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Mr Hugh Farren
Clerk to the Assembly Health Committee
Room 412
Parliament Buildings
Stormont
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Dear Mr Farren

Thank you for your invitation to provide evidence to the Assembly Health Committee's inquiry into obesity. The Royal College of Psychiatrists commends the Health Committee for its work in this area.

People with mental illness and those with learning disabilities are more likely than the general population to be obese, to have physical health problems arising from this, and to have difficulty managing weight. We therefore welcome the Health Committee's interest in including this group of people in considering an obesity strategy for Northern Ireland.

As a College, we are committed to helping the Assembly understand the issues involved in psychiatry in Northern Ireland, and hope the Committee will continue to call on us as appropriate.

Yours sincerely

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**The Royal College of Psychiatrists
Submission to the Northern Ireland Assembly Health Committee
Consultation on Obesity
February 2009**

The Royal College of Psychiatrists is the statutory body responsible for the supervision of the training and accreditation of psychiatrists in Britain and Ireland and for providing guidelines and advice regarding the treatment, care and prevention of mental and behavioural disorders.

The College has 294 members in Northern Ireland, as well as younger doctors in training. These doctors provide the backbone of the local psychiatric service, offering inpatient, day patient and outpatient treatment, as well as specialist care and consultation across a large range of settings.

The College welcomes the Assembly Health Committee's inquiry to examine the current approach to tackling obesity, and is grateful for the opportunity to contribute to this.

Why consider people with mental illness and learning disability?

It is widely acknowledged that people with severe mental health problems and/or learning disability are more likely than the general population to be obese, and have a higher level of associated physical health problems.

This is an international trend, not unique to the United Kingdom, and is associated with a complexity of factors including medication, disadvantage and lifestyle. However, research in England and Wales quantifies the problem.

The Disability Rights Commission's Closing the Gap report on healthcare inequalities experienced by people with mental health problems and learning disability in England and Wales (2006) found people with mental illness are much more likely than other people to be obese (33% of people with schizophrenia and 30% of those with bipolar were obese, compared to 21% of the remaining population), and to have significant related health risks and major health problems such as heart disease, hypertension, stroke and diabetes¹. They are twice as likely to die from coronary heart disease as the general population².

¹ Health Inequalities Experienced By People With Schizophrenia and Manic Depression: Analysis of General Practice Data in England and Wales, Report for the Disability Rights Commission (2005), Q Research, available at http://83.137.212.42/sitearchive/DRC/library/health_investigation/research_and_evidence.html (accessed February 2009)

² Department of Health. *Choosing health: supporting the physical health needs of people with severe mental illness*. August 2006

Both people with mental illness and people with learning disability are likely to die younger than other people. People with serious mental health problems are also more likely than others to get illnesses such as strokes and coronary heart disease before 55. Once they have them they are less likely to survive for five years.

A review of international research³ found that children and adolescents with major depressive disorder may be at increased risk for developing overweight; obese people seeking weight-loss treatment may have elevated rates of depressive and bipolar disorders; general obesity is associated with major depressive disorder in women; and abdominal obesity may be associated with depressive symptoms in men and women. However, it found that most overweight and obese persons in the community do not have mood disorders.

Obesity can be a particular issue in inpatient settings, particularly where patients are resident for a lengthy period, for example when they are detained. One forensic mental health trust in England found that it is not uncommon for patients to put on 30-40 kg while in hospital⁴.

Why do people with mental health problems and learning disability carry more weight?

Many of the reasons that people with mental health problems and learning disability are obese are the same as for the general population: eating too much calorie-rich food and exercising too little.

However, the reasons for this can be complex.

- Social deprivation – obesity is a greater problem in areas of social deprivation, and people with mental illness are among the most socially excluded group. While it is possible to maintain a cheap, balanced diet, people may need education and encouragement to do this.
- Inactivity – people with mental illness tend to be more inactive than the general population due to both motivation and

³ McElroy SL et al, Are mood disorders and obesity related? A review for the mental health professional. *Journal of Clinical Psychiatry*, 2004 May;65(5):634-51

⁴ West London Mental Health Trust (2006), Draft Obesity Management Strategy, available at www.rcpsych.ac.uk/pdf/Draft%20Obesity%20Strategy%20June%202007_West%20London%20MHT.pdf (accessed February 2009)

opportunity, and may need to be proactively engaged in activities. Inactivity can be a particular issue in inpatient settings.

