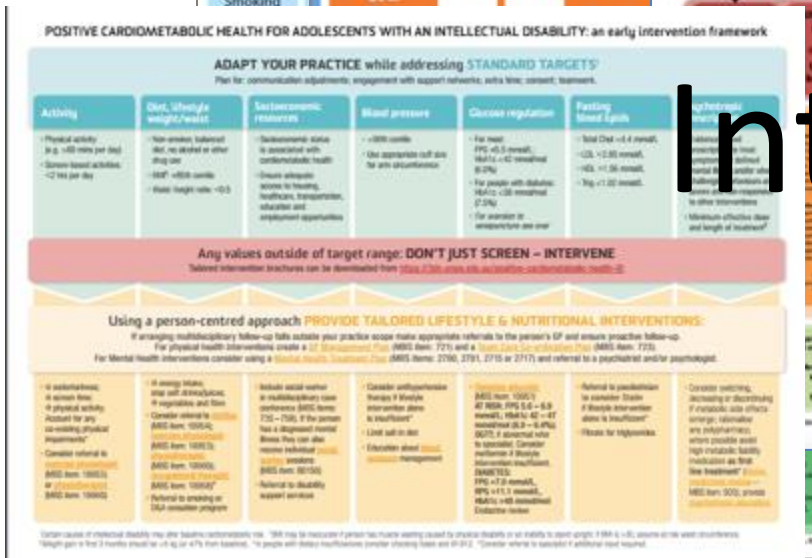

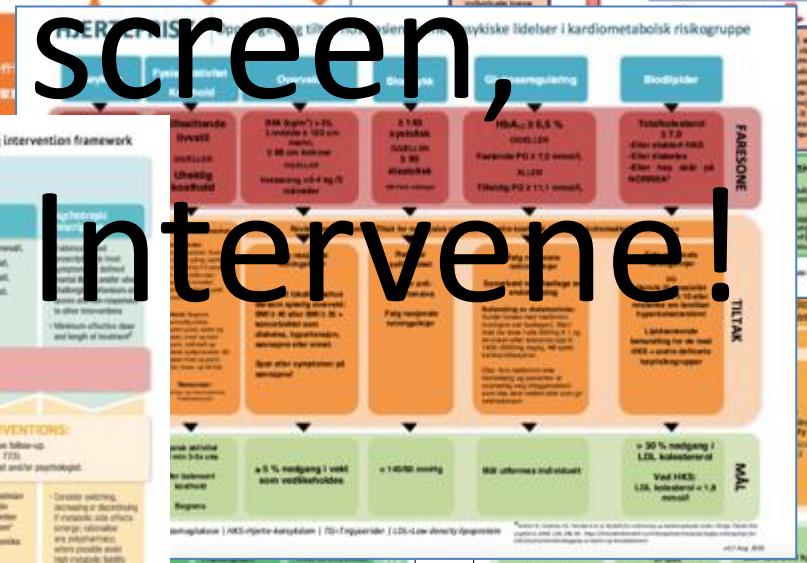

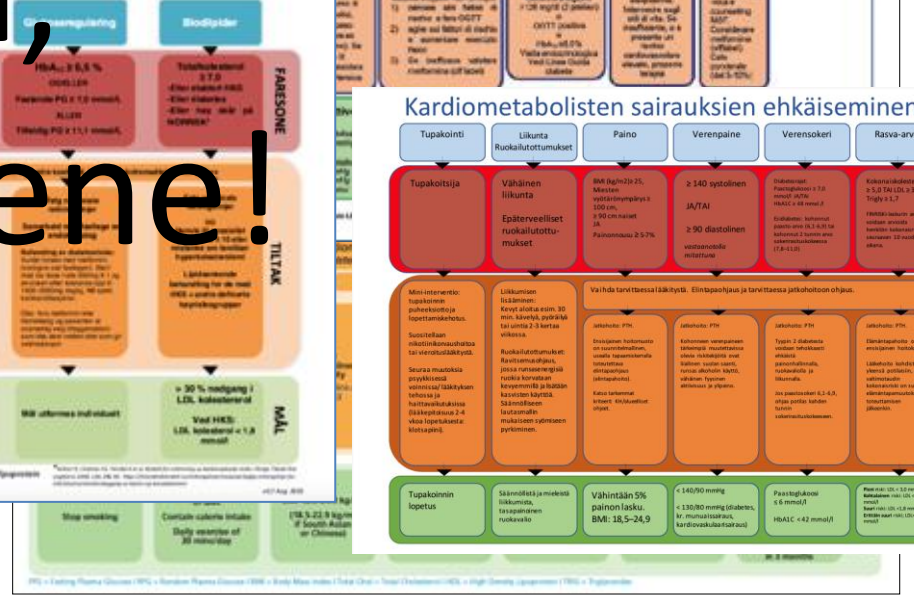

