North of England
Mental Health Development Unit

Health Needs Assessment of People with Severe Mental Illness and design and delivery of associated training

South Tyneside Locality Interim Report

July 2012

Supporting better mental health

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Contents

1.0 Introduction and acknowledgements

The North of England Mental Health Development Unit (NEMHDU) was commissioned to assess the physical health needs of people with Severe Mental Illness (SMI) and provide recommendations and training that will improve their physical health and address current health inequalities for this group. The project was carried out across the South Tyneside and Sunderland PCT Localities. This report focuses on the South Tyneside locality.

This project was delivered in partnership between the North of England Mental Health Development Unit and the mental health service user and carer groups in the area:

- South Tyneside Service Users (via the locality Service User Development Lead)
- North East Together - Regional mental health service user and carer group

NEMHDU was the lead organisation for delivery of this project however all service user and carer facilitation and development input was remunerated.

Acknowledgements

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- Women's Health in South Tyneside (WHIST)
- Project Steering Group:
  Catherine Mackereth
  Jackie Nixon
  Mish Lorraine
  Jayne Guppy
  Lynda Irvine

We would also like to acknowledge all of the commissioners and service providers who took part in the interviews.

2.0 Aims of the project and delivery methods

Aim	Delivery methods
1. Describe the physical health and well-being needs of people with severe and enduring mental illness, with a particular focus on users' views	We developed and delivered four focus groups for service users and carers. Each focus group was facilitated by the NEMHDU programme lead in partnership with a service user/carer from the locality. All focus group attendees were paid an involvement fee and travelling expenses were reimbursed. Questionnaires were developed for service users and carers. A period of field research was carried out, consisting of interviews with lifestyle service providers and mental health care professionals.
2. Provide recommendations for commissioners and service providers about services and interventions that will meet these needs	Data and information gathered from the focus groups and field research interviews has been collated into a locality specific report (this report) which is being delivered to commissioners and the project steering group.
3. Develop training for professionals, with a focus on working with people with SMI around their physical health, to be delivered throughout the summer of 2012, to a range of front line professionals, including lifestyle services, housing officer, library workers, primary care nurses, Children's Centre workers	A four day intensive programme of training development will be undertaken, shaping the findings of the report into a detailed training programme. The development group will include service user/carer representatives. Training will be delivered via ten workshops, to be guided by commissioners on the outcomes of the written report. All workshops will be co-facilitated by a service user or carer.
	A final end of project report will then be prepared and delivered to commissioners.

3.0 Desktop Research

In order to provide a context for this study a short period of desktop research was carried out which revealed the following information.

As part of the study we felt it was important to consider the wider determinants of physical health and wellbeing, for example, most medical staff will consider needs in terms of healthcare services that they can supply either in primary or secondary care. Service users and carers, however, may have a different view of what would make them healthier, for example, a job, a bus route to the hospital or health centre, or decent housing.

This view of health needs can incorporate the wider social and environmental determinants of health, such as deprivation, housing, education and employment.

For health and social care systems, health needs assessment provides the opportunity for:

- Describing the patterns of disease in the local population and the differences from district, regional, or national disease patterns;
- Learning more about the needs and priorities of their patients and the local population;
- Highlighting the areas of unmet need and providing a clear set of objectives to work towards to meet these needs;
- Deciding rationally how to use resources to improve their local population's health in the most effective and efficient way;
- Influencing policy, interagency collaboration, or research and development priorities.

Importantly, health needs assessment also provides a method of monitoring and promoting equity in the provision and use of health services and addressing inequalities in health. (Pritchard P, 1994, pp26-28)[1].

It is also important for this study that we understand the population we are studying. The term 'severe mental illness' (SMI) brings together two complex concepts. The first is defined in terms of five groups of disorders from the International Classification of Diseases (ICD):

- schizophrenic and delusional disorders
- mood (affective) disorders, including depressive, manic and bipolar forms
- neuroses, including phobic, panic and obsessive–compulsive disorders
- behavioural disorders, including eating, sleep and stress disorders
- personality disorders of eight different kinds.

[1] Pritchard P. Community involvement in a changing world. In: Heritage Z, ed. *Community participation in primary care*, London: Royal College of General Practitioners, 1994: 26-28

The second component of SMI places the ICD symptoms and disorders within the context of a judgement of behaviour, course and potential vulnerability. For example:

- active self-injury, food refusal, suicidal behaviour
- threatening or injurious behaviours, drug abuse, severe personality disorder
- embarrassing, overactive or bizarre behaviours
- long-term 'negative' symptoms, such as slowness, self-neglect, social withdrawal
- physical disability, learning disabilities, social disadvantage.

(Health Care Needs Assessments, 2004)[2]

Choosing Health (DH, 2004)[3] refers to SMI as particularly relating to bipolar disorder and schizophrenia. However, for the purpose of this study we will use the term severe mental illness at its most flexible, covering a wide range of diagnoses and context.

General physical health

A wide range of mental health conditions are consistently associated with unemployment, less education, low income and standard of living, poor physical health and adverse life events. (Friedli, 2009)[4] .

For example, some people with severe mental health problems experience inequalities in their physical health that can significantly reduce their average life expectancy. (Seymour L, 2003)[5] .

The Disability Rights Commission has given a stark picture of physical health outcomes, stating: "Someone with a major mental health problem is more likely to develop a significant illness such as diabetes, CHD, stroke or respiratory disease than other citizens, more likely to develop it before 55, and – once they have it – more likely to die of it within five years" (DRC, 2006)[6].

Research by the DRC (2006)[6] also found perceived negative or discriminatory attitudes of health professionals one of the most significant barriers to healthcare identified by respondents. Sometimes this stigma manifests itself in nurses not taking reported symptoms at face value, but re-labelling them as symptoms of a service user's mental illness.

[2] Health Care Needs Assessments, Vol2, 2004; Stevens, Rafferty, Mant, Simpson. Sec 13 Severe Mental Illness, John K Wing

[3] Department of Health, 2004; Choosing Health: Making healthy choices easier

[4] Friedli, L (2009) *Mental health, resilience and inequalities.* London. Mental Health Foundation & World Health Organisation

[5] Seymour L, (2003) *Not all in the mind*. London. mentality

[6] Disability Rights Commission, 2006, Equal Treatment: Closing the Gap. A Formal Investigation into Physical Health Inequalities Experienced by People with Learning Disabilities and/or Mental Health Problems. Stratford upon Avon: DRC

From the field research, two issues were raised consistently throughout the interviews, questionnaires and focus groups. These were smoking and weight gain; physical activity was closely aligned to weight gain.

Smoking

Although people with mental health problems are more likely to smoke, recent studies show that they have a similar level of motivation to quit as the general population, and are able to quit when offered evidence-based support (Jochelson and Majrowski, 2006[7] and Siru et al, 2009[8]). Review-level evidence has confirmed the effectiveness of smoking cessation interventions delivered to people with mental health problems (Campion et al. 2008[9] and Tsoi et al 2010[10]).

Research shows that effective smoking cessation treatment is not routinely offered to people with mental health problems. In addition, there is a lack of support for smoke free policies among mental healthcare staff. Staff are reported to lack specific knowledge about the influence of smoking – and cessation activities – on someone's mental health (McNeill 2004[11], McNally et al 2006[12] and Ratschen et al 2009b[13]). Evidence from a survey of clinical staff in one NHS mental health trust identified that more than a third of doctors were unaware that, following smoking cessation, doses of some antipsychotic medications may need to be reduced (Ratschen et al. 2009b[13]).

In addition, Campion et al (2010)[14] state that interactions between nicotine and some psychiatric medications make the medications less effective so that a higher dose is needed. In some instances, there is a need for a planned reduction of doses of medications during a quit attempt.

Those from routine and manual groups take in more nicotine from cigarettes than more affluent people (Jarvis 2010)[15]. This increases their exposure to the other toxins in tobacco smoke and, thus, increases their risk of smoking-related disease. Higher nicotine exposure can also make it harder for them to quit – and they are more likely to cut down first rather than quit smoking

[7] Jochelson K, Majrowski B (2006) Clearing the air: debating smoke-free policies in psychiatric units [online].
[8] Siru , Hulse and Tait (2009) Assessing Motivation to Quit Smoking in People with Mental Illness; a review. Addiction 104(5) 719-733
[9] Campion J, Checinski K, Nurse J (2008) Review of smoking cessation treatments for people with mental illness. Advances in psychiatric treatment 14: 208–16
[10] Tsoi, Mamta, Webster (2010) Efficacy and Safety of Bupropion for Smoking Cessation and Reduction in Schizophrenia; a systematic review and meta-analysis
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[12] McNally L, Oyefeso A, Annan J, et al. (2006) A survey of staff attitudes to smoking-related policy and intervention in psychiatric and general health care settings. Journal of Public Health 28 (3): 192–6
[13] Ratschen E, Britton J, Doody GA et al. (2009b) Tobacco dependence, treatment and smoke-free policies: a survey of mental health professionals' knowledge and attitudes. General Hospital Psychiatry 31: 576–82
[14] Campion J, Hewitt J, Shiers D, et al (2010) Pharmacy guidance on smoking and mental health
[15] Jarvis (2010) The Authors, Addiction - Society for the Study of Addiction

abruptly (Siahpush et al. 2010)[16]. As a result, people on a low income may need additional support to quit (The Marmot Review Team 2010)[17].

In 2005, the Disability Rights Commission (DRC, 2006)[6] found women with schizophrenia were 42% more likely to develop breast cancer than other women. Smoking is probably the biggest contributing factor to this.

NICE are currently developing smoking cessation guidance:

- Smoking cessation in secondary care; mental health services[18]. This guidance is proposed to be split into two sections that will address smoke free policies and smoking cessation in mental healthcare settings. It will cover assessment, care and treatment for people with severe mental illness in hospitals, outpatient clinics and the community, as well as intensive services in psychiatric units and secure hospitals.
- Smoking cessation in secondary care: acute and maternity services[19]. This guidance will address smoke free policies and smoking cessation in hospitals and other acute or maternity care settings. It will cover emergency care, planned specialist medical care or surgery, and maternity care provided in hospitals, maternity units, outpatient clinics and in the community.

Currently NICE are in the scoping phase and the guidance is proposed to be published in November 2013.

<u>Weight gain</u>

Obesity is a serious public health concern because it can be both a cause and a symptom of long-term conditions such as coronary heart disease and diabetes. Citrome and Vreeland (2009)[20] found obesity is the most common physical health problem in mental illness.

In patients with severe mental illness, as in the general population, obesity is associated with lifestyle factors, eg lack of exercise, poor diet, but also with illness-related (negative and depressive symptoms) and treatment-related factors, including weight liability of certain psychotropic agents.

There is a large amount of evidence that certain medications cause significant weight gain. World Psychiatry (2011, p54)[21] - reproduced at Appendix 1 - shows the weight gain liability of psychotropic agents used in treating severe mental illness.

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[16] Siahpush et al. (2010) - Socioeconomic position and abrupt versus gradual method of quitting smoking: Findings from the International Tobacco Four Country Survey

[17] Marmot Review (2010) Fair society, healthy lives. Strategic review of health inequalities in England post-2010. London: The Marmot Review

[18] NICE (2012) Smoking cessation in secondary care: mental health services; scope

[19] NICE (2012) Smoking cessation in secondary care: acute and maternity services; scope

[20] Citrome L, Vreeland B (2009) Obesity and mental illness. In: Thakore J, Leonard BE (eds) Metabolic Effects of Psychotropic Drugs. Modern Trends in Pharmacopsychiatry. Germany: Basel Karger

[21] World Psychiatry 10:1 - February 2011; WPA Educational Module: Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care

Significantly, as described above, obesity can lead to an increased risk of diabetes. Evidence suggests that the prevalence of diabetes mellitus in people with schizophrenia as well as in people with bipolar disorder and schizoaffective disorder is 2-3 fold higher compared with the general populations. The risk of diabetes mellitus in people with depression or depressive symptoms is 1.2 - 2.6 times higher compared to people without depression (World Psychiatry, 2011, p55)[21].

4.0 Field Research Findings

4.1 Service user and carer focus groups

A summary of the results from the service user focus groups and carer focus groups can be found at Appendix 2. The following are key points from all focus group findings.

Across the four focus groups delivered in the South Tyneside area, these were attended by 11 carers and 36 service users.

The focus groups were semi-structured and based around four key areas, the first of which was around what health and wellbeing services people felt they needed.

There was a high level of awareness of their own physical health needs. Participants were highly motivated and identified needs which generally fell into two main themes:

Specific physical health issues
Focus group participants identified the following as being important to them:

- Services need to come to the person
- Smoking cessation
- Easier access to GPs
- Exercise on prescription

Lifestyle/wellbeing issues
Many of the participants identified several issues that impacted on their wellbeing such as:

- Healthy eating
- Access to exercise and leisure centres, such as swimming
- Access to less formal activities such as allotments and walking groups
- Supported transition, eg hospital - community, young person - adult

The second key area covered in the focus groups asked participants about their level of awareness of existing health and wellbeing services within their locality. Generally across all focus groups there was a very good understanding and awareness of the availability of such services.

The third key area covered in the focus group was around barriers that prevented people accessing services. There are three themes - one being that people with long term mental health problems tend to be in the lower income bracket, live in the more deprived areas, and have the related physical health problems of that population, ie poor diet, lack of exercise. Costs of travel to and from venues was prohibitive for most people. Secondly, the issue of contract culture was also raised, which encourages narrow eligibility criteria; for example, funding for exercise and physical activity programmes generally comes from "obesity funds" - performance criteria therefore is almost exclusively focused on weight loss. For smoking cessation services, performance targets and funding follow specific "stop" targets which may not suit people with more complex needs. There was also strong feeling around the understanding of mental health within lifestyle services and an example was given of a gentleman who attended a Local Authority walking group and when he revealed that he used mental health services was told that on his next attendance at the walking group he would need to be accompanied by a carer.

The fourth and final key area was a 'wish list' question - to identify the one thing that would improve their physical and emotional health.

The main themes arising under this area were a desire for access to healthy eating, exercise, weight management and smoking cessation programmes. Secondly, a desire for quicker access to services, for both physical and mental health, which should have a focus on recovery. A final theme was around raising awareness of the links between mental health and physical health.

It should be noted that the focus group facilitators reported the challenge of keeping participants focussed on the above key areas, as the debate frequently turned to the changes in the benefit system and the impact that is having on their lives.

4.2 Service user and carer questionnaires

There were 40 service user respondents and 11carer respondents to the questionnaires. The service user and carer questionnaires were broadly similar, with some carer specific questions which we will make specific reference to. A full breakdown of responses can be found at Appendix 3.

Basic demographics show that the age range of service users and carers was spread across the adult age range, with the majority of service users falling in the 40-59 age group. There was a relatively equal split across the genders for service users, however carer respondents were predominantly female.

On a positive note, 87% of service users reported having had a physical health check at their GP practice within the last year. 72% of carers reported having a physical health check at their GP practice within the last two years.

Only 17% of service users reported receiving care as part of the Care Programme Approach (CPA).
18% of carer respondents could identify that the person they cared for was receiving care as part of the CPA, whilst 36% did not know.
45% of service user respondents said their care plan addresses their physical and wellbeing needs as well as their mental health needs.

It should be noted that the carer respondents were not necessarily the carers of the service user respondents.

36% of carer respondents knew of their legal right to an assessment of their own needs, however only 27% had received an assessment, and yet 72% identified that their caring responsibilities had a direct impact on their physical health and 91% reporting a direct impact on their emotional health and wellbeing.

Of the service user respondents 57% report being smokers, with 35% wanting help with this issue. This level of smoking is significantly higher than the national average in the general population which is 21% (NHS Information Centre, 2010)[22]. 27% of carers reported themselves as smokers, with 0% wanting any help.

30% of service users reported drinking more than the recommended limits and 22% reported wanting help with this issue. 1 carer reported drinking more than the recommended limits, and wanting help.

