

Radical Mentalities: Briefing Paper 2

Not all in the mind

The Physical Health of
Mental Health Service Users

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FOREWORD

This briefing is the second in a series called *radical mentalities*, designed to support and strengthen mental health promotion practice. *Not all in the mind* provides an overview of what we know about the poor state of physical health amongst mental health service users and explores some of the reasons why this should be so.

Service users take an interest in their own physical health but this is not always recognised by health and social care professionals or by carers. (Dean et al 2001, Meddings and Perkins 2002) They are also concerned about the disregard with which their physical health issues are sometimes treated within primary and secondary services. (Friedli and Dardis 2002) Given the thrust of government policy towards services with users and citizens at their core (NHSE 1999, NHSE 2000) this neglect is a serious omission.

Why is it that mental health professionals might find it difficult to either promote or provide adequate physical health care for their patients? They are committed to doing the best for their patients and available evidence demonstrates that the principal motivations for joining mental health services are vocational ones – to serve the community and “to make a difference in the lives of vulnerable people”. (SCMH 2000a, Walton 1966, Walton 1969)

However, mental health professionals do not always have the physical health expertise that might be required and they are unsure whose responsibility physical health care should be. (Dean et al 2001) They perceive their main role as taking care of the mental health of their patients and this stance can affect how they interpret mental health service users’ ‘getting better’. (Meddings and Perkins 2002) Their understanding of the physical health needs of their patients can sometimes be affected by myths and stereotypes about service users, for example that the latter are not interested in, or have enough to worry about, without thinking about their physical health. (Dean et al 2001, Friedli and Dardis 2002)

General medical professionals have also not always been responsive to the physical health needs of their patients with mental health problems. (Cohen and Hove 2001, Cohen and Phelan 2001) The **National Service Framework for Mental Health** (Department of Health 1999a) tasked primary care services with a wide range of activities that included recognising and assessing mental health problems, providing effective treatments and caring for the physical health of those with mental health problems. However research has shown that some primary care services have found it difficult to engage with this service agenda due to a perceived lack of requisite skills, an absence of quantifiable clinical outcomes and the time-intensive nature of chronic mental ill health conditions. (Rogers et al 2002)

This briefing:

- Describes the inextricable link between physical health and mental well-being
- Reviews the scale of morbidity and mortality amongst people with mental health problems
- Outlines some of the reasons why people with mental health problems have poor physical health
- Summarises the policy and statutory framework in support of improving the physical health of mental health service users
- Examines the role of services and health and social care professionals in promoting the physical health of mental health service users

- Assesses the views of mental health service users about their physical health needs
- Makes a series of recommendations on research, policy and practice to address gaps in addressing the physical health needs of mental health service users

Not all in the mind will be of interest to primary and secondary care services in the NHS, health and social care staff within community mental health teams and a wide range of voluntary and advocacy agencies. Local strategic partnerships, community groups and the user/survivor movement will all find a wealth of information to support action in this overlooked area of health care.

We hope that *Not all in the mind* will contribute both to giving key people the knowledge and understanding with which to meet service users' physical health needs more effectively and to generating further debate about what works, what doesn't work and why. We welcome your feedback and observations via our website www.mentality.org.uk

Not all in the mind builds on and complements *Making it happen: a guide to delivering mental health promotion* (Department of Health 2001a), which describes how to develop local mental health promotion strategies. The focus has now shifted away from the development of local mental health promotion strategies, which are required as part of the performance management framework for Standard One of the **National Service Framework for Mental Health**, (Department of Health 1999a) to the implementation of those strategies.

Standard One of the **National Service Framework** requires health and social services to combat the discrimination experienced by individuals and groups with mental health problems and to promote their social inclusion. Assessing, identifying and responding to the physical health needs of mental health service users is integral to the realisation of Standard One, as well as all the other **NSF** Standards, for this group of vulnerable people.

THE LINKS BETWEEN PHYSICAL HEALTH AND MENTAL HEALTH

Mental health may be central to all health and well-being because how we think and feel has a strong impact on physical health. There is a growing body of research that demonstrates the impact of mental health on physical health. Much of the research in this area is concerned with how the social environment acts on biology to cause disease. (Marmot and Wilkinson 1999)

What has been called 'stress biology' looks at the relationship between chronic stress and the nervous system, the cardio-vascular and the immune systems, influencing cholesterol levels, blood pressure, blood clotting and immunity. Chronic anxiety, insecurity, low self esteem, social isolation and lack of control over work appear to undermine mental and physical health. Perceived low control beliefs, such as powerlessness and fatalism, accounted for more than half the mortality risk for people of low socio-economic status. (Bosma et al 1997)

The power of psychosocial factors to affect health makes biological sense. The human body has evolved to respond automatically to emergencies. This stress response activates a cascade of stress hormones that affect the cardio-vascular and immune systems. The rapid reaction of our hormones and nervous system prepares the individual to deal with a brief physical threat. But if the biological stress response is activated too often and for too long, there may be multiple health costs. These include depression, increased susceptibility to infection, diabetes, high blood pressure and accumulation of cholesterol in blood vessel walls, with the attendant risks of heart attack and stroke. (Brunner and Marmot 1999)

Sustained stress or trauma increases susceptibility to viral infection and physical illness by damaging the immune system. (Stewart-Brown 1998, Cohen et al 1991 and 1997, Marucha et al 1998, Vedhara et al 1999) Depression has a significant impact on health outcomes for a wide range of chronic physical illnesses, including asthma, arthritis and diabetes (Turner and Kelly 2000) and is a risk factor for stroke. (Jonas and Mussolino 2000, Ostir et al 2001) Depression increases the risk of heart disease fourfold, even when other risk factors like smoking are controlled for. (Hippisley-Cox et al 1998) Lack of control at work is associated with increased risk of cardiovascular disease. (Bosma et al 1997, Marmot et al 1991, Niedhammer et al 1998)

Conversely emotional well-being is a strong predictor of physical health. Men and women who scored highest in a survey on emotional health were twice as likely to be alive at the study's end. The link between subjective feelings of happiness and good health held even after controlling for chronic disease, smoking, drinking habits, weight, sex and education. (Goodwin 2000)

The social environment can also act to promote mental and physical well-being. Recent research on social capital and inequality suggests that how individuals and communities feel - levels of trust, tolerance and participation - may be a critical factor in determining health. (Wilkinson 1996 and 2000, Cooper et al 1999, Kawachi et al 1997, Kawachi and Kennedy 1999).

