Clinical Practice Guidelines for the Management of Overweight and Obesity for Adults, Adolescents and Children in Australia

Draft Recommendations
November 2024

Australian Government
Department of Health and Aged Care

SUMMARY

The recommendations for the Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents and Children in Australia were derived through a GRADE Evidence-to-Decision process, informed by a series of systematic reviews and meta-analyses as outlined in the Technical Report. The Guidelines Development Committee provided oversight and input into the final Recommendations, which include Strong recommendations, Conditional recommendations, Consensus statements and Practice Points as detailed below. These recommendations are intended to support healthcare professionals to provide evidence-informed treatment recommendations for Australian adults, adolescents, and children living with overweight or obesity. They will also be of interest to other professionals, including relevant not-for-profit organisations who have contact with people living with overweight or obesity. The use of the Guidelines will vary depending on the role and scope of practice of different professional groups, as well as the setting in which care is provided. The Guidelines will be of interest to consumers and community organisations.

The recommendations are presented in a series of tables. As described below, the recommendations are based on the available evidence from our GRADE Evidence-to-Decision synthesis. For a number of interventions in specific population groups there was insufficient evidence to develop a recommendation. In these cases, we suggest referring to the general population guideline for the relevant age group, with appropriate clinical judgement.

General principles of overweight and obesity management are summarised in Table 4. The remaining tables comprise age-specific guidance, the Recommendations and Practice Points. Summary tables for children aged 2 to <12 years (Table 5) adolescents aged 12 to <18 years (Table 6), young and middle-aged adults aged 18 to <65 years (Table 7) and older adults aged 65 years and above (Table 8) are presented below. Guidance for the following sub-group populations is also presented; Aboriginal and Torres Strait Islander people (Table 9), people from culturally and linguistically diverse backgrounds (Table 10), people with disability (Table 11), people with an eating disorder (Table 12), people with a mental health condition (Table 13) and pregnant and post-partum women (Table 14). The Appendices (Appendix A: Guidance notes for Assessment; Appendix B: Tips for supporting children and adolescents in healthy habits; Appendix C: Pharmacotherapy for the treatment of obesity) contain specific guidance to support the recommendations.

APPROACH

The GRADE Evidence-to-Decision framework (1) was used by the Guideline Development Committee to determine the strength and direction of a Recommendation (for or against an intervention) and followed structured consideration of desirable effects, undesirable effects, balance of effects, certainty of evidence, resource requirements and cost effectiveness, equity, acceptability and feasibility. The strength of a Recommendation was determined using the framework's balance of effects and certainty of evidence. Recommendations are categorised as defined in Table 1.

Table 1: Categories of the guideline recommendations

SR	**S**trong **R**ecommendation: A strong recommendation was given when there was moderate to high certainty evidence that also showed benefits clearly outweighed reported harms.
CR	**C**onditional **R**ecommendation: A conditional recommendation was given when there was low certainty evidence that suggested benefits outweighed harms.
CS	**C**onsensus **S**tatement: A consensus statement was given where there was very low certainty evidence, or where evidence was absent or insufficient, and/or if there was an unclear balance between benefits and harms. The statements were made based on the Guideline Development Committee's expert opinion and formulated by a consensus process.
PP	**P**ractice **P**oints: A practice point was developed by the Guideline Development Committee to guide the practical application of the evidence. These points were formulated where important issues and additional considerations arose from discussion of evidence-based or consensus recommendations.

Recommendations are also assigned a strength rating, and certainty of evidence rating. The GRADE Evidence-to-Decision framework recommendation strength rating system is based on the GRADE Handbook (1), as shown in Table 2 below.

Table 2: GRADE Evidence-to-Decision framework recommendation strength rating system

Symbol representation	GRADE handbook definition of recommendation strength
★☆☆☆☆	Strong recommendation against the intervention
★★☆☆☆	Conditional recommendation against the intervention
★★★☆☆	Conditional recommendation for either the intervention or the comparison
★★★★☆	Conditional recommendation for the intervention
★★★★★	Strong recommendation for the intervention
Δ	Consensus statement for the intervention

The strength of certainty of evidence was rated using the system shown in Table 3. Certainty of evidence was based on risk of bias, inconsistency (heterogeneity), indirectness (PICOT and applicability), imprecision, other considerations (including publication bias, large effect, plausible confounding factors).

Table 3: GRADE certainty of the evidence rating system

Strength of evidence	GRADE handbook definition of recommendation strength
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect.
Very low	We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect.

Further detail regarding the methods can be found in the accompanying Technical Report.

Table 4: General principles of overweight and obesity management

No.	Type	Recommendation	GRADE Evidence-to-Decision framework recommendation strength rating; GRADE certainty of evidence
1.1	**General principles for the management of overweight or obesity**		
	Ask: Seek permission with compassion and empathy		
1.1.1.		Ask for permission to discuss the person's weight with empathy and compassion: "I understand that this can be a sensitive topic. Would it be alright if we discussed your weight as one potential factor contributing to your health problem/s?". This question also acknowledges the complex aetiology of many physical and mental health problems rather than having a singular focus on weight.	
1.1.2.		Recognise that maintaining or reducing body weight may not be appropriate for every person. Weight neutral approaches with a focus on other health measures and health behaviours may better support people whose preference is not to set a weight reduction goal.	
1.1.3.		Adopting a person-centred approach, begin with the person's concerns and understanding of their problem. For example, "What concerns do you have about your health, including your mental health?" and "What do you think would help in addressing your health problem/s?"	
1.1.4.		Healthcare professionals should acknowledge that the person may have experienced weight bias and discrimination and recognise their own potential weight bias.	
1.1.5.		Healthcare professionals should undertake professional development in the area of weight bias and stigma (such as The Obesity Collective's module Understanding the Science and Reality of Obesity for Better Patient Care).	
	Assess: Considerations for assessment		
1.1.6	**PP**	Approach the assessment in a non-stigmatising way that avoids simplistic explanations of obesity.	
1.1.7	**PP**	Ensure that the clinic equipment (e.g., weighing scales, blood pressure cuffs, chairs, examination couches) is properly sized for larger bodies in all clinical areas.	
1.1.8	**PP**	Never weigh people in front of others; instead, place weighing scales in a private area such as the consultation room.	

1.1.9	**PP**	Offer a comprehensive assessment that acknowledges the complex biopsychosocial factors contributing to weight and its management to counter stigmatising attitudes (e.g., perceptions of blame).
1.1.10	**PP**	History: Assess weight trajectory and previous weight management. Understand food habits, physical activity, sleep patterns, readiness to change and potential barriers. Consider potential contributing factors to weight, including medical conditions and medications, as well as the health and functional impact of excess weight, and the potential presence of eating disorders. Consider the person's living environment, potential social support and financial situation.
1.1.11	**PP**	Many obesity treatments are expensive to access. Consider the patient's context when developing a management plan.
1.1.12	**PP**	Examination: Seek permission to examine the person. Examination should include: • Weight, height, waist circumference. • Measurement of blood pressure • Assessment for signs of complications and secondary causes of obesity. • Blood tests should include consideration of cardiovascular risk factors, metabolic dysfunction-associated steatotic liver disease (MASLD), and others as appropriate for the individual. Compare measurements to relevant BMI cut-points or percentile charts (please refer to Appendix A: Guidance notes for Assessment).
1.1.13	**PP**	Consider the role of binge eating. Overweight or obesity can be a consequence of binge eating (63). Yet fewer than one in four people with eating disorders seek treatment and, even for those that do there is often a delay of many years before treatment is sought. Screening of eating disorders is therefore of high importance. There are several brief self-report questionnaires (e.g. the 7-item Binge Eating Disorder Screener) that can be administered to screen for the possible presence of an eating disorder. Follow up any responses suggesting the possible presence of an eating disorder with further assessment.
1.1.14	**PP**	Discuss with the person any comorbidities that are identified and arrange a holistic management plan. This should include goals of care that are developed in collaboration with the person.
1.1.15	**PP**	A tool used to assess overall health and function is the Edmonton Obesity Staging System for adults, and its paediatric version, Edmonton Obesity Staging System for Pediatrics. The mental, metabolic, and physical impacts experienced by an individual living with overweight or obesity are considered by these frameworks.

1.1.16	**PP**	For adults, a person's suitability to undertake physical activity should be assessed prior to commencement of any physical activity intervention using the Exercise & Sports Science Australia Adult Pre-Exercise Screening System (See Appendix A: Guidance notes for Assessment).
1.1.17	**PP**	For children and adolescents, healthcare professionals should use the Exercise & Sports Science Australia Pre-Exercise Screening System for Young People (PSS-YP) Screening Tool: Parents (5-15 years) or Pre-Exercise Screening System for Young People (PSS-YP) Screening Tool: Young Person (16-17 years) prior to commencement of a physical activity intervention (See Appendix A: Guidance notes for Assessment).
1.1.18	**PP**	The person's severity of obesity, associated mental and physical health problems and their goals for care should guide the type and intensity of treatment.
	Advise: Specific guidance population by population	
1.1.19	**Please refer to each individual population section below for treatment guidelines**	
	Assist: Collaborate on a person-centred plan	
1.1.20	**PP**	Using a person-centred approach, collaborate on a tailored treatment plan. Consider the person's description of their journey including their identity, self-worth and beliefs about body shape and health. Integrate the medical history, patient story and context to help set the direction and treatment priorities.
1.1.21	**PP**	Ensure the tailored treatment plan incorporates the person's preferences, fitness level, health status and lifestyle.
1.1.22	**PP**	Support the person to achieve realistic goals through acquiring the motivation, skills, confidence and supports (social and/or environmental) for behaviour change. Strategies include looking back on the person's journey (what had previously worked and not worked) and consider biopsychosocial barriers and how these can be managed. Financial barriers can cause significant problems with access to treatment and this needs to be acknowledged in any treatment plan that is developed.
1.1.23	**PP**	Education and resources should be provided in formats and languages that are suitable for the person. These should take into account their age, life stage, gender, cultural background, ethnicity, socioeconomic status, food security (such as access to food, refrigeration and cooking facilities), and any additional specific communication needs and literacy level (e.g. learning disabilities, physical or cognitive impairments).

1.1.24	**PP**	Personalise the approach by considering any opportunities for change identified in the consultation/s.
1.1.25	**PP**	Aim to address internalised weight stigma and other misconceptions about obesity as relevant.
1.1.26	**PP**	Reframe negative views that are often weight-centric to be positive towards health benefits that can be gained regardless of weight loss.
1.1.27	**PP**	Focus on the person's goals of treatment, and identify the tools or resources needed that support the person with overweight or obesity to achieve long-term success. Expectations of weight loss should be realistic; goals should be sustainable over the long term (i.e. years to decades).
	Arrange: Appropriate assessment, management and follow-up	
1.1.28	**PP**	Make plans for appropriate assessment, management and follow-up. Referral to other healthcare professionals should be considered.
1.1.29	**PP**	Consider the geographical and cost implications for many of the interventions, and eligibility for Chronic Disease Management Items.
1.1.30	**PP**	Arrange appropriate management for people with disordered eating, poor body image, depression and anxiety, weight-related bullying and other mental health issues where these are present. Note that some people will be at high risk for self-harm and suicide. Screening for high-risk situations should be prioritised.
1.1.31	**PP**	Ensure appropriate communication and handovers are given between treating teams in hospital/tertiary settings to the ongoing primary care team.
1.1.32	**PP**	Adolescents and youth who require ongoing tertiary care should receive support to transition between adolescent/ youth services to adult services while ensuring good communication with the primary care team. Healthcare professionals should identify such people in sufficient time to allow appropriate planning to occur in advance of them becoming ineligible due to their age.
1.1.33	**PP**	Transitioning through the healthcare system should take place with appropriate collaboration between the person, their family/ carers, and other stakeholders, and should be holistic and include education and support.