Of the service user respondents 40% and 52% respectively felt that they drank or smoked more during periods of increased mental ill health. However between 77% and 80% of service user respondents report exercising less, not sleeping well and worsening of existing physical health conditions during such periods.

82% of service user respondents felt that their confidence dropped during periods of increased mental ill health; 75% reported not visiting friends and family as much, 70% stopping doing their hobbies and 62% staying in bed a lot longer than usual, and 35% report a drop in the number of visitors they receive.

12% of service users reported being overweight and not wanting any help, whilst 27% report being overweight and wanting help to deal with this. This is also reflected in the carer respondents where 27% reported being overweight and would want help to deal with this.

37% of service user respondents had used or were currently using stop smoking services, 50% were using or had used exercise services, and 42% had used or were using drug and alcohol services, whilst only 15% had used or were using weight management services. There was a very low level of carer respondents reporting using any lifestyle services (9% = 1).

[22] NHS Information Centre, 2010; Statistics on smoking: England 2010. Leeds; NHS Information Centre

When asked if they had thought about using a service but not used it, why that was, we received a range of responses with some quoting lengthy waiting lists and some reporting feeling the services were or would not be suitable to their needs.

The voluntary sector is playing a significant role in supporting service user health and wellbeing, with 84% of service user respondents having regular (daily or weekly) support from this sector, with the other mainstay of regular support being family and friends (72% and 82% respectively). For carer respondents, friends and family are the mainstay of support, with support groups playing a significant role.

62% of service user respondents report having had no contact with job centres, whilst 40% report no contact with education or training centres.

When service users described the main things that help them to stay physically and emotionally well and happy the themes of family and third sector support as well as contact and activity within local communities were commonly reported.

When reporting what additional support would help with their physical health and emotional wellbeing 52% of service user respondents and indicated that meaningful activity in the form of education and training would be helpful, whilst 32% indicated that employment/voluntary work would be helpful, and 50% reported that meaningful activity in the form of hobbies would be helpful.

72% of service users and 63% of carers indicated that it would be helpful to understand the mental illness that they or the person they care for suffer from, and its potential effect on their physical health and wellbeing.

4.3 Interviews

From across the two areas of South Tyneside and Sunderland we have managed to access the full range of service provision but within the time constraints of the project it was not possible to access the full range of provision within each locality. 17 people in total were interviewed. The collated, anonymised results can be found at Appendix 4.

The interviews were structured around three key questions, the first of which being about what the interviewees think are the physical health and wellbeing needs of people with severe mental illness.

There is a real issue around the prescription of certain medications and weight gain which was recognised by a range of professionals however it was also recognised that there is a large degree of complacency and acceptance that this will happen, with only a few examples (Early

Intervention in Psychosis service, or EIP) where this is actively worked on.

There is a perception amongst professionals that the mental health 'label' continues to be a barrier to people having their physical needs addressed. Non-mental health professionals see the mental health 'label' and don't go beyond that, and mental health professionals focus on the mental health problem, so physical needs are not being met either way.

Another consistently identified perception was that people with severe mental illness tend to live in the poverty end of the spectrum and therefore face all the issues of other people in that situation, such as poor diet, lack of finance, etc.

Lifestyle service providers reported a high level of drop-out and non-attendance from people with severe mental illness and this does not fit with the current service provision of 'one strike', eg. smoking cessation prescriptions. There is currently no capacity to work with people on a long term basis. A further issue is that due to the way physical health services are commissioned, ie. from which pot of money are they funded, performance targets are focussed almost exclusively on that area eg. services funded from obesity monies will have targets focussed on reduction in obesity levels, there is therefore little incentive to actively work with groups for whom it would be more challenging to hit these targets.

There is also a perception that mental health service users do not want to change.

The second question was around what the perceived barriers are for people with severe mental illness accessing services to address their physical and wellbeing needs.

Access to services is an issue as there is an expectation that people will go to services, rather than services going to them. Lifestyle service providers acknowledged that a lack of confidence and knowledge of mental health problems was a potential barrier for them in engaging effectively with mental health service users and carers.

Capacity within CMHTs was reported as an issue in that as teams had so little capacity those people best placed to engage in wellbeing activities, ie. those whose mental health was stable, actually receive the least amount of contact from the teams.

The third question asked lifestyle providers what kind of changes they thought were needed to encourage people with severe mental illness to access their services.

Many of the professionals felt that the development of specific targets around physical health needs of people with severe mental illness would help the system focus on those outcomes. It was also suggested there

was a need to engage in conversations with commissioners of lifestyle services to review performance targets, as many of the current targets focus on specific success rates which does not encourage service providers to engage with challenging groups.

There were some ideas around putting physical health trainers in community mental health teams. There were also suggestions for health trainers to have a short term focus on mental illness.

It should be noted that many of the lifestyle providers highlighted the necessity to take services to the people rather than have people come to their services.

All interviewees acknowledged the need for confidence and knowledge training for lifestyle service provider staff. Lifestyle service providers have also expressed a lack of understanding of referral and support routes around mental health care.

5.0 Summary

There is a high level of awareness amongst service users and carers of physical health issues, coupled with high motivation to change. This contra-indicates the assumption among professionals who believe there are low levels of motivation.

Across the three types of research, there was a consensus that bringing lifestyle services to the places where service users feel safe and motivated would work better, and offer more flexible access.

Service users are telling us that when they are well they are in contact with friends and family, attending social and physical activity, usually via third sector organisations and it is during these times they feel most confident and motivated to meet their physical health needs. However issues of stigma (such as that reported from the walking group experience in the focus group feedback) and lack of understanding among service providers of mental health and the recovery process, limit their opportunities.

During periods of increased mental ill health service users experience a drop in confidence and motivation resulting in increased social exclusion which further impacts on their physical health.

There is consensus amongst all respondents that there is a real issue of cost for all people with severe mental illness accessing services; this is mainly due to the fact that people from this group tend to be on benefits or low income.

Whist service user and carer respondents from both the questionnaires and focus groups report a high level of desire for meaningful activity in the form of education or employment, there are very low levels of contact with these services.

Service users also report a desire to better understand their mental illness and its impact on their physical health.

There is a lack of focus within current mental health service provision on physical health needs and an acceptance that current lifestyle service providers require some support and training in the field of mental health.

Service users and carers also reported that poor communication between services or services not being joined up often led to being passed on to another service. This may indicate that physical care is not an intrinsic part within a mental health care pathway.

There is a specific issue around carers assessments with a number of carers reporting their assessments "disappearing into a black hole" with them receiving no communication once an assessment has been completed. This is leading to a lack of uptake in carers assessments.

6.0 Recommendations

1. We recommend that commissioners work on developing a CQUIN target for mental health service providers to ensure that each individual who receives prescribed psychotropic medications that are known to cause substantial or intermediate risk of weight gain (see Appendix 1) must be offered a weight management programme as part of their treatment This should apply to new and existing prescriptions.

2. We will continue to develop a training programme for lifestyle providers to increase confidence, skills and knowledge in working with people with mental health issues. We recommend the commissioners consider targeting a portion of that training at specific lifestyle services as we feel this will have a much greater impact working with teams rather than mixed groups.

The current commissioning of smoking cessation services will change in January 2013 to allow any service provider to provide smoking cessation services under contract and receive payment.

3. We recommend the commissioners work with current statutory providers of mental health care to ensure smoking cessation is offered as part of the care pathway.

4. We recommend commissioners working alongside third sector service providers, to develop business plans to ensure mental health services are in a state of readiness to maximise the opportunity of smoking cessation services re-provision.

5. We recommend that commissioners undertake a mapping exercise of all lifestyle services and referral pathways, to understand what is available and the eligibility criteria and patient flows within the system; to

explore the blocks and enablers for people with mental health problems using lifestyle services.

6. We recommend that the commissioners initiate discussions with Local Authority colleagues on the update and outcomes of carers assessments. This may result in the need to commission additional capacity to ensure this process meets the needs of local carers.

7. We recommend that the commissioners communicate with Medical Directors at the local Foundation Trust to ensure they are aware of the scoping document for the NICE smoking cessation in mental health guidelines, and in particular the links between prescribing levels and smoking cessation.

8. We recommend that the commissioners of this project explore with lifestyle service commissioners and mental health commissioners the possibility of changing performance targets or focussing resources towards the mental health community, for example, in Sunderland the exercise referral team already has one worker who focuses exclusively on maternal mental health - this could provide a model to have one worker focussing exclusively on the mental health community. Consideration on how this capacity would be resourced would be needed.

7.0 Areas for future discussion

7.1 One of the most common themes identified by service users and carers and also professionals was the cost implication of accessing services such as exercise on prescription and other wellbeing activities. For instance, if a person needed medication to improve their life and social wellbeing that medication would be free at point of contact dependent upon whether the person is receiving benefits. Currently, this is not the case with schemes such as exercise on prescription, which is time limited and only provided at a reduced subsidised rate, not free of charge, therefore excluding many people from the most disadvantaged and marginalised groups.

It is identified that people with multiple disadvantage, specifically long term severely mentally ill, have a lower life expectancy. We suggest that commissioners could explore the disparity between the availability of free medication (subject to circumstances) and the lack of availability of similar free lifestyle services, both of which are acknowledged to have an impact on increasing life expectancy and quality of life.

7.2 During the research phase there was a query raised about whether health trainers could be used in a different way within the system to focus on the needs of people with mental health problems. This would require further discussion to fully understand what recommendations could be made.

8.0 Contact Details

Paul Johnson, Director, North of England Mental Health Development Unit
Email: paul.johnson@nemhdu.org.uk
Tel: 07919 173917

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Appendix 1

Weight gain liability of psychotropic agents used in SMI

Drug Class	Weight loss	Relatively weight neutral	Weight gain
Antidepressants	Bupropion Fluoxetine	Citalopram Duloxetine Escitalopram Nefazodone Sertraline Venlafaxine	*Substantial:* Amitriptyline Imipramne Mirtazapine *Intermediate*: Nortriptyline Paroxetine
Anticonvulsants/ Mood stabilisers	Topiramate Zonisamide	Lamotrigine Oxcarbazepine	*Substantial:* Lithium Valproate *Intermediate:* Carbamazepine Gabapentin
Antipsychotics	Aripiprazole (in pre-treated individuals) Molindone (in pre-treated individuals) Ziprasidone (in pre-treated individuals)	Amisulpride Aripiprazole Asenapine Fluphenazine Haloperidol Lurasidone Perphenazine Ziprasidone	*Substantial:* Chlorpromazine Clozapine Olanzapine *Intermediate:* Iloperidone Quetiapine Risperidone Thioridazine Zotepine

From: World Psychiatry 10:1 - February 2011; WPA Educational Module: Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, p54.

Appendix 2a

Service User Focus Groups - summary of responses

Q1. What health and well being services do you think you need?	**Q2. Tell us what health and well being services you are aware of in your area**
Gym/exercise - leisure centre access ++ - exercise on prescription (free) - swimming (free) Lifestyle services to come to where you are - smoking cessation ++ - healthy eating +++ - social activities ++ - allotments/gardening ++++ - weekend activities - walking groups +++++ Services should come to you - be more aware of MH problems ++ - GPs easier to access +++ - social inclusion ++ - Transition: hospital - community and young people - adults	• Health trainers ++ • Smoking cessation ++ • Exercise on prescription (cost) • Get Active cards • Substance misuse (NB all mentioned were third sector) • Walking group (stigma) • Diabetes services • Swimming • Gardening/allotments • Healthy eating courses • Sexual health services
Q3. What are the barriers that stop you using these services + what are the good points of services? • Costs ++++++++ • Confidence to use services/support ++ • Contract culture (eligibility criteria for some services - don't fit the label therefore you don't get that service) • Services' understanding of mental health ++++++ • Social isolation +++++ • GPs vary even in practices on their understanding of mental health • Third sector organisations good at signposting • Lack of info/working between statutory organisations	**Q4. If you had one wish to help you improve your physical and emotional health, what would that be?** Lifestyle - healthy eating ++ - recovery be promoted - talking therapies and quick access ++++ - exercise - weight management +++ - stop smoking ++ Support - recovery focus - social inclusion - emotional support Awareness raising - mental health and physical health ++++ - more input from CPN & S/W re physical health +++

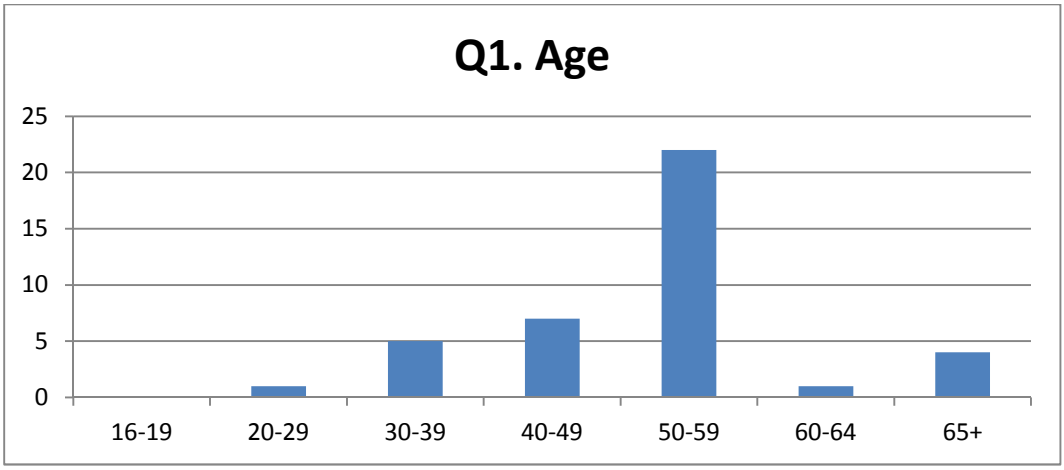
Appendix 2b

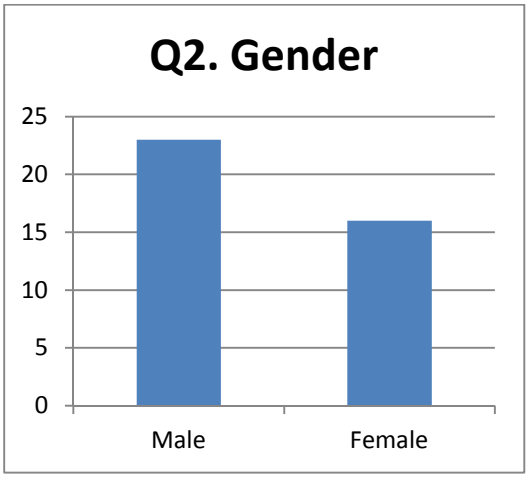
Carer Focus Groups - summary of responses

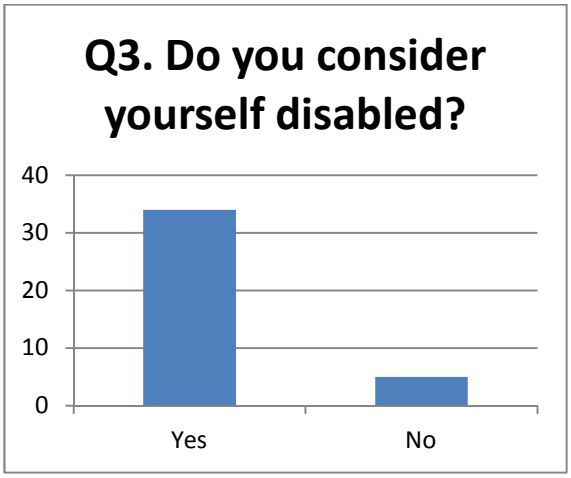
Q1. About you: What health and well being services do you think you need?	**Q2. What health and well being services have you accessed. If not, why not?**
Physical health - more awareness of carers physical needs Lifestyle - support ++++ - emotional resilience + Services - good third sector organisation carer support services	Physical health - carers assessments often no feedback - can't plan ahead because of caring role Lifestyle - social isolation Services - carers seen as a nuisance - lack of understanding of carers role - stigma re mental health services; don't want to go into issues ++
Q3. The person you care for - what services do you think would help their health and wellbeing + what are the barriers?	**Q4. If you had one wish for a service to improve your health and wellbeing, what would that be?**
Physical health - stop smoking - professionals don't talk to us Lifestyle - alternative therapies ++ - social networking +++ Services - rarely involved in care plans - transitions - young people to adults - temporary bank staff don't understand	Services - quicker responses - better inpatient - community services communication Lifestyle - alternative therapies