Social capital consists of the informal and formal networks, customs and relationships that make up our individual and community interactions. The key elements of social capital have been summed up into four broad themes:

- Social resources e.g. informal arrangements between neighbours or within a faith community
- Collective resources e.g. self-help groups, credit unions, community safety schemes
- Economic resources e.g. levels of unemployment, access to green, open spaces
- Cultural resources e.g. libraries, art centres, local schools

(adapted from Cooper et al 1999)

The positive impact of social capital on health

- Large and diverse social networks increase resistance to the common cold and upper respiratory tract infections. (Cohen et al 1997)
- In Roseto, a small town of descendants of Italian migrants in Pennsylvania, rates of heart attacks in the 1950s were 40% lower than in surrounding towns, although smoking, exercise and obesity rates were similar. The only significant feature distinguishing Roseto was the high level of social cohesiveness and income parity and as this was eroded during the late sixties and seventies, the rate of heart attacks rose. (Kawachi et al 1997)

The negative impact of low social capital on health

- In a cross sectional ecologic study based on data from 39 states in the USA, lower levels of social trust and reciprocity were associated with higher rates of most major causes of death, including coronary heart disease, malignant neoplasms, cerebrovascular disease, unintentional injury and suicide. (Kawachi et al 1997)
- A more recent study found that of trust in friends, family and community, only lack of trust in community predicted psychological distress. Thus an important factor that determines distress is the extent to which people believe that unfamiliar others are trustworthy. (Berry and Rickwood 2000)
- In a survey of nearly 6000 adults, (Rainford et al 2000) a range of social/ environmental factors were associated with increased likelihood of reporting poor health including:
 - lack of control over decisions affecting life
 - lack of influence over neighbourhood decisions
 - low neighbourhood social capital
 - having no personal support (especially for men)
 - no involvement in community activities

These factors also had a significant independent impact on stress levels.

On the whole research shows a relationship between high social capital and a range of positive social and economic outcomes such as lower crime rates, better health and improved educational and economic achievement. In short, the 'well connected' are more likely to be "housed, healthy, hired and happy". (Woolcock 2001)

More recently however caution has been expressed about the downside of social capital and the exclusion experienced by those who deviate from the norms of the larger group and close-knit societies are not necessarily 'healthy' particularly for outsiders. (McKenzie et al 2002) On most counts mental health service users exist on the margins of society and so social capital would not inevitably work to their advantage.

THE SCALE OF THE PROBLEM

More than 60 years ago the British Medical Journal noted a connection between mental illness and poor physical health. (Philips 1934) Research in many countries has reliably confirmed that psychiatric patients have high rates of physical illness, much of which goes undetected and results in increased rates of chronic morbidity and mortality. (Koran et al 1989, Makikyro et al 1998, Lawrence et al 2001)

People who use mental health services, in particular those with a diagnosis of schizophrenia or bipolar disorder, are at increased risk for a range of physical illnesses, including coronary heart disease, diabetes, infections and respiratory disease. They are almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease. (Phelan et al 2001, Harris and Barraclough 1998, Barr 2001)

A study of 101 people with severe and enduring mental illness living in the community found that:-

- 26 were obese
- 53 were current smokers
- 11 were hypertensive
- 21 reported daily cough and sputum
- 24 had shortness of breath
- 11 experienced wheezing
- 7 felt chest pain on exertion.

These rates of morbidity were significantly higher than in the general population. (Kendrick et al 1995)

A person with schizophrenia can expect to live for ten years less than someone without a mental health problem and much of this excess mortality is caused by physical health problems. (Brown et al 2000) A prospective survey of the lifestyle of 140 people with schizophrenia also found that their diet was unhealthy, i.e. low in fibre and high in fat, they took less exercise than the general population and had significantly higher levels of cigarette smoking. (Ibid) For example smoking-related fatal disease is much more common among people with schizophrenia than in the general population. (Addington et al 1998)

The evidence of high rates of illness and death from physical health causes amongst mental health service users has led to calls for health professionals to be more aware of and act on these findings. (Phelan et al 2001) However there is limited evidence to date that health and social care services have responded to these unmet needs. In fact the surfeit of illness and death amongst mental health service users has continued relentlessly and people managed as psychiatric outpatients are nearly twice as likely to die as the general population. (Harris and Barraclough 1998)

Given the poorer physical health of mental health service users, it is perhaps unsurprising that they visit their doctors frequently. The GP consultation rate for people who use mental health services is much higher than average, 13-14 times per year, compared with 3-4 times for the general population. However the data recorded for health promotion is significantly less than normal, even in those practices that were gaining extra remuneration for recording health promotion data for the general population. (Burns and Cohen 1998) A number of studies suggest that people who use mental health services are much less likely than the general population to be offered blood pressure, cholesterol, urine or weight checks, or to receive opportunistic advice on smoking cessation, alcohol, exercise or diet. (Burns and Cohen 1998, Cohen and Hove 2001)

Health promotion information rarely makes clear its importance and relevance to people with severe mental illness. There are very few resources that specifically address the physical health needs and concerns of service users. (Sherr 1998, Health Education Authority 1998) People with mental health problems have themselves noted this gap and qualitative research suggests that service users feel their physical health is neglected once they have received a mental health diagnosis. (Friedli and Dardis 2002)

WHY IS THE PHYSICAL HEALTH OF PEOPLE WITH SEVERE AND ENDURING MENTAL HEALTH PROBLEMS SO POOR?¹

There are a number of reasons for poor physical health among people with severe and enduring mental health problems. A complex mix of factors combines to significantly increase vulnerability to physical health problems and as a consequence contribute to greater morbidity and higher mortality than in the general population.

Factors that seem to affect the physical health of mental health service users include: -

- social exclusion and its impact
- health behaviours and their effect
- mental illness and its consequences

Social exclusion and its impact

Since the early 1980s there has been increasing recognition that the health of individuals and communities is closely linked to and affected by social and economic deprivation. (Department of Health and Social Security 1980, Whitehead 1987, Department of Health 1998a) On almost every count people with mental health problems are among the most excluded groups in society and they consistently identify stigma, discrimination and exclusion as major barriers to health, welfare and quality of life. (Dunn 1999, Department of Health 2001a, Mental Health Foundation 2000).

There is a relationship between psychiatric disorder and deprivation, one study demonstrating that social class and area level deprivation are independently associated with mental health problems. (Rasul et al 2001) Another study demonstrated that the consequences of schizophrenia on the lifestyle of people with this diagnosis made them more likely to die from diseases or suicide than from trauma. (Kendler 1986)

Having a diagnosis frequently results in direct socio-economic consequences such as bad housing, lack of meaningful activity and limited financial resources. The socio-economic circumstances of adults with mental health problems aged 16-74 means that in comparison to people without mental health problems:-

- more people are likely to fall behind with bills
- more people are likely to be living in a rented home
- more people will experience problems with daily living
- more people are likely to have experienced a major life event such as divorce or bereavement (ONS 2000)

Links between poor housing and mental and physical ill health are clear. According to the Social Exclusion Unit, in 1998 there were 2000 people who were literally roofless in England each night. Of these 20% had a severe mental illness and three times the incidence of multiple physical problems such as chest complaints and arthritis as the general population. (Took 2001a) A report by the charity Crisis estimated that six in ten homeless people suffer some sort of mental distress, 20% have a severe mental illness and people who sleep rough are 35 times more likely to kill themselves than the general population. (Crisis 1999)

People with mental health problems often suffer discrimination in the workplace and this is one of the greatest barriers to social inclusion. The lack of a job is a major impediment to independence.

