



## **SCOPING GROUP ON PHYSICAL HEALTH IN MENTAL HEALTH**

**Service specific standards *herewith***

***THE FULL REPORT OF THE SCOPING GROUP ON  
PHYSICAL HEALTH IN MENTAL HEALTH  
WILL BE PUBLISHED BY THE COLLEGE IN 2008.***

# SCOPING GROUP ON PHYSICAL HEALTH IN MENTAL HEALTH

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## Background

- General health morbidity among people with mental health problems is high.
- There is a need for quality general health care for psychiatric patients, whether in community settings or in-patient care.
- There is a need for clarity about the responsibility of the psychiatrist in general health care, in working in partnership and collaboration with primary health care and other specialist colleagues

There is a growing body of evidence that many psychiatrists lack the skills required to provide for the general health care of people with mental health problems. This may have arisen for good reason - Psychiatrists have sought to specialise in mental health matters, regarding physical health care as the province of other clinicians. However, as medical practitioners, psychiatrists clearly have a role to play in the management of general health problems among people with mental health problems. This entails understanding of the complex interactions between mental health and general health, and an appropriate level of competence in the prevention, detection and treatment of general health problems in their patients, including awareness of the indications for specialist referral.

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## Section 1.1

### Introduction to physical health of people with mental disorder and disabilities

Dr Irene Cormac

#### Introduction

People with mental disorders and disabilities have an increased risk of poor physical health and premature mortality compared with the general population (Phelan *et al*, 2001). In 1998, Harris and Barraclough reported findings from a meta-analysis of 27 studies, showing that the mean standardised mortality ratio for all forms of mental disorder was at least 1.5 and varied with the type and severity of the mental disorder.

In schizophrenia, standardised mortality ratios are increased 3-4 times compared to controls, with deaths mainly due to respiratory, circulatory, endocrine and digestive disorders (Brown *et al*, 2000, Osby *et al*, 2000, Enger *et al*, 2004). The risk of developing the metabolic syndrome for those with schizophrenia is 2-4 times greater than in the general population (Saari *et al*, 2005, Thakore, 2005). The risk of sudden death in schizophrenia increases incrementally with each additional psychotropic medication taken by a patient (Joukamaa *et al*, 2006).

High rates of preventable physical morbidity and premature mortality have been reported in people with learning disabilities (Hollins *et al*, 1998, Lyndsey, 2002, Ouellette-Kunz *et al*, 2004, Disability Rights Commission, 2006). In the Netherlands, van Shrojenstein Lantman-de Valk *et al* (2000) found there were 2.5 times more physical health problems in those with learning disabilities, than the general population.

Older people with mental disorders and disabilities have similar health problems to other older citizens, and may also experience adverse effects on their physical health, from their mental disorder. In study in the USA, it was shown that deficits in the quality of medical care played a significant part in the excess mortality from cardiovascular disease in older patients with mental disorders (Druss *et al*, 2001).

#### Role of psychiatrist

As doctors, psychiatrists have a responsibility to provide their patients with good standards of practice and care ([www.gmc.org/standards/good.htm](http://www.gmc.org/standards/good.htm)). Psychiatrists have a key role to play in improving the physical health of their patients. In the document 'Good Psychiatric Practice' (Royal College of Psychiatrists, 2005), it is stated that psychiatrists should: '

Initiate investigations where necessary

- Act on the outcome of investigations
- Arrange specialist or medical treatments in collaboration with the general practitioner (GP), by referral to specialists or generalist colleagues, or undertake physical investigation and treatment with competencies'

Psychiatrists should also be able to assess the physical health of their patients by taking a medical history, conducting a physical examination and by liaison with other health professionals as above. They should be able to deal with medical emergencies at a basic level and be trained in delivering life support. Psychiatrists should keep their skills and knowledge in physical healthcare up-to-date. However, the level and range of expertise in physical health care, which a psychiatrist needs varies according to the characteristics of the patients they treat and the type of psychiatric service being provided. For example, patients will have different physical health needs if they are withdrawing from alcohol in a hospital setting, or have dementia and live at home, or if they have schizophrenia and are living in a long-stay institution.

In many psychiatric in-patient services, psychiatrists continue to provide routine and emergency physical health care. However, it has been shown that an additional weekly primary care clinic can complement the physical healthcare service provided by psychiatrists in an acute psychiatric unit (Welthagen *et al*, 2004). In a population of long-stay psychiatric patients, it was found that there were high rates of physical co-morbidity and recommendations were made to provide a primary healthcare service to meet the health needs of patients (Cormac *et al*, 2005).

