Mental Health Capacity Unit, Department of Health NI - Briefing Paper 3: The Physical Wellbeing of People with Mental Health Problems

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Briefing Paper 3: The physical wellbeing of people with mental health problems

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This briefing paper summarises key findings from three rapid evidence reviews (*Transforming mental health services*; *International policy guidance and response to COVID recovery*; *International learnings on mental health plans, policies and implementation*) commissioned by the Mental Health Foundation to help support the development of Northern Ireland's ten year mental health strategy. It highlights **some** of the national and international evidence, offers examples of best practice and innovation and may be of interest to those responsible for developing the strategy. International best practice suggests that the relationship between physical and mental health has to be seamless in the delivery of care. Making every contact count with individuals to help embed a holistic approach to mental and physical health is crucial in trying to close the mortality gap in mental illness.

Key considerations include:

Human Rights Perspective
- Closing the gap – the premature mortality (up to 20 years) of people with severe and enduring mental health problems is a human rights issue.
- Evidence shows that making physical healthcare connections easy to access for mental health service users can transform outcomes.

Physical Health
- Life expectancy is considerably lower in the SMI population compared to the general population. People with severe mental health problems have 1.5 to 2 times higher rate of cardiovascular disease and diabetes. The associated risks and comorbidity with other diseases is high and increasing screening, and opportunities to assess, monitor can help reduce these risks.
- Connections between physical and mental health can improve holistic care – attending to the physical health needs of mental health service users has the potential to assist in the treatment and help promote recovery.
- Health promotion targeted at SMI populations are useful. Research demonstrates that these groups are less likely to receive public health messaging or offered routine screening for diseases including cancer. While a public health approach is important, targeting at risk groups and delivering messaging using accessible formats, technology and routes of engagement have found to be important in promoting health and wellbeing. However, computers, smart phones, internet or public spaces may not be routinely accessed by people with severe mental health problems and as a result the messaging can be lost.
- Reducing risk behaviours may be seen as a responsibility of primary care and GPs and not mental health services, promoting opportunities to screen and monitor physical health in community mental health settings have been shown to be very effective.

- There is research evidence that some risky health behaviours are tolerated within mental health settings (e.g. supported living settings), or seen as a way of helping to manage symptoms of stress or coping with boredom – smoking, poor diet (takeaways), alcohol use, sedentary behaviour.
- Addressing inequalities in palliative care for people with serious mental illness has been identified as an area of improvement (Sheridan, 2019), access to palliative care is a human right which is at risk of being undermined. For example patients with schizophrenia are less likely to receive specialist cancer treatment and receive palliative care than those without a diagnosis of mental illness. Reasons for reluctance to intervene have been associated with concerns about capacity to consent or participate in decision-making, or treatment that could destabilize patients' mental state or expectations of lack of engagement (Morgan, 2016; Thornicroft, 2011).

Making Every Contact Count
- Opportunities to make every contact count are important. Research in this area has pointed to universal screening measures for key touchpoints with public services e.g. beyond healthcare including the police, education etc. and helping to create shared responsibility for promoting care.
- This approach supports community-based mental health models that offer in-reach services to communities, emergency community responses, and universal programmes to promote health and wellbeing, which also help to reduce mental health stigma.
- Specialist training in primary care has been demonstrated to equip professionals to better recognise and plan treatment pathways for comorbid conditions, and promote the concept that mental health should not be treated in isolation.
- Integrated primary care MDT can be effective in delivering joined-up care
- Offering training across services and disciplines would help staff to develop the confidence to talk about physical health and assist people to access the appropriate services. Research shows that the type of physical activity and how it is delivered is very important.
- Collaborative Care Models provide a framework to deliver holistic evidence-based care and can be effectively delivered in outpatient settings. Promising findings from a randomised controlled trial in community mental health patient programmes in Maryland, USA reported significant reductions in overall cardiovascular risk, smoking reduction, and improved blood pressure and lipid risk score in patients with serious mental illness. Physical health improvements are likely to improve symptoms in a number of mental health conditions (Carlo, Barnett, & Unützer, 2020).
- Similarly bespoke smoking cessation trials in England and have reported high rates of sustained abstention after 12 months (Gilbody et al., 2019) and the evidence base for successful, tailored lifestyle programmes is growing.

Physical Activity
- People with SMI have considerably lower rates of physical activity than the general population. This population are at higher risk of cardiovascular disease, obesity and comorbid health conditions associated with lifestyle behaviours such as smoking, alcohol use, sedentary behaviour.

- Treatment pathways cognisant of the relationship between poverty and deprivation and the impact this can have on decision-making around nutrition and exercise can achieve more positive outcomes for service users.
- Physical activity can be an effective element of both prevention and supporting recovery. There is evidence that it can improve self-esteem, cognitive functioning and potentially as affective as many drug interventions at preventing cardiovascular disease mortality.
- The NICE clinical guidelines recommend physical activity for persistent subthreshold depressive symptoms or mild to moderate depression, generalized anxiety disorder and panic disorder.
- Not engaging in physical activity is a risk factor for developing depression and anxiety in both children and adults.
- Physical activity interventions can be effective given the right circumstances.
- Research has looked at trying to understand some of the barriers and facilitators to being active and this evidence could help inform the development of new interventions.
- Physical activity is a low-cost intervention and has been shown to be easy to deliver in home-based, clinical or community settings.
- Recent qualitative research Northern Ireland identified the importance of the social benefits and connections that being active can offer long term users of mental health services (McCartan et al., 2019). Physical health can often feel neglected.
- Access to gym equipment and supervised physical activities within inpatient units have been shown to reduce negative symptoms and promote better wellbeing.

References

Carlo, A. D., Barnett, B. S., & Unützer, J. (2020). Harnessing Collaborative Care to Meet Mental Health Demands in the Era of COVID-19. *JAMA Psychiatry*. doi:10.1001/jamapsychiatry.2020.3216

Gilbody, S., Peckham, E., Bailey, D., Arundel, C., Heron, P., Crosland, S., . . . Li, J. (2019). Smoking cessation in severe mental illness: combined long-term quit rates from the UK SCIMITAR trials programme. *The British Journal of Psychiatry*. doi:https://doi.org/10.1192/bjp.2019.192

McCartan, C., Best, P., Blenman, R., Bradley, L., Davidson, G., Farara, A., . . . Breedvelt, J. (2019). *Empowering people through physical activity: A co-produced research project studying how to improve physical activity for people with severe and enduring mental health problems* Belfast, London: Mental Health Foundation, Praxis Care, Queen's University Belfast,.

Morgan, B. D. (2016). "No Right Place to Die" Nursing Attitudes and Needs in Caring for People With Serious Mental Illness at End-of-Life. *Journal of the American Psychiatric Nurses Association, 22*(1), 31-42.

Sheridan, A. J. (2019). Palliative care for people with serious mental illnesses. *The Lancet Public Health, 4*(11), e545-e546.

Thornicroft, G. (2011). Physical health disparities and mental illness: the scandal of premature mortality. *The British Journal of Psychiatry, 199*(6), 441-442.