PP, Practice Point

SUMMARY OF GUIDELINES BY AGE

Table 5: Overweight or obesity management in children (2 to <12 years)

CHILDREN (2 TO <12 YEARS)

No.	Type	Recommendation	GRADE Evidence-to-Decision framework recommendation strength rating; GRADE certainty of evidence
2.1	**General principles for overweight or obesity management in children**		
2.1.1	**PP**	The focus for many children is on weight maintenance which is supported by the Australian Dietary Guidelines and the Australian 24-hour Movement Guidelines.	
2.1.2	**PP**	A range of approaches may be effective with a focus on the parents/carers as the agent of change. These approaches include a combination of nutrition, physical activity and family-centred or psychological interventions.	
2.1.3	**PP**	Early intervention gives families and children the opportunity to embed healthy behaviours into daily routines. Discuss the health benefits of obesity management. Benefits include improved cardiorespiratory fitness, blood pressure, increased HDL-C levels and decreased biomarker indicators of metabolic dysfunction-associated steatotic liver disease. Additionally, a reduction in mental health symptoms (depression, anxiety and eating disorder problems including bulimia, binge eating and emotional eating) may also be experienced.	
2.1.4	**PP**	Healthy habit tips for children can be found in Appendix B: Tips for supporting children and adolescents in healthy habits.	
2.1.5	**PP**	Interventions need to be tailored to the developmental stage of the child.	
2.1.6	**PP**	Strategies that incorporate inclusion, engagement and awareness of weight stigma and sensitivities are needed.	
2.1.7	**PP**	Choice of treatment should consider individual needs and preferences, and additional factors including obesity related comorbidities, ethnicity, socioeconomic status, social history, family medical history, mental health and wellbeing, and special educational needs and disabilities. The financial situation of the family can also impact their ability to access management.	
2.1.8	**PP**	Consider referral to an appropriate specialist for children who are living with obesity and have significant comorbidities or complex needs (for example, learning disabilities or other additional support needs).	
2.1.9	**PP**	Parents may require support in how to help their child with adherence to programs and how to manage resistance from their child.	

2.2		Behavioural interventions: nutrition alone, physical activity alone, and combined interventions	
2.2.1	PP	Children involved in behavioural interventions may experience challenges in adhering to programs due to increased stress, difficulty managing hunger, and resistance to making behavioural changes.	
2.2.2	PP	Behavioural changes may be more achievable for children if families are encouraged to engage in some changes together. This can also help alleviate stigma on the child.	
2.2.3	PP	Inaccurate beliefs and unsafe behaviours regarding weight loss, such as skipping meals and fad diets should be identified and addressed.	
		Nutrition interventions	
2.2.4	CS	Dietary approaches with no specific daily energy intake goal may be encouraged as part of a comprehensive approach to management of weight-related health and wellbeing.	Δ Very low
		Physical activity interventions	
2.2.5	PP	Appropriate enjoyable physical activities, that include realistic goal setting, should be developed with a goal to minimise risk of injury and stigma, while protecting mental health and engagement.	
2.2.6	CS	Aerobic activity interventions may be encouraged as part of a comprehensive approach to management of weight-related health and wellbeing.	Δ Very low
2.2.7	PP	Peer support and enjoyment of physical activities further contributes to improved mental and physical health, creating a sense of accomplishment and collaboration in achieving weight loss goals.	
2.2.8	PP	Identify opportunities to support habitual physical activity at school and within the community.	
		Combined behavioural interventions	
2.2.9	CR	The following multimodal combination may be recommended as part of a comprehensive approach to management of weight-related health and wellbeing: Combined multimodal (four or more) behavioural interventions.	★★★★☆ Low

2.2.10	**CS**	The following multimodal combinations may be encouraged as part of a comprehensive approach to management of weight-related health and wellbeing: Combined nutrition and physical activity interventions. Combined nutrition, physical activity, and psychological interventions. Combined nutrition, physical activity and family-centred interventions. Combined nutrition and family-centred interventions.	Δ **Very low** Δ **Very low** Δ **Very low** Δ **Low**
2.2.11	**PP**	Family-centred interventions, in combination with nutrition and physical activity, may be effective for the management of overweight or obesity. Evidence-based types of family-centred interventions include: • Educating parents about healthy eating. • Encourage parents to attend dietitian consultations with their child. • Provide parents with practical food shopping and preparation advice. • Encourage parents to role-model weight management behaviours, provide children with positive reinforcement, and a home environment that is supportive of healthy behaviours.	
2.3	**Pharmacological management**		
2.3.1	**CS**	There is no evidence to guide the use of pharmacological interventions in the management of children with obesity.	
2.4	**Surgical management**		
2.4.1	**CS**	No evidence was identified to guide the use of surgical interventions for the management of obesity in children.	
2.4.2	**PP**	Children with severe obesity should be referred for management in a specialist paediatric multidisciplinary service.	

CR, Conditional Recommendation; CS, Consensus Statement; PP, Practice Point

Table 6: Overweight or obesity management in adolescents (12 to <18 years)

ADOLESCENTS (12 TO <18 YEARS)			
No.	Type	Recommendation	GRADE Evidence-to-Decision framework recommendation strength rating; GRADE certainty of evidence
3.1	**General principles for overweight or obesity management in adolescents**		
3.1.1	**PP**	Strategies that incorporate inclusion, engagement and awareness of weight stigma and sensitivities are needed. This is an age when participation rates in physical activity/sport, particularly among adolescent girls, are known to decline.	
3.1.2	**PP**	Consider the role of eating disorders. Eating disorders predominately affect girls and women (although the gender ratio is more equivalent for binge eating disorder), and have their peak age of onset in adolescence and young adulthood.	
3.1.3		Healthcare professionals should engage with families to foster a supportive relationship. Family support for adolescent weight management programs is essential for success.	
3.1.4	**PP**	Discuss the health benefits of overweight or obesity management. Benefits include increased remission of metabolic syndrome, improved cardiorespiratory fitness, blood pressure, physical function, decreased biomarker indicators of metabolic dysfunction-associated steatotic liver disease, and reduction in depressive symptoms.	
3.1.5	**PP**	Treatment needs to be tailored to the developmental stage of the adolescent.	
3.1.6	**PP**	Choice of treatment should consider individual needs and preferences, and additional factors including obesity related comorbidities, ethnicity, socioeconomic status, social history, family medical history, mental health and wellbeing, and special educational needs and disabilities. The financial situation of the adolescent may also impact their ability to access care.	
3.1.7	**PP**	A range of approaches may be effective with the preferred approach negotiated with the adolescent and their parents/carers. These include a combination of nutrition, physical activity and family-centred or psychological interventions. For those with more severe obesity, consider pharmacological interventions or bariatric surgery, provided by teams with expertise in adolescent care.	
3.1.8	**PP**	Healthy habit tips for adolescents can be found in Appendix B: Tips for supporting children and adolescents in healthy habits.	

3.1.9	**PP**	For adolescents, plan weight management programs that involve frequent contact with healthcare professionals.	
3.1.10	**PP**	Consider referral to an appropriate specialist for adolescents who are living with obesity and have significant comorbidities or complex needs (for example, learning disabilities or other additional support needs).	
3.2	**Behavioural interventions: physical activity alone, and combined interventions**		
3.2.1	**PP**	Behavioural interventions may result in health benefits in addition to weight loss. These include improvements in health-related quality of life and a reduction in mental health symptoms (depression, anxiety and eating disorder problems including bulimia, binge eating and emotional eating).	
3.2.2	**PP**	Adolescents involved in behavioural interventions may experience challenges in adhering to programs due to increased stress, difficulty managing hunger, and resistance to making behavioural changes.	
3.2.3	**PP**	Inaccurate beliefs and unsafe behaviours regarding weight loss, such as skipping meals and fad diets may be identified and should be addressed.	
	Nutrition interventions		
3.2.4	**PP**	No evidence was identified to guide the use of nutrition interventions for the management of overweight or obesity in adolescents. Healthy eating behaviours, such as following the Australian Dietary Guidelines, should be encouraged.	
	Physical activity interventions		
3.2.5	**PP**	Appropriate individually tailored and monitored physical activity programs, that include realistic goal setting, should be developed with a goal to minimise risk of injury and stigma, while protecting mental health and engagement.	
3.2.6	**CS**	Physical activity interventions may be encouraged as part of a comprehensive approach to management of weight-related health and wellbeing.	Δ **Very low**
3.2.7	**PP**	Peer support and enjoyment of physical activities further contributes to improved mental and physical health, creating a sense of accomplishment and collaboration in achieving weight loss goals.	
3.2.8	**PP**	Identify opportunities to support habitual physical activity at school and within the community.	

	Combined behavioural interventions		
3.2.9	**CR**	The following multimodal combinations may be recommended as part of a comprehensive approach to the management of weight-related health and wellbeing: Combined nutrition and physical activity interventions. Combined nutrition, physical activity and family-centred interventions. Combined multimodal (four or more) behavioural interventions.	★★★★☆ **Low** ★★★★☆ **Low** ★★★★☆ **Low**
3.2.10	**CS**	The following multimodal combination may be encouraged as part of a comprehensive approach to the management of weight-related health and wellbeing: Combined nutrition, physical activity and psychological interventions.	Δ **Very low**
3.2.11	**PP**	Family-centred interventions, in combination with nutrition and physical activity, may be effective for the management of overweight or obesity. Evidence-based types of family-centred interventions include: • Raising awareness about goals. • Social support. • A healthy home food environment.	
3.2.12	**PP**	Appropriate individually tailored and monitored physical activity programs, that include realistic goal setting, should be developed for adolescents living with overweight or obesity with a goal to minimise risk of injury and stigma, while protecting mental health and engagement.	
3.3	**Pharmacological management**		
3.3.1	**PP**	Two medications are approved by the Australian Therapeutic Goods Administration (TGA) for the treatment of obesity in adolescents (12-17 years) at the time of these Guidelines: phentermine and semaglutide (2.4 mg), although none are currently funded in Australia through the Pharmaceutical Benefits Scheme. As this is a rapidly evolving field, it is recommended to check for updates to this statement through the TGA website.	
3.3.2	**SR**	Pharmacological interventions, approved by the TGA for weight management, should be considered, where clinically appropriate, as part of a comprehensive treatment program to improve weight-related health and wellbeing. Refer to Appendix C: Pharmacotherapy for the treatment of obesity for further guidance regarding specific pharmacological options. • Semaglutide, 2.4mg.	★★★★★ **Moderate**
3.3.3	**PP**	A long-term, comprehensive follow-up strategy involving caregivers is required to monitor health and well-being.	

3.3.4	**PP**	When prescribing a pharmacological intervention, clinical judgement will be required to ensure the agent is tailored to both the adolescent's health and their developmental stage.
3.3.5	**PP**	Based on clinical trials underway, the evidence is rapidly evolving. Healthcare professionals need to be aware of the evidence as it changes over time.
3.3.6	**PP**	Discuss with the person and their caregiver the potential benefits they may experience from pharmacological interventions in addition to weight loss. Healthcare professionals should be aware that each drug class has a different profile of additional benefits which may be relevant when prescribing, and the evidence regarding additional benefits is emerging rapidly and healthcare professionals should monitor regularly.
3.3.7	**PP**	Healthcare professionals should be aware each drug class has a different profile of adverse effects, which may be relevant when prescribing (Appendix C: Pharmacotherapy for the treatment of obesity). The evidence regarding adverse effects is rapidly emerging and therefore requires regular monitoring by healthcare professionals.
3.3.8	**PP**	Pharmacological intervention-related adverse effects are common, most gastrointestinal effects are mild and transient. Many adverse effects can be minimised or mitigated by starting at a low dose followed by a gradual increase.
3.3.9	**PP**	Regular review of medication and long-term follow-up are necessary.
3.3.10	**PP**	Awareness of possible drug-drug interactions is necessary. These differ by drug class.
3.3.11	**PP**	There is very limited long-term data from pharmacotherapy studies. We recommend regularly checking for updates or similar.