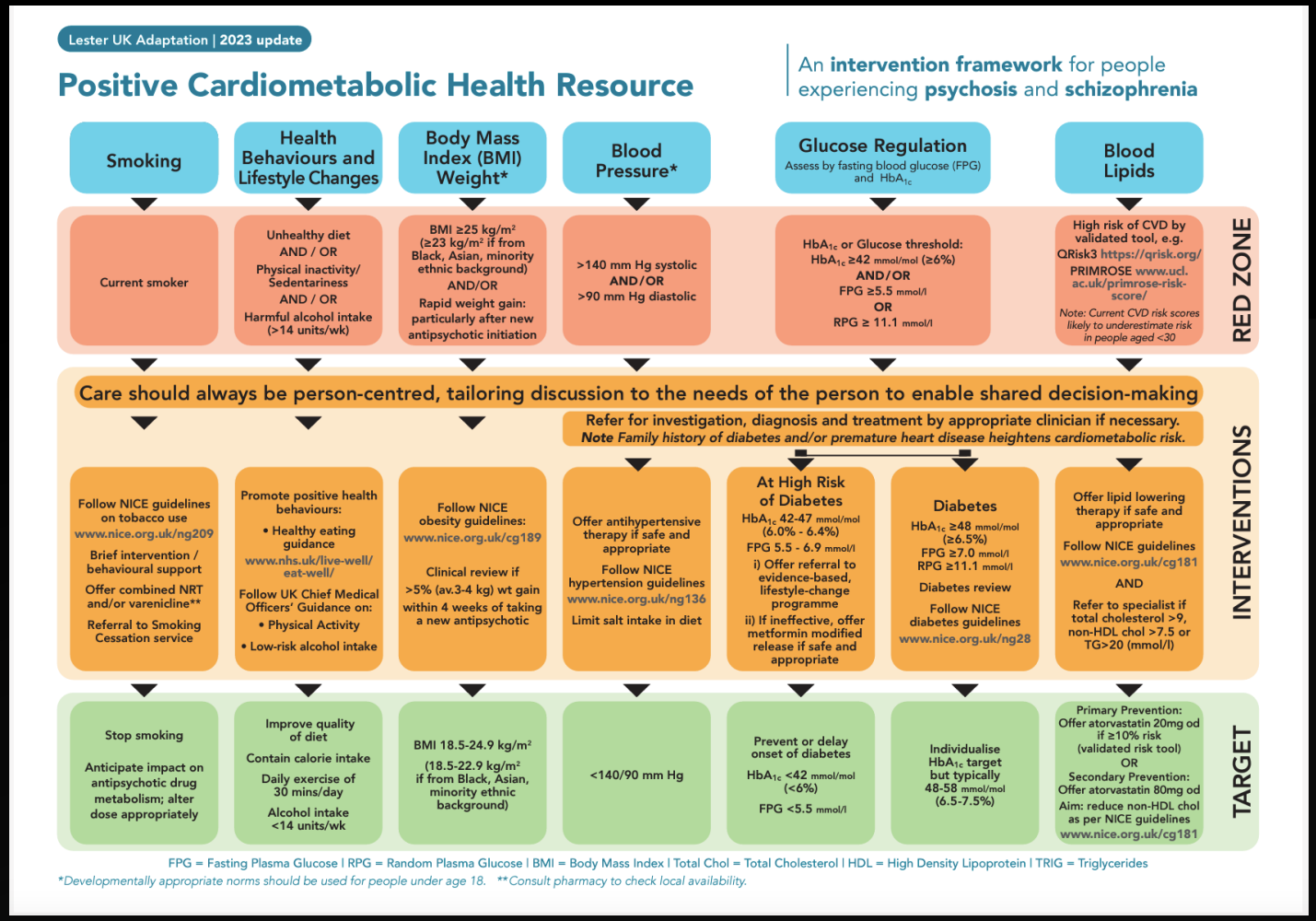

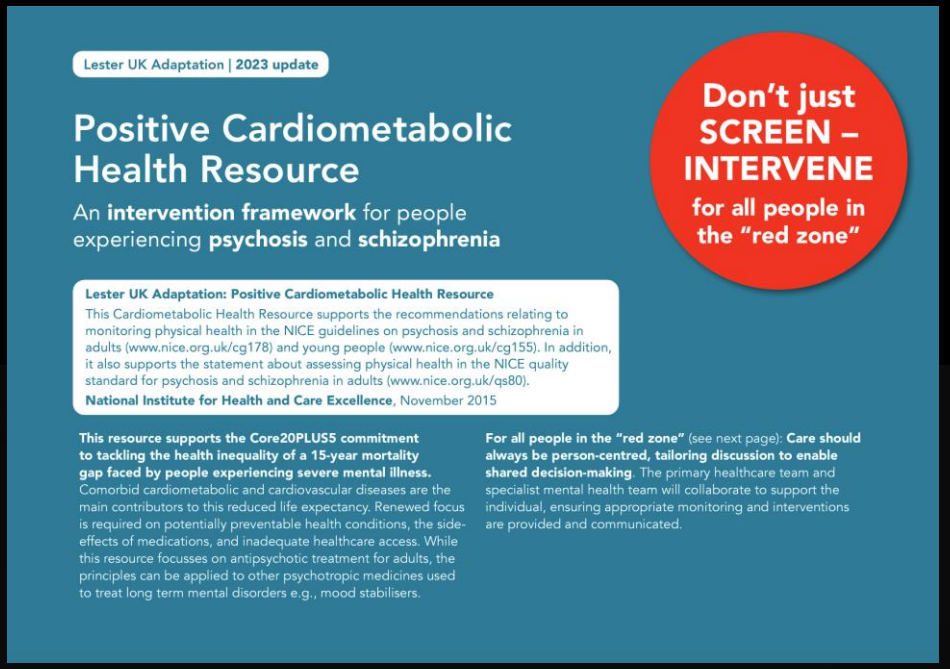

lester-tool-june-2023.pdf (rcpsych.ac.uk)