### **Primary health care**

Primary healthcare services deliver acute medical care, chronic disease management, health-screening and disease prevention. All psychiatric patients should have access to primary healthcare services (Beecroft *et al*, 2001), whether they are in-patients, living in the community or in other settings. Psychiatrists and mental health professionals should work together with GPs, and carers when appropriate, to ensure that psychiatric patients are registered with a GP and a dental practitioner.

Guidance for staff working in primary care services, in the community, has been prepared by NIMHE (2004) recommending that active links be made between primary care services and psychiatric services. They suggest that GPs should set up specific clinics for people with mental disorders, which are advertised through psychiatric services and could identify patients by using disease registers; for example searching by diagnosis, medication and for a history of contact with mental health services. They also outline the need for regular and appropriate physical health checks for patients in psychiatric services (*ibid*). A training package is available for GP educators on the physical health care of psychiatric patients (Cohen and Hove, 2001). People with learning disabilities should have a health action plan to facilitate appropriate physical health care (Department of Health, 2002).

It is important to recognise that health policy and guidance on physical health also applies to psychiatric patients, for example; the National Service Frameworks and NICE guidance (Department of Health, 1999a, 1999b, 2000, 2001).

**Other health services**

Comprehensive physical health care includes dental care and oral hygiene as well as the provision of health services such as chiropody, physiotherapy, optometry and audiometry. Dieticians have a key role to play in monitoring diet and nutrition as well as assisting patients to choose a healthy diet (Cormac *et al*, 2004). Some speech and language therapists are specialists in the investigation and treatment of dysphagia, which is more prevalent in psychiatric patients than in the general population. Exercise professionals may also contribute to health by providing exercise and fitness programmes.

**In summary**, psychiatrists should promote the physical health of their patients and, when appropriate, refer patients to colleagues from other medical specialties, to enable their patients to receive the same standard of health care as other citizens.

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## **Section 2: Examples of Physical Health Standards in four services**

### **Section 2.1 - Physical Health Standards - West London Mental Health Trust**

**Dr M Phelan**

#### **1. Initial physical assessment of inpatients**

##### **Physical examination**

- All patients should have a comprehensive physical examination within 24 hours of admission.
- If an examination is not possible (e.g. patient refuses or is too disturbed) the reason should be clearly stated in the notes, and relevant observations documented (e.g. nutritional status, gait, abnormal movements).

##### **Physical health review**

- A full physical health review should be completed within 2 weeks of admission. This should include:
  - details of past and present illnesses
  - a comprehensive symptom review
  - all current medication
  - health promotion history (including smoking, diet, & exercise)
  - details of health screening (e.g. dental care, cervical screening).
- It is recommended that this information is collected on a standard form, and an action plan agreed with the patient.

##### **Physical investigations**

- Appropriate physical investigations should be completed during the first week of admission.
- Results of physical investigation should be reviewed and filed in notes.

##### **Appropriate medical equipment available on wards** *(see appendix 1)*

- Necessary medical equipment must be available and accessible on each ward.
- Equipment must be maintained in working order.

## **2. Ongoing Physical Health Care Of Inpatients**

- Patients should have their weight and blood pressure recorded at least monthly
- Physical health review, examination and investigations should be repeated at least every 6 months.
- Patients should have access to dental care, chiropody, dietician, physiotherapy, sexual health care, and an optician.

## **3. Management of Long-Term Physical Illness of Inpatients**

- Symptoms, progress and treatment of long term physical disorders (e.g. diabetes, hypertension, arthritis) should be reviewed with the patient and documented at least monthly by medical staff.
- Long-term physical disorders should be reviewed by a GP or hospital specialist at least every 6 months.

## **4. Health Promotion for inpatients**

- Patients should have easy access to appropriate written health promotion information.
- Patients should have access to exercise, smoking cessation support, and appropriate dietary advice.

## **5. Environment for inpatients**

- Patients should be provided with appropriate food and drink to meet their nutritional, therapeutic and cultural needs.
- Patients should have access to fresh air and exercise space.
- A smoke free environment should be provided.
- Access to appropriate clean washing/toilet facilities should be maintained at all times.

## **6. Emergency care for inpatients**

- Wards should have access to resuscitation equipment which is regularly maintained.
- Wards should have rapid access to emergency medical care.
- A first aid kit should be available on each ward.

## 7. Community Physical Health Standards (Enhanced CPA)

- Discharge summaries should include section on physical health.
- CPA care co-ordinators should liaise with patients' GPs every year to confirm that annual physical health assessment has been conducted. If this is not possible alternative arrangements should be found for patients to have a physical assessment.
- CPA reviews should include a review of physical health needs and an agreed care plan to address identified needs.
- Community patients should have access to appropriate community groups that support and encourage good physical health e.g. walking groups, weight management and healthy living groups.