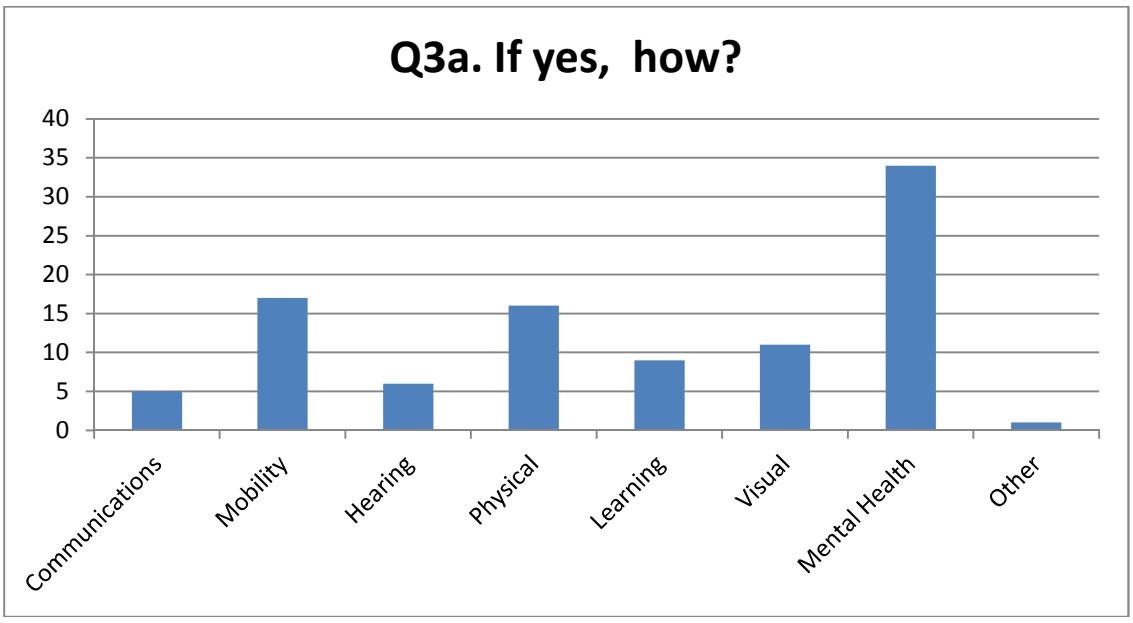
Appendix 3a

Service User Questionnaires - collated responses









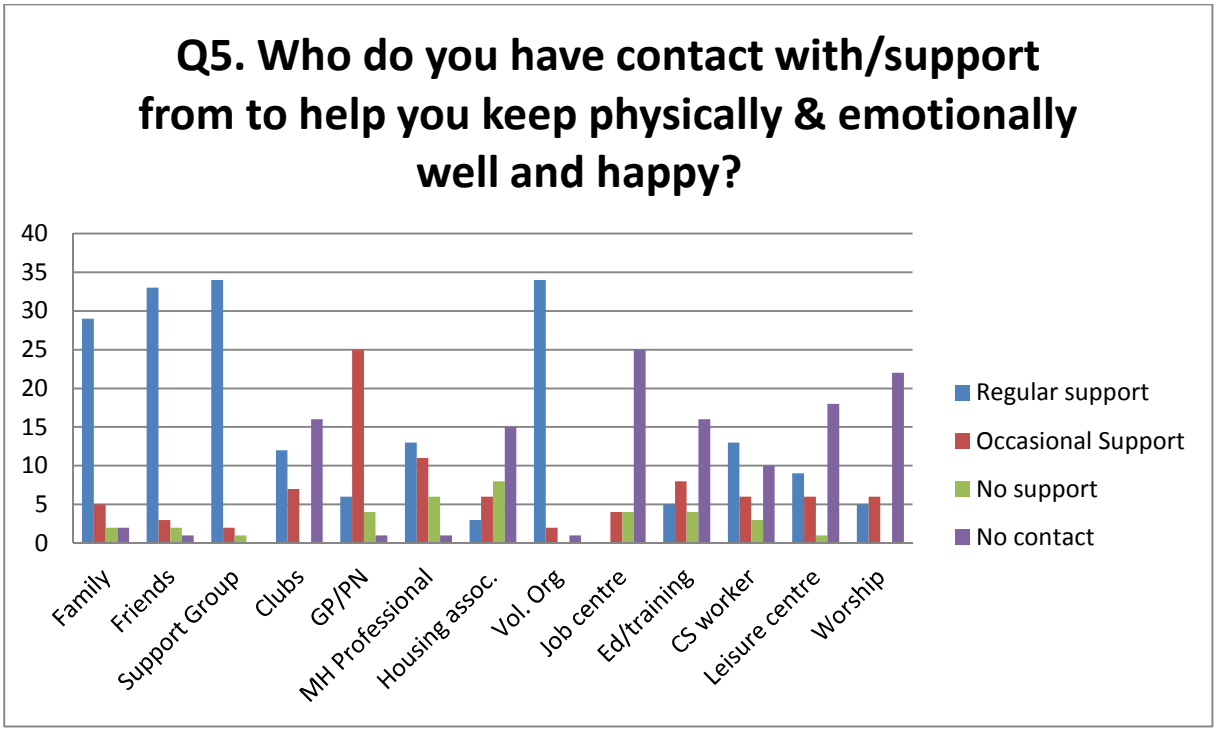
Other:	Diabetic, emphysema, COPD, diverticular disease
3a cont - Please give further d1etails if you wish:	Emotional difficulties
	Concentration often fluctuates - a recent problem. Fit + heart attack (heart stopped twice)
	Depression, anxiety, alcohol
	I have mental health issues but do not consider myself disabled
	I have depression + anxiety
	I have a lot of physical disabilities also mental health issues

Q4. Please tell us the three most important things to you that help you stay physically and emotionally well and happy

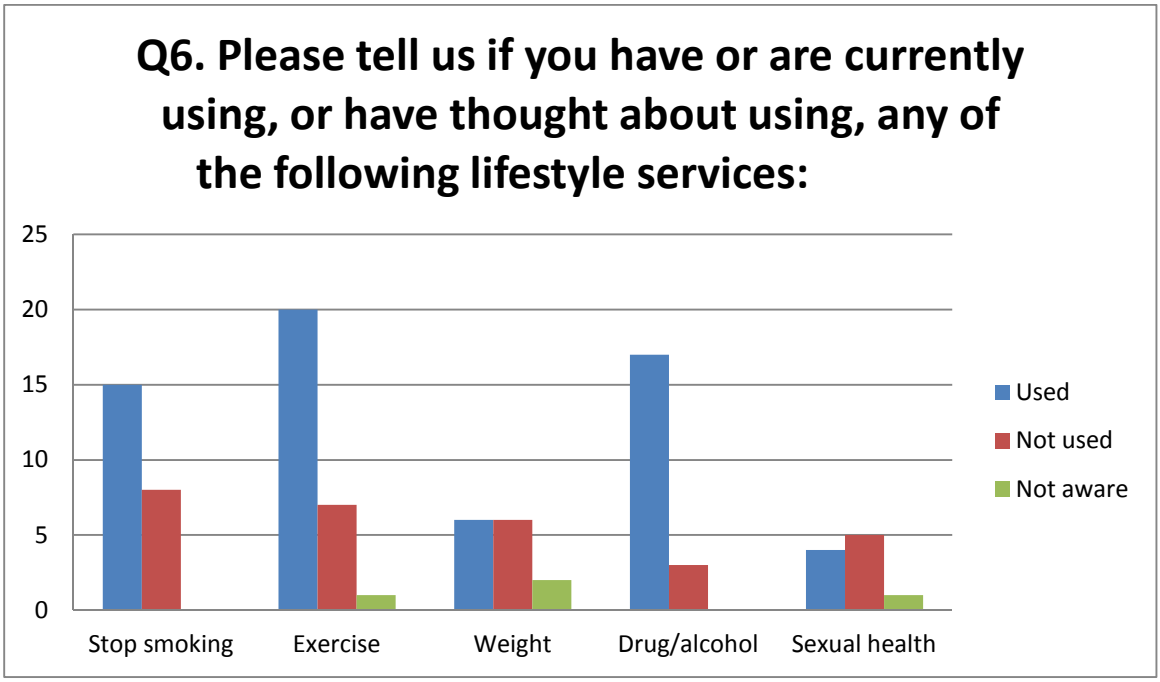
1	2	3
Family - wife/sons	Dog	Home
Contact with others	Taking part in activities eg. Music group	Things going reasonably well in my life
Walking	Football	Friends
Keeping occupied	Friends and family	Emotional support
Social inclusion - able to communicate within group settings	People being aware of my physical impairments & organisation that help me deal with mobility issues. But now shopmobility has closed.	Staff awareness re my dyslexia so they can be included in courses etc, eg. College that helps with English lit.
Me and husband still together (60 years)	Can still manage to do my own housework	Going to MF South Shields to see friends and socialise
Friends/socialising	MF S.Tyneside - interacting with people with similar impairments	Education - various courses including IT
Family - 2 daughters, grandson, wife	My daughter's dogs	Sky TV
Medicines	Social interaction via support groups	Playing music
Staying active - voluntary work for 20 years	Socialising	Immediate family - sons - knowing they are thriving
MF - SS. Participation in groups	Getting out of the house	Socialising
Social outlet (Moving Forward ST)	Regular exercise	Listening to music
Support network - people who helped me with alcohol recovery + medical services	My religion	Occupation - volunteering with recovery centre + recovery courses
Education courses, eg counselling, health & safety, kitchen hygiene	Family (sons) + dog	Partner

1	2	3
MF S. Tyneside: socialisation, art group, volunteering, courses - health & safety	Shopping and eating	Relaxation: TV/wine or lager/DVDs/ Housework - cleaning kitchen
Daughters	Music - singing, writing, listening. Attending/chairing peer support DD recovery group	Physical exercise, eg. Gym + mountain biking
Being financially sound	Health	Family
Helping people - eg. With shopping etc	Learning new skills & finding new activities - eg. Clippie mat making, gargoyle making	Walking
Interacting with people	Having goals - things to work towards	Exercise
Having a lot of friends to socialise with	Regular activities that motivate me to get out of bed in the morning. Social events.	Helping other people - I get joy from seeing people happy about something I've done for them
Moving Forward. Derby Tce S/S eg. Women's group + other activities	Love & support from family, husband & 2 daughters	Gardening
My dog - he's kept me alive; was suicidal when I got him and he keeps me going	My mother	Medication
Derby Tce meetings including SURFs group (being an active committee member)	Being active and in social environment, eg. Cooking course, education course, health & hygiene etc	Family: 3 sons + 2 daughter
Going to MF South Shields - help with depression, amnesia, PSY points out the need to get out of the house	Fishing/snooker	8 year old daughter
Exercise: walking	Being with friends	Line dancing
When I'm not drinking	My dog - I know I've got to get up for him	Getting out of the house
Relationships	Socialising/friends	Beacon peer support group
Family: son, daughter + grandchildren	TV + laptop	Trying to be as self sufficient as possible/independence
Company	Access to drop-ins	Having enough money

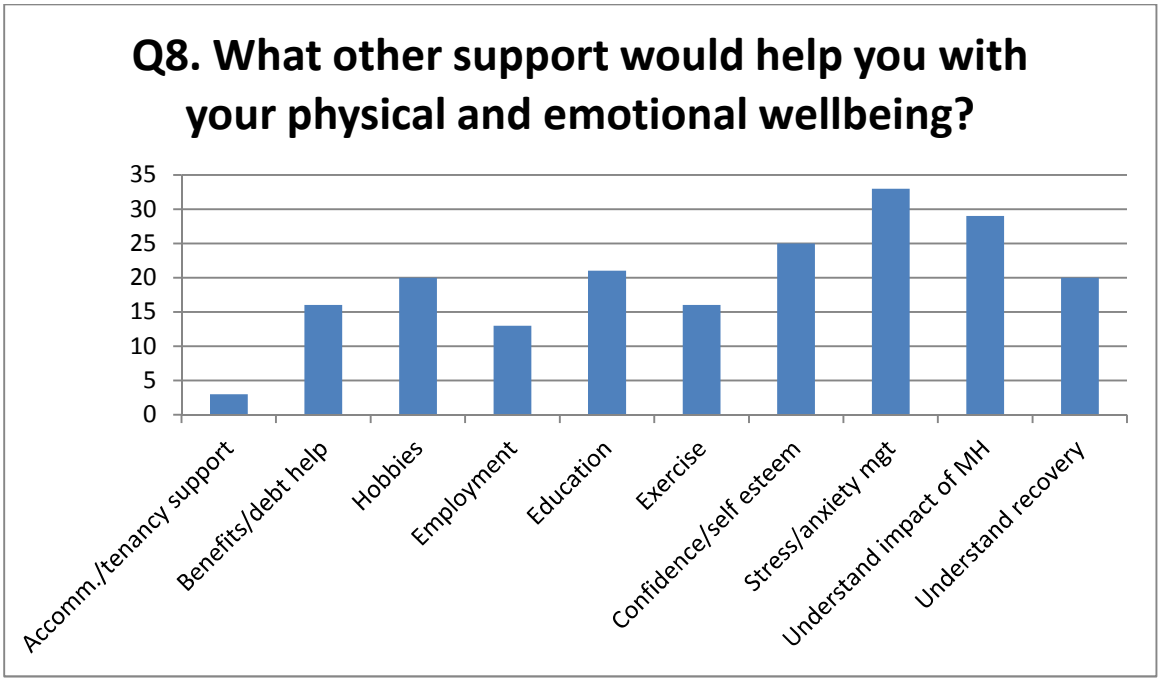
1	2	3
Being able to exercise - unfortunately I haven't been able to due to osteoarthritis	Being aware of triggers and avoiding situations which can cause these, and having understanding of mental health	Having my time organised, with friends, family and having goals in life
I still enjoy learning about things I have always been interested in: physics, cosmology, philosophy, religion, computers.	Being an officer in 'Onwards & Upwards'. It helps to meet people, get out and do things worthwhile.	Contact with my 2 sons, daughter, 2 grandchildren, 2 sisters and my mother
Talking to support worker	Alcohol awareness groups; onwards/upwards	Street level & AA
Meeting my friends for coffee	Learning new skills and attending my substance misuse support group	Walking and relaxing with my dog and family
My children aged 17, 16 and 8.	Coming to WHIST	Mixing with the community
Talking to others at WHIST	Exercise that's not too strenuous	Helping others at WHIST
Not being alone	Talking to others/family & friends	Being involved in voluntary work which incorporates 1 & 2
Being with family and accessing services at women's organisation	Being healthy	Being with friends
Going to WHIST, volunteering, felt valued as a volunteer, the staff are very helpful + supportive and have helped me enormously through difficult times in my life	My medication -anti depressants	Keeping in contact with friends & family. When I am really unwell I heal myself by being alone for 4-5 days, that is very important for me to do.
Going to WHIST among people. If it wasn't for my counsellor at WHIST I would be bad, she helps me an awful lot.	Seeing my counsellor at WHIST because of my mental health.	Meeting new people. My family are a great help to me.
House	Money	Company/friends



Q5 - cont.	Bede Wing
Other - Regular:	WHIST
Other - Occasional:	Barnado's stay in touch