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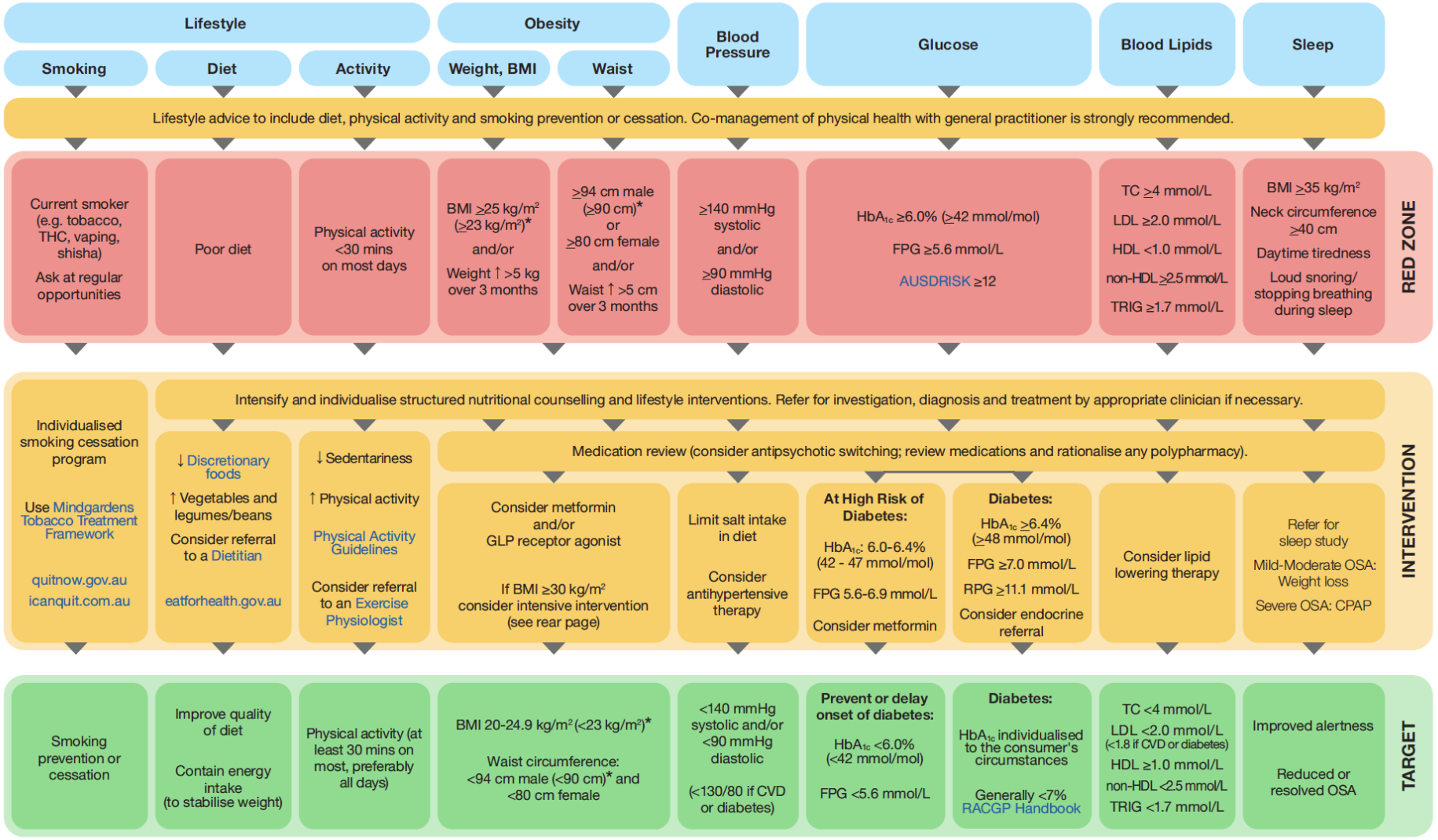
Positive Cardiometabolic Health Resource

An early intervention framework for people on psychotropic medication



*For South Asian, Chinese, Japanese, Ethnic South and Central Americans. | BMI = Body Mass Index | CVD = Cardiovascular disease | FPG = Fasting Plasma Glucose | GLP = Glucagon-like Peptide | HbA_{1c} = Glycated Haemoglobin | HDL = High Density Lipoprotein | LDL = Low Density Lipoprotein | OSA = Obstructive Sleep Apnoea | RPG = Random Plasma Glucose | TC = Total Cholesterol | TRIG = Triglycerides

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Positive Cardiometabolic Health Resource

An early intervention framework for people on psychotropic medication

Access the guide and complete list of references online either by scanning the QR code or by visiting mindgardens.org.au/KBIMResources

History and examination following initiation or change of psychotropic medications

History: Seek history of smoking, poor diet (e.g. high calorie, high fat/sugar), physical activity and sedentariness (e.g. screen time), sleep, and polycystic ovary syndrome. Ask about family history (diabetes, obesity, early CVD), gestational diabetes. Note ethnicity.

Investigations: Fasting estimates of plasma glucose (FPG), HbA1c, and lipids (total cholesterol, LDL, HDL, non-HDL, triglycerides). If fasting samples are impractical then non-fasting samples are satisfactory for most measurements except for triglycerides.

Frequency: At a minimum, those starting or changing antipsychotics should be monitored as below. After 12 months, continue to monitor at 6-month intervals, with increased frequency if abnormalities emerge, which should then prompt appropriate action and/or continuing review at least every 3 months.

Monitoring Intervals

	Baseline	Weekly*	3 months	6 months	9 months	12 months	Continue 6 monthly
Personal/Family History	✓					✓	✓
Lifestyle Review	✓	✓	✓	✓	✓	✓	✓
Weight	✓	✓	✓	✓	✓	✓	✓
Waist	✓		✓	✓	✓	✓	✓
Blood pressure	✓		✓	✓		✓	✓
FPG, RPG, HbA_{1c}	✓		✓	✓		✓	✓
Lipid profile	✓		✓	✓		✓	✓
Vitamin D	✓			✓		✓	✓

*Weight should be assessed weekly to fortnightly in the first 6 – 8 weeks following initiation or change of medication. Commencing antipsychotics is a time of particular risk of rapid weight gain and this may predict severe weight gain in the longer term.

Other Considerations:

Other baseline investigations are not included here and need to be performed as clinically required (e.g. TFTs, UECs, FBC, ECHO). Additional monitoring requirements apply for those on mood stabilisers and clozapine (e.g. medication plasma levels). Prolactin measurement is only recommended if symptomatic. Consider ECG/cardiology review if concern regarding QT prolongation or cardiovascular risk factors present.

Screen for polycystic ovary syndrome in all women: No menstrual cycle for 3 months, acne, hirsutism. Check prolactin, consider metformin and endocrine referral. Treatment may restore fertility, ensure contraception is discussed. Some medications used to treat metabolic disorder are contraindicated in pregnancy (e.g. some antihypertensives and lipid lowering drugs).