3.3.12	**PP**	A number of medications **not approved** by TGA for weight loss therapy are being used off-label in Australia for the management of obesity by practitioners experienced in obesity care. Off label prescribing requires discussion with the patient and documentation of the decision as the prescriber has an increased personal liability in the setting of an adverse event (Ongoing challenges of off-label prescribing) (Appendix C: Pharmacotherapy for the treatment of obesity).	
3.4	**Surgical management**		
3.4.1	**SR**	For adolescents with severe obesity, healthcare professionals should consider bariatric surgery interventions as part of a comprehensive approach to management of weight-related health and wellbeing.	★★★★★ **High**
3.4.2	**PP**	Surgical management should form part of a multidisciplinary approach in the management of obesity. Interventions need to be considered as part of a comprehensive care plan focussed on treating the adolescent within their family and social context.	
3.4.3	**PP**	Discuss with the person the potential adverse events that may be experienced from surgical management and the need for a long-term comprehensive follow-up strategy with their healthcare providers. Adverse events include vitamin and nutrient deficiencies (e.g., iron thiamine, vitamin D, calcium, vitamin B12 and albumin). Adolescent specific supports to enable compliance with nutritional supplementation and post-bariatric surgery follow up should be considered.	

CR, Conditional Recommendation; CS, Consensus Statement; PP, Practice Point; SR, Strong Recommendation

Table 7: Overweight or obesity management in young and middle-aged adults (18 to <65 years)

YOUNG AND MIDDLE-AGED ADULTS (18 TO <65 YEARS)

No.	Type	Recommendation	GRADE Evidence-to-Decision framework recommendation strength rating; GRADE certainty of evidence
4.1	**General principles for overweight or obesity management in young and middle-aged adults**		
4.1.1	**PP**	Discuss with the person the benefits of overweight or obesity management. These benefits include a reduction in blood pressure, reduced risk of cardiovascular disease, type 2 diabetes, cancer risk and a decrease in the risk of mortality from cardiovascular disease. Additionally, improvements in various health-related quality of life domains may be experienced (e.g., global Health Related Quality of Life, physical, and emotional functioning).	
4.1.2	**PP**	A range of interventions may be effective, with the preferred approach negotiated with the person with overweight or obesity, including nutrition, physical activity, sedentary behaviour, sleep, and psychological interventions. Combinations of these approaches are recommended. Pharmacological or surgical interventions in conjunction with the listed behavioural interventions may also be recommended as guided by the eligibility criteria in the corresponding sections below.	
4.1.3	**PP**	The management plan should be reviewed at an appropriate interval and assess whether it needs to be modified. Arrangements should be made for ongoing follow up as more frequent contact is generally associated with better outcomes.	
4.1.4	**PP**	If there is no weight loss in line with the expected timeframe outlined in the management plan, potential reasons for this should be reviewed. Intensive weight loss interventions may also be considered depending on the goals of the person, degree of overweight or obesity and whether comorbidities are present.	
4.1.5	**PP**	Discuss with the person the possible harms they may experience while undertaking a behavioural intervention.	

4.2		**Behavioural interventions: nutrition alone, physical activity alone, and combined interventions**	
		Nutrition interventions	
4.2.1	**PP**	A range of nutrition approaches are effective for weight loss and/or maintenance. Tailoring nutrition approaches to achieve treatment goals should occur in partnership with the person to accommodate food preferences, allow flexibility and avoid overly restrictive and/or nutritionally inadequate diets. Evidence-based dietary approaches for weight management include: • DASH diet. • Mediterranean diet. • Low energy diets. • Intermittent fasting. • Commercially available meal replacements. • Very low energy diets. • Healthy dietary pattern consistent with the Australian Guide to Healthy Eating. Some individuals will require guidance on linking this to a specific daily diet or energy intake goal.	
4.2.2	**CS**	Different levels of evidence were identified for selected nutrition interventions. Nutrition interventions overall may be encouraged as part of a comprehensive approach for the management of weight-related health and wellbeing. Included selected nutrition interventions, in order of recommendation strength, were:	Δ **Very low**
		Strong recommendation: Dietary approaches with no specific daily energy intake goal should be recommended as part of a comprehensive approach for the management of weight-related health and wellbeing.	★★★★★ **Moderate**
		Conditional recommendation: Nutrition interventions with a daily energy intake goal may be recommended as part of a comprehensive approach for the management of weight-related health and wellbeing.	★★★★☆ **Low**
		Consensus statement: Nutrition interventions with an initial daily energy intake goal, followed by dietary approaches with no specific daily energy intake goal may be encouraged as part of a comprehensive approach for the management of weight-related health and wellbeing.	Δ **Very low**
		Physical activity interventions	
4.2.3	**PP**	Assess current physical activity levels using an available questionnaire (e.g. the Active Australia Survey) and identify those who do not meet Australian physical activity guidelines for adults. Encourage the person to regularly break up sitting time and replace with any intensity level of physical activity.	

4.2.4	**PP**	Appropriate individually tailored and monitored physical activity programs, that include realistic goal setting, should be developed for people living with overweight or obesity with a goal to minimise risk of injury and stigma, while protecting mental health and engagement.	
4.2.5	**PP**	Adults should be encouraged to undertake regular physical activity, as it may result in additional health benefits even in the absence of weight loss. Recommended types of physical activity include: • aerobic activities such as brisk walking, swimming, cycling • muscle strengthening activities • reducing and breaking up sitting time throughout the day is also beneficial.	
4.2.6	**PP**	For inactive adults who are living with overweight or obesity, particularly those who are older than 40 years and those with comorbidities, there should be an individualised approach to gradually increase physical activity to reach national physical activity guidelines of at least 150 minutes a week and muscle strengthening activities on at least two days a week. Prior to commencement of physical activity assess the person's suitability using the Exercise & Sports Science Pre-screening tools for Adults (See Appendix A: Guidance notes for Assessment).	
4.2.7	**PP**	Seek advice and support from appropriately qualified exercise specialists. In the case of chronic or complex comorbidities (or other situations where assistance for participation in physical activity is needed), healthcare professionals should arrange for the support of an Accredited Exercise Physiologist.	
4.2.8	**CR**	Different levels of evidence were identified for selected physical activity interventions. Physical activity overall may be recommended as part of a comprehensive approach to management of weight-related health and wellbeing. Included selected physical interventions, in order of recommendation strength, were: Strong recommendation: Combined aerobic exercise interventions should be recommended as part of a comprehensive approach to management of weight-related health and wellbeing. Conditional recommendation: Aerobic and strengthening activity interventions may be recommended as part of a comprehensive approach to management of weight-related health and wellbeing. Consensus statement: Strengthening activity interventions may be encouraged as part of a comprehensive approach to management of weight-related health and wellbeing.	★★★★☆ **Low** ★★★★★ **Moderate** ★★★★☆ **Low** Δ **Very low**
4.2.9	**PP**	Identify opportunities to support habitual physical activity within the community.	

	Combined behavioural interventions		
4.2.10	**CR**	The following multimodal combination may be recommended as part of a comprehensive approach to management of weight-related health and wellbeing: Combined multimodal (four or more) behavioural interventions.	★★★★☆ **Low**
4.2.11	**CS**	The following multimodal combinations may be encouraged as part of a comprehensive approach to management of weight-related health and wellbeing: Combined nutrition and physical activity (with or without sedentary behaviour) interventions. Combined nutrition, physical activity and psychological interventions. Combined nutrition, physical activity and sleep interventions. Combined nutrition and family-centred interventions. Combined nutrition and psychological interventions. Combined physical activity and psychological interventions.	Δ **Very low** Δ **Very low** Δ **Very low** Δ **Low** Δ **Very low** Δ **Very low**
4.2.12	**PP**	Family-centred interventions, in combination with nutrition and physical activity, may be effective for the management of overweight or obesity. Evidence-based types of family-centred interventions include: • Raising awareness about goals. • Social support. • A healthy home food environment.	
4.2.13	**PP**	Psychological interventions, in combination with nutrition and physical activity, may be effective for the management of overweight or obesity. Evidence-based types of psychological interventions include: • Motivational interviewing to build readiness to change • Cognitive behavioural therapy to learn the skills to support long term behaviour changes.	
4.2.14		Sleep interventions may be prescribed for the management of overweight or obesity, in combination with nutrition and physical activity interventions. Evidence-based sleep interventions include: • Sleep hygiene.	
4.2.15	**PP**	While less is known about effects of multimodal approaches to weight management, some people may be encouraged to take up multimodal treatments with specific tailoring to their needs.	

4.2.16	**PP**	Behavioural interventions may result in health benefits in addition to weight loss. These include improved health-related quality of life (vitality, physical function and reduced body pain) and a reduction in mental health symptoms (depression, anxiety and eating disorder problems including binge eating and emotional eating).	
4.3	**Pharmacological management**		
4.3.1	**PP**	Within a holistic management plan that includes behavioural supports, all adults with a BMI over 30kg/m2 or BMI over 27kg/m2 with weight-related co-morbidities, should be offered a pharmacological intervention. A shared decision-making approach should be used including discussion about benefits, side effects, cost, potential long-term risks and emerging risks of medications.	
4.3.2	**PP**	Six medications are approved by the Australian Therapeutic Goods Administration (TGA) for the treatment of obesity at the time of these Guidelines: phentermine, orlistat, liraglutide (3.0 mg), naltrexone/bupropion and semaglutide (2.4 mg), and tirzepatide, although none are currently funded in Australia through the Pharmaceutical Benefits Scheme. Further detail on these medications can be found in Appendix C: Pharmacotherapy for the treatment of obesity. As this is a rapidly evolving field, it is recommended to check for updates to this statement through the TGA website.	
4.3.3	**SR**	Pharmacological interventions, approved by the TGA for weight management, should be considered as part of a comprehensive treatment program to improve weight-related health and wellbeing. Refer to Appendix C: Pharmacotherapy for the treatment of obesity for further guidance regarding specific pharmacological options. Specific pharmacological interventions included in the evidence review were: • Semaglutide, 2.4mg • Liraglutide, 3.0mg • Orlistat, 360mg • Naltrexone, 32 mg plus Bupropion, 360 mg • Tirzepatide, 5 mg • Tirzepatide, 10 mg • Tirzepatide, 15 mg	★★★★★ **Moderate** **Moderate** **Low** **Moderate** **High** **High** **Moderate**
4.3.4	**PP**	Discuss with the person the potential benefits they may experience from pharmacological interventions in addition to weight loss. Healthcare professionals should be aware that additional benefits vary according to medication class, which may be relevant when prescribing (Appendix C: Pharmacotherapy for the treatment of obesity).	

4.3.5	**PP**	The profile of adverse effects vary according to medication class, which may be relevant when prescribing (Appendix C: Pharmacotherapy for the treatment of obesity). Medication-related adverse effects are common and can include gastrointestinal effects, headache, insomnia, and palpitation. Most gastrointestinal effects are mild and transient. Many adverse effects can be minimised or mitigated by starting at a low dose followed by a gradual increase.	
4.3.6	**PP**	A number of medications not approved by TGA for weight loss therapy are being used off-label in Australia for the management of obesity by practitioners experienced in obesity care. Off label prescribing requires discussion with the patient and documentation of the decision as the prescriber has an increased personal liability in the setting of an adverse event (Ongoing challenges of off-label prescribing) (Appendix C: Pharmacotherapy for the treatment of obesity). Documentation should be shared to a patient's My Health Record (if applicable) to enable continuity of care.	
4.4	**Surgical management**		
4.4.1	**PP**	Metabolic and bariatric surgery may be considered a treatment option for people with class I obesity with obesity related co-morbidities who do not achieve substantial or durable weight loss or co-morbidity improvement with non-surgical methods, and should be discussed for anyone with class II or more obesity regardless of the presence of obesity related co-morbidities. For guidance on obesity classification refer to Appendix A: Guidance notes for Assessment.	
4.4.2	**CR**	Bariatric surgery interventions may be recommended as part of a comprehensive approach to management of weight-related health and wellbeing.	★★★★☆ **Low**
4.4.3	**CS**	Some endoscopic therapies may be considered as part of a comprehensive approach to management of weight-related health and wellbeing.	Δ **Very low**
4.4.4	**CR**	Adjunct therapy (e.g., cognitive behavioural therapy and, physical activity) combined with bariatric surgery interventions may be recommended as part of a comprehensive approach to management of weight-related health and wellbeing.	★★★★☆ **Low**
4.4.5	**PP**	Surgical management should form part of a multidisciplinary approach in the management of obesity.	
4.4.6	**PP**	Discuss with the person that most endoscopic therapies are intended to be reversible so may not offer sustainable weight loss.	
4.4.7	**PP**	Discuss with the person the potential benefits of a more proven sustainable treatment effect that comes with surgery.	
4.4.8	**PP**	Discuss with the person the potential adverse events that may be experienced from surgical management and the need for a long-term comprehensive follow-up strategy with their healthcare providers. Adverse events include vitamin and nutrient deficiencies (e.g., iron, thiamine, vitamin D, calcium, vitamin B12 and albumin) and surgery related adverse events.	