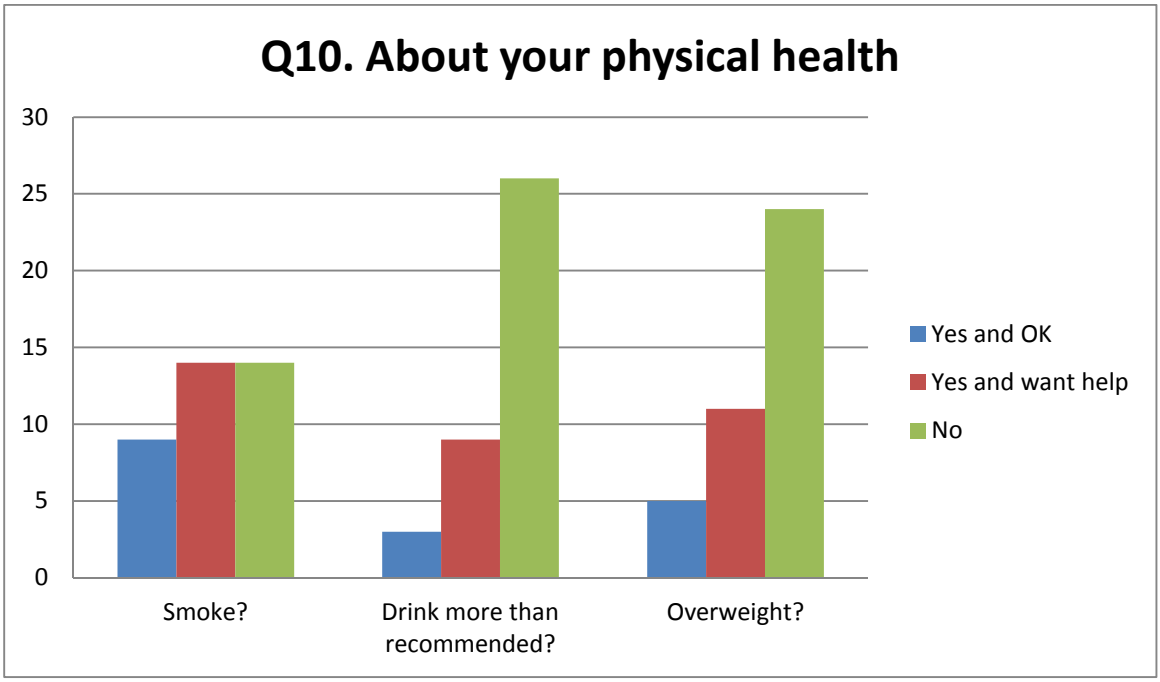


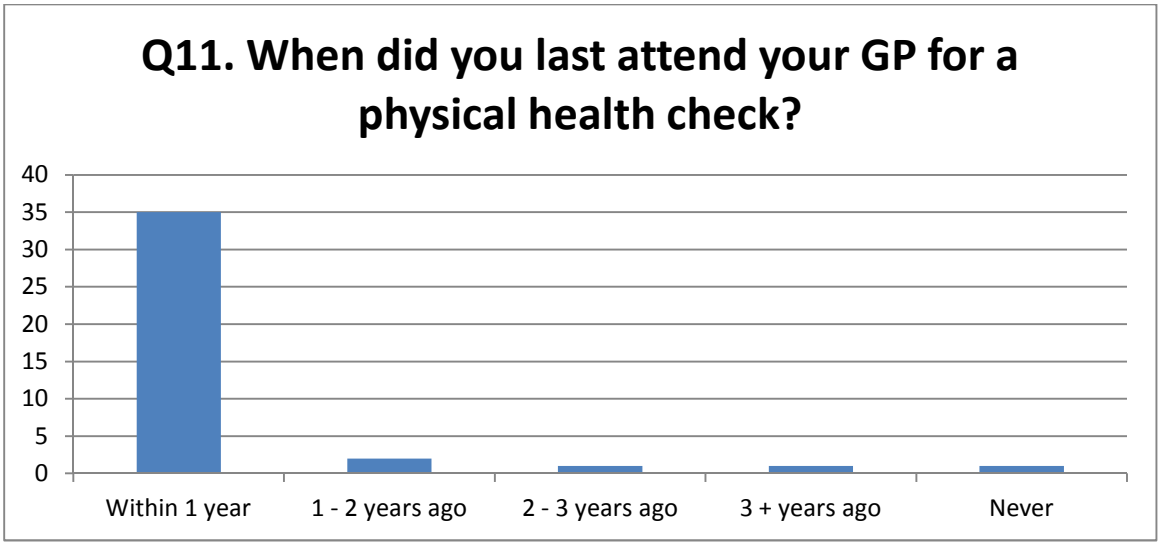
Q7. If you have thought about using a service but not used it, please tell us why that is:	
Service	Reason for not using
CMHT	Waiting to hear this week
An emotional support service	Not been informed of what exists as yet. Waiting to hear
Swimming pool aerobics	Would like to know where to access such a service
AA	Reputation - people not being very convivial or welcoming
Samaritans	Can only listen but cannot give you advice
CMHT out of hours svc	Put off by their bad attitude. Misdirected advice
Veterans support groups	Don't acknowledge what I need or what I've done. Eg. Combat Stress turned me down because of MH needs
Ocean Road community centre	Not yet checked out. Now MF has changed looking for services to use when necessary
GP	Concerns about (how) to get across my needs + my thoughts about how to get MH support + what kind of support there might be. GP had said a few years ago "how would you like me to help you" - was too confronting & not what I expected. No choices given.
NECA	Didn't like it
Desperate need to give up smoking	Not found a suitable service yet
Stop smoking; weight management; alcohol	Not ready
An arthritis self help service	Other people were older and there were transport problems
Exercise sessions	Prefer walking - much cheaper
Weight management	They don't work
Sexual health service	Got over my hypochondria
Exercise sessions	I am overweight and the sessions I have seen are in gyms and I feel uncomfortable because of my size. I also have high blood pressure so would like a gentle exercise programme.
Sexual health service	I have found no need to use this service. I receive all I need from my doctor/nurse
Exercise	Because of the waiting list
Drug or alcohol	Because of the waiting list
	I tried to do courses but I have poor concentration

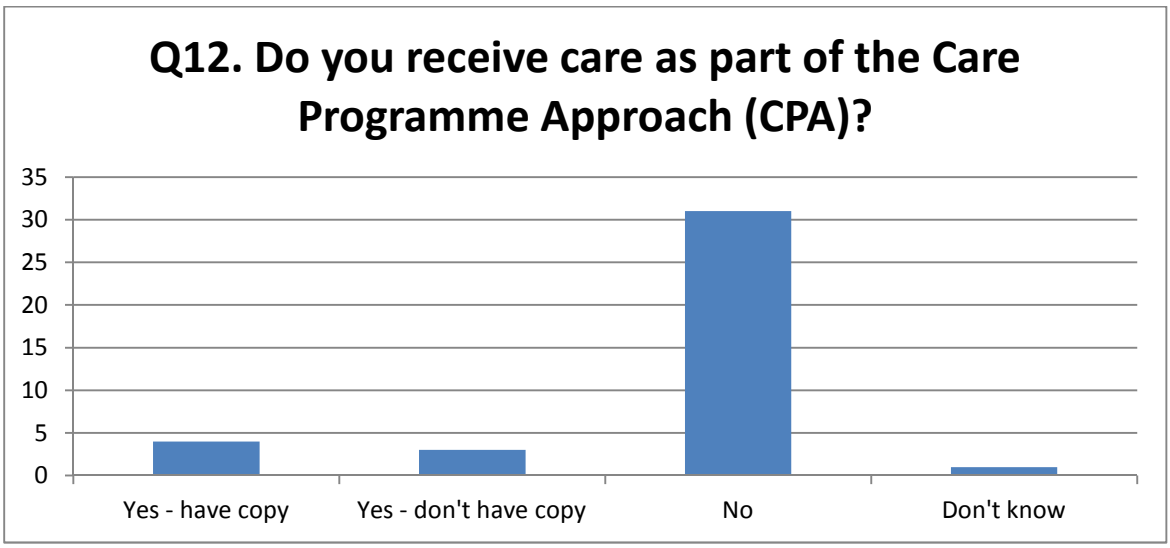


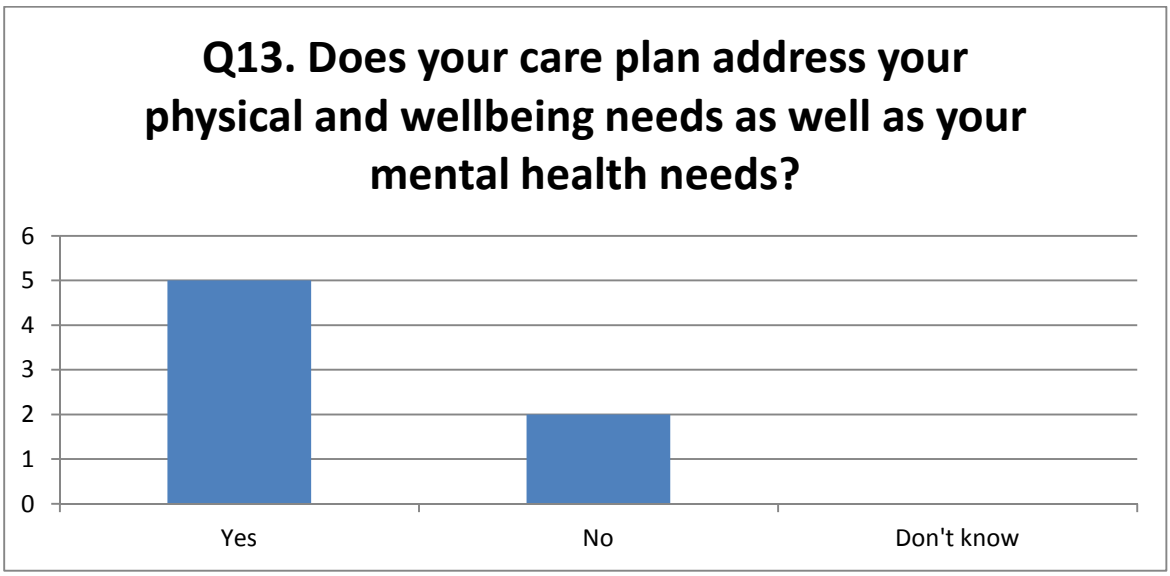
Q9. If there was one thing that we could do to make it easier for you to live a healthier and happier lifestyle, what would it be?
More contact with others
Cure my health problems
Provide emotional support
Confidence & self esteem help managing help with low moods/loneliness
As long as I've got (my husband) I'll be alright. We're here for each other
More drop-in centres for people with MH problems
A cookery course
24hr access to services - for the times when feeling isolated and in need of support
Keeping MF S/S open longer - changes to services have not been. Loneliness and isolation setting cos of changed hours
Would like to understand people more. Sometimes I don't grasp what people are saying
Unrealistic question
Relaxation techniques to help switch very active brain off. A mental thermostat
To be able to live nearer to my sons/ help with loneliness
Get help with eyesight problem. Arthritis in both feet - advice re footwear/re operations on feet in the past, has plates in
To meet a very special woman
Happiness + peace of mind and companionship
Help to become employed - I get anxious, scared and demotivated. It's not working out for me
Change back to drop in idea at Derby Terrace/Moving Forward
A change to medication, eg 1 tablet instead of different types - mood swings, depression, 3 re waterworks
Further support to help what I'm already doing

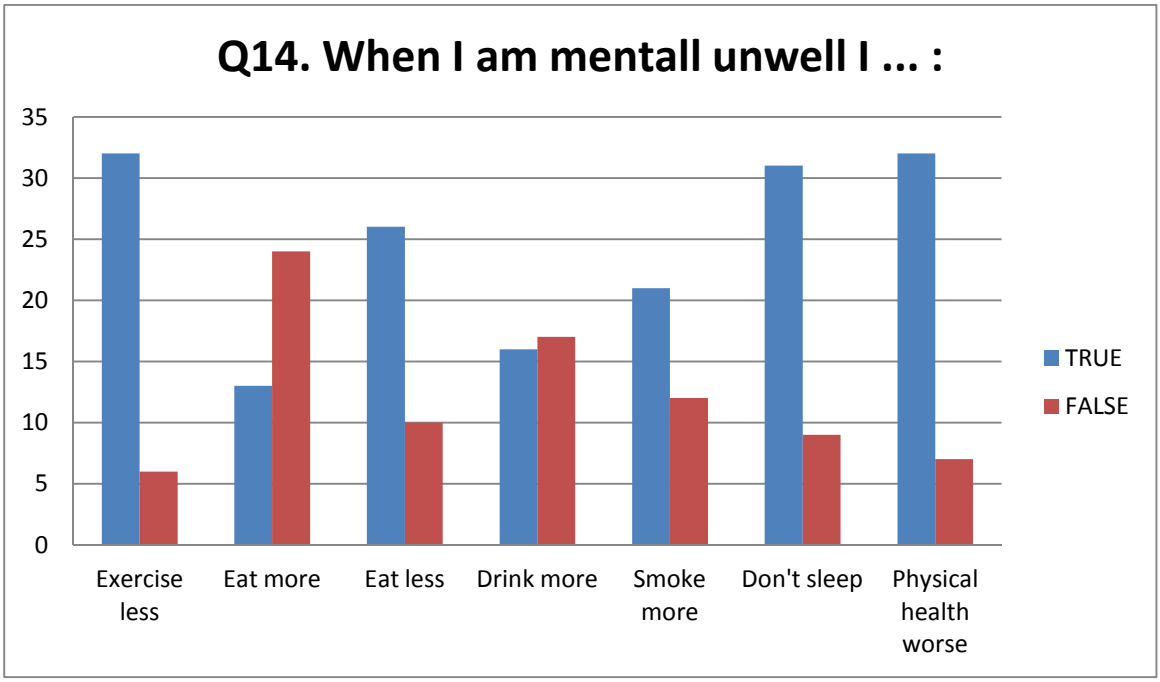
More care & support. Concerned cos next week might be put on a drug that has side effects = tired & drowsy
To understand more clearly the symptoms and how to keep well without medical jargon
I just want to be happy - when I'm off the drink I can be
Open more community centre
Help to stop smoking and getting my body to work properly again
More support, and access to services at an affordable price
Arthritis cures (not harmful types)
Better access to complimentary therapies: aromatherapy, Indian head massage etc
Working on my confidence and self esteem; coping better with stress in life
More one to one support from WHIST
Accommodation
Always having my health and being happy with myself
Affordable exercise/dance classes outside of WHIST (as it is £1 donation at WHIST) I would like to do more outside of WHIST but I cannot afford to
It would be to take all the illness away so I could do all things I used to do