Other issues such as sexual health, blood borne virus screening, oral health, vaccination status, and substance use have not been included in this resource though are important to discuss with all consumers.

DON'T JUST SCREEN
INTERVENE
for all people in the 'red zone'

Decision making surrounding screening and agreed interventions should be made with the consumer and include consultation with carers, families, and key stakeholders (e.g. general practitioner, mental health clinicians, and community providers).

Review of antipsychotic and mood stabiliser medications

- Choose lower metabolic liability medication first line where possible
- Review diagnosis and ensure ongoing need for all psychotropic medications
- Consider switching to a more weight neutral medication where possible
- Avoid antipsychotic polypharmacy
- Avoid off-label use of antipsychotic medications
- Changing antipsychotic medication requires careful clinical judgement to weigh any benefits against the risk of relapse of psychosis

Review should be a priority if there is:

- Rapid weight gain (e.g. 5 kg < 3 months) following antipsychotic initiation or change
- Rapid development (< 3 months) of abnormal lipids, BP, or glucose

If consumer has not successfully reached targets after 3 months, then consider specific pharmacological interventions

Intensive Interventions

Intensive interventions to support weight loss may be considered with a BMI of ≥30 kg/m² or if unsuccessful in reducing weight or has regained weight using lifestyle approaches. Intensive interventions may include:

- Metformin and/or GLP receptor agonist
- Very low energy diets for 8-16 weeks under medical supervision, replacing one or more meals per day with food or formulas that provide a specified number of kilojoules (e.g. 1675-3350 kJ/day)
- Referral to obesity clinic
- Consider referral for assessment for bariatric surgery

Specific pharmacological interventions

Consider metformin trial for:

- Impaired fasting glucose
- Obesity or rapid weight gain
- Polycystic ovary syndrome

Note that **off-label use** requires documented informed consent

Metformin therapy:
Start at 250 mg before dinner for two weeks, then increase to 250 mg bd. Dose can be increased by 500 mg per week to a maximum of 3 grams daily (taken in split doses with meals). If side-effects of nausea or abdominal cramping shift to after meal (or the XR preparation)

Lipid lowering therapy:
Co-management with GP recommended. Consider lipid lowering therapy (use PBS guidelines). If severe hyperlipidaemia or other risk factors, consider specialist referral

Antihypertensive therapy:
Refer to general practitioner or specialist

Vitamin D:

- <50 nmol/L: **Cholecalciferol treatment** 3000–5000 IU daily for 6–12 weeks to replenish stores followed by a maintenance dose of 1000–2000 IU daily
- Target: >80 nmol/L

2023 Update. Adapted from Curtis J, Newall H, Samaras K. ©HETI 2011

Funded by the Mental Health Commission of New South Wales

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ADOLESCENT
Positive Cardiometabolic Health Resource

An early intervention framework for adolescents on psychotropic medication

	Lifestyle			Obesity		Blood Pressure	Glucose	Blood Lipids	Polycystic Ovary Syndrome
	Smoking	Diet	Activity	Weight, BMI	Waist				
	Lifestyle advice to include diet, physical activity and smoking prevention or cessation. Co-management of physical health with general practitioner is strongly recommended.								
RED ZONE	Current smoker (e.g. tobacco, THC, vaping, shisha) Ask at regular opportunities	Poor diet	Physical activity <60 mins on most days Screentime >2 hrs/day	BMI ≥85th centile* and/or Weight ↑> 5 kg over 3 months	Waist-to-height ratio ≥0.5 and/or Waist ↑>5 cm over 3 months	Blood pressure ≥90th centile systolic and/or diastolic	HbA_{1c} ≥6% (≥42 mmol/mol) FPG ≥5.6 mmol/L	TC ≥5.2 mmol/L LDL ≥3.4 mmol/L HDL <1.0 mmol/L non-HDL≥3.7 mmol/L TRIG ≥1.5 mmol/L	Delayed menarche No menstrual cycle for 3 months Acne Hirsutism
INTERVENTION	Brief advice using Ask, Advise, Help Individualised smoking cessation program quitnow.gov.au icanquit.com.au	Intensify and individualise structured nutritional counselling and lifestyle interventions. Refer for investigation, diagnosis and treatment by appropriate clinician if necessary. ↓ Discretionary foods ↑ Vegetables and legumes/beans Consider referral to a Dietitian eatforhealth.gov.au	↓ Sedentariness ↑ Physical activity Physical Activity Guidelines Consider referral to an Exercise Physiologist	Medication review (consider antipsychotic switching; review medications and rationalise any polypharmacy). Consider metformin If BMI is ≥95th centile* refer to specialist	Limit salt intake in diet Co-management with GP and consider specialist referral	**At High Risk of Diabetes:** HbA_{1c}: 6.0-6.4% (42-47 mmol/mol) FPG 5.6-6.9 mmol/L Consider metformin	**Diabetes:** HbA_{1c} ≥6.5% (≥48 mmol/mol) FPG ≥7.0 mmol/L RPG ≥11.1 mmol/L Endocrine referral	Intensify lifestyle interventions as per the NHLBI Guidelines Co-management with GP and consider specialist referral	Check prolactin Consider metformin Recommend contraception if sexually active, as treatment may restore fertility Endocrine referral
TARGET	Smoking prevention or cessation	Improve quality of diet Contain energy intake (to stabilise weight)	Physical activity ≥60 mins on most, preferably all days Screentime ≤2 hrs/day	Waist-to-height ratio <0.5 BMI <85th centile*	Blood pressure <90th centile	**Prevent or delay onset of diabetes:** HbA_{1C} <6.0% (<42 mmol/mol) FPG <5.6 mmol/L	**Diabetes:** HbA_{1c} individualised to the adolescent's circumstances Generally, HbA_{1C} <6.0-7.0% (42-53 mmol/mol)	TC <4.4 mmol/L LDL <2.8 mmol/L HDL >1.2 mmol/L non-HDL<3.1 mmol/L TRIG <1.0 mmol/L	Regular menstrual cycle

*BMI sex-specific centile chart, either US-CDC or WHO. Ensure that the same chart is used over time to allow for consistent monitoring of growth.