CR, Conditional Recommendation; CS, Consensus Statement; PP, Practice Point; SR, Strong Recommendation

Table 8: Overweight or obesity management in older adults (> 65 years)

OLDER ADULTS (> 65 YEARS)

No.	Type	Recommendation	GRADE Evidence-to-Decision framework recommendation strength rating; GRADE certainty of evidence
5.1		**General principles for overweight or obesity management in older adults**	
5.1.1	**PP**	Clinical judgement is required for older adults living with overweight or obesity to balance priorities for health care in the presence of co-morbidities (e.g. chronic kidney disease, insulin-requiring Type 2 diabetes mellitus, cancer) as well as age-related conditions (e.g. sarcopenia, osteoporosis/osteopenia, etc.) and treatment with medications that have weight or nutrition requirement implications.	
5.1.2	**PP**	Discuss with the person the benefits of overweight or obesity management. Benefits in adults in general include a reduction in blood pressure, reduced risk of cardiovascular disease, type 2 diabetes, cancer risk and a decrease in the risk of mortality from cardiovascular disease. Additionally, improvements in various health-related quality of life domains may be experienced (e.g., global Health Related Quality of Life, physical, and emotional functioning).	
5.2		**Behavioural interventions: nutrition alone, physical activity alone, and combined interventions**	
		Nutrition interventions	
5.2.1	**PP**	Tailoring nutrition approaches to achieve weight management goals should occur in partnership with the person to accommodate food preferences, allow flexibility and avoid overly restrictive and/or nutritionally inadequate diets to ensure nutrient intakes are optimised. Evidence-based dietary approaches for weight management in older adults include: • Low energy diets.	
5.2.2	**CS**	Different levels of evidence were identified for selected nutrition interventions. Nutrition interventions overall may be encouraged as part of a comprehensive approach for the management of weight-related health and wellbeing. Included selected nutrition interventions, in order of recommendation strength, were: **Consensus statement:** Nutrition interventions with a daily energy intake goal may be encouraged, for individuals for whom weight loss is the primary goal, as part of a comprehensive approach for the management of weight-related health and wellbeing. **Consensus statement:** Dietary approaches with no specific daily energy intake goal may be encouraged as part of a comprehensive approach for management of weight-related health and wellbeing.	Δ **Very low** Δ **High** Δ **Very low**

5.2.3	**PP**	When considering nutrition interventions in older adults living with overweight or obesity, healthcare professionals will need to balance the potential benefit from improving diet quality (and hence improved food and nutrient intakes) versus the need for weight reduction. Healthy dietary approaches with no specific daily energy intake goal may better align with quality-of-life goals.	
	Physical activity interventions		
5.2.4	**CS**	Different levels of evidence were identified for selected physical activity interventions. Physical activity overall may be encouraged as part of a comprehensive approach to management of weight-related health and wellbeing. Included selected physical interventions, in order of recommendation strength, were: **Conditional recommendation:** Aerobic and strengthening exercise interventions may be recommended as part of a comprehensive approach for the management of weight-related health and wellbeing. **Consensus statement:** Strengthening exercise interventions may be encouraged as part of a comprehensive approach for the management of weight-related health and wellbeing.	Δ **Very low** ★★★★☆ **Low** Δ **Moderate**
5.2.5	**PP**	For inactive older adults who are living with overweight or obesity, particularly those with comorbidities, there should be an individualised approach to gradually increase physical activity to reach national physical activity guidelines for older Australians of 30 minutes of moderate intensity physical activity on most days, and strength exercises on 2 or 3 days. Prior to commencement of physical activity assess the person's suitability using the Exercise & Sports Science Pre-screening tools for Adults (See Appendix A: Guidance notes for Assessment).	
5.2.6	**PP**	Appropriate individually tailored and monitored physical activity programs, that include realistic goal setting, should be developed with a goal to minimise risk of injury and stigma, while protecting mental health and engagement.	
5.2.7	**PP**	Older adults should be encouraged to increase their physical activity, even if it does not result in weight loss, as it has additional health benefits. Recommended types of physical activity include: • muscle strengthening activities • reducing and breaking up sitting time throughout the day is also beneficial.	
5.2.8	**PP**	Seek advice and support from appropriately qualified exercise specialists. In the case of chronic or complex comorbidities (or other situations where assistance for participation in physical activity is needed), healthcare professionals should arrange for the support of an Accredited Exercise Physiologist.	

5.2.9	**PP**	Identify opportunities to support habitual physical activity within the community.	
	Combined behavioural interventions		
5.2.10	**CR**	The following multimodal combinations may be recommended as part of a comprehensive approach to management of weight-related health and wellbeing: Combined nutrition, physical activity and psychological interventions.	★★★★☆ **Low**
5.2.11	**CS**	The following multimodal combinations may be encouraged as part of a comprehensive approach to management of weight-related health and wellbeing: Combined nutrition and physical activity interventions. Combined nutrition and sedentary behaviour interventions.	Δ **Very low** Δ **Low**
5.2.12	**PP**	Psychological interventions, in combination with nutrition and physical activity, may be effective for the management of overweight or obesity. Evidence-based types of psychological interventions include: • Motivational interviewing to build readiness to change. • Cognitive behavioural therapy to learn the skills to support long term behaviour change.	
5.2.13	**PP**	Appropriate individually tailored and monitored physical activity programs, that include realistic goal setting, should be developed with a goal to minimise risk of injury and stigma, while protecting mental health and engagement.	
5.3	**Pharmacological management**		
5.3.1	**CS**	There is a lack of evidence to guide the use of pharmacological interventions for the management of overweight or obesity specifically in older adults. Whilst there were pharmacological studies identified which allowed for the inclusion of adults >65 year, the average age of included participants was <65 years and these studies did not provide specific information relating to the older adults only.	
5.3.2	**PP**	Pharmacological interventions, approved for weight management in conjunction with adjunctive behavioural therapy may be appropriate as part of a comprehensive treatment program to improve weight-related health and wellbeing. Balancing of risks and benefits required to determine appropriateness. Refer to Pharmacological management in young and middle-aged adults.	

5.4	Surgical management	
5.4.1	**CS**	There is a lack of evidence to guide the use of surgical interventions for the management of obesity in older adults. Whilst there were surgical studies identified which allowed for the inclusion of adults >65 year, the average age of included participants was <65 years and these studies did not provide specific information relating to the older adults only.
5.4.2	**PP**	Bariatric surgery could be considered where the person living with obesity could benefit from weight loss to improve health, physical function or quality of life.
5.4.3	**PP**	There is no evidence to support an age limit on people seeking metabolic and bariatric surgery and a holistic assessment of the person, including quality of life, impact of co-morbidities and anaesthetic risk, is recommended.

CR, Conditional Recommendation; CS, Consensus Statement; PP, Practice Point

SUMMARY OF GUIDELINES FOR SUB-GROUP POPULATIONS

Table 9: Overweight or obesity management in Aboriginal and Torres Strait Islander people

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

No.	Type	Recommendation	GRADE Evidence-to-Decision framework recommendation strength rating; GRADE certainty of evidence
6.1		**General principles for overweight or obesity management in Aboriginal and Torres Strait Islander people**	
6.1.1	**CS**	Aboriginal and Torres Strait Islander people have continuously cared for the land and seas of Australia and are the longest living culture on Earth spanning 65,000 years. Since colonisation there have been significant challenges to the health and wellbeing of Aboriginal and Torres Strait Islander people, and voices of the community need to be valued and respected when applying the Guidelines in this group. Strong connection to culture and community are essential for wellbeing. Access and affordability to culturally responsive health services including through existing community controlled health services, for pharmacological and surgical interventions is essential. Due to the impact of colonisation, Aboriginal and Torres Strait Islander people are disproportionately affected by poverty and disadvantage. There are challenges of affordability and access to healthy food, housing options and appropriate healthcare. These challenges need to be considered when creating a treatment plan for Aboriginal and Torres Strait Islander patients.	
6.1.2	**CS**	There is no current research evidence that is specific for Aboriginal and Torres Strait Islander people to guide clinical management. Refer to age specific guidance to help guide overweight or obesity management in Aboriginal and Torres Strait Islander people.	
6.1.3	**PP**	Healthcare professionals should familiarise themselves with key documents such as the Obesity, diet and physical activity in Aboriginal and Torres Strait Islander adults and the National Aboriginal and Torres Strait Islander Health Plan 2021-2031 .	

CS, Consensus Statement; PP, Practice Point

Table 10: Overweight or obesity management in people from culturally and linguistically diverse backgrounds

PEOPLE FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

No.	Type	Recommendation	GRADE Evidence-to-Decision framework recommendation strength rating; GRADE certainty of evidence
7.1		**General principles for overweight or obesity management in people from culturally and linguistically diverse backgrounds**	
7.1.1	**CS**	We acknowledge and recognise the experiences of people living in Australia from culturally and linguistically diverse backgrounds. Additional challenges may exist in interacting and engaging with the Australian health system. The voices of these individuals and their communities need to be valued and respected when applying the Guidelines. Improved access and affordability to culturally responsive health services, including pharmacological and surgical interventions are needed for people living with overweight or obesity.	
7.1.2	**CS**	There is a lack of evidence to guide clinical management specific for culturally and linguistically diverse people. Refer to age specific guidance to help guide overweight or obesity management in people from culturally and linguistically diverse backgrounds.	
7.1.3	**PP**	There may be variations in adiposity cut-points and differential risk for comorbidities for some ethnicities, including Asian populations.	
7.1.4	**PP**	Healthcare professionals are encouraged to engage with interpreter and translation services for people for whom English is a second language. TIS is available nationally Translating and Interpreting Service (TIS National).	
7.1.5	**PP**	Healthcare professionals should consider different cultural practices regarding food and physical activity when making recommendations. These may include periods of fasting and celebration and culturally significant foods.	
7.1.6	**PP**	Healthcare professionals should consider cultural beliefs about body shape and size and provide culturally sensitive advice to support healthy growth.	