### Appendix 1

Recommended medical equipment for psychiatric wards

*(adapted from G. Garden, Advances in Psychiatric Practice 2005, 11, 142-9)*

Examination couch	Ophthalmoscope/Auroscope
Stethoscope	Alcometer
Sphygmomanometer	Oximeter
Thermometer	Neurological testing pins
Tendon hammer	Snellen chart
Tuning fork (256Hz)	Height measure
Weighing scales	Disposable gloves
Urinalysis sticks	

## Section 2.2 - Physical Health Standards - Psychiatry of Learning Disability

Dr Glyn Jones

### HEALTH CARE NEEDS OF PEOPLE WITH LEARNING DISABILITY

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The Disability Rights Commission investigation "Equal Treatment : Closing the Gap" (Disability Rights Commission 2006) has highlighted major deficits in the physical health care of people with Learning Disability and/or Mental Health problems. This concurs with an extensive existing body of research evidence that people with Learning Disability experience health inequality when compared to the general population (Cooper *et al* 2004). Patterns of physical and mental health needs are different in nature (Cooper *et al* 2004; Kerr 1998) and are of increased frequency (Howells 1986; Wilson & Haire 1990). This is mirrored by an increased rate and different pattern of mortality compared to the general population (Hollins *et al* 1998; NHS Health Scotland (2004); Janicki *et al* 1999). Unmet physical disorders are also implicated in the aetiology of self-injury and other challenging behaviours, especially in individuals with more severe Learning Disability (Cataldo & Harris 1982).

Despite an extensive evidence base the health care needs of people with Learning Disability are often not recognised (Howells 1986; Wilson & Haire 1990) and, therefore, not met (Royal College of General Practitioners Working Party 1990; Lennox & Kerr 1997). People with Learning Disability are also less likely to access Generic Health Promotion initiatives (Lennox & Kerr 1997; Beange *et al* 1995; Webb & Rogers 1997) and do not access Primary Care services at a level commensurate with their physical needs (Whitfield *et al* 1996; Lennox & Kerr 1997; Howells 1986; Wilson & Haire 1990). The reasons for these inequalities are complex and are likely to include characteristics of the individual, for example, genetic predisposition (O'Brien & Yule 1995), difficulties in communicating health needs and deficits in, or barriers to, effective health service provision. Carers may be unaware of the significance of health deficits or may view them as an intrinsic aspect of the individual's condition and not appropriate for, or amenable to, treatment. Individuals with Learning Disability are also at increased susceptibility to the physical side effects of medication. This is particularly important in view of the high rates of prescription of antipsychotic medication in this population. Given evidence of inadequate review and the limited ability of the individual to advocate for their own health care needs, there are concerns that people with Learning Disability are being unnecessarily exposed to unpleasant and potentially harmful medication side effects (Ahmed *et al* 2000).

The health care system in the United Kingdom is mainly reactive in that contact is largely dependent on initiation by the patient. This can present particular problems for people with little or no effective verbal communication where health care is, in effect, delivered by proxy through Carers who often fail to recognise or are

unaware of the importance of health deficits. It must also be remembered that people with Learning Disability are not a homogeneous group and that personal characteristics must be considered when offering health services. For example, patients with mild Learning Disability will have difficulty negotiating systems, which assume competence in areas such as literacy or failure to adjust communication according to individual need.

Even if the individual and/or carers seek assistance from Primary Health Care services there remain many potential barriers (Lennox *et al* 1997). Recognition of disease in people with intellectual and communication problems takes time and skills (Kerr 1998). Unfortunately, most Primary Health Care professionals are not trained to work with people with Learning Disability and are often unaware of the range of health care needs (Melville *et al* 2005; Howells 1986; Lennox & Kerr 1997). Surveys have shown that many General Practitioners lack confidence in treating people with Learning Disability (Stein 2000) and are unsure over legal issues such as capacity to consent to medical treatment (Minihan & Dean 1990). People with Learning Disability may need longer or even additional consultations (Chambers *et al* 1998) and consideration must be given to environmental stressors as well as examination difficulties, including behaviour that is either challenging or perceived as such (Minihan & Dean 1990; Lennox *et al* 1997). It is also important to obtain consistent information from relevant informants as high turnover in residential services can result in Carers with inadequate knowledge accompanying the patient (Lennox *et al* 1997). There is an obligation under the Disability Discrimination Act 1999 to make "reasonable adjustments" to aid accessibility to premises and services.