BMI = Body Mass Index | FPG = Fasting Plasma Glucose | HbA_{1c} = Glycated Haemoglobin | HDL = High Density Lipoprotein | LDL = Low-Density Lipoprotein | RPG = Random Plasma Glucose | TC = Total Cholesterol | TRIG = Triglycerides

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Blood pressure	✓		✓	✓		✓	✓
FPG, RPG, HbA_{1c}	✓		✓	✓		✓	✓
Lipid profile	✓		✓	✓		✓	✓
Vitamin D	✓			✓		✓	✓

*Weight should be assessed weekly to fortnightly in the first 6 – 8 weeks following initiation or change of medication. Commencing antipsychotics is a time of particular risk of rapid weight gain and this may predict severe weight gain in the longer term.

Other Considerations:

Other baseline investigations are not included here and need to be performed as clinically required (e.g. TFTs, UECs, FBC, ECHO). Additional monitoring requirements apply for those on mood stabilisers and clozapine (e.g. medication plasma levels). Prolactin measurement is only recommended if symptomatic. Consider ECG/cardiology review if concern regarding QT prolongation or cardiovascular risk factors present.

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Specific pharmacological interventions

Consider metformin trial for:

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- Obesity or rapid weight gain
- Polycystic ovary syndrome

Note that **off-label use** requires documented informed consent

Metformin therapy:
Start at 250 mg before dinner for two weeks, then increase to 250 mg bd. Dose can be increased by 500 mg per week to a maximum of 2 grams daily (taken in split doses with meals). If side-effects of nausea or abdominal cramping, shift to after meal (or the XR preparation)

Lipid lowering therapy:
Consider lipid lowering therapy (use PBS guidelines) if severe hyperlipidaemia or other risk factors, with appropriate specialist referral

Antihypertensive therapy:
Refer to general practitioner or specialist

Vitamin D:

- <50 nmol/L: **Cholecalciferol treatment** 1,000-2,000 IU daily for 3 months to replenish stores followed by a maintenance dose of 1000 IU daily
- Target: >80 nmol/L

Funded by the Mental Health Commission of New South Wales

Tobacco Treatment Framework

- Newly developed framework that guides health professionals on specialist tobacco treatment for people experiencing mental illness.

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Tobacco Treatment Framework

An intervention framework for people on psychotropic medication

Brief advice at regular opportunities
Use the 'Ask Advise Help' model

1. ASK | **2. ADVISE** | **3. HELP**

Assess level of dependence

1. Time to first tobacco use <30 minutes from waking
2. >10 cigarettes/day or equivalent
3. History of withdrawal symptoms in previous quit attempts
4. >10ppm carbon monoxide (CO) reading

Yes to 1 or more – Moderate to high dependence

Behavioural support using Cognitive Behavioural Therapy (CBT) or Motivational Interviewing (MI) should be offered in conjunction with pharmacological treatments and should be continued throughout

Consider varenicline therapy
(Contraindicated in adolescents, pregnant or lactating women, and end stage renal failure. See PI for more information)

Yes – Varenicline suitable

Prescribe initial 4 week supply:

Week 1 - Dose titration:
- Day 1-3: 0.5mg daily
- Day 4-7: 0.5mg twice daily
- Day 8+: 1mg twice daily

No instruction to change tobacco usage in first week (to allow adverse reactions identification)
Take baseline CO reading

No – Varenicline not suitable, or consumer would prefer other treatment options

There are two equally effective quitting options with varenicline (RACGP p.40):
- **Fixed approach:** Where the person sets a quit date and starts taking varenicline one or two weeks before the quit date
- **Flexible approach:** Where the person starts taking varenicline and quits smoking between days 8 and 35 of varenicline commencement

Monitor for adverse reactions (confirm these are not nicotine withdrawal symptoms. If so, trial NRT concurrent therapy with varenicline)

No or mild adverse reactions reported

Continue varenicline therapy for weeks 2-4 at 1mg twice daily
During this period, it is not suggested to add any other pharmacological methods. If on the flexible approach, the person may sponateneously quit smoking during this time

Significant adverse reactions reported

Spontaneous reduction to <10 cigarettes/day OR a CO reading of <10ppm?

Yes – Continue varenicline for weeks 5-12 at same dose. Monitor tobacco use, CO levels and side effects

No – Prescribe further 8 weeks of varenicline at the same dose and supplement with NRT

Encourage further 12 weeks of varenicline treatment for relapse prevention*
Continue to monitor for relapse and restart the framework if required

* If relapse occurs during treatment, explore behavioural and environmental triggers, and consider adding or increasing NRT

No to all – No or low dependence

Offer behavioural support using Cognitive Behavioural Therapy (CBT) or Motivational Interviewing (MI)

If still smoking, commence Nicotine Replacement Therapy (NRT). (Behavioural support should be offered in conjunction with pharmacological treatments and should be continued throughout)

Prescribe one 21mg nicotine patch to be applied daily plus oral NRT dose to be prescribed in combination, based on the level of nicotine dependence. See Quick Guide to NRT for dosing based on dependence. Note: NRT is unsuitable for children under 12. People <45 kg may need a lower dose

Take CO reading (if available)

CO readings and level of dependence:
- 0-6ppm: Non smoker
- 7-20ppm: Light smoker
- 21-100ppm: Heavy smoker

Weekly review of withdrawal symptoms and adverse reactions

Smoking ceased or CO ≤6ppm

Assess for withdrawal symptoms

Smoking ceased with no withdrawal symptoms

Smoking ceased with withdrawal symptoms

Add short acting oral NRT if not prescribed at the start (e.g. lozenges, gum, spray, inhaler)