CS, Consensus Statement; PP, Practice Point

Table 11:Overweight or obesity management in people with disability

PEOPLE WITH DISABILITY

No.	Type	Recommendation	GRADE Evidence-to-Decision framework recommendation strength rating; GRADE certainty of evidence
8.1	**General principles for overweight or obesity management in people with disability**		
8.1.1	**PP**	Consistent with Article 25 of the United Nations' Convention on the Rights of Persons with Disabilities, healthcare professionals are to provide the same quality of care to people with disability as to others, including gaining free and informed consent.	
8.1.2	**PP**	Treatment needs to be person-centred, based on the nature of a person's disability and age.	
8.1.3	**PP**	Access to healthcare professionals with expertise in metabolic conditions and disabilities should be considered in complex situations. A holistic approach to the management of overweight or obesity should be taken, ensuring the person is not viewed only in terms of their impairment.	
8.1.4	**PP**	Discuss with the person and/or their family the benefits, other than weight loss, that may be experienced through the management of overweight or obesity. Please refer to the appropriate age group section above for guidance.	
8.1.5		Information provided to the person should be in formats and languages that are suited to the person. Specific communication needs should be taken into consideration (e.g., because of intellectual disabilities, physical disabilities or neurocognitive impairments).	
8.2	**Behavioural interventions: nutrition alone, physical activity alone, and combined interventions**		
	Nutrition interventions		
8.2.1	**CS**	Dietary approaches with no specific daily energy intake goal may be encouraged as part of a comprehensive approach for management of weight-related health and wellbeing.	Δ **Very low**

	Combined behavioural interventions		
8.2.2	**CS**	Multimodal interventions may be encouraged as part of a comprehensive approach to management of weight-related health and wellbeing: Combined nutrition and physical activity (with or without sedentary behaviour) interventions. Combined nutrition, physical activity and family-centred interventions.	Δ **Very low** Δ **Very low**
8.2.3	**PP**	Family-centred interventions, in combination with nutrition and physical activity, may be effective for the management of overweight or obesity. Evidence-based types of family-centred interventions include: • Provide instructions to parents/guardians on behavioural strategies such as diet and physical activity monitoring, "stimulus control" modifications in the home, goal setting and positive reinforcement. • Engage parents/guardians in education/behavioural counselling sessions.	
8.2.4	**PP**	Identify opportunities to support habitual physical activity within the community.	
8.2.5	**PP**	Consider whether specialist advice and support for physical activity may be beneficial.	
8.2.6	**CS**	Based on the age of the person with a disability, refer to the recommendations for the relevant treatment type. A lack of evidence was identified to guide the use of physical activity alone, pharmacological, or surgical interventions for the management of overweight or obesity in people with disability.	

CS, Consensus Statement; PP, Practice Point

Table 12: Overweight or obesity management in people with an eating disorder

PEOPLE WITH AN EATING DISORDER

No.	Type	Recommendation	GRADE Evidence-to-Decision framework recommendation strength rating; GRADE certainty of evidence
9.1	**General principles for overweight or obesity management in people with an eating disorder**		
9.1.1	**PP**	Healthcare professionals should familiarise themselves with Eating Disorder Safe Principles: Whole-of Community Approaches To Do No Harm in Relation to Eating Disorders, Disordered Eating and Body Image Distress (Eating Disorder Safe Principles).	
9.1.2	**PP**	Treatment for eating disorders should be prioritised before targeting weight loss given that features of eating disorders could be exacerbated by a premature focus on weight loss (e.g., overconcern with body shape/weight and maladaptive dieting and other weight control behaviours) and/or interfere with successful weight management (e.g., binge eating).	
9.1.3	**PP**	For individualised treatment planning, discuss with the person (and their family as appropriate) the relative benefits and limitations of undertaking professionally-supported weight management versus a weight-neutral approach.	
9.1.4	**PP**	Consider the risks associated with overweight or obesity and the health and other benefits of moderate weight loss, as well as the challenges of sustaining weight losses and the health benefits from changing eating and physical activity patterns irrespective of weight loss.	
9.1.5	**PP**	Monitoring to assess undesirable health outcomes (including the potential exacerbation of eating disorder symptoms) in the context of weight management is essential.	
9.1.6	**PP**	In conjunction with the management of the eating disorder, where clinically appropriate, individually tailored and monitored treatments for overweight or obesity, that include realistic goal setting, and weight related health and wellbeing may be encouraged. For further information on the management of the eating disorder, see the Management of Eating Disorders for People with a Higher Weight: Clinical Practice Guideline.	

9.2	**Behavioural interventions: combined interventions**		
	Combined behavioural interventions		
9.2.1	**CS**	Where clinically appropriate, the following multimodal combinations may be encouraged as part of a comprehensive approach to management of weight-related health and wellbeing:	
		Combined nutrition and physical activity interventions.	Δ **Very low**
		Combined nutrition, physical activity and psychological.	Δ **Low**
9.2.2	**CS**	Based on the age of the person with an eating disorder, refer to the recommendations for the relevant treatment type. A lack of evidence was identified to guide the use of nutrition alone, physical activity alone, pharmacological, or surgical interventions for the management of overweight or obesity in people with an eating disorder.	

CS, Consensus Statement; PP, Practice Point

Table 13: Overweight or obesity management in people with a mental health condition

PEOPLE WITH A MENTAL HEALTH CONDITION

No.	Type	Recommendation	GRADE Evidence-to-Decision framework recommendation strength rating; GRADE certainty of evidence
10.1	**General principles for overweight or obesity management in people with a mental health condition**		
10.1.1	**PP**	All people with a serious mental illness and other mental health conditions living with overweight or obesity should be offered treatment for their weight-related health and wellbeing.	
10.1.2	**PP**	Antipsychotic medications cause significant weight gain. Weight-gain is greatest with olanzapine followed by asenapine, risperidone, aripiprazole, quetiapine XR, brexpiprazole, cariprazine, and lurasidone.	
10.1.3	**PP**	A long-term comprehensive follow-up strategy is required to monitor weight-related health and wellbeing. This is particularly important for people newly diagnosed with a serious mental illness to prevent weight gain associated with some medications prescribed for the treatment of a mental health condition.	
10.1.4	**PP**	Access to healthcare professionals with skills in managing both serious mental illness and metabolic conditions is needed, including General Practice and mental healthcare professional review.	
10.1.5	**PP**	Discuss with the person (and their family as appropriate) the risk associated with overweight or obesity. Please refer to the appropriate age group section above for guidance.	
10.1.6	**PP**	Discuss with the person (and their family as appropriate) the benefits, other than weight loss, that may be experienced through the management of overweight or obesity. Please refer to the appropriate age group section above for guidance.	
10.1.7	**CS**	Based on the age of the person living with overweight or obesity and a mental health condition, refer to the recommendations for the relevant treatment type. A lack of evidence was identified to guide the use of nutrition alone, physical activity alone, pharmacological or surgical interventions for the management of overweight or obesity in people with a mental health condition.	

10.2	**Behavioural interventions: combined interventions**		
	Combined behavioural interventions		
10.2.1	**CR**	The following multimodal combinations may be recommended as part of a comprehensive approach to management of weight-related health and wellbeing: Combined nutrition, physical activity and psychological interventions.	★★★★☆ **Low**
10.2.2	**CS**	The following multimodal combination may be encouraged as part of a comprehensive approach to management of weight-related health and wellbeing: Combined nutrition and physical activity interventions.	Δ **Very low**
10.2.3	**CS**	Combining nutrition, physical activity and family-centred interventions may result in little to no difference in adiposity in people with a mental health condition.	Δ **Low**
10.2.4	**CS**	A combination of four or more behavioural interventions likely results in little to no difference in adiposity.	Δ **Moderate**
10.2.5	**PP**	While less is known about effects of multimodal approaches to weight management, some people may be encouraged to take up multimodal treatments with specific tailoring to their needs.	
10.2.6	**PP**	Identify opportunities to support habitual physical activity within the community.	
10.3	**Pharmacological interventions**		
10.3.1	**PP**	Based on the age of the person living with overweight or obesity and a mental health condition, refer to the recommendations for the pharmacological interventions in the relevant age group.	
10.3.2	**PP**	Prescribers should be aware that there are medications with specific contraindications to people with a mental health condition, including the medications they are currently on. Please refer to Appendix C: Pharmacotherapy for the treatment of obesity and the TGA website for further information and updates regarding contraindications and side effects of medications.	

CR, Conditional Recommendation; CS, Consensus Statement; PP, Practice Point

Table 14: Overweight or obesity management in pregnant and post-partum women

PREGNANT AND POST-PARTUM WOMEN

No.	Type	Recommendation	GRADE Evidence-to-Decision framework recommendation strength rating; GRADE certainty of evidence
11.1		**General principles for overweight or obesity management in pregnant and post-partum women**	
11.1.1	**CS**	Evidence regarding overweight or obesity management in pregnant and post-partum women was not reviewed in these guidelines. General guidance only has been provided in these recommendations. For detailed guidance in this population please refer to the nutrition and physical activity section of the Australian pregnancy care guidelines.	
11.1.2	**PP**	While weight loss interventions are contraindicated during pregnancy, dietary and exercise interventions in pregnancy can reduce gestational weight gain to a modest degree (of the order of 1kg) but have no impact on clinical outcomes for the woman or her baby.	
11.1.3	**PP**	Nutrition during pregnancy should be appropriate to support foetal development and align with recommendations in the Australian Dietary Guidelines.	
11.1.4	**PP**	Low- to moderate-intensity physical activity during pregnancy is associated with a range of health benefits and is not associated with adverse outcomes.	
11.1.5	**PP**	Higher level activities may be possible for women who were involved in these before pregnancy and have the required level of fitness. Intensity of activity should be reduced in the third trimester.	
11.1.6	**PP**	Behavioural counselling may reduce maternal weight gain.	
11.1.7	**PP**	Very low-energy diets, weight loss medications and bariatric surgery are contraindicated in pregnancy.	
11.1.8	**PP**	After pregnancy, extended breastfeeding is recommended. Infants who are exclusively breastfed for at least six months are less likely to gain excessive weight and develop obesity later in life.	

CS, Consensus Statement; PP, Practice Point

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APPENDIX A: GUIDANCE NOTES FOR ASSESSMENT

ASSESSMENT OF WEIGHT STATUS

Guidance for measurement of weight

- Seek permission to weigh the person
- Use a calibrated scale on a hard, level surface
- Ask the person to remove shoes and any heavy outer clothing
- Ask the person to stand on the scale with weight distributed on both feet
- Record their weight. Be aware that some people will not want to know their own weight, have a technique for recording weight in this circumstance.

Guidance for measurement of height

- Use a height measure that is vertical with the base at floor level
- Ask the person to remove shoes and any heavy outer clothing
- Ask the person to stand with their back to the height measure. The person should look straight ahead and their back of the head, back and buttocks should touch the height measure
- Press hair flat and record height

Guidance for calculation of BMI

BMI is calculated by the equation Weight (kg)/Height (m)2 with classifications shown below. This is a guide and should be interpreted in terms of the patient's clinical history, examination and investigations. BMI cut points for different obesity-associated health risks also vary according to ethnicity.

CLASSIFICATION	GENERAL POPULATION BMI (KG/M²)	POPULATION SPECIFIC BMI (KG/M²)*
Healthy weight	18.5 to 24.9	
Overweight	25.0 to 29.9	23.0 to 27.4
Obese	>30	>27.5
Obese class I	30.0 to 34.9	27.5 to 32.4
Obese class II	35 to 39.9	32.5 to 37.4
Obese class III	≥ 40	≥ 37.5

BMI, body mass index; kg, kilograms; m, metres.

*Population specific cut-offs apply to people with a family background of either South Asian, Chinese, other Asian, Middle Eastern, Black African or African Caribbean (3).

Source: Adapted from Department of Health and Aged Care, Body mass index (BMI) and waist measurement (4).

Adjustments to these measures may be needed for certain populations such as Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse groups, and for older adults.

Guidance for interpreting BMI

- BMI is only one part of the assessment of personal health risk and should be considered alongside other clinical markers
- People with the same BMI may have different proportions of fat and fat-free mass
- A higher BMI threshold may be appropriate for some groups including for people who have a high muscle mass (e.g. athletes)
- At an equivalent BMI, women will usually have more body fat than men
- At the same BMI, older people will usually have more body fat than younger people
- Currently there is no validated adjusted threshold for Aboriginal and Torres Strait Islander people, however a BMI of 22kg/m2 may be a more accurate reflection of risk, particularly in those from remote communities.
- People originally from some Asian countries (e.g. South Asian countries, China, Japan) may have high body fat at lower weights, so a lower BMI (e.g. >23kg/m2) may be considered to be within the overweight range.
- People originally from some Pacific Islands (including Māori) may have a higher proportion of lean body mass, so consider a higher BMI threshold.
- Central deposition of fat increases health risk so waist circumference may be a more appropriate guide for personal health risk.