¹ *Making it effective* (mentality 2003) provides a range of evidence for effective mental health promotion interventions. Many of these will also impact positively on the physical health of service users.

(Department of Health 2002c) Unemployment affects those with long-term mental disorders more than any other groups of people with disabilities. Only 13% are in employment in comparison to over a third of people with disabilities generally. (ONS 1998) Not only is this discrimination wasteful but also it could be unlawful where a person with mental health problems has a disability that is protected by the Disability Discrimination Act 1995.

Inability to gain employment results in significant poverty for people with mental health problems. A survey of service users asked about their own experiences of having mental health problems and living on a low income. The main findings included:

- 72% of respondents said that they were on a low income by their own definition
- 66% of respondents said that they had difficulties making their income last for a week
- 81% of respondents thought that mental health problems increased the likelihood of being on low income
- 50% of respondents said that their financial situation meant they were excluded from their community

(Focus 2001)

The impact of inequality falls disproportionately on some groups of mental health service users more than others. Gender inequalities in income and wealth, in combination with women's role as mothers and carers, make them particularly susceptible to poverty, which is associated with mental and physical ill health. (Department of Health 2002a)

Social exclusion and deprivation both have a significant impact on the physical and mental health of refugees and asylum seekers. In a study of Iraqi asylum seekers, depression was more closely linked with poor social support than with a history of torture. (Gorst-Unsworth et al 1998) Burnett and Peel in a review of the issues (2001), identify support for people within their own communities and opportunities for developing links and friendships with the host community as crucial to promoting health and well-being.

Older people with mental health problems face age discrimination, negative stereotyping, isolation and low income, which maintains their social exclusion and increases their vulnerability to poor physical health. (Health Education Authority 1997, Roberts et al 2002, McCulloch 2002)

Health behaviours and their effect

People who use mental health services often suffer from poor nutrition, obesity, higher levels of smoking, heavy alcohol use and lack of exercise, all of which contributes to very high rates of physical morbidity and excess mortality. (Harris and Barraclough 1998, Kendrick et al 1995, Brown et al 1999, Brown et al 2000) Deprivation and social exclusion are closely linked to unhealthy behaviours in the general population. For example, cigarette smoking has become increasingly concentrated in the most deprived groups. There is a clear inverse relationship between smoking prevalence and social class. (ONS 2000)

People with schizophrenia and also bi-polar disorders have significant co-morbidities with cardiovascular and respiratory diseases and also diabetes. These are linked to lifestyle factors and mental health service users' health behaviours reflect their deprived position in society as well as the fact that they have missed out on health promotion messages and campaigns. (Cohen and Hove 2001) Qualitative research has shown that service users feel that existing health promotion campaigns are "not for us..." (Friedli and Dardis 2002)

Nutrition: obesity and malnutrition

There is some evidence of poor nutrition among people with mental illness. In the Nithsdale schizophrenia surveys it was found that patients with schizophrenia had high intake of saturated fats with low consumption of vegetables and fibre and low dietary intake of vitamin C and vitamin E. (McCreadie et al 1998) Increased appetite and weight gain are side-effects of some anti-psychotic medication (Health Education Authority 1998, Dean et al 2001) and low income and reduced living conditions can lead to people with mental health problems buying mainly convenience foods. As a consequence overweight and obesity are particular problems. (Wallace and Tennant 1998, Brown et al 2000, Kendrick et al 1995)

Conversely, malnutrition may be a problem for mental health service users. Protein-calorie malnutrition is linked to insufficient consumption of food or an unbalanced diet. Alcohol consumption is known to reduce the amount of B vitamins in the body. (Lawrence et al 2001, Zimatkin and Zimatkina 1996) Mental health service users with related drug or alcohol problems are at increased risk.

Exercise

Many patients with chronic schizophrenia experience obesity, which is often associated with antipsychotic medication. (Wetterling 2001) This fact combines with the low status attributed to exercise as part of any therapeutic model and continuing dualistic tendencies which separate mental from physical health and treatment (Mutrie and Faulkner, in press, McEntee and Halgin 1996) to hinder access to exercise for mental health service users. There is also imperfect understanding of the effect of certain types of medication, such as beta blockers, neuroleptics or antidepressants, on service users' ability to exercise. (Wilson and Maughan 1992, Martinsen and Stanghelle 1997, Mutrie and Faulkner, in press)

Smoking²

Smoking prevalence is significantly higher among people with mental health problems than among the general population, some studies showing rates to be as high as 80% among people with schizophrenia. (McNeill 2001) People with depression are more likely to smoke and to have difficulty when they try to stop. (Ibid) People with psychotic disorders who live in institutions are particularly vulnerable. Over 70% of this group smoke including 52% who are heavy smokers. (Meltzer et al 1995)

Explanations offered to account for such high smoking rates include social exclusion and deprivation, the impact of time in institutional settings that allow smoking and use cigarettes as currency and the possible use of nicotine as self-medication both to counter the effects of illness and the side-effects of prescribed medication. (Boyd et al 2001, Health Development Agency 2001, McNeill 2001)

A case control study of substance misuse in schizophrenia revealed that even though problem use of drugs and alcohol by people with schizophrenia was greater than in the general population, tobacco use was far and away the greatest problem. (McCreadie 2002)

Substance abuse

Alcohol consumption can be a particular problem for mental health service users. Over half the men who present to hospital after deliberate self harm regularly drink excessive amounts of alcohol and 23% are alcohol dependent. (Merrill et al 1992) A study in south London found prevalence rates of 32% for alcohol

² There is significantly more information about smoking and mental health service users than any other area of health behaviour. For a comprehensive discussion of the issues see Smoke Free London (2001) *Smoking and mental health: Symposium Report*. Available from www.lho.gov.uk

abuse and 16% for the use of street drugs amongst mental health service users. (Took 2001a) There is a considerably increased risk of acquiring HIV or hepatitis amongst service users who also abuse drugs. Research from America found an incidence of HIV five times higher than in the general population and that of hepatitis C up to ten times higher. A significant proportion of people with hepatitis C will develop hepatocellular carcinoma (a form of liver cancer) in later life. (Cohen and Phelan 2001)

Indian-born men have more than twice the prevalence rates of alcohol related disorders than White men and alcohol related admissions accounted for 25% of all psychiatric admissions in this group in 1981 (Cochrane and Bal 1989). There are known gender differences in alcohol and substance misuse. In the general population men are more likely to misuse both. There seems however to be greater social stigma attached to women misusing substances, particularly alcohol. This may lead to women's problems being missed or ignored, with consequent difficulties in accessing services. (Department of Health 2002a) About 11% of dementia is related to alcohol use and is consequently preventable. (Audit Commission 2000)

Mental illness and its consequences

Once a person has received a diagnosis of mental illness, the consequences for all aspects of their lives are profound. Qualitative research with mental health service users has revealed that care and treatment of their physical health needs often takes second place to their mental health care. (Friedli and Dardis 2002, Dean et al 2001) This continued disregard has been shown to have extremely negative outcomes for mental health service users, whose rate of illness from a range of chronic diseases is no greater than the general population. (Lawrence et al 2001) The significant difference appears to be the impact of mental illness as a block to obtaining appropriate care and treatment.