Smoking reduced to 5-10 cigarettes/day or a CO reading <50% of baseline

If smoking persists or oral NRT already prescribed

Add a second 21mg patch
(Note, if second patch has minimal impact, ensure the patch is being used correctly)

Smoking >10 cigarettes/day or a CO reading ≥50% of baseline

Continue NRT as required. May continue NRT after smoking ceased as a relapse prevention strategy. Note: if still experiencing withdrawal symptoms see NRT guide

Continue NRT for a minimum of 8 weeks, up to 24 weeks.
Reduce as indicated (reduce oral before patches)

If NRT is prescribed in conjunction with varenicline

Continue to monitor for relapse and restart the framework if required

Colour Key: Behavioural Support | Pharmacological | Assessment/Review | Outcome/Statement

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Tobacco Treatment Framework

An intervention framework for people on psychotropic medication

Brief advice at regular opportunities

Use the 'Ask Advise Help' model

1. ASK:

about smoking status (including what and how they are smoking) and document this in their medical record.

2. ADVISE:

all people who smoke to quit (note: a combination of smoking cessation medicine and counselling increases the chances of successfully quitting). Discuss the negative impacts of smoking on **physical** and **mental health**, and the additional benefits of quitting (e.g. financial, social).

3. HELP:

by offering all people who smoke an opt-out referral to behavioural support through **Quitline** (13 78 48), providing **behavioural support with CBT**, and by prescribing (or helping people to access) approved pharmacological treatments, such as nicotine replacement therapy (NRT) or varenicline.

The relationship with the person who is wanting to cease tobacco use is vital. The framework should be used as a guide for best practice, however, it should always be tailored to the individual's situation, preferences, and needs.

Behavioural support

Behavioural support is important for exploring triggers for smoking and developing strategies to prevent relapse.

Behavioural support should be offered in conjunction with pharmacological treatments and should be continued throughout. This may include Cognitive Behaviour Therapy and Motivational Interviewing.

Scan the QR code for online access to this guide and a complete list of references, or visit the link below

mindgardens.org.au/KBIMResources

Psychotropic medication interactions

Tobacco products can affect the metabolism of clozapine and olanzapine. Therefore, a reduction in smoking may lead to a significant rise in blood serum levels of these medications. If a person is prescribed clozapine or olanzapine, assess their current medication dosage and adherence and monitor for signs of higher serum levels. For clozapine, blood levels should be tested at the beginning of smoking cessation treatment and regularly throughout. NRT does not impact a person's blood serum levels.

Signs of higher serum levels:

- Sedation
- Hypersalivation
- Hypotension
- Tachycardia
- Seizures or other neurological effects
- Akathisia
- Prolonged QTc interval

Consider a dose reduction when the person completely ceases smoking or reduces to <7 cigarettes a day. A recommended dose reduction of 30% for olanzapine and 30-50% for clozapine is suggested (see the **clozapine, olanzapine and smoking cessation tool**). When making reductions, it is important to consider the steady-state trough levels of clozapine and conduct a thorough clinical risk-benefit evaluation.

If a person restarts smoking, their medication dose may need readjusting if it was previously reduced.

Other interactions (including caffeine and alcohol)

A change in a person's level of smoking can impact the levels of other medications and may increase the risk of adverse reactions from these medications. Some of these other medications include:

- Benzodiazepines
- Beta blockers
- Chlorpromazine
- Clopidogrel
- Flecainide
- Fluvoxamine
- Haloperidol
- Heparin/Warfarin
- Imipramine
- Insulin
- Theophylline
- Methadone

Follow the **drug interactions with smoking cessation** tool to determine if any changes to dosage are required. If smoking has ceased, advise that smoking cessation causes caffeine and alcohol levels to rise, and due to this they may need to reduce caffeine and alcohol intake by 50% within one week.

Expired Carbon Monoxide Monitoring (CO Monitoring)

Follow the guide to **Using a Carbon Monoxide Monitor** for instructions on use.

In people prescribed antipsychotic medications (e.g. clozapine or olanzapine), a significant drop in CO over a short period of time along with symptoms such as nausea may indicate changes in medication serum levels.

MBS items and PBS NRT subsidies

There are a range of **Medicare Benefit Schedule Items** for Smoking Cessation that allow bulk billed consultations for people seeking GP services for nicotine and smoking cessation counselling.

If NRT is prescribed, it can be dispensed at a **PBS subsidised** charge for a specific period of time. This may reduce financial barriers to accessing NRT that are present if purchased over the counter.

Use of NRT for harm minimisation

NRT can be used as a harm minimisation technique for people who want to continue smoking to reduce the amount of tobacco use even if they are continuing to smoke.

Adverse reactions

Note that the reasons behind these adverse reactions can be complex and varied. Adverse reactions to NRT are usually minor. Refer to the **quick guide to Nicotine Replacement Therapy (NRT)** for advice on responding to adverse reactions.

Confirm that the potential adverse reaction symptoms are not nicotine withdrawal symptoms.

Withdrawal symptoms

Nicotine withdrawal symptoms may occur in people who reduce or cease smoking. Symptoms are detailed in the **assessing nicotine dependence** tool.

The most common nicotine withdrawal symptoms include:

- Cravings
- Anxiety
- Restlessness
- Depressed mood
- Decreased heart rate
- Insomnia
- Irritability
- Frustration
- Difficulty concentrating
- Nausea
- Increased appetite
- Cough

If the person's smoking behaviour indicates morning cravings, prescribe the NRT patch to be applied at night to ensure peak nicotine release upon waking.