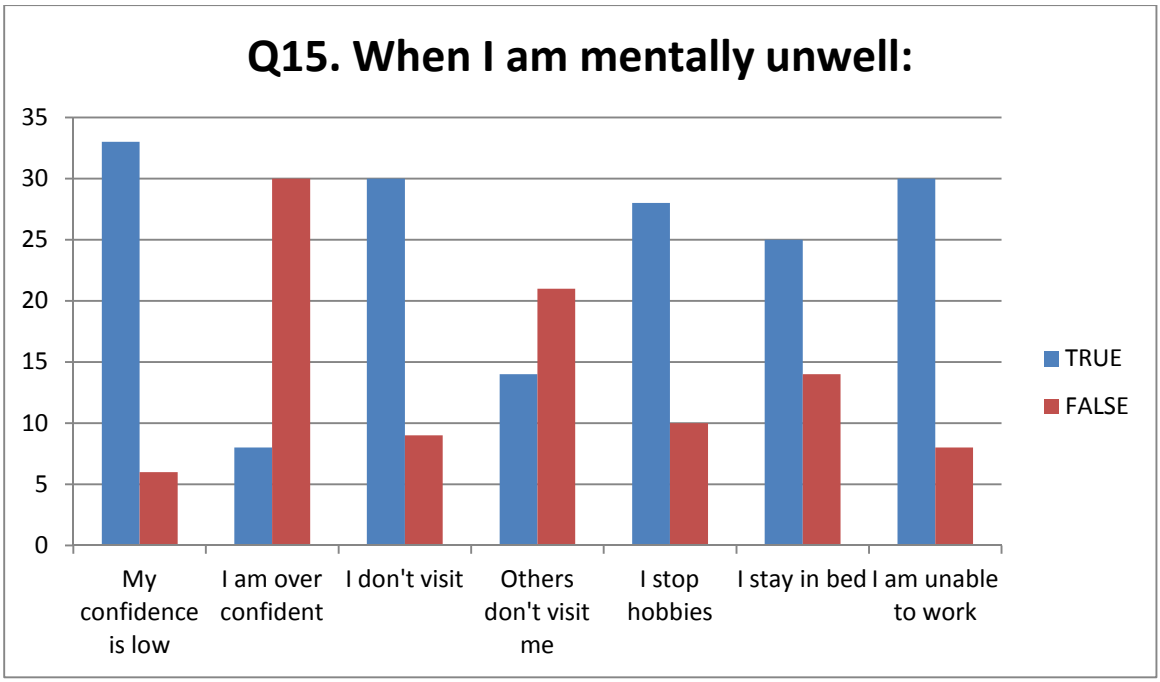


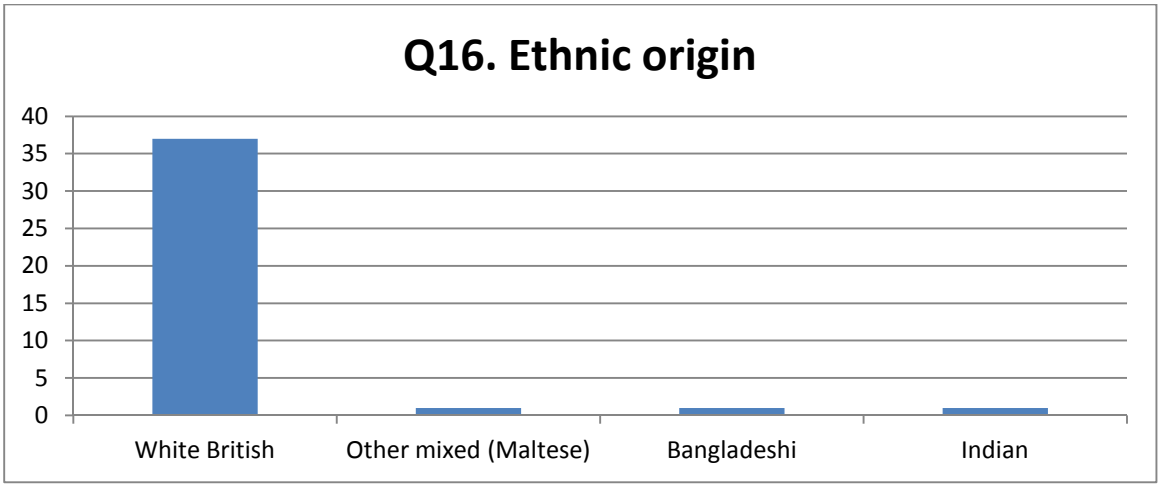

Q11. When did you last attend your GP for a physical health check?
40
35
30
25
20
15
10
5
0
Within 1 year
1 - 2 years ago
2 - 3 years ago
3 + years ago
Never

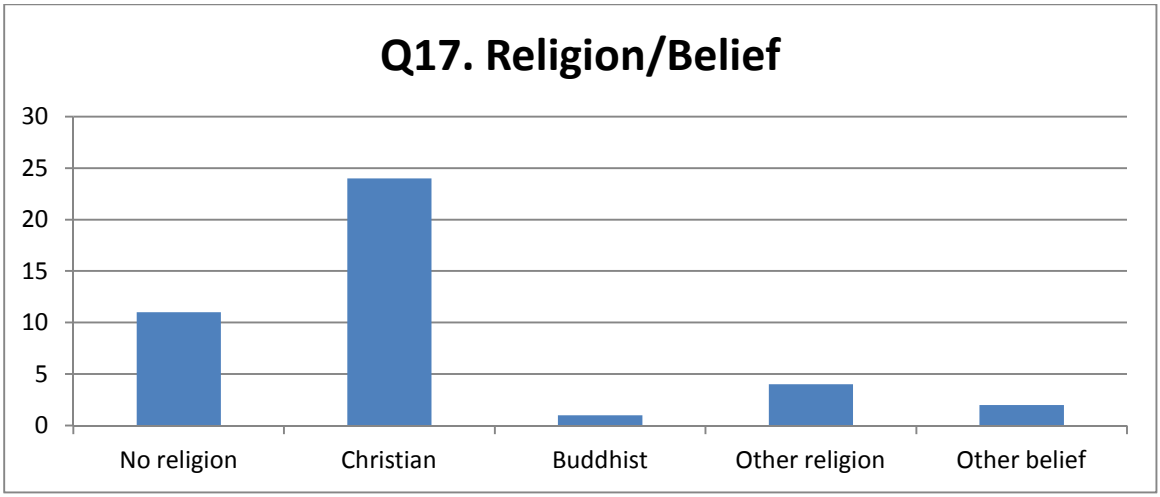

Q12. Do you receive care as part of the Care Programme Approach (CPA)?
35
30
25
20
15
10
5
0
Yes - have copy
Yes - don't have copy
No
Don't know


Q13. Does your care plan address your physical and wellbeing needs as well as your mental health needs?
6
5
4
3
2
1
0
Yes
No
Don't know

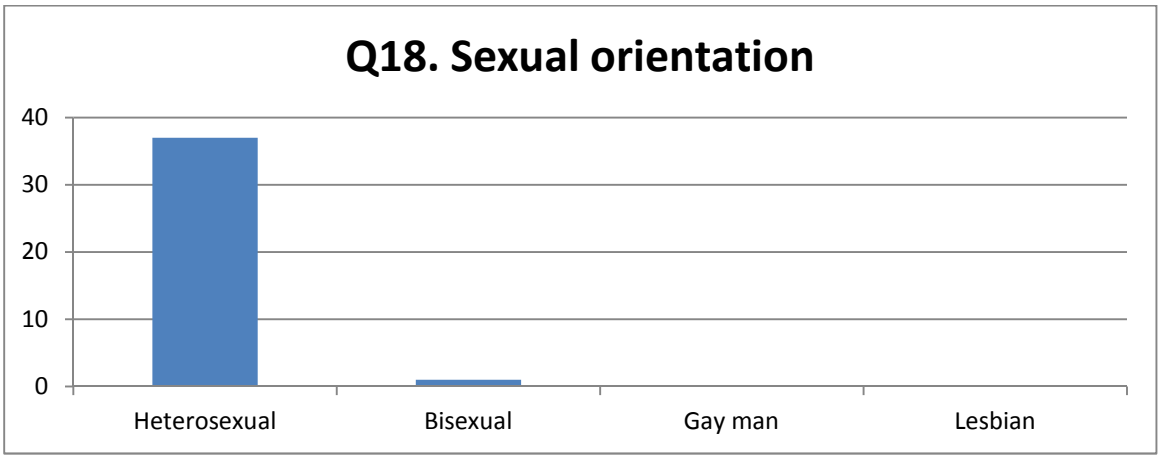

Q14. When I am mentall unwell I ... :
35
30
25
20
15
10
5
0
Exercise less
Eat more
Eat less
Drink more
Smoke more
Don't sleep
Physical health worse
TRUE
FALSE

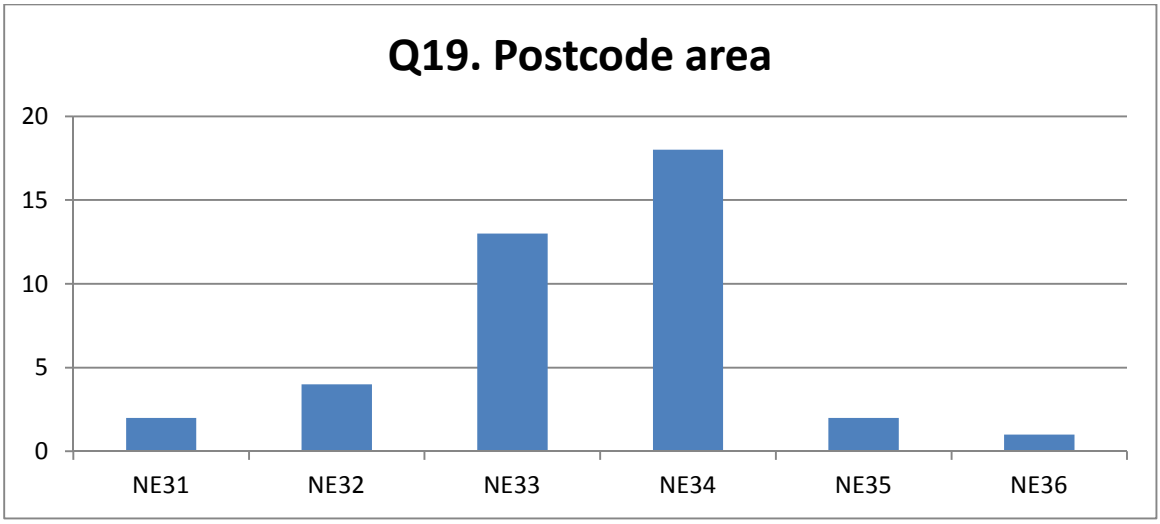

Q15. When I am mentally unwell:
35
30
25
20
15
10
5
0
My confidence is low
I am over confident
I don't visit
Others don't visit me
I stop hobbies
I stay in bed
I am unable to work
TRUE
FALSE





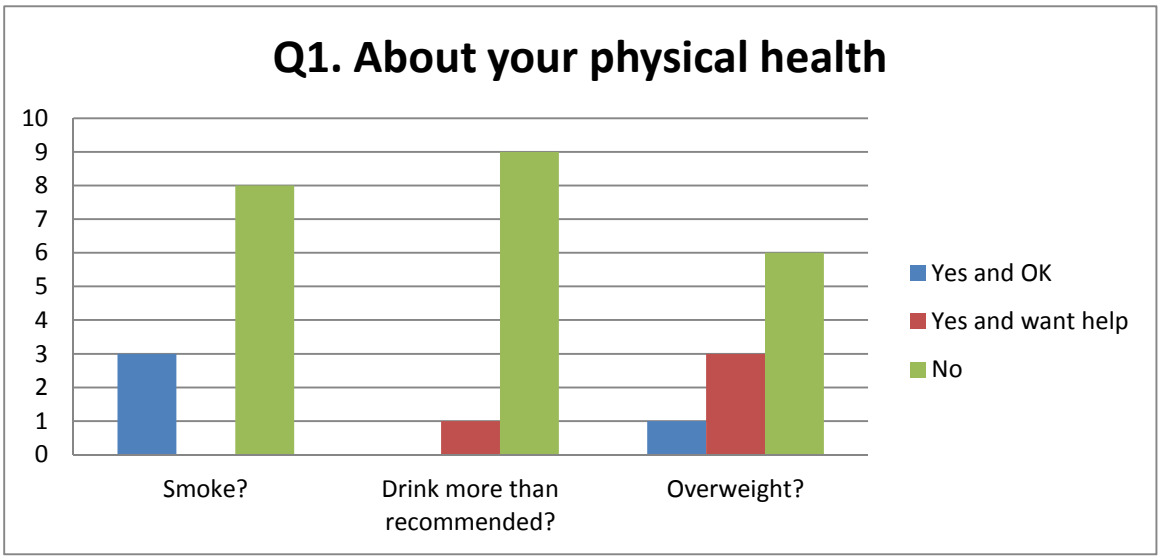
Other religion	Humanist Catholic Spiritual is not confined to religion Theist
Other belief	I just believe in God/Shamanick Reincarnation, karma