Source: Adapted from the previous Guidelines (5, 6)

Limitations of BMI and alternative measurements

Due to the known limitations of BMI for assessing individual health risk, other clinical indicators should be used during diagnosis. Waist circumference is an indicator of visceral adiposity; hence it complements BMI by assessing weight distribution. For adults, risk of chronic disease is increased when waist circumference is ≥94cm (men) or ≥80cm (women), while risk is greatly increased at ≥102 cm (men) and ≥88cm (women) for people of European descent (4). There may be variations in adiposity cut-points for some ethnicities (7).

Percentile charts, z scores and monitoring change over time support assessment of weight, height and BMI of children and adolescents (see the World Health Organization growth charts for children).

Guidance for measurement of waist circumference (8, 9)

- The measurement should be taken between the top of the iliac crest and the lower margin of the last palpable rib in the mid axillary line
- Measuring tape should be at a level parallel to the floor
- Consistent tension should be kept in the measuring tape

	WOMEN*	MEN*
Increased risk	>80 cm	>94 cm
Greatly increased risk	>88 cm	>102 cm

*These measurements do not apply to children and pregnant women (4).

Source: Adapted from Department of Health and Aged Care, Body mass index (BMI) and waist measurement (4).

ASSESSMENT OF NUTRITION

Children and Adults

The Eat for health program provides up-to-date advice about the amounts and kinds of foods that individuals need to eat for health and wellbeing. The recommendations are based on the latest scientific evidence, developed after looking at all the good quality research.

Eat for health calculators can estimate energy (kilojoule) needs, nutrient requirements and the number of serves from the five food groups people need daily.

ASSESSMENT OF PHYSICAL ACTIVITY

Children and adolescents

The Pre-Exercise Screening System for Young People is to be completed for the healthcare professional by a parent or carer on behalf of the child or adolescent prior to commencement of a physical activity intervention.

Adults

Prior to commencement of a physical activity intervention, the Adult Pre-Exercise Screening System may be self-administered or administered by the healthcare professional.

PRE-EXERCISE SCREENING SYSTEM FOR YOUNG PEOPLE

PARENT TOOL (PSS-PARENT)

Important Information: This tool is part of the Pre-Exercise Screening System (PSS) and should be used in conjunction with the PSS User Guide which covers how to use the information collected and to address the aims of each stage. This does not constitute medical advice. These guidelines and the PSS (together 'the material') is not intended for use to diagnose, treat, cure or prevent any medical conditions, is not intended to be professional advice and is not a substitute for independent health professional advice. Exercise & Sport Science Australia, Fitness Australia, Sports Medicine Australia and Exercise is Medicine (together 'the organisations') do not accept liability for any claims, howsoever described, for loss, damage and/or injury in connection with the use of any of the material, or any reliance on the information therein. While care has been taken to ensure the information contained in the material is accurate at the date of publication, the organisations do not warrant its accuracy. No warranties (including but not limited to warranties as to safety) and no guarantees against injury or death are given by the organisations in connection with the use or reliance on the material. If you intend to take any action or inaction based on the guidelines and/or the PSS, it is recommended that you obtain your own professional advice based on your specific circumstances.

Child/Young Person's Details:

Full Name: _____

Date of Birth: _____ Age: _____ Gender: *Male* ☐ *Female* ☐ *Prefer not to say* ☐ *Other* ☐

Pre-exercise screening results will be kept as confidential files and shared only among individuals involved in the event of urgent medical care, and/or with the consent of the young person and/or parent/guardian.

STAGE 1 (COMPULSORY)

To be completed with a parent/guardian in conjunction with an exercise professional or the individual who is responsible for the medical care of the young person.

These questions are part of a screening system designed for young people participating in exercise. The aim is to identify any young person with medical conditions or warning signs that may put them at a higher risk of an unwanted event during activity or exercise sessions. Unwanted events may include something unexpected during exercise leading to illness, physical harm or death.

Definition of Child: Any young person between the age of 5-15 years old in your care

Please tick your response

Does your child have, or previously had:	YES	DON'T KNOW	NO
1. A heart condition?			
2. A close relative who has died suddenly from a heart condition before the age of 50?			
3. Uncontrolled epilepsy or seizures/convulsions?			
4. Fainting or dizzy spells with physical activity/exercise?			
5. Diabetes?			
6. An asthma attack requiring immediate medical attention at any time over the last 12 months?			
7. Anaphylactic reactions?			
8. Surgery in the last month?			
9. Any other conditions that may require special consideration for your child to exercise?			
IF YOU ANSWERED 'YES' or 'DON'T KNOW' to any of the 9 questions above, please discuss with the exercise leader or the person administering this form prior to undertaking exercise.			
IF YOU ANSWERED 'NO' we recommend you proceed to Stage 2 with the exercise leader or those providing medical care for the young person.			
10. Over the past seven days, on how many days was your child physically active for a total of 60 minutes or more per day?	Number of days:		

Parent/Guardian - I hereby acknowledge that:

- To the best of my knowledge, all of the information supplied within this tool is correct.
- I will inform the exercise leader or those providing medical care for the young person if there are any changes to the information provided.

Name: _____ Signature: _____ Date: _____

24-hour Physical Activity Guidelines

Following these guidelines may be challenging at times; however, meeting them will benefit health. Achieving these guidelines is associated with better health and leads to improved body composition, cardiorespiratory and musculoskeletal fitness, cardiovascular and metabolic health, academic achievement and cognition, and improved mental health and emotional regulation. For those not currently meeting these guidelines, a progressive adjustment towards them is recommended.

Figure 1. 24-hour physical activity guidelines
(http://www.health.gov.au/internet/main/publishing.nsf/Content/health-24-hours-phys-act-guidelines)

STAGE 2 (RECOMMENDED)

This stage is to be completed with an activity or exercise leader, or a relevant health professional, to highlight possible medical conditions or warning signs that may put a child/young person at a higher risk of an unwanted event during activity or exercise sessions.

11. Does your child take any regular medications or supplements?

YES ☐ **NO** ☐

If your child is taking any regular medications or supplements, provide details:

_____

12. Does your child have any current health or medical management plans (e.g. anaphylaxis, asthma or diabetes)?

YES ☐ **NO** ☐

If yes, provide details:

_____

If yes, does your child always carry the relevant medication?

- Anaphylaxis - Epipen? **YES** ☐ **NO** ☐ **NA** ☐
- Diabetes - insulin or glucose? **YES** ☐ **NO** ☐ **NA** ☐
- Asthma - reliever (Ventolin or other)? **YES** ☐ **NO** ☐ **NA** ☐

13. Has your child experienced heat related illness previously?

YES ☐ **NO** ☐

If yes, provide details:

_____

14. Has your child spent time in hospital (including day admission) for any medical condition/ illness/ injury during the last 12 months?

YES ☐ **NO** ☐

If yes, provide details:

---

15. Does your child have any muscle, bone or joint problems and/or pain that could be made worse by participating in activity?

YES ☐ **NO** ☐

If yes, provide details:

---

16. In the last month has your child suffered an episode of concussion?

YES ☐ **NO** ☐

If yes, provide details:

---

17. Which of the following behaviours did your child do in the last 7 days?	Yes/No	Frequency	Duration (average)
Sport (including training)			
Physical Education class			
School physical activity (e.g. fitness, lunch time sports)			
Active travel (e.g. walk or cycle to shops/school)			
Other physical activity (e.g. gym, walking the dog, play at playground)			

Over the last week, what time did your child go to bed (Sunday to Thursday evening)?	
Over the last week, what time did your child wake up (Monday to Friday morning)?	
On the weekend (Friday or Saturday evening), what time did your child go to bed?	
On the weekend (Saturday or Sunday morning), what time did your child wake up?	

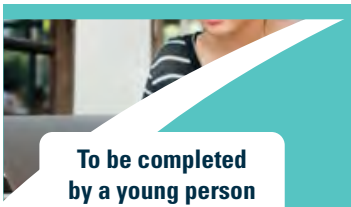
On the last 5 school days (Monday to Friday), how much time on average did your child spend:	Hours
- watching movies or TV shows on any device (TV, computer, tablet or smartphone?)	
- surfing the internet for fun?	
- texting or messaging, or using social media?	
- playing videogames on smartphones, computers, tablets or consoles like Playstation?	

OPTIONAL

18. Is your child pregnant or have they given birth previously?

YES ☐ **NO** ☐

If yes, provide details:



To be completed by a young person 16-17 years old

PRE-EXERCISE SCREENING SYSTEM FOR YOUNG PEOPLE

YOUNG PERSON TOOL (PSS-YP)

Important Information: This tool is part of the Pre-Exercise Screening System and should be used in conjunction with the PSS User Guide which covers how to use the information collected and to address the aims of each stage. This does not constitute medical advice. These guidelines and the PSS (together 'the material') is not intended for use to diagnose, treat, cure or prevent any medical conditions, is not intended to be professional advice and is not a substitute for independent health professional advice. Exercise & Sport Science Australia, Fitness Australia, Sports Medicine Australia and Exercise is Medicine (together 'the organisations') do not accept liability for any claims, howsoever described, for loss, damage and/or injury in connection with the use of any of the material, or any reliance on the information therein. While care has been taken to ensure the information contained in the material is accurate at the date of publication, the organisations do not warrant its accuracy. No warranties (including but not limited to warranties as to safety) and no guarantees against injury or death are given by the organisations in connection with the use or reliance on the material. If you intend to take any action or inaction based on the guidelines and/or the PSS, it is recommended that you obtain your own professional advice based on your specific circumstances.

Child/Young Person's Details:

Full Name: _____

Date of Birth: _____ Age: _____ Gender: *Male* ☐ *Female* ☐ *Prefer not to say* ☐ *Other* ☐

Pre-exercise screening results will be kept as confidential files and shared only among individuals involved in the event of urgent medical care, and/or with the consent of the young person and/or parent/guardian.

STAGE 1 (COMPULSORY)

To be completed with an exercise professional or individual who is responsible for the medical care of the young person.

These questions are part of a system designed for young people participating in exercise. The aim is to identify any young person with medical conditions or warning signs that may put them at a higher risk of an unwanted event during activity or exercise sessions. Unwanted events may include something unexpected during exercise leading to illness, physical harm or death.

Please tick your response

Do you have, or previously had:	YES	DON'T KNOW	NO
1. A heart condition?			
2. A close relative who has died suddenly from a heart condition before the age of 50?			
3. Uncontrolled epilepsy or seizures/convulsions?			
4. Fainting or dizzy spells with physical activity/exercise?			
5. Diabetes?			
6. An asthma attack requiring immediate medical attention at any time over the last 12 months?			
7. Anaphylactic reactions?			
8. Surgery in the last month?			
9. Any other conditions that may require special consideration for you to exercise?			
IF YOU ANSWERED 'YES' or 'DON'T KNOW' to any of the 9 questions above, please discuss with the exercise leader or the person administering this form prior to undertaking exercise.			
IF YOU ANSWERED 'NO' we recommend you proceed to Stage 2 with the exercise leader or those providing medical care.			
10. Over the past seven days, on how many days were you physically active for a total of 60 minutes or more per day?	Number of days:		

Young Person - I hereby acknowledge that:

- To the best of my knowledge, all of the information I have supplied within this screening tool is correct.
- I will inform the exercise leader or person administering this form if there are any changes to the answers above.

Name: _____ Signature: _____ Date: _____

Parent/Guardian Consent (*required if young person 15 years old or younger) - I hereby acknowledge that:

- To the best of my knowledge, all of the information supplied within this tool is correct.
- I will inform the exercise leader or those providing medical care immediately if there are any changes to the information provided.

Name: _____ Signature: _____ Date: _____

24-hour Physical Activity Guidelines

Following these guidelines may be challenging at times; however, meeting them will benefit health. Achieving these guidelines is associated with better health and leads to improved body composition, cardiorespiratory and musculoskeletal fitness, cardiovascular and metabolic health, improved cognition, mental health and emotional regulation. For those not currently meeting these guidelines, a progressive adjustment towards them is recommended.

Figure 1. 24-hour physical activity guidelines
(http://www.health.gov.au/internet/main/publishing.nsf/Content/health-24-hours-phys-act-guidelines)

STAGE 2 (RECOMMENDED)

This stage is to be completed with an activity or exercise leader, or a relevant health professional, to highlight possible medical conditions or warning signs that may put a young person at a higher risk of an unwanted event during activity or exercise sessions.