People with mental health problems appear to be less willing to disclose concerns about their health in primary care or to request health checks or access to follow-up services. People with schizophrenia are less likely than people without a diagnosis to report physical symptoms spontaneously. (Jeste et al 1996) Some people who use mental health services may not always be able to articulate their symptoms or the side-effects of their anti-psychotic medication which may confuse the clinical picture. (Cohen and Phelan 2001, Phelan et al 2001)

The stigma of mental illness

People with mental health problems consistently identify stigma as an impediment to their overall health and wellbeing. (Mental Health Foundation 2000) A recent review of psychiatric stigma (Byrne 2001) argues that despite scientific advances and the rise of the medical model in treatment, stigma has not disappeared. Conversely changes in policy, especially the 'relocation of madness' and moves towards more community care has created a community backlash. To carry the label of 'mental illness' carries internal (secrecy, lower self-esteem and shame) and external (social exclusion, prejudice and discrimination) consequences. Mental health service users reveal that their diagnosis can subsume the rest of their persona. (Sayce 2000)

Research to inform the Royal College of Psychiatrists 'Changing Minds' campaign in 1998 identified that stigmatising opinions about mental illness are still widely held by the general population. (Crisp 2000) Several enduring perceptions of people with mental illness that emerged included their being dangerous, unpredictable, difficult to talk to, having only themselves to blame, being able to pull themselves together, having a poor outcome and responding poorly to treatment. All of these misperceptions contribute to an increase in low self-esteem which also militates against good physical health.

Two important findings from this research were related to perceptions of dangerousness and the impact of increased knowledge about mental illness. A continuing association between mental illness and 'fear of violence' seems to ensure that people with mental illness are negatively affected through stigmatisation. Having a diagnosis can make people fearful of being seen as 'troublesome' or 'difficult and demanding'. Service users have revealed their reluctance to complain about primary care services or professionals for fear of being 'struck off', and the difficulty in finding a good GP- particularly if you have a mental health problem. (Friedli and Dardis 2002)

Medication and its side effects

Another important factor that impacts on the physical health of service users is the physical side effects of prescribed medication. All anti-psychotic medication can cause severe side effects, which will differ from person to person. Individual bio-chemical make-up, the type and dosage of medicine(s) prescribed and the length of time that medication has been taken will all affect side effects. So will individual circumstances such as diet, exercise, occupation and stress.

Research suggests that 5% of people taking traditional anti-psychotic drugs experience 'tardive dyskinesia' in the course of a year; this affects the movement of the mouth and tongue and sometimes the limbs, similar to the symptoms of Parkinson's disease. These side effects may not recede even if the drug is stopped. (Mental Health Foundation 1999)

A survey undertaken jointly by MIND, National Schizophrenia Fellowship (now Rethink) and the Manic Depression Fellowship found that in their sample the most reported physical side effects of anti-psychotic medication were weight gain and effects on the eyes. (National Schizophrenia Fellowship 2000) Excessive weight gain is a not uncommon side effect of the new atypical neuroleptics. (Allison et al 1999) Users who gain a significant amount of weight are at increased risk of developing type II diabetes mellitus, hypertension, cardiovascular disease, osteoarthritis and some types of cancer. (Goldman 1999) Weight gain can also make a person lethargic and less likely to take an interest in nurturing their physical health.

Some psychotropic drugs alter the effectiveness of oral contraceptives. They may also have a damaging effect on foetal development and are contraindicated in pregnancy, others are required at lower doses in pregnancy, and some are excreted in breast milk. (Department of Health 2002a)

As a consequence of the range and severity of side effects of anti-psychotic medication, mental health service users are often reluctant to continue its use. They may however concurrently stop using medication for physical health complaints, which could contribute to increased illness and death from physical health conditions that are less well controlled. (Cohen and Phelan 2001)

THE POLICY AND STATUTORY CONTEXT FOR PROMOTING PHYSICAL HEALTH OF MENTAL HEALTH SERVICE USERS

Since the current government came into office in 1997 modernising health and social services has been high on the policy agenda. The core themes that underpin this programme are: -

- patient and public involvement in debates and decision-making about health and social care services
- quality services which are more responsive to the needs of users
- partnership working across agencies to deliver modern services

There is a statutory framework that supports the policy agenda and a cross-cutting theme of eliminating poverty and ending social exclusion for marginalised communities.

All of these elements in the policy and statutory framework have the potential to support improvements in meeting the physical health care needs of people who use mental health services.

Patient and public involvement in debates and decision-making about health and social care services

The current emphasis on accessing the views and perspectives of the public – as citizens and also as users of particular services – dates back to the reform of the NHS in the early 1990s. The drive for more efficient use of resources was coupled with a range of initiatives to improve the quality of the services that people received.

For example the *Local Voices* initiative (NHS Management Executive 1992) placed health authorities' responsiveness to the needs, views and preferences of local people as central to the commissioning of health services. Within NHS Trusts a variety of quality programmes emerged, under the banner of 'integrated patient care', which placed users at the centre of services. *Patients Charters* set out the standards of care that the public could reasonably expect to receive from the NHS.

A range of methods for assessing how well the NHS was responding to public need was brought into play. There were a number of one-off approaches drawn from the world of market research, such as customer or patient satisfaction surveys. There were short-term initiatives such as Citizens Juries, which might spend several days debating a particular service development and end by making recommendations on the way forward. Standing committees such as 'patients panels' were established in many hospital trusts, to give continuous feedback to management on the quality of services, based on the experience of those using the services.

Even though these reforms were initiated by the previous Conservative government, the current Labour government has extended them beyond the NHS and opened them out to include social care and health and other public services.

The NHS Plan (Department of Health 2000a) and Modernising Health and Social Services (Department of Health 2000b) both promise to bring these key public services up to date and lay people have a central role to play in that process. For example clinical governance panels in NHS Trusts, whose remit includes continuous quality improvement, should engage with and encourage service user input. (Department of Health 1998a) Many local authorities have established permanent Citizens Panels to feed back on the quality of their services. Stakeholder events are regularly utilised to access local communities' views on plans for the development of health and other services.