- Medication factors – some psychotropic medications, in particular antipsychotics and mood stabilisers, increase hunger levels. Particular antipsychotics are well known to be linked to significant weight gain.
- Emotional eating – some people with mental health problems will over eat when emotionally distressed, or to deal with low self esteem. There is a strong correlation between obesity and depression (especially in women) and anxiety⁵⁶. Over-eating and bingeing can be self-harming behaviours in some patients⁷.
- Medical practitioners can sometimes be loathe to raise the issue of weight with a person who is already vulnerable, but should be prepared to sensitively address this and to check for associated physical health risks.
- Community dieticians often do not know how to cope with people with mental health problems, who may have fluctuations in motivation and difficulty managing medication side effects.

What could be done to address this?

All aspects of an obesity strategy are likely to apply to people with a mental health problem, but this group may be difficult to engage and require additional input and support.

People who use mental health services need to be educated about the physical health effects of food intake and obesity and encouraged to agree to positive changes to diet and exercise. Care planning should be used to support dietary modification, and encourage activity.

NICE Guidance on Obesity states that “Managers and health professionals in all primary care settings should ensure that preventing and managing obesity is a priority at both strategic and delivery levels. Dedicated resources should be allocated for action”⁸.

⁵ McElroy SL et al, Are mood disorders and obesity related? A review for the mental health professional. *Journal of Clinical Psychiatry*, 2004 May;65(5):634-51

⁶ Simon GE et al, Association between obesity and psychiatric disorders in the US adult population. *Arch Gen Psychiatry*. 2006 Jul;63(7):824-30

⁷ West London Mental Health Trust (2006), Draft Obesity Management Strategy

⁸ NICE. *Obesity*. Clinical guideline 43. December 2006

It does not set out guidance specifically for managing obesity in people with mental illness.

However, NICE Guidance on Schizophrenia states that GPs and other primary healthcare professionals should monitor the physical health of people with schizophrenia. Physical health checks should be carried out at least annually and have results clearly documented by the primary care clinician and communicated to the mental health care coordinator and/or psychiatrist, and recorded in secondary care notes. Monitoring should include: weight gain and obesity (waist hip ratio or waist circumference); blood pressure; dietary intake; activity levels and exercise; blood levels of glucose; and lipids.

General practitioners may need to be proactive in helping people with mental illness manage their weight. This may be a sensitive issue, but should not be avoided. Mental health staff should also be proactive about addressing the issue, and where appropriate liaise with, and encourage contact with, the GP.

Diet can be problematic for people with severe mental illness. Health professionals should take this into account, and support and education should be provided to help people maintain a healthy diet. GPs should also ensure that advice on diet is given to people with severe mental illness, as included in the 2006 GP contract.

Mental health staff should be able to directly refer patients to community dietitians, and there should be a pool of dietitians trained to offer advice and support to people with mental illness. This could potentially be offered in community mental health settings.

People with severe mental illness may find shopping for food and cooking difficult, and should be provided with practical support to manage this. Mental health teams could take some responsibility for providing practical support to address these issues.

Keeping active is an important element of protecting the body from physical health problems, and can also be beneficial for mental health. GPs could consider prescribing exercise programmes for people with mental health problems who are becoming overweight. People with mental illness should be able to access leisure facilities at a concessionary rate.

In summary, the Royal College of Psychiatrists would encourage the Health Committee to consider how any obesity strategy will engage

people with mental health problems, and how health practitioners can be supported to provide the necessary input.

Appendix 1

Key findings from the Disability Rights Commission

The rates of co-morbidity of severe mental illness and physical illness that are sometimes linked to obesity are higher than in the remaining population (unadjusted for differences in age distribution):

- Ischaemic heart disease is more common in people with schizophrenia (4%) and bipolar disorder (5%) compared to the remaining population (3%)
- Stroke is more common in people with schizophrenia (2%) and bipolar disorder (1.5%) compared to the remaining population (1%)
- Hypertension is more common in people with schizophrenia (12%) and bipolar disorder (15%) compared to the remaining population (10%)
- Diabetes is more common in people with schizophrenia (6%) and bipolar disorder (4%) compared to the remaining population (2%)