Various models have been suggested in order to address deficits, including education initiatives, health facilitation by specialist services and Health Checks performed in Primary Care services. Health Checks involve systematic questioning and structured physical examination followed by action plans to address any identified health need. It does not appear that carrying out such Health Checks on an opportunistic basis is effective even if this is backed up by prompts and educational aids (Jones & Kerr 1997). Clinical studies have confirmed the need for systematic health care screening (Martin *et al* 1997; Webb & Rogers 1999) and further studies have confirmed not just the ability to discover high levels of unmet need (Baxter *et al* 2006), but that the benefits of such interventions are sustained (Cooper *et al* 2006). It is also important to remember that any Health Check is only effective if the identified health deficits result in an action plan actively addressed. Experience shows that omissions are likely to occur and that a failsafe system for checking completion is to be recommended.

Even after health problems have been identified and investigations recommended there are similar practical barriers to accessing Secondary Health Care services, which must be anticipated and addressed. Specialist Learning Disability services have skills in facilitation but, even though these teams are generally valued by General Practitioners (Kerr *et al* 1996), they often appear unaware of referral pathways or reluctant to use them (Stein 2000). It would appear that some form of care co-ordination is essential for people with Learning Disability to effectively access health care services at both Primary and Secondary levels (McConkey & McAteer 1999).

Reports from various bodies in the fields of Learning Disability and Primary Care have advocated the introduction of Health Checks (Royal College of General Practitioners Working Party 1990; Lennox & Kerr 1997). However, the lack of statutory obligation and financial remuneration have, until now, proven major obstacles to comprehensive implementation. Recent Learning Disability policy in the UK has recommended proactive health checking as well as a range of other special arrangements specifically designed to address the health needs of people with Learning Disability. In England the White Paper *Valuing People (Department of Health 2001)* set out deadlines for the implementation of Health Facilitators, Health Action Plans and the registration of all people with Learning Disability with a General Practitioner. In Scotland, *A Partnership for a better Scotland (Scottish Executive 2003)* advocated piloting of a health screen for people with Learning Disability and a subsequent Health Needs Assessment Report, *People with Learning Disabilities in Scotland (NHS Health Scotland 2004)*, recommended written antidiscrimination policies backed up by widespread training on the needs of people with Learning Disability for relevant staff. In Wales advice to the Welsh Assembly Government in the report *Fulfilling the Promises (Learning Disability Advisory Group 2001)* included recommendations on health promotion and the implementation of regular Health Checks and systematic follow up. Subsequent Section 7 Guidance issued by the Welsh Assembly Government also recommended that the Multidisciplinary Unified Assessment Process, co-ordinated by the Local Authority, should identify a plan for health needs as well as social care needs.

The Learning Disability component to the Royal College of Psychiatrists Curriculum for Basic Specialist Training (2001) emphasise the importance of Psychiatrists recognising the influence of physical disorders on psychological presentation. They must therefore be aware not just of the high rates of, and atypical patterns of, health deficits in people with Learning Disability, but also of the potential atypical presentation of physical symptoms (Evenhuis 1997) and the dangers of diagnostic overshadowing where physical disorders and side effects of medication can be mistaken for the symptoms of mental disorders. Trainees must also be able to demonstrate competency in the diagnosis and treatment of psychiatric disorders and Epilepsy in people with Learning Disability. Epilepsy is a common co-morbidity and the presentation is more complex and frequently more intractable as compared to the general population. An awareness of the potential neuropsychiatric sequelae and familiarity with the use of regular and rescue medication is essential. Therefore, a comprehensive systems enquiry and investigations of potential health care problems are core components of the psychiatric assessment of any person with Learning Disability whether as an inpatient or during community assessments. If admission to an Assessment and Treatment facility becomes prolonged it is essential that Psychiatrists recognise the need for active health promotion, including formal Health Checks. This is particularly important in the Continuing Health Care setting where Psychiatric services have, in effect, assumed the role normally carried out by the individual's Primary Health Care Team.

The discharge of any patient back to the Primary Health Care system must involve the transfer of quality information in relation to health status. This is particularly important when the individual has been a "long stay" patient. Just as health

deficits have been identified as potential barriers to deinstitutionalisation (Bond *et al* 1997) so the provision of health care both before (Lennox *et al* 2006) and after discharge (Jones & Kerr 1997) has been shown to be beneficial to effective health care provision.