Form of pharmacotherapy	Possible adverse reactions or problems	Strategies to manage the adverse reactions or problems
Nicotine patches	Skin rashes where the patch is applied	Rotate the patch site and try patches with alternative adhesive formulas or apply hydrocortisone 1% cream for skin irritation
	Patch keeps falling off – doesn't stick	Use adhesive tape over the patch
	Sleep disturbance (can be due to nicotine withdrawal, increased caffeine levels, or timing of the patch)	Check for other symptoms of nicotine withdrawal. Decrease caffeine intake by half. Apply the patch in the morning rather than at night. Remove the patch before sleep
Oral NRT products	Irritation of the mouth or throat, headaches, hiccups, indigestion, nausea, and coughing	Check for correct use of the oral product or change to a different oral product
Varenicline	Ensure that side effects are not better explained by nicotine withdrawals. Consider commencing on NRT pathway to address this. For varenicline side effects, refer to the **Pharmacotherapy for Smoking Cessation Guide**	

2023. Funded by the Mental Health Commission of New South Wales

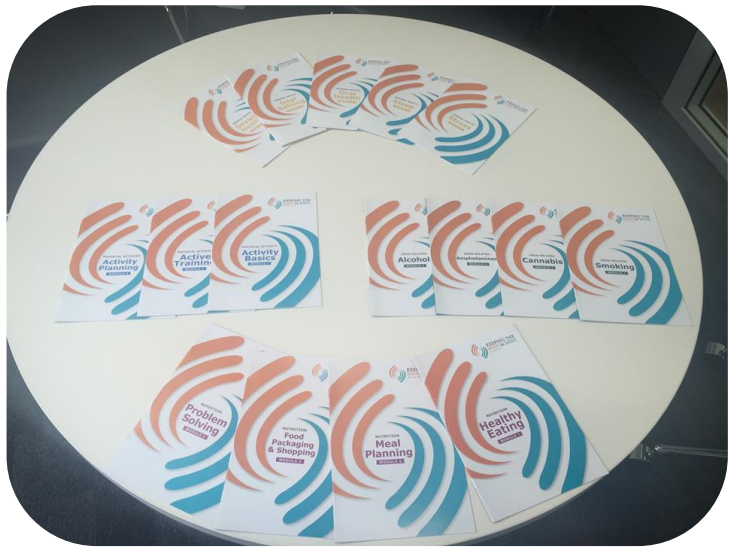
Video Training Resources

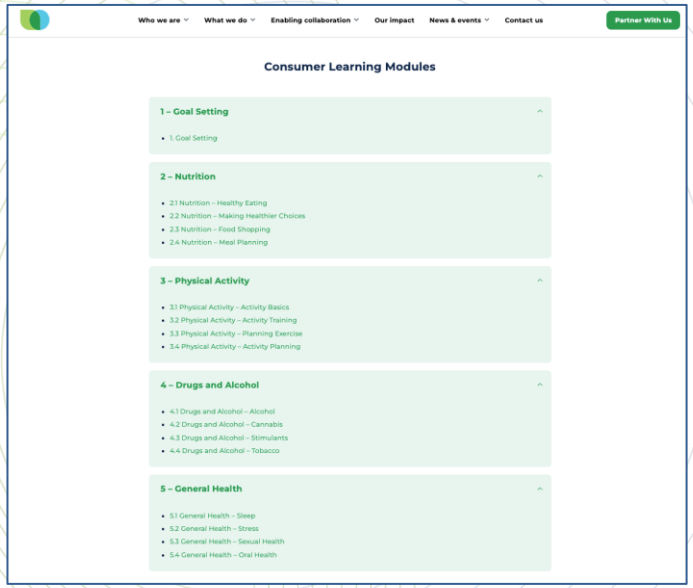
- Three clinician training videos
- To provide education and training for mental health clinicians on delivery of lifestyle interventions for consumers experiencing SMI
  - Nutrition
  - Physical Activity
  - Tobacco Treatment

Consumer Health Module Resources

- Can be used individually by consumers or in conjunction with a clinician, support worker or carer.

- 17 Modules have been developed with a focus on goal setting to promote lifestyle change.





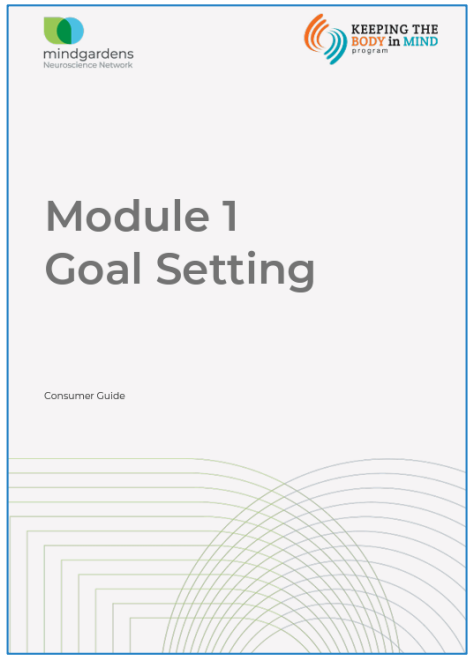
Consumer Modules

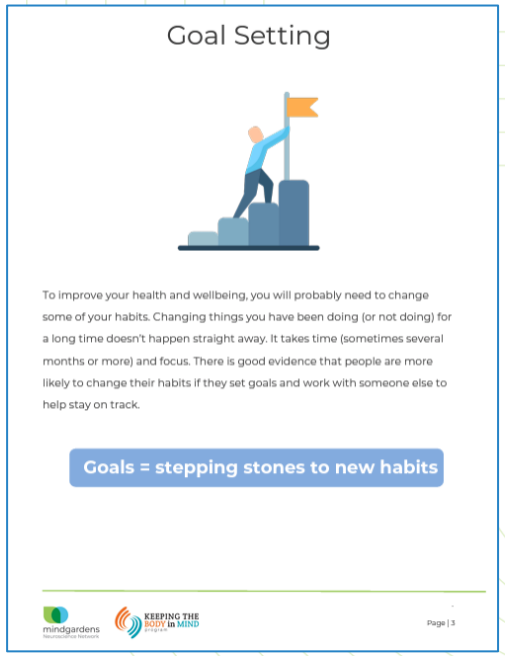
- **Goal Setting**
- **General Health:**
  - Sleep
  - Stress
  - Sexual Health
  - Oral Health