11. Do you take any regular medications or supplements?

YES ☐ **NO** ☐

If you are taking any regular medications or supplements, provide details:

_____

12. Do you have any current health or medical management plans (e.g. anaphylaxis, asthma or diabetes)?

YES ☐ **NO** ☐

If yes, provide details:

_____

If yes to above, do you always carry any required medication?

- Anaphylaxis - Epipen? **YES** ☐ **NO** ☐ **NA** ☐
- Diabetes - insulin or glucose? **YES** ☐ **NO** ☐ **NA** ☐
- Asthma - reliever (Ventolin or other)? **YES** ☐ **NO** ☐ **NA** ☐

13. Have you experienced heat related illness previously?

YES ☐ **NO** ☐

If yes, provide details:

_____

24-hour Physical Activity Guidelines

Following these guidelines may be challenging at times; however, meeting them will benefit health. Achieving these guidelines is associated with better health and leads to improved body composition, cardiorespiratory and musculoskeletal fitness, cardiovascular and metabolic health, improved cognition, mental health and emotional regulation. For those not currently meeting these guidelines, a progressive adjustment towards them is recommended.

Figure 1. 24-hour physical activity guidelines
(http://www.health.gov.au/internet/main/publishing.nsf/Content/health-24-hours-phys-act-guidelines)

STAGE 2 (RECOMMENDED)

This stage is to be completed with an activity or exercise leader, or a relevant health professional, to highlight possible medical conditions or warning signs that may put a young person at a higher risk of an unwanted event during activity or exercise sessions.

11. Do you take any regular medications or supplements?

YES ☐ **NO** ☐

If you are taking any regular medications or supplements, provide details:

_____

12. Do you have any current health or medical management plans (e.g. anaphylaxis, asthma or diabetes)?

YES ☐ **NO** ☐

If yes, provide details:

_____

If yes to above, do you always carry any required medication?

- Anaphylaxis - Epipen? **YES** ☐ **NO** ☐ **NA** ☐
- Diabetes - insulin or glucose? **YES** ☐ **NO** ☐ **NA** ☐
- Asthma - reliever (Ventolin or other)? **YES** ☐ **NO** ☐ **NA** ☐

13. Have you experienced heat related illness previously?

YES ☐ **NO** ☐

If yes, provide details:

_____

This screening tool is part of the Adult Pre-Exercise Screening System (APSS) that also includes guidelines (see User Guide) on how to use the information collected and to address the aims of each stage. No warranty of safety should result from its use. The screening system in no way guarantees against injury or death. No responsibility or liability whatsoever can be accepted by Exercise & Sport Science Australia, Fitness Australia, Sports Medicine Australia or Exercise is Medicine for any loss, damage, or injury that may arise from any person acting on any statement or information contained in this system.

ADULT PRE-EXERCISE SCREENING SYSTEM (APSS)

This screening tool is part of the Adult Pre-Exercise Screening System (APSS) that also includes guidelines (see User Guide) on how to use the information collected and to address the aims of each stage. No warranty of safety should result from its use. The screening system in no way guarantees against injury or death. No responsibility or liability whatsoever can be accepted by Exercise & Sport Science Australia, Fitness Australia, Sports Medicine Australia or Exercise is Medicine for any loss, damage, or injury that may arise from any person acting on any statement or information contained in this system.

Full Name: _____

Date of Birth: _____ Male: ☐ Female: ☐ Other: ☐

STAGE 1 (COMPULSORY)

AIM: To identify individuals with known disease, and/or signs or symptoms of disease, who may be at a higher risk of an adverse event due to exercise. An adverse event refers to an unexpected event that occurs as a consequence of an exercise session, resulting in ill health, physical harm or death to an individual.

This stage may be self-administered and self-evaluated by the client. Please complete the questions below and refer to the figures on page 2. Should you have any questions about the screening form please contact your exercise professional for clarification.

	Please tick your response YES	NO
1. Has your medical practitioner ever told you that you have a heart condition or have you ever suffered a stroke?		
2. Do you ever experience unexplained pains or discomfort in your chest at rest or during physical activity/exercise?		
3. Do you ever feel faint, dizzy or lose balance during physical activity/exercise?		
4. Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months?		
5. If you have diabetes (type 1 or 2) have you had trouble controlling your blood sugar (glucose) in the last 3 months?		
6. Do you have any other conditions that may require special consideration for you to exercise?		

IF YOU ANSWERED 'YES' to any of the 6 questions, please seek guidance from an appropriate allied health professional or medical practitioner prior to undertaking exercise.

IF YOU ANSWERED 'NO' to all of the 6 questions, please proceed to question 7 and calculate your typical weighted physical activity/exercise per week.

7. Describe your current physical activity/exercise levels in a typical week by stating the frequency and duration at the different intensities. For intensity guidelines consult figure 2.

Intensity	**Light**	**Moderate**	**Vigorous/High**
Frequency (number of sessions per week)	_____	_____	_____
Duration (total minutes per week)	_____	_____	_____

Weighted physical activity/exercise per week

Total minutes = (minutes of light + moderate) + (2 x minutes of vigorous/high)

TOTAL = _____ minutes per week

- If your total is less than 150 minutes per week then light to moderate intensity exercise is recommended. Increase your volume and intensity slowly.
- If your total is more than or equal to 150 minutes per week then continue with your current physical activity/exercise intensity levels.
- It is advised that you discuss any progression (volume, intensity, duration, modality) with an exercise professional to optimise your results.

I believe that to the best of my knowledge, all of the information I have supplied within this screening tool is correct.

Client signature: _____ Date: _____

ADULT PRE-EXERCISE SCREENING SYSTEM (APSS) V2 (2019)

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FIGURE 1: Stage 1 Screening Steps

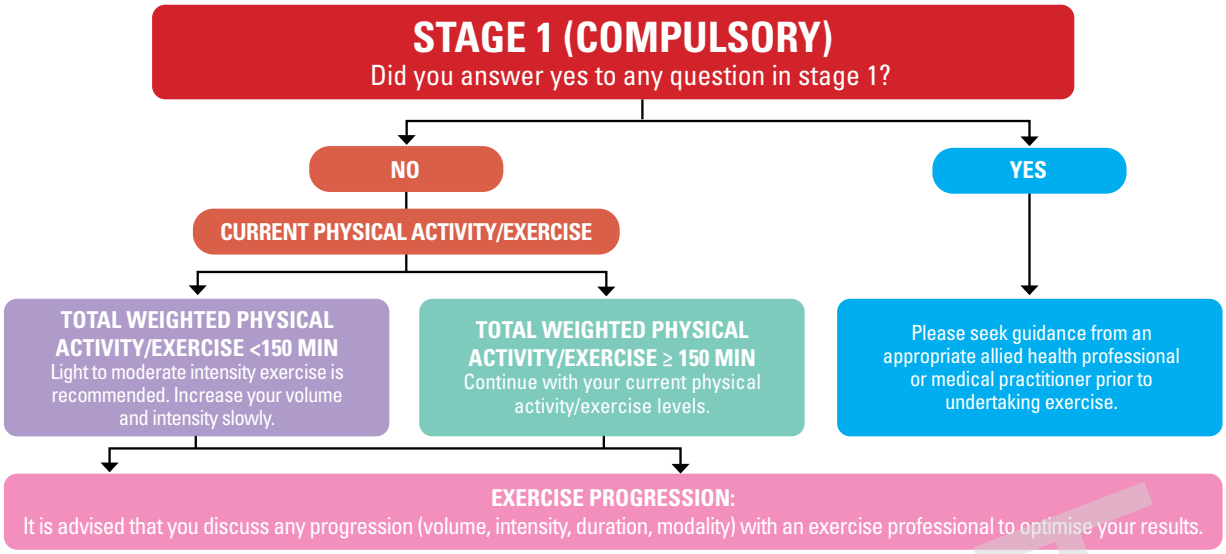

FIGURE 2: Exercise Intensity Guidelines

INTENSITY CATEGORY	HEART RATE MEASURES	PERCEIVED EXERTION MEASURES	DESCRIPTIVE MEASURES
LIGHT	40 to <55% HRmax*	VERY LIGHT TO LIGHT RPE# 1-2	• An aerobic activity that does not cause a noticeable change in breathing rate • An intensity that can be sustained for at least 60 minutes
MODERATE	55 to <70% HRmax*	MODERATE TO SOMEWHAT HARD RPE# 3-4	• An aerobic activity that is able to be conducted whilst maintaining a conversation uninterrupted • An intensity that may last between 30 and 60 minutes
VIGOROUS	70 to <90% HRmax*	HARD RPE# 5-6	• An aerobic activity in which a conversation generally cannot be maintained uninterrupted • An intensity that may last up to 30 minutes
HIGH	≥ 90% HRmax*	VERY HARD RPE# 7	• An aerobic activity in which it is difficult to talk at all • An intensity that generally cannot be sustained for longer than about 10 minutes

* HRmax = estimated heart rate maximum. Calculated by subtracting age in years from 220 (e.g. for a 50 year old person = 220 - 50 = 170 beats per minute).

= Borg's Rating of Perceived Exertion (RPE) scale, category scale 0-10.

Modified from Norton K, L. Norton & D. Sadgrove. (2010). Position statement on physical activity and exercise intensity terminology. J Sci Med Sport 13, 496-502.

ADULT PRE-EXERCISE SCREENING SYSTEM (APSS) V2 (2019)

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STAGE 2 (RECOMMENDED)

AIM: This stage is to be completed with an exercise professional to determine appropriate exercise prescription based on established risk factors.

CLIENT DETAILS	GUIDELINES FOR ASSESSING RISK
8. Demographics Age: _____ Male ☐ Female ☐ Other ☐	Risk of an adverse event increases with age, particularly males ≥ 45 yr and females ≥ 55 yr.
9. Family history of heart disease (e.g. stroke, heart attack)? Relationship (e.g. father) Age at heart disease event _____ _____ _____ _____ _____ _____	A family history of heart disease refers to an event that occurs in relatives including parents, grandparents, uncles and/or aunts before the age of 55 years.
10. Do you smoke cigarettes on a daily or weekly basis or have you quit smoking in the last 6 months? Yes ☐ No ☐ If currently smoking, how many per day or week? _____	Smoking, even on a weekly basis, substantially increases risk for premature death and disability. The negative effects are still present up to at least 6 months post quitting.
11. Body composition Weight (kg) _____ Height (cm) _____ Body Mass Index (kg/m²) _____ Waist circumference (cm) _____	Any of the below increases the risk of chronic diseases: BMI ≥ 30 kg/m² Waist > 94 cm male or > 80 cm female
12. Have you been told that you have high blood pressure? Yes ☐ No ☐ If known, systolic/diastolic (mmHg) _____ Are you taking any medication for this condition? Yes ☐ No ☐ If yes, provide details _____	Either of the below increases the risk of heart disease: Systolic blood pressure ≥ 140 mmHg Diastolic blood pressure ≥ 90 mmHg
13. Have you been told that you have high cholesterol/ blood lipids? Yes ☐ No ☐ If known: Total cholesterol (mmol/L) _____ HDL (mmol/L) _____ LDL (mmol/L) _____ Triglycerides (mmol/L) _____ Are you taking any medication for this condition? Yes ☐ No ☐ If yes, provide details _____	Any of the below increases the risk of heart disease: Total cholesterol ≥ 5.2 mmol/L HDL < 1.0 mmol/L LDL ≥ 3.4 mmol/L Triglycerides ≥ 1.7 mmol/L