Responsibility for the health care of all people with Learning Disability in the community lies with Primary Care services. Specialist Learning Disability services will have a vital role in facilitating this process including the provision of relevant education, guidance and, if necessary, practical support. This may also involve assistance in the development of relevant Health Care Pathways and the completion of any statutory Health Care initiatives. However, the temptation for specialist Learning Disability services to take over responsibility for the health care needs of people with Learning Disability should be resisted.

The following health recommendations are in accordance with the model for Physical Health Standards outlined by Dr Phelan (above) and have been reviewed and approved by the Medical Audit Committee of the largest Learning Disability Directorate in South Wales.

The Welsh Health Check (Appendix 1) is a clinical and research tool used extensively in Primary Care and specialist Learning Disability services both in the UK and internationally (Webb & Rogers 1999; Kerr *et al* 1996). The Welsh Assembly Government has funded a Directed Enhanced Service for Primary Care services to carry out Annual Health Checks using the Welsh Health Check since April 2006.

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## Psychiatry of Learning Disability

### Physical Health Standards

#### 1. Initial Physical Assessment of Inpatients

##### ◆ Physical Examination

- ◆ All patients should have a comprehensive physical examination within 24-hours of admission.
- ◆ All patients exhibiting confusion should have a comprehensive physical examination at the time of admission.
- ◆ If a risk assessment confirms that examination within this time frame is not possible, then the reason should be clearly stated in the notes, and all possible relevant observations documented.

##### ◆ Physical Health Review

- ◆ At the time of admission or as soon as possible thereafter, a full physical health review should be completed. This should include:
  1. Details of past medical history (or request made for information from relevant agencies).
  2. A comprehensive systems / symptom review
  3. Current medication
- ◆ Within one week of admission additional information should be obtained in relation to:
  1. Health promotion history
  2. Details of health screening
  3. Any relevant past medication history
- ◆ For any patient with epilepsy, information should be gathered on:
  1. Seizure type
  2. Seizure frequency and stability
  3. Protocol for use of rescue medication.

##### ◆ Physical Investigations

- ◆ Appropriate physical investigations should be carried out or requested as soon as possible after admission.
- ◆ Results of physical investigations should be reviewed, signed and filed in the clinical notes.

## **Ongoing Physical Healthcare of Inpatients**

- ◆ Patients should have their weight and blood pressure recorded at least monthly.
- ◆ Physical Health Review Examination and investigations should be repeated at least annually
- ◆ Patients on antipsychotic medication should be screened for movement disorders on initiation of medication, after one month and three months of treatment and thereafter every six months.
- ◆ Patients with epilepsy should have seizure type and frequency recorded on standardised charts.
- ◆ Patients should have continued access to appropriate Primary and Secondary Health Care Services including Dental Care, Chiropody, Dietetics, Physiotherapy, Speech and Language Therapy, Ophthalmology etc.
- ◆ Patients taking certain groups of medication (Clozapine, anticonvulsant agents, Lithium etc) will require regular blood tests in accordance with therapeutic guidelines.

## **2. Management of Long-Term Physical Illness of Inpatients**

- ◆ Symptoms, progress and treatment of long-term physical disorders should be reviewed and documented at least monthly by medical staff
- ◆ A comprehensive Health Evaluation including physical examination and symptom / systems review should be carried out at least annually.

## **3. Health Promotion for Inpatients**

- ◆ Patients should be supported to access appropriate Health Promotion and provided with relevant information in a format compatible with their intellectual capacity and communication skills.
- ◆ Patients should have access to exercise, smoking cessation support and appropriate dietary advice.

## **5. Environment for Inpatients**

- ◆ Patients should be provided with appropriate food and drink to meet their nutritional therapeutic and cultural needs (including consideration of the Neuropsychiatric effects of caffeine).
- ◆ Patients should have access to fresh air and exercise space
- ◆ A smoke-free environment should be provided
- ◆ Access to appropriate clean washing / toilet facilities should be maintained at all times

## **6. Emergency Care for Inpatients**

- ◆ Wards should have rapid access to Emergency Medical Care (either directly or via Emergency Services).
- ◆ Wards should have access to resuscitation equipment commensurate with the nature of the Unit

- ◆ Basic First Aid equipment should be available on each ward.