New plans proposed for public involvement include the establishment of patients' forums to facilitate and strengthen the patients' voice in every NHS Trust and Patient Advice and Liaison Services (PALS) in each Trust to provide on the spot help and advice. (Department of Health 2001b)

These developments have been driven by government policy that places informed citizens at the core of debates about the future of public services and mental health services have not been excluded from this trend.

A core principle from the **National Service Framework for Mental Health** is that all mental health services must be planned and implemented in partnership with local communities and involve service users and carers.

The National Institute of Mental Health (England) has made a significant contribution to the effective development of user involvement in mental health services. They have appointed a number of service user champions at a local level. Nationally they have created the post of Fellow in Expert by Experience which is filled by a service user. (www.nimhe.org.uk)

Quality services which are more responsive to the needs of users

The **NHS Plan** (Department of Health 2000a) and **Modernising Health and Social Services** (Department of Health 2000b) both position improved quality of services as a core rationale for change and modernisation. Users of services are meant to be involved at all levels of service design and delivery. (Department of Health 1998a)

Specifically within mental health services **Modernising Mental Health Services** and subsequently the **National Service Framework for Mental Health (NSF)** both emphasised the importance of responsive, quality services. They created the framework within which physical health care of mental health service users could be best promoted. The **NSF** has specific standards on the physical health of people with mental health problems.

Service users are more likely to be involved in design, review and delivery of services in order to improve their quality. A systematic review of randomized controlled trials and other comparative studies of involving users in the delivery and evaluation of mental health services showed a positive effect. Involving users as employees, trainers or researchers had no negative effect on services and in some cases conferred added benefit. Involving users with severe mental disorders in the delivery and evaluation of services was also deemed to be feasible. (Simpson and House 2002)

A different systematic review examined the effects of involving patients in the planning and development of healthcare. (Crawford et al 2002) The papers selected for the review described changes to services that were attributed to involving patients, such as making services more accessible and producing better information. Changing in the attitudes of organizations to involving patients and positive responses from patients who had taken part were also described. The authors concluded that evidence supports the notion that involving patients has contributed to changes in the provision of services across a range of different settings. However an evidence base for the effects on use of services, quality of care, satisfaction or health of patients did not exist.

These findings led to some primary research on methods for involving service users in the planning and delivery of psychiatric services and the factors which either helped or hindered this process. (Crawford et al 2003) A cross-sectional postal survey of user groups and providers of psychiatric services in Greater London was undertaken. The study found that although service providers employed a range of different methods for involving service users, none met national standards for

user involvement.

Service providers said that the main obstacle to effective user involvement was a lack of representativeness amongst those users who did take part. User groups highlighted staff resistance as a major obstacle to taking part and 80% of respondents said they were not satisfied with current arrangements. Although some change had resulted from user involvement, this was not as far-reaching as it might have been due to the identified obstacles.

Partnership working across agencies to deliver quality services

The new arrangements under **Shifting the Balance of Power** (Department of Health 2001c) give primary care trusts (PCTs) the lead in assessing need and commissioning health services. NHS trusts will continue to provide services, working within delivery agreements with Primary Care Trusts. Primary Care Trusts are meant to spearhead the creation of Local Strategic Partnerships to involve a wide range of community and voluntary groups.

The four directorates of health and social care, which were established in 2002 to oversee joint developments between the NHS and social care, (Department of Health 2002b) will cease to exist by 2004. Strategic health authorities will become the local headquarters of the NHS. (Stephenson 2003) Local people and users of services are integral to this change and are intended to become active partners in design, delivery and development of local services.

Local councils have been required, since April 2000, to develop Best Value performance plans. These plans offer a framework to help councils improve the way they deliver services and implement the Government's modernisation agenda.

The new arrangements for service user involvement through PALS in health and Citizen Panels in local government, is compatible with policy on partnership working. The underpinning principle is for citizens to have more of a say, beyond the use of the ballot box in local and national elections, in how publicly funded services are organized and delivered

Statutory framework in support of mental health service users' physical health

The statutory framework lends itself to addressing the physical health needs of mental health service users. For example S117 of the Mental Health Act 1983 entitles people who have been detained to a comprehensive after-care package following discharge from hospital.

These rights are closely linked to assessments under the Care Programme Approach. People who come into contact with specialist services should be assigned a Care Co-Ordinator who will formulate a care plan that addresses identified health and social care needs. These needs will be monitored regularly. (Department of Health 1999b)

The recently implemented **Human Rights Act** could provide a mechanism for service users to challenge statutory agencies when they feel their needs have been neglected. Certain absolute rights are guaranteed by the Act, and these cannot be limited or qualified.

Article 2, the right to life, is an absolute right and the Court has emphasised that in addition to refraining from the intentional and unlawful taking of life, States are required to take appropriate steps to safeguard the lives of those within its jurisdiction. (Sainsbury Centre for Mental Health 2000b)

Poverty and social exclusion

A cross-cutting theme of eliminating poverty and ending social exclusion for marginalised communities underpins government modernisation plans. Consequently the government has set in train a number of initiatives that utilise whole systems approaches to tackling deprivation, social exclusion and poverty. They target economically and socially disadvantaged areas and build programmes around certain settings or issues, or across whole communities.

As has been demonstrated, mental health service users are among some of the most economically deprived and excluded members of society. There are several programmes which have most relevance to this group of people. For example Healthy Living Centres (www.nof.org.uk) include 350 partnership projects involving voluntary organisations and the community to help people in disadvantaged areas improve their health and wellbeing. Neighbourhood Renewal, launched in January 2001, aims to ensure that within 20 years no one should be disadvantaged by where they live. (www.neighbourhood.gov.uk) Physical Activity Pilot Schemes, which commence in late 2002, will include a range of activities targeted at disadvantaged communities, such as an expansion of exercise referral schemes focusing on deprived and high risk groups. (www.doh.gov.uk)

Social inclusion is a key value within NIMH(E), a central strand in the Equalities programme and a major imperative for any work that stands for fairness, justice and opportunity. NIMH(E) starts from a commitment to supporting the efforts of mental health service users and local organisations in delivering access to the mainstream opportunities that are so important to hope, ambition and recovery.

Closely aligned with mental health promotion and the action strategies for overcoming barriers based on race and gender, the programme draws on concepts from the worlds of social capital, renewal and regeneration in setting an agenda to promote opportunity through action at both individual and organisational levels.

Mental health and social exclusion, is a project from within the office of the Deputy Prime Minister and aims to address the barriers to opportunity faced by adults with mental health problems. The project is managed by the Social Exclusion Unit and is examining what more can be done to reduce social exclusion among this group. The project will seek to build on national and local initiatives for adults with mental health problems. In particular, it is considering two questions: a) what more can be done to enable more adults with mental health problems to enter and to retain work? b) what more can be done to ensure that adults with mental health problems have the same opportunities for social participation and access to services as the general population?