CLIENT DETAILS	GUIDELINES FOR ASSESSING RISK
14. Have you been told that you have high blood sugar (glucose)? Yes ☐ No ☐ If known: Fasting blood glucose (mmol/L) _____ Are you taking any medication for this condition? Yes ☐ No ☐ If yes, provide details _____	Fasting blood sugar (glucose) ≥ 5.5 mmol/L increases the risk of diabetes.
15. Are you currently taking prescribed medication(s) for any condition(s)? These are additional to those already provided. Yes ☐ No ☐ If yes, what are the medical conditions? _____	Taking medication indicates a medically diagnosed problem. Judgment is required when taking medication information into account for determining appropriate exercise prescription because it is common for clients to list 'medications' that include contraceptive pills, vitamin supplements and other non-pharmaceutical tablets. Exercise professionals are not expected to have an exhaustive understanding of medications. Therefore, it may be important to use common language to describe what medical conditions the drugs are prescribed for.
16. Have you spent time in hospital (including day admission) for any condition/illness/injury during the last 12 months? Yes ☐ No ☐ If yes, provide details _____	There are positive relationships between illness rates and death versus the number and length of hospital admissions in the previous 12 months. This includes admissions for heart disease, lung disease (e.g., Chronic Obstructive Pulmonary Disease (COPD) and asthma), dementia, hip fractures, infectious episodes and inflammatory bowel disease. Admissions are also correlated to 'poor health' status and negative health behaviours such as smoking, alcohol consumption and poor diet patterns.
17. Are you pregnant or have you given birth within the last 12 months? Yes ☐ No ☐ If yes, provide details _____ _____ _____	During pregnancy and after recent childbirth are times to be more cautious with exercise. Appropriate exercise prescription results in improved health to mother and baby. However, joints gradually loosen to prepare for birth and may lead to an increased risk of injury especially in the pelvic joints. Activities involving jumping, frequent changes of direction and excessive stretching should be avoided, as should jerky ballistic movements. Guidelines/fact sheets can be found here: 1) www.exerciseismedicine.com.au 2) www.fitness.org.au/Pre-and-Post-Natal-Exercise-Guidelines
18. Do you have any diagnosed muscle, bone, tendon, ligament or joint problems that you have been told could be made worse by participating in exercise? Yes ☐ No ☐ If yes, provide details _____ _____	Almost everyone has experienced some level of soreness following unaccustomed exercise or activity but this is not really what this question is designed to identify. Soreness due to unaccustomed activity is not the same as pain in the joint, muscle or bone. Pain is more extreme and may represent an injury, serious inflammatory episode or infection. If it is an acute injury then it is possible that further medical guidance may be required.

APPENDIX B: TIPS FOR SUPPORTING CHILDREN AND ADOLESCENTS IN HEALTHY HABITS

Healthy eating gives your child energy to play, grow and learn

Start each day with a healthy breakfast

This helps your child to focus. Healthy options include porridge, low-sugar wholegrain cereal, eggs, wholegrain toast, rice, veggies, fruit and yoghurt.

Offer a variety of foods from the 5 food groups

To support good health, include plenty of vegetables, fruit, cereals and grain foods, dairy or plant-based alternatives with added calcium, and meat, chicken, fish, seafood, eggs, beans/legumes, nuts and seeds.

Offer healthy snacks

Healthy snacks can give kids energy between meals. Try fruit, veggies, nuts, yoghurt or wholegrain bread/crackers and cheese.

Drink plenty of water each day

Water is the best drink for growing minds and bodies. It also helps keep teeth and gums healthy.

Eat together when you can

Sharing and cooking meals together encourages kids to try different healthy foods. It's also a great way to spend time as a family.

Brush teeth in the morning and before bed

Healthy teeth and gums help us smile, speak, eat and socialise.

Movement and sleep help with health, mood and focus

Be active each day

3 to 5 years: at least 3 hours being active. Including 1 hour energetic play.

5 to 17 years: at least 1 hour doing things that make the heart beat faster and build strength. Plus several hours of light physical activity such as walking to school.

Balance screen time and sitting with other activities

Break up screen time and sitting with activities that help support development. Limit screen time to:

3 to 5 years: no more than 1 hour a day.

6 to 17 years: no more than 2 hours a day (not counting school activities).

Follow a bedtime routine to help kids get enough sleep. Aim for:

3 to 5 years: 10 to 13 hours (including naps) each day.

6 to 13 years: 9 to 11 hours a night.

14 to 17 years: 8 to 10 hours a night.

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For more healthy habits, scan the QR codes

Healthy, low cost recipes

Free programs for the whole family

Raising Children Network – advice for all ages

NSW GOVERNMENT

Sourced from Healthy Kids for Professionals at pro.healthykids.nsw.gov.au

APPENDIX C: PHARMACOTHERAPY FOR THE TREATMENT OF OBESITY

	Phentermine	Orlistat	Liraglutide 3 mg	Naltrexone plus Bupropion	Semaglutide 2.4 mg	Tirzepatide
Year of TGA approval	1991	2000	2015	2018	2022	2024
Route and form	Oral (capsule)	Oral (tablet)	Subcutaneous (injection)	Oral (tablet)	Subcutaneous (injection)	Subcutaneous (injection)
Recommended dose	15 mg, 30 mg or 40 mg once daily	120 mg three times a day, with meals	Starting dose 0.6 mg daily, escalating by 0.6 mg per week over five weeks to 3 mg once daily	Starting dose one 8 mg naltrexone–90 mg bupropion tablet daily, escalating by one tablet per week over four weeks to two tablets twice daily (16 mg naltrexone–180 mg bupropion twice a day)	Starting dose 0.25 mg weekly, escalating every four weeks to 2.4 mg weekly over 16 weeks	Initial dose of 2.5mg per week, increasing to 5mg per week after 4 weeks and may increase dose by 2.5 mg increments after > 4 weeks on current dose up to a maximum of 15 mg per week, maintenance 5, 10 or 15 mg per week (10, 11)
Mechanism of action for weight loss	Reduces appetite by stimulating neural release of noradrenaline, serotonin and dopamine	Reduces absorption of dietary fat by inhibiting gastric and pancreatic lipases	Reduces appetite by stimulating GLP-1 receptors in several brain areas	Reduces appetite by stimulating activity of POMC neurons in the hypothalamus	Reduces appetite by stimulating GLP-1 receptors in several brain areas	Dual GIP/GLP-1 receptor agonism (11)
Population approved for use in* (12)	Adolescents and Adults	Adults only	Adults only	Adults only	Adolescents and Adults	Adults only
PBS subsidised for weight management† (13)	No	No	No	No	No	No
Contraindications and precautions	• Coronary artery disease • Uncontrolled hypertension • Hyperthyroidism • Glaucoma • Cardiac arrhythmias • MAOI • Pregnancy • Breastfeeding • Not recommended with SSRIs	• Pregnancy • Breastfeeding • Chronic malabsorption syndrome (11) • Cholestasis (11)	• Pregnancy • Breastfeeding • Personal or family history of medullary thyroid carcinoma or, • Multiple endocrine neoplasia syndrome type 2	• Pregnancy • Breastfeeding • Uncontrolled hypertension • Seizure disorders • Bipolar disorder • Undergoing abrupt discontinuation of alcohol or anticonvulsant drugs • Chronic opioid use • MAOI	• Pregnancy • Breastfeeding • Personal or family history of medullary thyroid carcinoma or, • Multiple endocrine neoplasia syndrome type	• Pregnancy • Personal or family history of medullary thyroid carcinoma or, • Multiple endocrine neoplasia syndrome type 2 (10, 11)

	Phentermine	Orlistat	Liraglutide 3 mg	Naltrexone plus Bupropion	Semaglutide 2.4 mg	Tirzepatide
Side effects[‡]	• Dry mouth • Insomnia • Palpitations • Tachycardia • Hypertension • Anxiety • Dizziness • Constipation	• Steatorrhea • Oily spotting • Faecal urgency	• Nausea • Diarrhoea • Constipation • Vomiting • Headache • Dyspepsia • Cholelithiasis	• Nausea • Constipation • Headache • Vomiting • Dizziness • Insomnia • Dry mouth • Diarrhoea • Hypertension	• Nausea • Diarrhoea • Constipation • Vomiting • Headache • Dyspepsia • Cholelithiasis	• Nausea • Diarrhoea • Vomiting • Constipation • Abdominal pain • Dyspepsia (10, 11)
Mean placebo-subtracted weight loss	7.4 kg over 36 weeks	4% at 52 weeks	4–6% at 56 weeks	5% at 56 weeks	12–14% at 68 weeks	17.8% at 72 weeks (14)
Proportion of clinical trial participants with 5% and 10% weight loss at ~12 months	NA	73% and 41% (v 45% and 21% placebo)	63% and 33% (v 27% and 11% placebo)	48% and 25% (v 16% and 7% placebo)	86% and 69% (v 32% and 12% placebo)	91% and 84% (35 and 19% placebo) (14)
Effects on reward-related drivers of eating	Reduced craving for fats and sweets v placebo (Food Craving Inventory) at 12 weeks	No difference in changes to eating restraint, disinhibition, or binge eating v placebo after 18–33 months (Three Factor Eating Questionnaire, Binge Eating Scale)	Reduced desire to consume sweet, salty, fatty and savoury foods v placebo (visual analogue scales) at 16 weeks	Reduced desire to consume sweet and starchy foods, reduced incidence and strength of food cravings, reduced eating in response to food cravings, increased ability to resist food cravings and control eating during 56 weeks (Control of Eating Questionnaire). No difference v placebo on Food Craving Inventory Altered activation v placebo in several brain areas in response to palatable food cues on functional MRI after four weeks of treatment	Improved control of eating, reduced incidence and strength of food cravings v placebo (Control of Eating Questionnaire) following 20 weeks of treatment	NA
Effect on health-related quality of life (HRQoL)	NA	No difference in quality of life compared with lifestyle intervention plus placebo	Greater improvement in all domains (IWQOL-Lite) v placebo at 12 months	Greater improvement in all domains (IWQOL-Lite) v placebo at 12 months from week 8 of treatment	Greater improvement in physical function (IWQOL-Lite) v placebo and greater increase in mental component summary v placebo (SF-36)	No difference in overall HRQoL compared with placebo measured using EQ-5D-5L instrument (15)

	Phentermine	Orlistat	Liraglutide 3 mg	Naltrexone plus Bupropion	Semaglutide 2.4 mg	Tirzepatide
Approximate cost per month at maximum dose[§]	$145	$93	$387	$240	$140 (Ozempic) $460 (Wegovy)	$690
Other considerations	• It is recommended that phentermine be used with caution, and with monitoring of blood pressure, in people with hypertension.	• Reduction in risk of developing type 2 diabetes by 37% v placebo in people at high risk at four years.	• Reduction in risk of developing type 2 diabetes by 66% v placebo in people at high risk over three years.	• No improvement in blood pressure with weight loss. • Caution and reduced dosing in patients treated with antidepressants and some antipsychotics.	• Greater improvements in semaglutide group for HbA1c, fasting plasma glucose. • Greater percentage of patients in the semaglutide group with normoglycaemia at week 68–84.1% vs 47.8% (16)	• Pooled data for tirzepatide doses. Improved return to normoglycaemia from prediabetes. • Improved fasting insulin levels. (16)

GI, Gastrointestinal; HRQoL, Health-related quality of life; IWQOL-Lite, Impact of Weight on Quality of Life-Lite questionnaire; MAOI, Monoamine oxidase inhibitors; NA, Data not Available; SF-36, 36-Item Short Form Health Survey; SSRI, selective serotonin reuptake inhibitor. *Based on Therapeutic Goods Administration (TGA) Australia approvals as of 10th October 2024. †Based on Pharmaceutical Benefits Scheme (PBS) as of 26th September 2024. ‡List of side effects is not comprehensive and does not list serious but rare side effects. Please refer to the TGA website for a more complete list. §Private script costs are at the discretion of individual pharmacies. Costs in table are correct as of 10th October 2024.

¶Disclaimer: Any differences in this table with outcomes reported in the Technical Report may be due to inclusion criteria resulting in different studies being incorporated.

Source: Table is adapted from Current and emerging medications for the management of obesity in adults, The Medical Journal of Australia (MJA), Box 2 (17). Data on tirzepatide has been added due to its recent approval by the TGA for weight management.