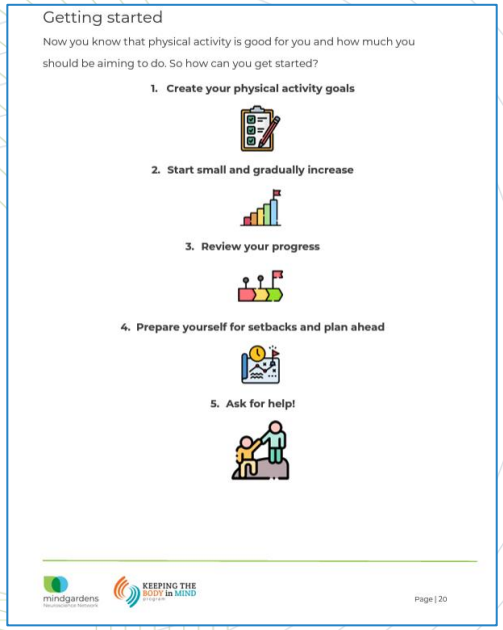
- **Physical Activity:**
  - Activity Basics
  - Active Training
  - Planning Exercise
  - Activity Planning

- **Drugs and Alcohol:**
  - Alcohol
  - Cannabis
  - Stimulants
  - Tobacco

- **Nutrition:**
  - Healthy Eating
  - Making Healthier Choices
  - Food Shopping
  - Meal Planning



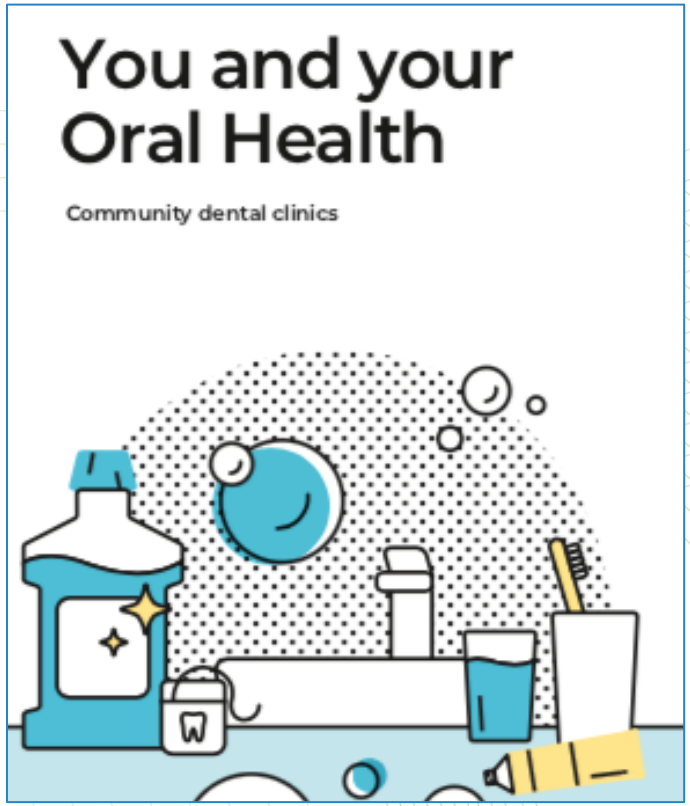


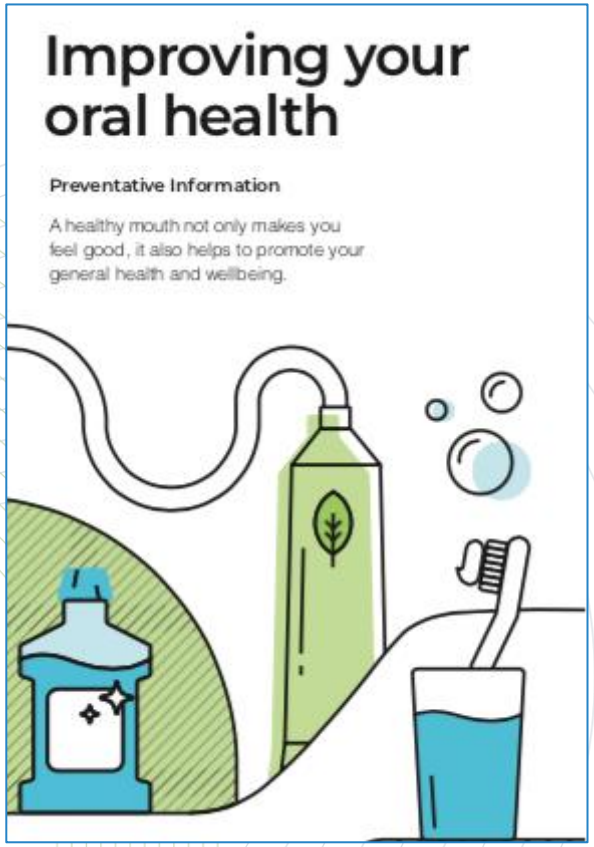


Consumer Oral Health Resources

New oral health brochures developed in collaboration with NEAMI National and University of Melbourne.

1. A guide to improving oral health
2. Assessing dental health care





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KBIM(gardens) Resource Package

KEEPING THE BODY in MIND program

Access the guide and complete list of references online either by scanning the QR code or by visiting **mindgardens.org.au/KBIMResources**

New target areas & raising expectations

Vaccine (in)equity

Equally Well NZ | EQUALLYWELL Aus | Equally Well UK

A Global Call to Action

Fair and equitable access to vaccination for people living with mental illness and substance use disorders

Addi Moves

Primary Care

Mental Health Commission of New South Wales

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