## 7. **Discharge Arrangements**

- ◆ All patients should receive a comprehensive systems review and physical examination prior to discharge.
- ◆ Discharge Summaries should include a section on Physical Health

## 8. **Community Physical Health Standards**

- ◆ CPA Care Coordinators / Case Managers should be aware of the health needs of patients, include this in any statutory reviews and liaise with the patients Primary Health Care Team in accordance with relevant statutory guidelines.
- ◆ Responsibility for the health care of all people with Learning Disability in the community lies with Primary Care services. Specialist Learning Disability services will have a vital role in facilitating this process including the provision of relevant education, guidance and, if necessary, practical support. This may also involve assistance in the development of relevant Health Care Pathways and the completion of any statutory Health Care initiatives.
- ◆ Community Learning Disability Teams should facilitate access to appropriate activities, which encourage good physical health, e.g. walking groups, weight management and Health Living Groups.

### *Appendix:*

#### Recommended Minimum Medical Equipment for Psychiatric Units

1. Stethoscope
2. Sphygmomanometer
3. Thermometer
4. Tendon Hammer
5. Ophthalmoscope / Auroscope
6. Weighing Scales
7. Height Measure
8. Video Camera (for monitoring of seizures and Movement Disorders)

## Welsh Health Check for People with a Learning Disability

Date:

Name:

Marital status:

Ethnic origin:

Principal carer:

Date of Birth:

Sex:

Address:

Tel:

---

Weight (kg/stone)..... Height (meters /feet) .....

Blood Pressure ..... Urine Analysis .....

Smoke (per day) ..... Alcohol (units per week) .....

Body Mass Index  
(weight in kg / height in m2) ..... Cholesterol/  
Serum lipids .....

---

**Immunization** - People with learning disability should have the same regimes as others and the same contra indications apply. (Please circle)

Tetanus in last ten years? Yes  No

If no has tetanus been given? Yes  No

Tetanus in last ten years? Yes  No

Has influenza vaccine been given? Yes  No

Is Hepatitis B status known? Yes  No

Result? .....

---

**Cervical screen** – people with a learning disability have same indications for cervical cytology as others.

Is a smear indicated? Yes  No

If yes when was last smear? ...../...../..... When is next due? ...../...../.....

What was the result? .....

---

**Mammography** – this should be arranged as per local practice.

Has mammogram been performed?                      Yes                       No

**CHRONIC ILLNESS** - Does your patient suffer from any chronic illnesses.

Diabetes    Yes     No

Asthma    Yes     No

---

**SYSTEMS ENQUIRY** – the answer to these will not always be available.

Respiratory cough    Yes     No

Haemoptysis    Yes     No

Sputum    Yes     No

Wheeze    Yes     No

Dyspnoea    Yes     No

---

**Cardiovascular system**

Chest pain    Yes     No

Swelling of ankles    Yes     No

Palpitations    Yes     No

Postural nocturnal dyspnoea                                      Yes     No

Cyanosis    Yes     No

---

**Abdominal**

Constipation    Yes     No

Weight loss    Yes     No

Diarrhoea    Yes     No

Dyspepsia    Yes     No

Melaena    Yes     No

Rectal bleeding	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Faecal incontinence	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Feeding problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>

---

C.N.S. – for epilepsy see overleaf

Faints	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Parasthesia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Weakness	Yes <input type="checkbox"/>	No <input type="checkbox"/>

where .....

---

### Genito-urinary

Dysuria	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequency	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Haematuria	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Urinary Incontinence	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes has M.S.U. been done	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Would you consider other investigations?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

---

### Gynaecological

Dysmenorrhoea	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Inter menstrual bleeding	Yes <input type="checkbox"/>	No <input type="checkbox"/>
PV discharge	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is patient post menopausal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Contraceptives	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Other.....

**EPILEPSY**

Yes

No

Type of fit .....

Frequency of seizures (fits/month) ...../.....

Over the last year have the fits

Worsened

Improved

Remained the same

**Antiepileptic medication**

Name	Dose/frequency	Levels (if indicated)

Side effects observed in the patient

.....

.....

**BEHAVIOURAL DISTURBANCE**

Behavioural disturbance in people with a learning disability is often an indicator of other morbidity. For this reason it is important to record it as it can point to other morbidity.

Aggression

No

more than once   
a month

less than   
once a month

very   
infrequently

Self injury

Yes

No

more than once   
a month

less than   
once a month

very   
infrequently

Overactivity

yes

No

more than once   
a month

less than   
once a month

very   
infrequently

Other .....

more than once   
a month

less than   
once a month

very   
infrequently

**PHYSICAL EXAMINATION**

General appearance

Anaemia

Yes

No

clubbing

Yes

No

Lymph nodes

Yes

No

Jaundice

Yes

No

Hydration

Yes

No

**CARDIO VASCULAR SYSTEM**

Pulse .....beats/min

Blood pressure /

Heart sounds .....  
(describe)

S.O.A. Yes  No

---

**RESPIRATORY SYSTEM**

Respiratory rate ..... breaths/min

Breath sounds Yes  No

Wheeze Yes  No

Tachypnoea Yes  No

Additional sounds Yes  No

(describe).....