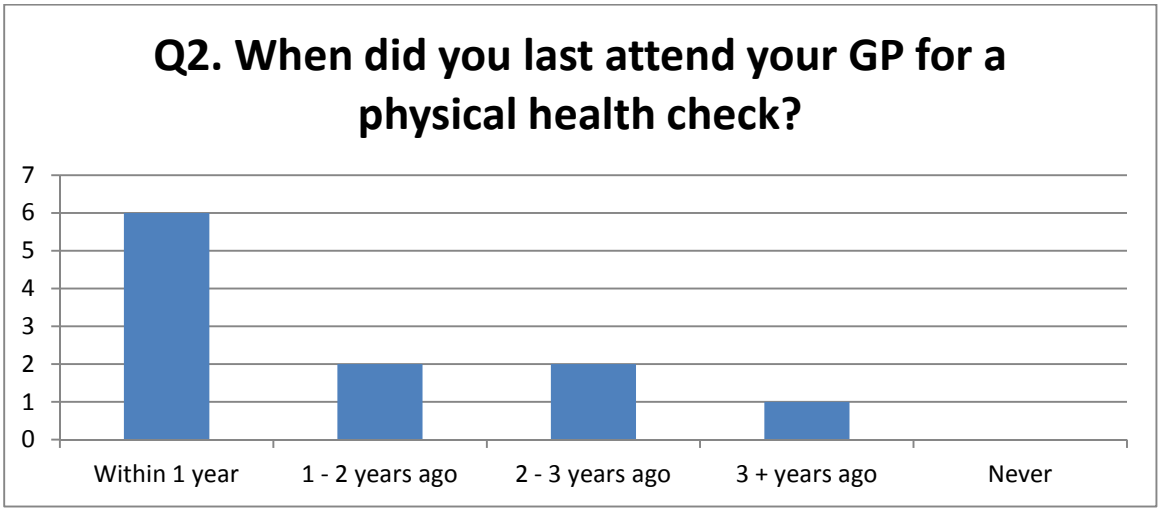


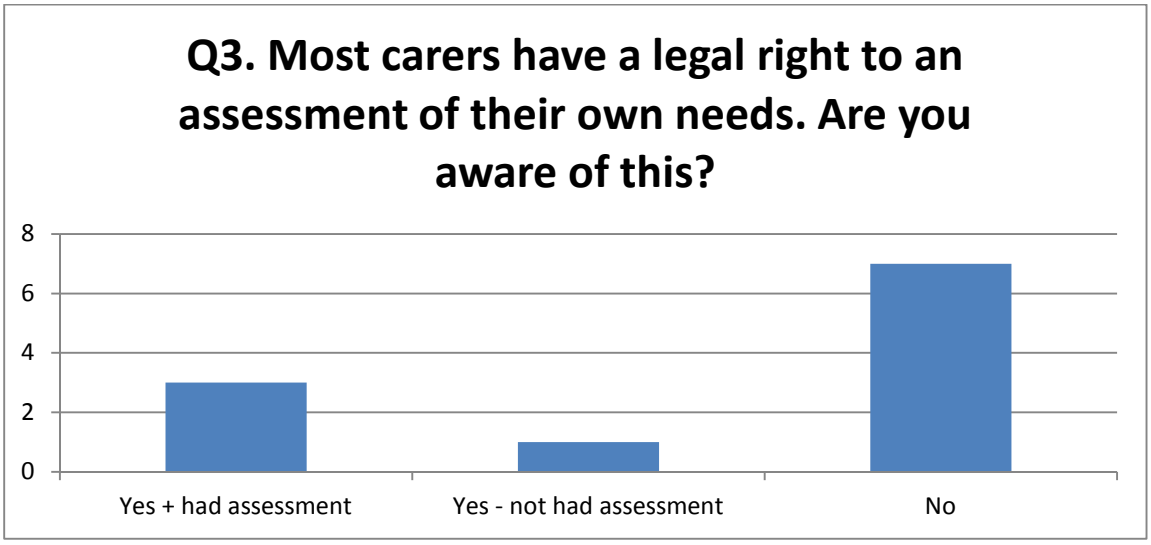

Q19. Postcode area
20
15
10
5
0
NE31
NE32
NE33
NE34
NE35
NE36

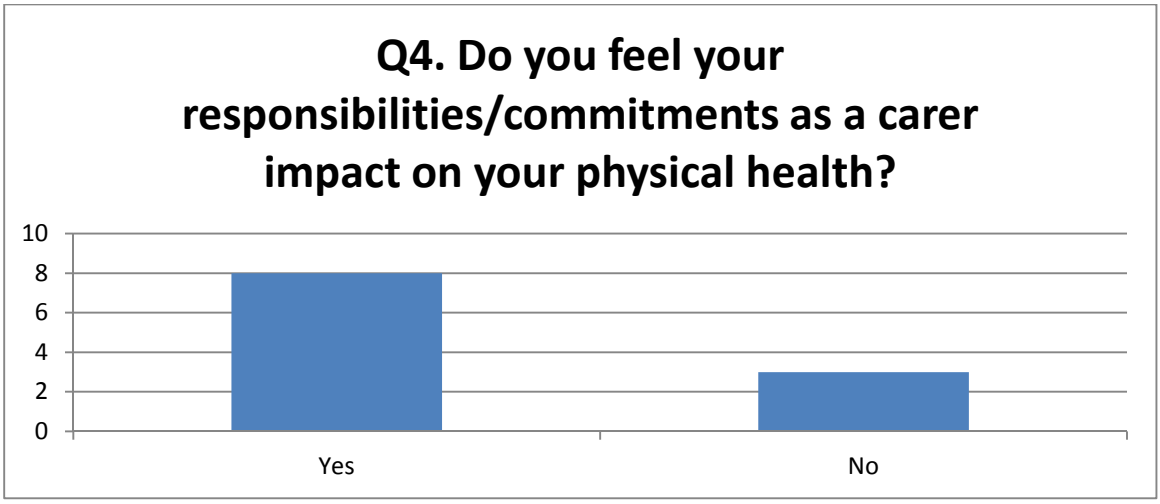
Appendix 3b

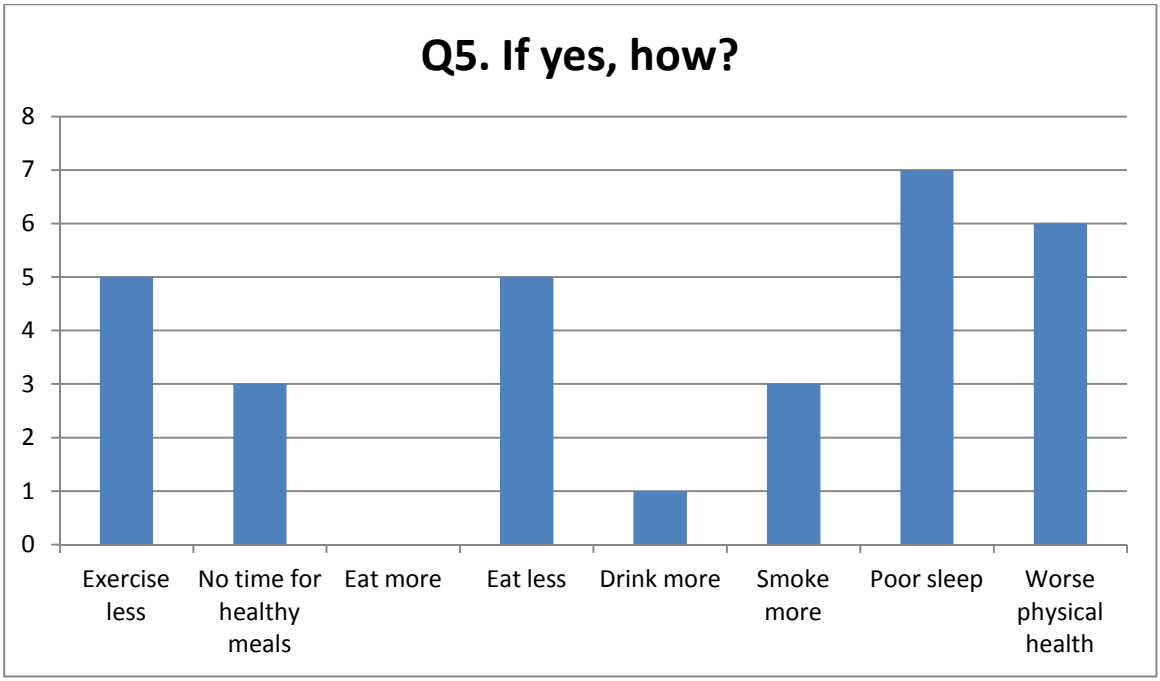
Carer Questionnaires - collated responses

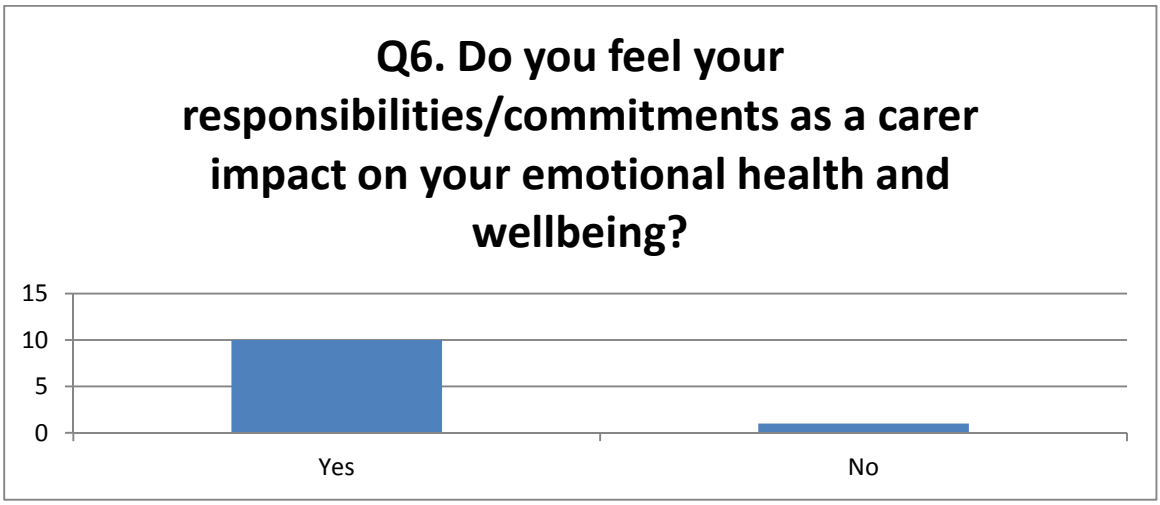


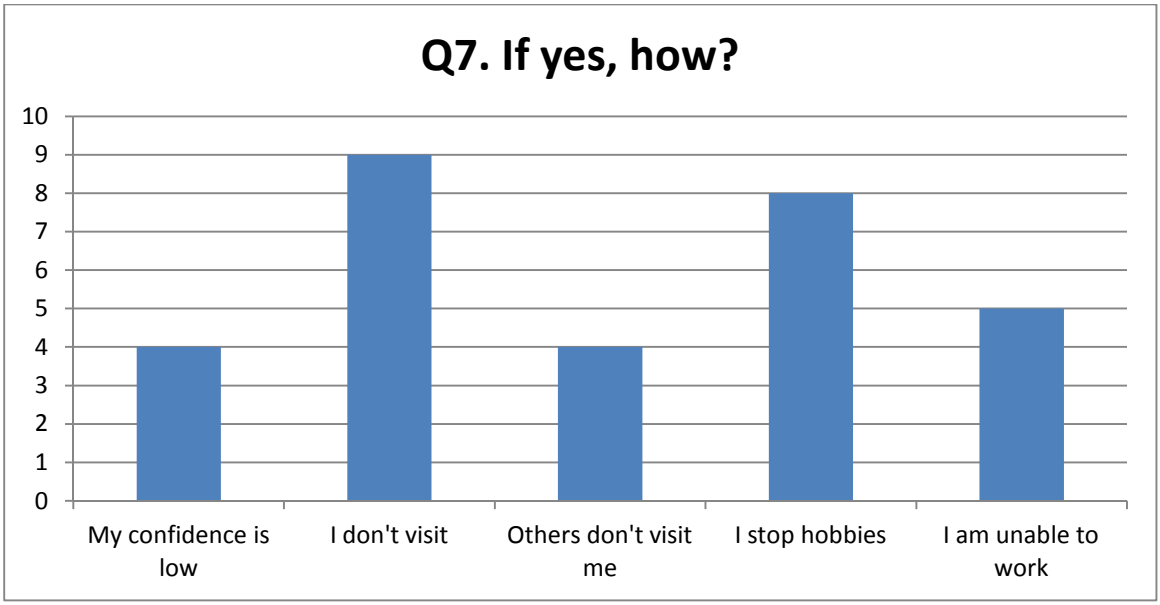


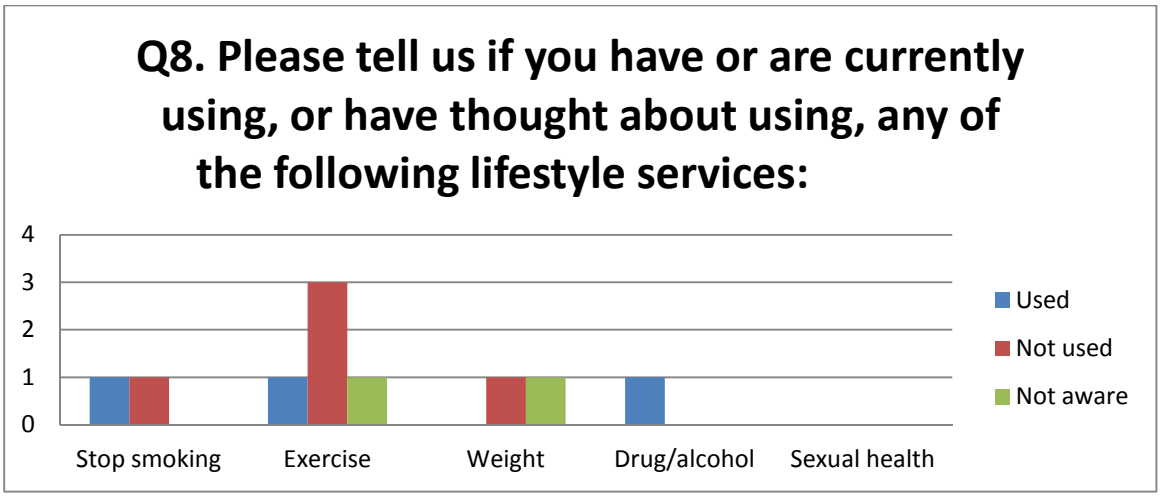


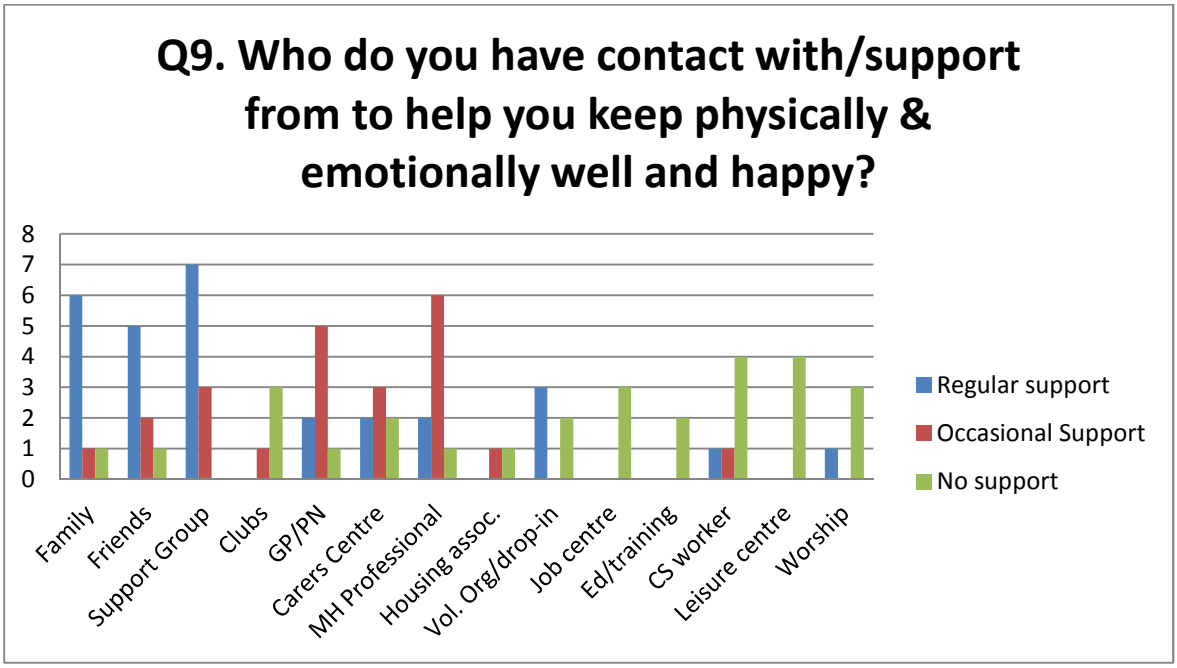

Q4. Do you feel your responsibilities/commitments as a carer impact on your physical health?
10
8
6
4
2
0
Yes
No

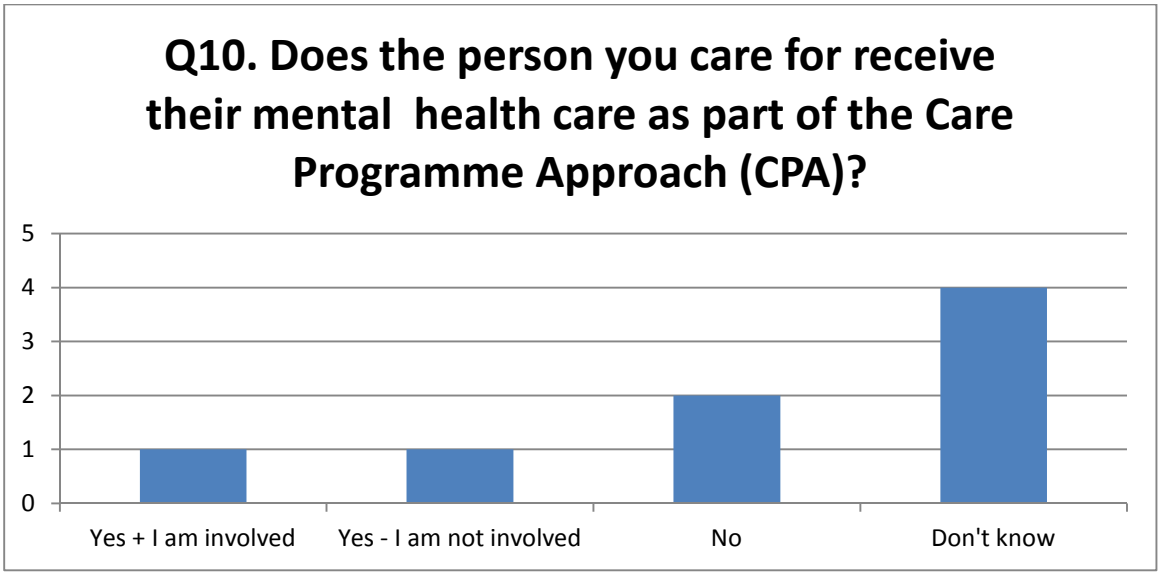

Q5. If yes, how?
8
7
6
5
4
3
2
1
0
Exercise less
No time for healthy meals
Eat more
Eat less
Drink more
Smoke more
Poor sleep
Worse physical health