This brief overview has demonstrated that the policy framework is largely in place to realise user centred service modernisation goals. Furthermore the statutory framework is available to support these policy goals or to challenge services if they are deficient. Despite this framework however research has repeatedly shown that mental health service users are not receiving the physical health care that would confer health gain. (Cohen and Phelan 2001, Phelan et al 2001, Dean et al 2001, Friedli and Dardis 2002) Service delivery still lags behind policy aspirations.

THE ROLE OF SERVICES IN IMPROVING PHYSICAL HEALTH OF MENTAL HEALTH SERVICE USERS

Health and social care services are the key to identifying and responding to unmet physical health needs of people who use mental health services. Despite substantial evidence of unmet need and its consequences however the toll of excess morbidity and mortality amongst mental health service users continues. A combination of factors impedes mental health service users receiving the care, treatment and information that could improve their overall physical - and mental - health. The explanation is situated in the nature of services themselves and the perception of the people with mental health problems who use them.

The nature of services

Reform in mental health care has led to the closure of long stay units and the development of a range of community based services, including community mental health teams, Crisis Intervention, Assertive Outreach & Early Intervention. Community Mental Health Teams were meant to meet the whole range of health and social needs of service users. However physical health care is not necessarily a priority and at any rate many mental health practitioners have little training in physical health care. (Phelan et al 2001)

Ward and day care staff interviewed felt uncertain of their role in relation to physical health needs of mental health service users. (Dean et al 2001) This uncertainty is exacerbated within teams where lack of clear professional boundaries adds to ambiguity about who should be taking the lead. (Onyett et al 1995) Continuing problems in recruitment and retention of skilled staff into health and social care services affects staff morale and ability to work in innovative ways. (Department of Health 2003)

Even when secondary care staff take an interest in the physical health of their patients, their lack of confidence and the absence of any care protocols often results in care varying with the member of staff who happens to be on duty. (Dean et al 2001) A briefing on acute mental health services found that lack of a clear vision about service goals, difficulties in recruitment and retention of inpatient staff and increasingly distressed patients being cared for on the wards combine to undermine any therapeutic environment which can address all the needs of service users. (Sainsbury Centre for Mental Health 2002)

Over 90 per cent of patients with mental health problems are treated within primary care. (Goldberg and Huxley 1992) However there is a deficit in mental health training for GPs. About half of GP trainees in the UK do a six month psychiatry rotation and although by 1998 80 % of GP training schemes had a recognised psychiatry component, only 59% of places were taken up. (Lewis and Chana 1998) GPs who may feel inexperienced in, or uncomfortable with, mental health work are unlikely to engage with service users at any deep level. (Phelan et al 2001, Rogers et al 2002)

The new GP contract (www.bma.com) has introduced quality outcome measures in mental health. Some of the measures include producing a register of people with severe long-term mental health problems and reviewing the physical health and care co-ordination with secondary care for this group of people. Currently however people with depression and those with psychotic illness have been grouped together. The needs of these two groups of people are quite different and further refinement on how the contract should be implemented will add value to addressing the physical health needs of those with severe and enduring mental illness.

Perception of mental health service users

There is a perception gap between mental health service users and their professional and lay carers about physical health needs. Research has demonstrated that staff and carers think users are uninterested in their physical health, but users do not share this view. (Dean et al 2001, Meddings and Perkins 2002)

A cross-sectional study of screening in primary care for cardiovascular risk amongst people with schizophrenia or similar mental illnesses revealed a higher level of uptake and interest amongst this group than had been anticipated. (Osborn et al 2003) Many people with psychosis accepted the offer of a cardiovascular risk assessment, providing a valuable opportunity for health education and promotion. Participation rates were similar to those in other community research involving blood tests. The study provides evidence for the interest of mental health service users in their physical health and its care and treatment.

Although there has been a shift in the perception of service users as passive participants within medical care, this has been a slow process. Power relations between health professionals and mental health service users still informs the care and treatment available. (Seymour 1998) Until the health care reforms of the early 1990s there was no challenge to a dominant biomedical model of care within which doctors acted in their patient's best interest that they alone defined. (Williamson 1992) However the assumption that 'doctor knows best' has continued to be challenged and even the most disadvantaged people have been championed as having "...*their claim to engage in their care.*"(Kennedy 2003)

What do people want from their doctors? A review amongst the general population of what makes a good doctor (Coulter 2002) revealed that patients increasingly think they should be involved in decisions about their own care. However these aspirations were rarely met and failures in communication and incorrect assumptions about patient preferences were very common.

Qualitative research into how doctors engage with patients with psychotic illness in routine consultations revealed a need for improved communication. Despite patients repeatedly attempting to talk about the content of their psychotic symptoms, their doctors exhibited reluctance and discomfort in discussing this topic. (McCabe et al 2002)

It would seem that the organisation of services and their hierarchical nature can serve to impede effective treatment and care of mental health service users' physical health needs. In addition the perception of service users hinders their having the effective communication necessary to address their concerns about their physical health.

WHAT DO PEOPLE WHO USE MENTAL HEALTH SERVICES THINK ABOUT THEIR PHYSICAL HEALTH AND HEALTH PROMOTION?³

Available evidence supports the conclusion that people with severe and enduring mental health problems are at increased risk for physical illness, much of which remains undetected. During 2001 **mentality** ran a series of nine focus groups with people using psychiatric services to explore their experiences of health promotion information and support and to identify some priorities for developing more appropriate and accessible promotion and prevention services. (Friedli and Dardis 2002) This qualitative research focused in the main on primary care services.

In line with other research in secondary care (Dean et al 2001, Meddings and Perkins 2002) the findings suggest that service users may be less likely than other vulnerable groups to receive physical health checks or to access services like smoking cessation. This is symptomatic of a range of inequalities affecting people with mental health problems.

In the **mentality** study, a commonly held view from professionals, notably in relation to smoking, was that “*people have enough to worry about*”, whereas participants in the focus groups expressed a very strong interest in and commitment to ‘*healthy living*’ and achieving better physical health. Qualitative evidence suggests however that service users feel that once they have received a diagnosis, their physical health is neglected. This finding is borne out in many studies (Sayce 2000, Dean et al 2001) As one user put it, ‘*they really don’t care if you smoke as long as you’re taking your medication*’.

Physical health

A main area of concern for service users was smoking and related physical ill health.

“When I came out (from a mental health ward) I was wrecked physically. Smoking, over-weight, unfit. Getting back (my fitness) was my biggest priority but I couldn’t get any help..... I did it myself, one step at a time – diet, exercise, information – but all they wanted to tell me was ‘take your medication.’”