---

**ABDOMEN**

Masses Yes  No

Liver Yes  No

Spleen Yes  No

PR indicated Yes  No

Results .....

**CENTRAL NERVOUS SYSTEM – It is often difficult and not relevant to perform a full neurological examination, however, people with a learning disability are particularly prone to abnormalities in vision, hearing and communication – a change in function would suggest further investigation is necessary**

**VISION**

Normal vision  Minor visual problem  Major visual problems

Is the carer/key worker concerned? Yes  No

When did the patient last see an optician? ...../...../.....

Is there a cataract? Yes  No

Result of Snellen chart .....

Any other data .....

---

### HEARING

Normal hearing  Minor hearing problem  Major hearing problem

Is the carer/ key worker concerned? Yes  No

Does he/she wear a hearing aid? Yes  No

Any wax? Yes  No

Does your patient see an audiologist? Yes  No

Other investigation .....

---

### COMMUNICATION

Does your patient communicate normally? Yes  No

Does your patient communicate with aids? Yes  No

Does your patient have a severe communication problem? Yes  No

Does your patient see a speech therapist? Yes  No

### MOBILITY

Is your patient fully mobile? Yes  No

Is your patient fully mobile with aids? Yes  No

Is your patient immobile? Yes  No

Has immobility been assessed? Yes  No

---

**DERMATOLOGY**

Any abnormality? Yes  No

Diagnosis .....

---

**BREAST**

Any lumps? Yes  No

Any discharge? Yes  No

Nipple retraction? Yes  No

---

**OTHER INVESTIGATIONS**

Are there any further investigations necessary? Yes  No

If yes please indicate .....

---

**SYNDROME SPECIFIC CHECK - Certain syndromes causing learning disabilities are associated with increased morbidity (information can be found in the education pack provided) for this reason it is important to record:**

Is the cause of learning disability known? Yes  No

If yes, what is it? .....

Has the patient had a chromosomal analysis? Yes  No

Result? .....

Is the degree of learning disability?

mild  moderate  severe  profound

If your patient has Down's syndrome he/she should have a yearly test for hypothyroidism.

Has this been done? Yes  No

---

**OTHER MEDICATION**

Drug	Dose	Side Effects	Levels (if indicated)

**THANK YOU**

The Welsh Health Check for People with a Learning Disability is based upon the Cardiff Health Check developed by Professor M Kerr, Welsh Centre for Learning Disabilities:  
[http://www.cardiff.ac.uk/medicine/psychological\\_medicine/research/welsh\\_centre\\_learning\\_disabilities/pdf/cardiff\\_health\\_check\\_for\\_people\\_with\\_a\\_learning\\_disability.pdf](http://www.cardiff.ac.uk/medicine/psychological_medicine/research/welsh_centre_learning_disabilities/pdf/cardiff_health_check_for_people_with_a_learning_disability.pdf)

## **Section 2.3 - Physical Healthcare Standards - Forensic psychiatric services**

**Dr Irene Cormac and Dr Mary Walsh**

### **1 INTRODUCTION**

These physical health care standards are the minimum standards expected for the care of psychiatric patients who are in-patients in forensic psychiatric services. If a patient declines to be examined or interviewed about their physical health, their wishes should be respected unless there are reasons not to do so. It is recommended that all patients have access to a primary healthcare service.

### **2 INITIAL PHYSICAL ASSESSMENT OF IN-PATIENTS**

#### **Physical examination**

- All patients should have a comprehensive physical examination within 24 hrs of admission.
- If examination is not possible, for example if a patient refuses or is too disturbed, the reason must be clearly stated in the clinical record and relevant observations documented. These could include nutritional status, gait, abnormal movements or other observations. The situation should be reviewed at an appropriate interval.

#### **Physical health review**

A full physical health review should be completed at the first Care Programme Approach review following admission. This review should include:

- Details of past and present illnesses.
- A comprehensive symptom review.
- Health promotion history (including, smoking, diet and exercise).
- Details of health screening (e.g. dental care, cervical screening).
- All forms of medication and allergies should be recorded.

It is recommended that the above information should be recorded on standard forms or in a standard format.

A Medical Alert Card should be completed and stored at the front of the clinical record (see Appendix 2 for copy of Medical Alert Card).

## **Physical investigations**

- Appropriate physical investigations should be completed during the first week of admission.
- Results of physical investigation should be checked by the doctor and filed in the clinical record.
- Appropriate action should be taken to address identified needs.