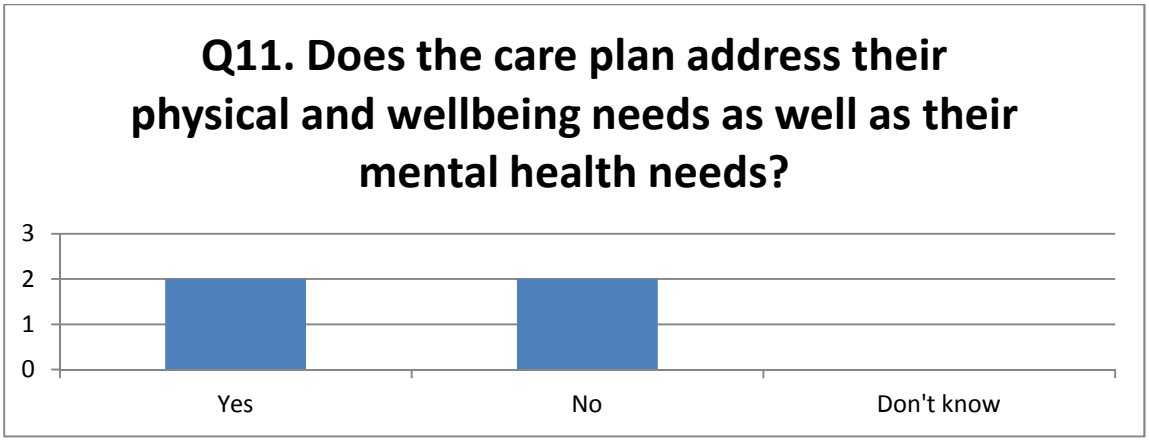

Q6. Do you feel your responsibilities/commitments as a carer impact on your emotional health and wellbeing?
15
10
5
0
Yes
No

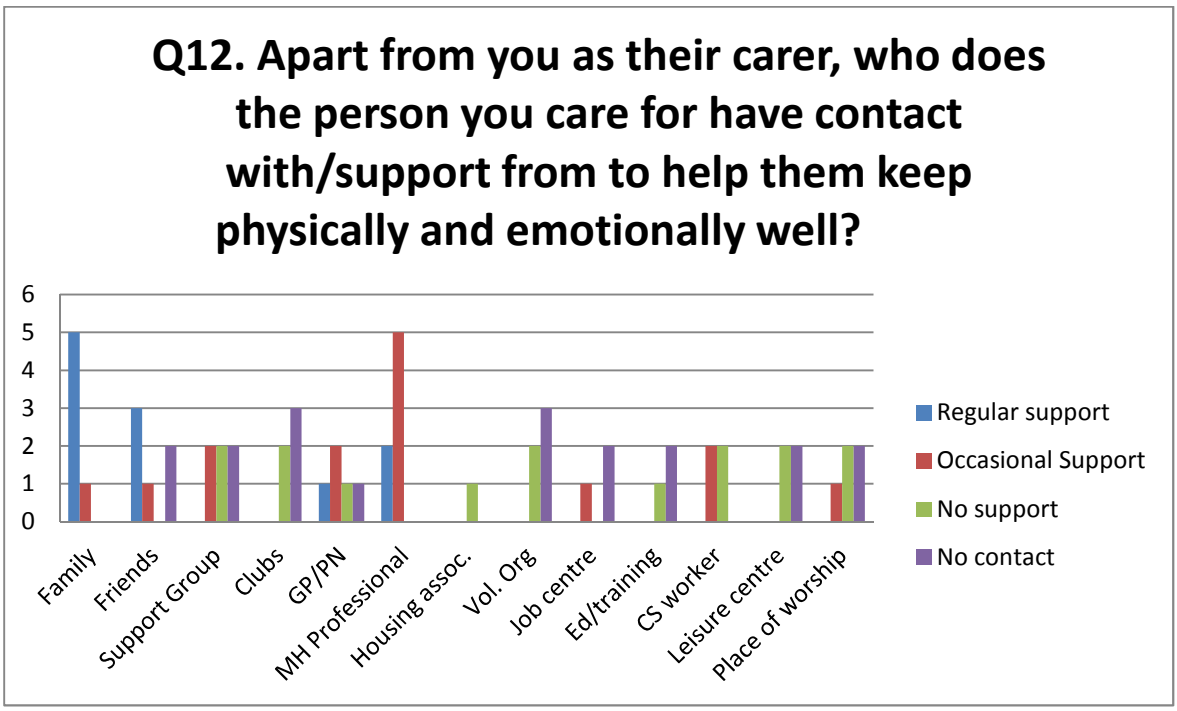

Q7. If yes, how?
10
9
8
7
6
5
4
3
2
1
0
My confidence is low
I don't visit
Others don't visit me
I stop hobbies
I am unable to work


Q8. Please tell us if you have or are currently using, or have thought about using, any of the following lifestyle services:
4
3
2
1
0
Stop smoking
Exercise
Weight
Drug/alcohol
Sexual health
Used
Not used
Not aware

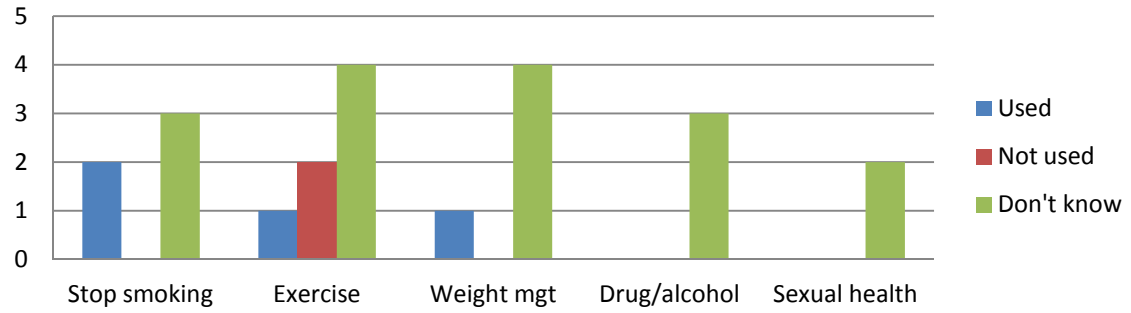

Q9. Who do you have contact with/support from to help you keep physically & emotionally well and happy?
8
7
6
5
4
3
2
1
0
Family
Friends
Support Group
Clubs
GP/PN
Carers Centre
MH Professional
Housing assoc.
Vol. Org/drop-in
Job centre
Ed/training
CS worker
Leisure centre
Worship
Regular support
Occasional Support
No support


Q10. Does the person you care for receive their mental health care as part of the Care Programme Approach (CPA)?
5
4
3
2
1
0
Yes + I am involved
Yes - I am not involved
No
Don't know


Q11. Does the care plan address their physical and wellbeing needs as well as their mental health needs?
3
2
1
0
Yes
No
Don't know


Q12. Apart from you as their carer, who does the person you care for have contact with/support from to help them keep physically and emotionally well?
6
5
4
3
2
1
0
Family
Friends
Support Group
Clubs
GP/PN
MH Professional
Housing assoc.
Vol. Org
Job centre
Ed/training
CS worker
Leisure centre
Place of worship
Regular support
Occasional Support
No support
No contact

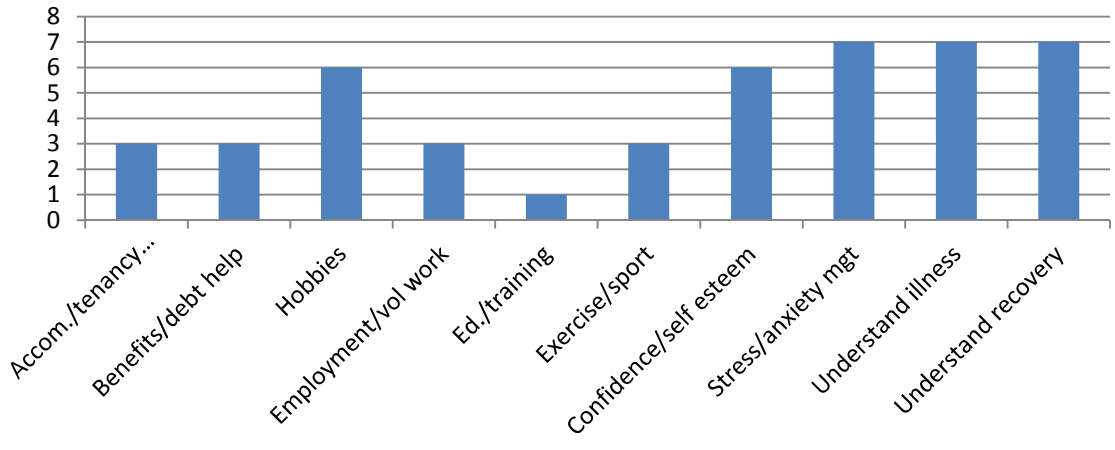
Q13. Please tell us if the person you care for has or is currently using, or has thought about using, any of the following lifestyle services:



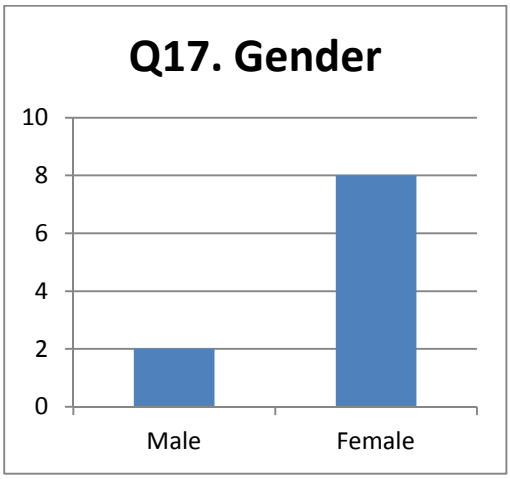
Q14. If the person you care for has thought about using a service but not used it, please tell us if you know why that is:

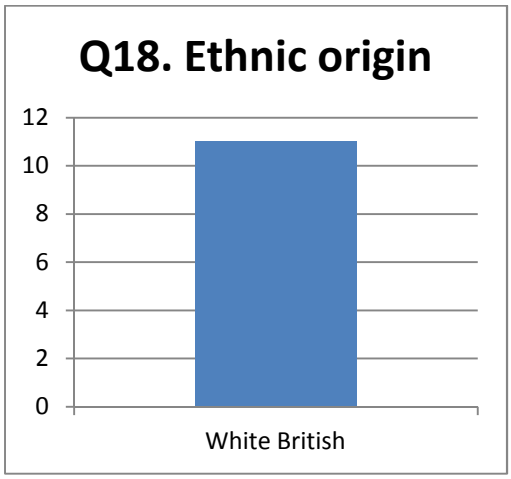
Service	Reason for not using
	My Mam does not use any services offered as she suffers bipolar; got lots of mental health issues cannot focus on anything
Exercise sessions	Physical health - think the classes won't be adapted to enable me to join in/also very shy

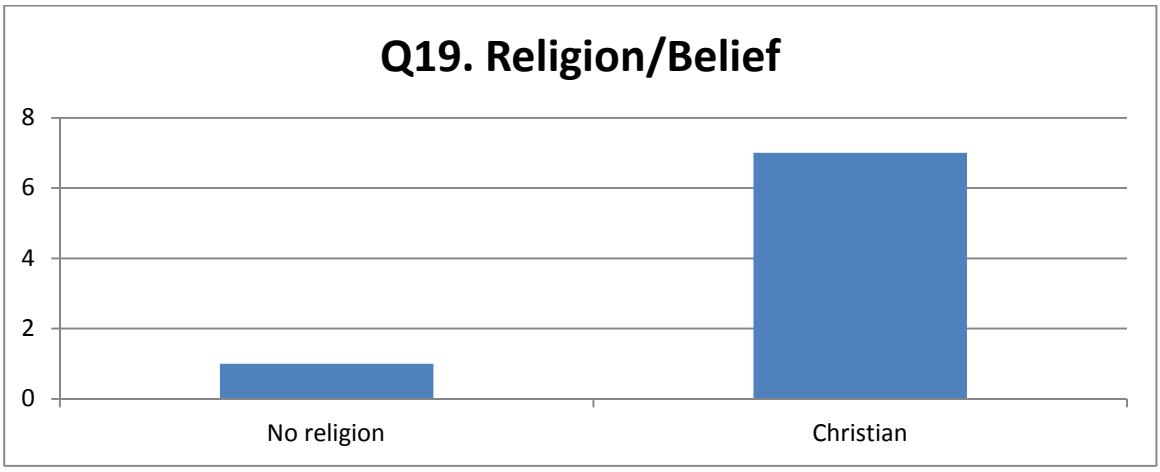
Q15. What other support do you think would help the physical and emotional wellbeing of the person you care for?

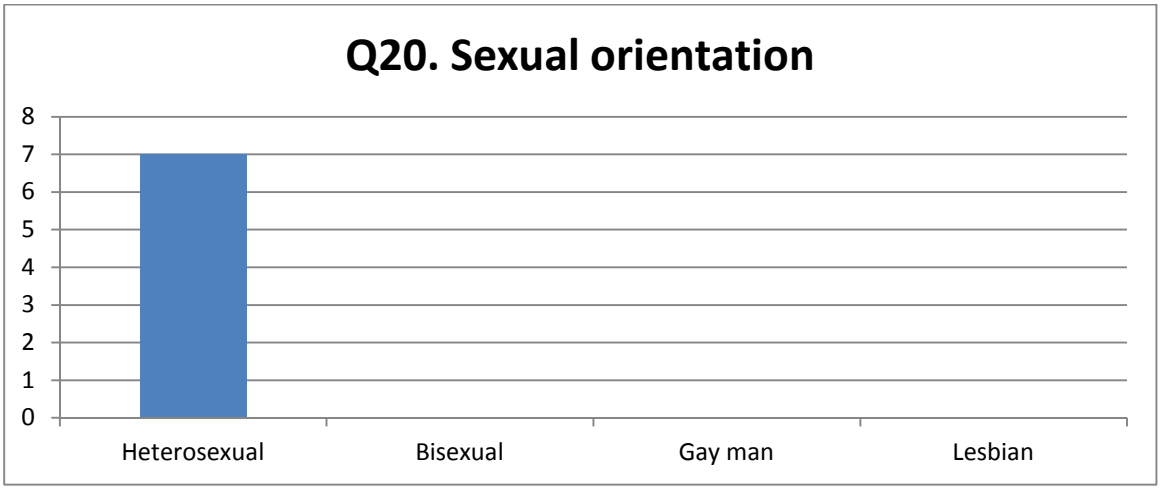


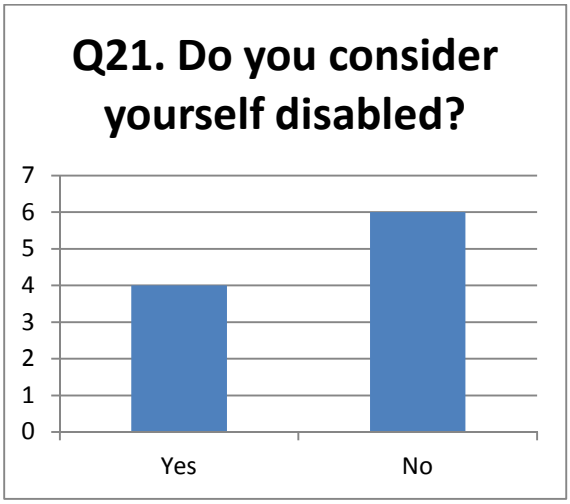
Q16. If there was one thing that we could do to make it easier for the person you care for to live a healthier and happier lifestyle, what would it be?
Consistency of support
Understanding his illness
My Mam would appreciate a person who can go to her house a few times a week for company - loneliness plays a big part in Mam's depression.
X has a support worker who spends 1hr per week with him. He would like to spend more time with his support worker. 2 hrs would be an acceptable time.
More help with day trips and hols away. I know the money has been dropped to nothing but it was something the carers and the people in your care look forward to.
Get the professionals more involved in everyday life. This would help relieve stress and anxiety issues.