All participants in the focus groups smoked between 10 and 60 cigarettes or roll-ups a day and most had tried to give up smoking at some time. Of the 24 people (all current smokers) interviewed about smoking, everyone had tried to quit. Most had asked for help, but felt they had received little or no appropriate support from specialist services or from primary care. The main reason given for wanting to quit was that smoking was too expensive, but health risks were also mentioned.

A key factor in anxiety about quitting is fear of the potential weight gain, and this was seen as a major issue in preventing people from giving up. Weight gain is a very common side effect with certain medications, with a significant impact on the way people feel and on their self-esteem. Unwanted weight gain is often the sole reason for people discontinuing their prescribed medication. There are also physical health risks attached to weight gain.

“I put on a stone and a half in 6 months when I stopped smoking.”

The smoking culture on psychiatric wards

One of the key reasons given for smoking was the culture within psychiatric wards and the mental health system. A trip to the smoking room often breaks up the day and relieves boredom and the

³ During 2003 **mentality** in collaboration with NIMH(E) will be producing guidance for primary and secondary care services, and also for mental health service users, on the physical health needs of people who use mental health services. Stakeholder consultation underpins this resource.

smoking room was seen as a place where people go to socialise. Other participants mentioned smoking as ‘something to do to occupy yourself’ or to help with relaxation when stressed.

“I find myself smoking when I’m really stressed, sometimes 40 cigarettes a day and even up to 50 when I’m over-stressed”

“When I’ve been an in-patient in a hospital, smoking seems to be the only thing to do. I initially started smoking because of a mental health problem”

“The nurses encourage you to smoke because it calms your nerves”

“It’s the environment of the ward. You’re bored stiff, you’ve got nothing to do, all you’re doing is killing time and the cigarettes are there one after the other, you just can’t help yourself”

“I usually smoke about five a day but when I was in hospital I smoked 20 a day”

Research into tobacco control policies in psychiatric units (Health Development Agency 2001) revealed that few proactively addressed the issue of service user smoking.

Health promotion information

A recurring issue for participants was the feeling that GPs do not take them seriously, are often judgmental in their attitude towards people with mental health problems, and may assume that physical health problems are either irrelevant or a side effect of medication.

“The way you get treated if you have a general medical need and they know you have a mental health problem, the difference is really significant. As soon as the doctor knows I have a mental health problem his whole body language changes.”

“I don’t bother telling the GP, dentists etc anymore that I’ve got mental health problems”

Participants said that they were rarely provided with health promotion information, even when this was specifically requested. This was particularly the case in relation to information on smoking cessation, diet, nutrition and weight control, which were seen as important issues by people with mental health problems. In each case, users wanted information that acknowledged the impact of particular symptoms or diagnoses on their physical health and which addressed the specific challenges they faced in maintaining positive health.

“You don’t get information on how to manage things like food; eating and depression isn’t really addressed and you can either end up overeating, when you’re eating for comfort or under eating, where you are virtually starving yourself.”

“I once showed an interest in diet sheets but again my GP could not offer any and told me to buy the BBC diet book.”

“Medication makes you put more weight on, not lose it.”

The users interviewed had been given very little information about physical health checks and why blood pressure checks, urine analysis or influenza protection might be particularly important for them. Some participants recalled being given certain health checks, but only because of an existing health problem rather than being checked for any new physical health problems. Generally, they felt that the only checks they received were related to their medication. Not one participant

could recall being offered a test in a primary care setting that was related to protecting their physical health.

“Several people said that this was the first opportunity they’d had to talk about their physical health. People have real concerns and want more information. One group hoped the research would continue so that they could meet again.”

Where information was available such as leaflets, the specific concerns and information needs of people with mental health problems were not addressed. This meant that while some people knew that leaflets were available in surgeries, they tended to believe they had no relevance for people with mental health problems.

In the case of smoking cessation and weight gain, participants wanted information that acknowledged the side effects of their medication, any specific problems they might experience such as nicotine withdrawal and how to access ‘user friendly’ support such as exercise facilities or smoking cessation groups. Some people tried to get hold of health promotion information elsewhere, rather than in primary care. Individuals mentioned getting health promotion information and advice from friends, a pharmacist, a counsellor, a keyworker, local Mind groups or user groups and one participant mentioned getting advice from a dietician in hospital.

“I feel we need some sort of advocate to see the patient before they are discharged and during their stay in hospital to inform you of what services are available. When I came out of hospital I didn’t know where to go.”

“I live on my own and find it more difficult. I try very hard to cook properly for myself, even when I’m not well and I will force-feed myself if I’m depressed. But I smoke.”

“I smoke to keep my weight down.”

“I went to my GP and asked for a diet sheet and I thought, naturally I would get one but he couldn’t supply me with one. Being on medication, my weight was ballooning and I didn’t want to come off lithium.”

Many participants had experienced even more excessive weight gain following quitting smoking. Some participants described asking their doctors for help with dieting, because they had put on weight with their medication, but felt they had received no support. Although broader health promotion messages about diet, nutrition and exercise are often included in smoking cessation resources, dedicated information on these issues are of paramount importance to service users who may not access smoking cessation advice and therefore no advice on diet, nutrition and exercise at all.

Health promotion services

For those participants who had gained weight, some had been told to exercise but did not have access to facilities such as gyms or exercise classes. Others said they felt inhibited by their diagnoses and had lost the confidence to try something new or to meet new people. Perhaps as a consequence of the negative symptoms of their illness, they felt dissuaded from accessing services open to all. This may suggest that such services need to make special efforts to demonstrate that mental health service users are welcome, and also to set up and publicise facilities specifically for people with mental health problems.

“I’ve found my motivation has gone as a consequence of taking the medication and physical changes, I’ve put on over two stone.”

“It’s fine being told to exercise but not if you’ve got the problems I have. Number one, getting out and number two being around people. As soon as I get changed and get into a swimming pool I have to get straight back out because I’m having a panic attack.”

“Stuff about exercise, if you can’t get out of bed in the morning, someone telling me to go to the gym is not helpful.”

“My psychiatrist recommended a day hospital and I found that very beneficial. It’s got a full gym and instructors, art therapy, computers and relaxation therapies, but you were only allowed to go there for four months.”

All those who had tried to give up smoking were still smoking, but many would like help to give up for good. In many cases, smoking cessation services were not seen as accessible to people with mental health problems. There are very few cessation groups specifically for service users who would prefer user only support.

Of those participants that had tried to give up, nearly all had tried a nicotine replacement therapy (NRT) of some kind. In the main they had either purchased these products themselves or had been given gum or patches by friends or relatives. Only a couple of people had quit with ‘will power’ alone. No one interviewed was aware that some forms of NRT are available on prescription.

“I have used the Nicorette chewing gum, my mum bought me them, I think they cost £10 for 30 in a pack?”