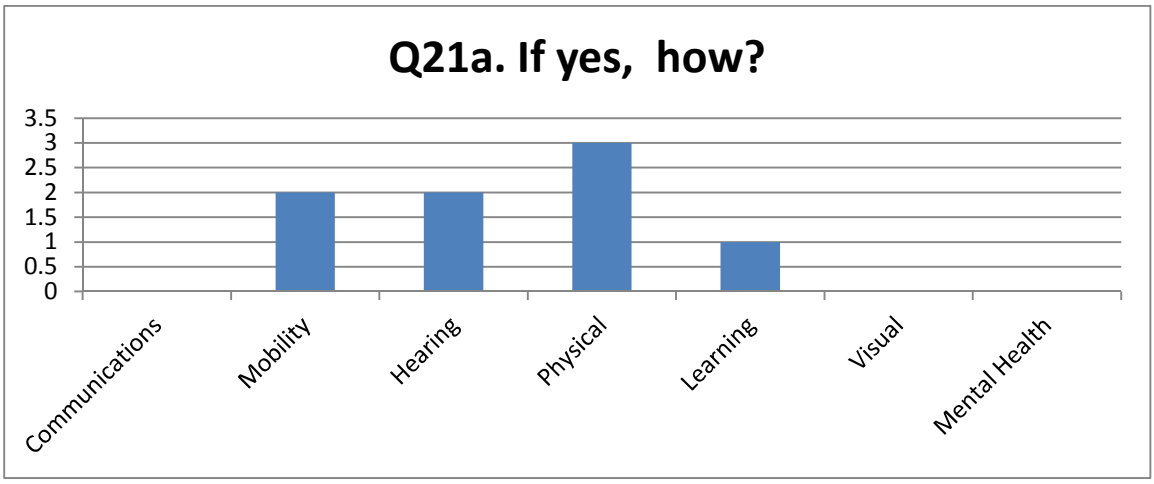


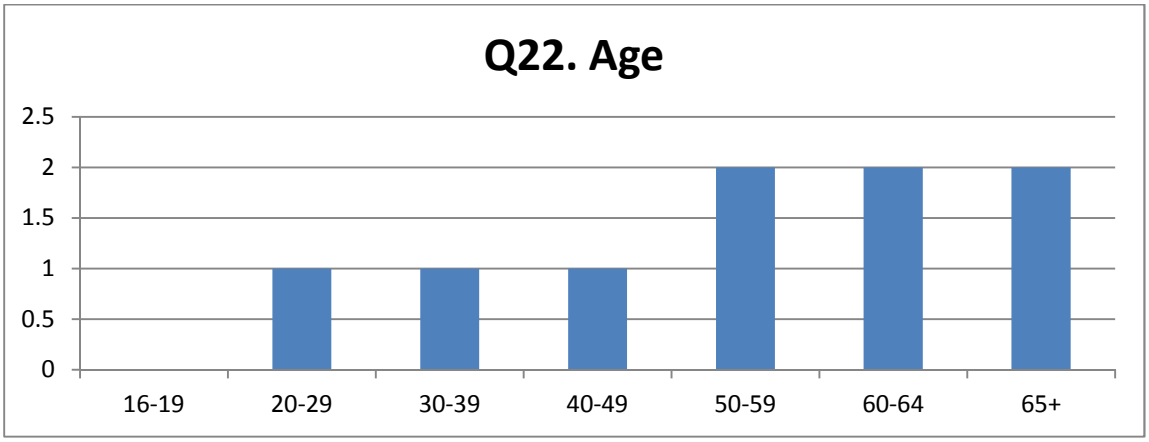


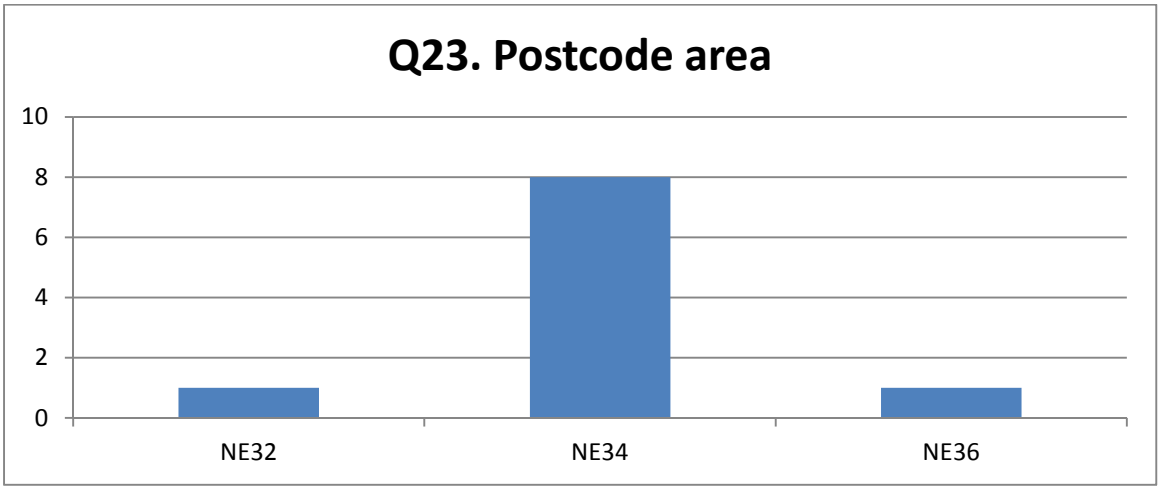



Q20. Sexual orientation
8
7
6
5
4
3
2
1
0
Heterosexual
Bisexual
Gay man
Lesbian


Q21. Do you consider yourself disabled?
7
6
5
4
3
2
1
0
Yes
No


Q21a. If yes, how?
3.5
3
2.5
2
1.5
1
0.5
0
Communications
Mobility
Hearing
Physical
Learning
Visual
Mental Health


Q22. Age
2.5
2
1.5
1
0.5
0
16-19
20-29
30-39
40-49
50-59
60-64
65+


Q23. Postcode area
10
8
6
4
2
0
NE32
NE34
NE36

Appendix 4

Interviews - collated responses

1. What do you think are the physical health and wellbeing needs of people with SMI?

- Not one I know is in good physical health
- Smoking, drinking - and use as a prop
- Living in long term poverty, no money for food
- Tend to be chaotic, day to day survival not planning for the next week for shopping etc
- Economically stuck
- Not addressing physical problems unless MH problems sorted and stable
- Smoking tends to be higher in people with SMI
- High use of alcohol and ?other substances
- Under-nourishment
- Late diagnosis (interesting link to Health Check)
- If you are schizophrenic you..
- Smoking - people with MH smoke half the tobacco in the country
- Sexual health - vulnerability
- - unhealthy choices
- Substance misuse
- Obesity - medication people are on
- Physical activity - discrimination
- - less confident about going out and doing things
- Emotional health - people who are not flourishing have a big impact on mental health
- Less likely to work so more likely to be in poverty
- Diet
- Don't get many SMI. Have to be stabilised
- First most popular re obesity, Second anxiety/depression (about 4 in 10) but high drop-out rate due to instability of illness.
- Tend to be overweight because of medication.
- Much greater
- Smoking greater, alcohol and drug misuse greater - they all come with a range of health issues.
- Social and cultural issues around smoking
- Lack of exercise
- Currently collect MH assessment GHQ12 - but it's not used, not asked for or used by commissioners - what do we do with someone if they score 23?
- Don't like group based stuff (when is it quiet - gym example)
- Tend to smoke more, exercise less.
- Smoking
- Weight issues
- Lack of activity - sedentary lifestyle
- EIP there is a real focus on medication and not gaining weight

- Community Services
- EIP South of Tyne
- Recovery Treatment Service - mostly around medication, clozeril etc
- Looking to move clinics
- Physical monitoring
- Maybe moving into GP practice
- About to develop medication management service
- More likely to have more smoking, less exercise
- Medication issues
- *Socio-economic drivers
- Very little drive to look at sexual health
- Can't deny the fact that there is a problem, they are not as physically healthy
- Historic focus on their MH as a barrier to looking at physical health
- Introduction of new wave of antipsychotics and weight gain issues
- Smoking cessation
- Medication makes life expectancy lower
- Weight gain - obesity
- Smoking - majority do - crutch for some people
- Shorter lives
- Poverty
- Bored and not getting...
- Patient in mind
- Psychotic with CMHT follow up. 20-50 yrs, smoking, obesity - diabetes
- consequences of anti psychotic meds
- We know it is important but in a 10 min consultation it will come last.
- More focus on prodromal side effects, ie. Clozaril
- Would refer either to NTW or mainstream providers
- What makes them different is their illness which takes a lot of time and energy so the focus.
- Impact of medication - weight, motivation, just accepted
- Over prescription of beta-blockers and tranquillisers for anxiety and 'to take the edge off'.
- Reflection of a deprived area, not seen as an issue. People approach it from completely different question. All aspects of their wellbeing. LA view is that GP or secondary care responsibility to pick it up. Physical health not high on LA priority list. They use FACs.
- DD 60% of alcohol users had dual diagnosis.
- Same as everyone else.
- What percentage of people with SMI smoke/overweight etc. Exercise services.
- Diet and exercise slips when people with depression have low mood
- Depression stops people going out
- Medication - obesity - attributable to mental illness
- Can people access services when they are unwell?
- There is currently a weight management/12 week plan at Headlight

2. What do you think are the barriers for people with SMI accessing services to address their physical and wellbeing needs?

- Barriers - the reaction of the others to them when unwell
- Stigma to deal with
- Got other things on their mind than stopping
- Benefit reforms are a nightmare
- Lot of agencies are bums on seats
- Funding 3rd sector is a big issue
- Physical health is often left until last.
- How we have silo'd things up and paid for things, ie exercise was tackled via obesity.
- Workforce issues in dealing with SMI - competencies in advisors.
- Do we take the service to them or make the service flexible enough for them to come.
- Discrimination - SMI can be more obvious
- - exists within lifestyle services themselves
- Really how accessible? tend to be geared around people who can access them.
- Do they have the confidence to be able to access services.
- Drop-out due to lack of support (family or service)
- If people are working it can be difficult.
- No more or less than general group - time, money, childcare
- Advisors are frightened of people with mental health conditions.
- Way they have been commissioned people with but not a specific group they are contracted to do, lack of skills but also not helpful to hit their targets.
- People with diagnosis of mental health issues are high DNAs
- Costs (travel etc) costs of sessions
- Not up on a morning, lack of life pattern/sleep pattern, transport issues
- drop-out rates are high
- We have set sessions, not always accessible
- Motivation and engagement
- Awareness
- Need a lot of support to get to and keep it up
- Being patronised by services
- Assumption that they are separate and not their issue
- *Acceptance of mental health services that people will gain weight
- What about the legal side
- Staff apathy
- Primary care staff - there is a certain amount of fear
- Are people with SMI accessing them - no
- Do they know they exist
- Are they being treated differently, attitudes and stigma around stopping people joining
- GPs - getting fed up being asked to do complex physical health checks - now want paying for it (there is in current QOF)
- Stigma, would never think of going to a gym
- Only focus on mental health and not physical health
- Go there for smoking, somewhere else for obesity
- Integrating into community life
- Implicit
- Getting people to come through the door

- Invisible barrier of primary focus on MH disorder, perception of lack of interest in change
- Perceived as this is going to be tough, don't want to upset the apple cart
- Annual check, who is looking after it - psychiatry/primary care
- Because caseloads are huge if you're doing alright you get left.
- Practice staff get freaked by mental health, even though focus should be bloods etc - no training and lots of misconceptions.
- Are people with SMI getting the annual health check?
- Secondary care teams under immense stress.
- Losing a lot of knowledge and skills through compartmentalising, o skill mix. Cultural barriers, split health and social care. We don't know what is out there and how to access it. It's not high on the patients list of priorities. Resources are quite scarce in this borough.
- Access (even physical access) ie. transport, confidence, finance. Making that first step, is there enough info to let people know what is there? Main stream or specialist service.
- (Can medication be used by people with MH)
- Family/social situation.
- Communication with a professional.
- Building their capacity to recognise their own physical health needs - how do you do that?
- A 12 week weight management plan doesn't suit people if they get unwell - same with smoking.
- Exercise on referral - if they drop out they can't get back in again.
- Clinicians don't always understand the preventative side.
- Never get asked about individual Health Plan outcomes - just measured on caseload and assessment numbers, number of referrals, number of people complete, number of 5-a-day, number of 30 minutes exercise.

3. What kind of changes do you think need to be made to encourage people with SMI to access lifestyle services?

- Physical health problems tend to be ignored by health professionals
- Can't get past mental health
- People who attend use social meetings but not cooking lessons or exercise classes
- Need to have really skilled tutors to deal with people with SMI
- Even if needs are articulated they are not believed
- Incorporating different approaches to things
- Something about the concept of how physical health affects mental health - training for service users and others.
- Wellness service - good way to think about it.
- Take smoking cessation services into mental health instead of how will GPs address this (GP mental health leads)
- Link to NHS Health Check
- Could be tweaked
- Speaking to local people, don't get it right from a service perspective.
- Should we be making current services accessible or do we want specialist services.
- Develop a known pathway, spend time on Bede and get faces known then support people to come from staff there.

- Some need ongoing support after
- Group interventions rather than 1-1
- Going to existing mental health groups - health trainers?
- Training for lifestyle service providers on mental health
- Any service can train up and deliver smoking cessation.
- Sunderland and Washington Mind.
- Contract - insurance
- - one member of staff trained up to be a smoking advisor can generate significant income, now have business model for getting organisations signed up. Contract changes in £15 for each person who sets a stop date, £35 for everyone who quits at 4 wks & ?another £41 if still quit in 12 weeks.
- Are we targeting services at these groups?
- Are we communicating them well?
- Reinforcing the issue with commissioners of lifestyle services
- Use GHQ12 for referral on
- Point of referral - people often don't know what they have been referred to and why
- More 1-1 time with people
- More training for staff on mental health and it's relation to exercise
- Storyboard
- They did some stuff with Washington Mind
- Who do people with SMI have access to/real practical advice?
- We run a football groups
- Based in GP practices, take services out to patient (their own physical health services she is talking about it)
- Improve relationships with GPs
- Something built into paperwork to highlight and record what interventions
- Education and attitude change
- Accessible
- Sunderland IAPT delivered by MH Trust so closer links with Physical Treatment Service. Both primary care and IAPT.
- Good Practice Compendium.
- Do more to encourage people to attend
- There has been some shifts by inclusion papers
- Physical trainers in CMHTs
- STR workers - on Teesside a while ago sent them on health trainers course
- Using CQUINS in contracts - physical health checks - NTW
- There will be some outcomes re physical health needs in new CPPP
- Put it all in one place
- Need one to one support - go to health trainer
- Need to try and mainstream people not put them in boxes
- Want to move to integrated teams, smoking, obesity etc
- Tackle discrimination
- Keep holding events and expect people to come to use, reviewing health trainers
- We need to embed emotional health and wellbeing fully integrated into physical health services
- Need to be more proactive with this client group, not aware of any special measures as GPs; local enhanced services.

- written in CQUIN scheme for trust to encourage people to attend health checks
- A clearer line
- Has capacity to employ 1 session a week (2 people) to do the work.
- GP contacts interested in MH/LD/Dementia in South Tyneside.
- Change commissioning targets to make wellbeing a target but not on top of everything else.
- Physical health is not part of clustering (not a key clustering criteria) so if this is how the money comes then it will never be a priority.
- Part of discharge planning for primary care mental health teams.
- Use STR workers to support people to access services or do it themselves.
- Connect the STR workers directly with the lifestyle providers.
- Green gym.
- Some kind of networking, communication opportunity might help.
- No formal comms system in statutory services - needs to be a collective approach Make it a target again, make it a priority.
- Make it front page of assessment and part of care plan to treat each physical health problem.
- If they are in touch with services we need to skill up the workforce.
- Improved marketing and comms; what is currently done is it in the right places?
- Learning disability - lack of resources, lack of knowledge and skills.
- Training to do cholesterol checks.
- Health trainers are outreach.
- Lower smoking targets to less cigarettes rather than complete stopping.
- Measuring how many people start and finish, so anyone who drops out is seen as a failure.
- Services need to be more flexible in terms of outcomes.
- Services need to go to people.
- Confusion re services, ie active bus, health trainers, health champions.
- Over 40's checks; if there is a need they should be referred in.

North of England Mental Health Development Unit

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