“My sister gave me a nasal spray which she had got from her GP in X. When I visited my GP in Y and asked for the prescription to be continued I was told it was not available on the NHS and told to go to the chemist and buy them there”

As with mental health issues generally, there is a range of myths and stereotypes about service users who smoke, which have made it very difficult for users to gain smoking cessation information and support. Although around 50% of people with a diagnosis want to quit, smoking is often condoned or encouraged for users. In the **mentality** research, service users described considerable barriers to getting support with quitting:

“My GP hasn’t bothered to support me to stop smoking. I think its maybe who I am, or I’m not an important enough person in their eyes or maybe they think I’m not serious, maybe they don’t see me because I have a mental illness. I think my GP has got a lot of discrimination towards how I am as an individual”

Some participants had been told by their GP to give up smoking but felt they had not received any support to do so. Only a few of the participants had seen information leaflets on cessation, and none were directed to them. They only accessed information if they took the initiative themselves.

Some people had seen smoking adverts on the television and knew about national smoking cessation helplines such as Quitline or the NHS Smoking Helpline, but only one person had actually called to try and receive help. Participants found it difficult to relate to the adverts and tended to believe that the information and resources were not aimed at them. Given the wide

range of specific health issues faced by service users it is not unsurprising that they would want information and support which is more targeted at their specific concerns.

Summary remarks

The findings from this piece of primary research reflect those of other research. Mental health service users do have concerns about their physical health. They would value helpful and effective health promotion information and advice, but this is largely lacking within existing primary and secondary care services.

RESEARCH, POLICY & PRACTICE RECOMMENDATIONS

Not all in the mind has demonstrated evidence for poor physical health and excess morbidity and mortality amongst mental health service users, as well as the seeming lack of responsiveness amongst primary and secondary care services. Contributory factors to this deficit include:-

- lack of appropriate skills amongst primary and secondary staff in assessing physical health problems and providing appropriate care and treatment
- organisation of services which address mental and physical health separately
- prevailing stigma surrounding mental illness and perceptions of service users
- service users' reluctance or inability to press their case for physical health treatment with professionals

A cultural shift will be required to make a significant impact on the poor physical health and related higher incidence of morbidity and mortality amongst mental health service users. This transformation is part of a more general change within health and social care, where partnerships with patients are an important part of care transactions. (Department of Health 1998a, Department of Health 2001a, Department of Health 2001c) Mental health service users should not be denied the benefits of patient partnership on offer to the general population.

However the onus remains firmly on services and the professionals within them to ensure that mental health service users receive the information, advice and care to address all of their physical health concerns and needs. The move towards increased partnership working between health organisations and across health and social care should facilitate a more positive and collaborative environment.

The research, policy and practice recommendations which follow form a coherent whole which will we trust inform discussion, debate and development of services. We welcome readers' feedback and observations via our website www.mentality.org.uk

Research recommendations

Comparative studies have failed to compare the morbidity and mortality of people with mental health problems with people who do not use services from similar backgrounds. Consequently it is not clear to what extent poverty, poor housing and unemployment are causal factors rather than the direct effects of mental illness.

- **Comparative research looking at morbidity and mortality of lower socio-economic groups in comparison with people with mental health problems**

Record linkage involves the collation of information about individual respondents or units – such as persons, households or businesses – from two or more different sources in order to form combined individual micro-records. (Davies 2002) This method has been used successfully in Australia (Lawrence et al 2001) to build up a comprehensive picture of morbidity and mortality amongst people with mental health problems, but it is not without precedent in the United Kingdom. (Acheson 1967, Goldacre et al 1994, Kendrick and Clarke 1993, Ryan 1994)

- **Construction of a linked database on morbidity and mortality amongst mental health service users in the United Kingdom**

There is very little evidence of effective health promotion programmes targeted at people with mental health problems.

- **Review of effective health promotion programmes for mental health service users**

Policy recommendations

Given the high rates of smoking prevalence amongst service users and the conclusion that smoking is far and away the most important aspect of substance abuse in schizophrenia (McCreadie 2002) the single most important contribution that can be made to positive physical health for mental health service users is help them to stop or reduce their smoking.

- **Smoking cessation or reduction programmes should be developed specifically for mental health service users and designed with their assistance and input.**

Research has shown that many mental health service users are concerned about their physical health and would like help and advice to look after themselves more effectively. However they also feel that existing health promotion campaigns are not targeted at them or take their specific issues into consideration.

- **Development of health promotion campaigns targeted at mental health service users, involving users in their design and delivery. These campaigns should address areas of major concern in addition to smoking, especially weight gain, fitness and exercise.**

A particular health issue for those with severe and enduring mental ill health is an inability to engage with health care services and the resulting paucity of recorded health promotion information. The lack of these data makes the individual more likely to suffer from late identification of cardiovascular disease and/or respiratory disease and as a result be more at risk of influenza. (Cohen 2001)

- **Department of Health should include people with severe and enduring mental illness on the “at risk” group to be offered protection against influenza**

Practice recommendations

Due to the higher levels of morbidity from a range of factors, people who use mental health services should have routine physical health checks, annually at the very least, to include the following:-

- **Cardiovascular assessment including Blood Pressure**
- **Respiratory assessment including peak flow reading**
- **Endocrine assessment including urine analysis to exclude diabetes**
- **Body Mass Index – heath and weight (for obesity)**
- **Smoking history**
- **Hepatitis C and HIV status**

Respect for diversity should always inform these assessments and each person’s unique profile - gender, age, ethnicity⁴, existing physical disability, language – should form part of any assessment of the physical health care they require.. (Department of Health 2002a, Department of Health 2002d, Department of Health 2001e)

⁴ During 2003 **mentality** will be producing a toolkit which has been commissioned by NIMH(E) on mental health promotion for black and minority ethnic communities

Given the varied and sometimes pernicious side effects of prescribed medication for a mental illness, we would stress the following recommendation:

- **Service users should have their medication reviewed regularly and any reported side effects monitored. Relevant physical health information should be provided in light of any medication changes and resulting side effects.**

Research into the role of services and physical health needs of mental health service users demonstrates that mental health professionals frequently lack the skills in identifying need appropriately, and general medical professionals lack the confidence in working with mental health service users

- **Training and guidance for secondary care staff in assessing physical health problems and accessing necessary medical input, either in primary or secondary care, whichever is more appropriate .**
- **Training for primary care staff to provide a structured care programme for people with severe and enduring mental illness, in line with other chronic conditions.**
- **Training for general medical professionals in appropriate communication skills to effectively assess physical health problems in their patients who also use mental health services**
- **Training for practice nurses, receptionists and other staff in order to reduce any stigma associated with mental health problems**
- **Access to the training package provided by the Royal College of Psychiatrists, for primary and secondary care staff, in the core interventions in the treatment and management of schizophrenia. (NICE 2003a, 2003b)**

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