## **Medical equipment available on wards**

Appropriate medical equipment must be available and accessible on each ward. Equipment must be maintained in working order.  
(See Appendix 1 for recommendations for medical equipment)

## **3 CONTINUING PHYSICAL HEALTH CARE**

- Patients should have their weight and blood pressure measured and recorded monthly.
- Physical health review, examination and investigations should be repeated as necessary, at least annually.
- Patients should have access to dental care, chiropody, physiotherapy, dietetics, hearing tests and an optometry. When appropriate, patients should have access to advice and treatment from nurse specialists in the management of diabetes, asthma, wound care, incontinence, substance misuse, infectious diseases and sexual health.

## **4 MANAGEMENT OF CHRONIC PHYSICAL ILLNESS OF IN-PATIENTS**

- Symptoms, progress and treatment of chronic physical disorders such as diabetes, hypertension, arthritis, should be reviewed with the patient at appropriate intervals.
- Chronic physical disorders should be reviewed according to need in primary, secondary or tertiary health care facilities as required.

## **5 EMERGENCY CARE**

The geographical location of the forensic service must be taken into account when planning the provision of emergency medical care. In secure forensic services, emergency medical services must be able to gain rapid access to the emergency situation and, if necessary, to be able to transfer a patient to a general hospital, whilst maintaining the appropriate level of security.

- Wards should have access to resuscitation equipment, which is regularly maintained.
- Wards must have rapid access to emergency medical care.
- A First Aid kit should be available on each ward.

## **6 MANAGEMENT OF A POTENTIALLY VIOLENT OR VIOLENT PATIENT**

- The standards in the NICE Guidelines (Clinical Guideline 25, 2005) should be applied for clinical observations and for rapid tranquilization.
- Staff training in Life Support should be at the level recommended in the above document.
- The physical well being of patients in seclusion should be monitored in accordance with the relevant Mental Health Act Code of Practice.

## **7 HEALTH PROMOTION**

- Patients should have access to written health promotion information.
- Patients should have access to exercise facilities, smoking cessation treatment, weight management and dietary advice.

## **8 ENVIRONMENT**

- Patients should be provided with fluids and a diet, which is nutritious and sufficient to meet their needs.
- Patients should have access to fresh air and exercise facilities.
- A smoke-free environment should be provided.
- Access to adequate washing and toilet facilities must be available at all times.
- There must be sufficient shower or bathing facilities to meet needs for cleanliness.

## **9 CARE PROGRAMME APPROACH PHYSICAL HEALTH STANDARDS**

- CPA review should include a review of physical health needs.
- CPA care plans should include an agreed care plan to meet physical health care needs.
- Patients should have access to support and encouragement to promote good physical health.

## **10 DISCHARGE PLANS FOR COMMUNITY CARE**

- Discharge summaries should contain a section on physical health.
- Arrangements for future plans for physical health care should be included.
- Community patients should have access to appropriate community services, which support and encourage good physical health, for example weight management and healthy living groups.
- All patients should have access to primary health care service and a review of physical health at least annually.

## **11 DISCHARGE PLANS FOR TRANSFER TO PENAL ESTABLISHMENTS**

- Discharge summaries should contain a section on physical health.
- Arrangements for future plans for physical health care should be included.
- Whenever possible, the CPA co-ordinator should liaise with the healthcare centre of the penal establishment about the physical health of the patient.

### **APPENDIX 1**

Recommended medical equipment for psychiatric wards (adapted from G Garden, *Advances in Psychiatric Practice* 2005, 11, 142-9).

#### **1 Essential equipment**

Examination couch  
Stethoscope  
Sphygmomanometer  
Thermometer  
Tendon hammer  
Tuning fork (256 Hz)  
Weighing scales  
Urinalysis sticks  
Disposable gloves  
Ophthalmoscope  
Auroscope  
Height measure

#### **2 Desirable equipment**

##### **Routine**

Alcometer  
Oximeter  
Neurological testing pins  
Blood sugar monitoring device  
Peak flow meter

##### **Emergency**

Torch or examination light  
Intravenous infusion equipment  
Syringes with retractable needles  
Dressings and wound closure adhesive  
Emergency medication  
Sharps box  
Urinary catheters  
Copy of Glasgow Coma Scale

## **References**

National Institute for Clinical Excellence (2005). *Quick reference guide. Violence. The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments.* Clinical Guideline 25. [www.nice.org.uk](http://www.nice.org.uk). Mental Health Act 1983, Code of Practice.

## **Acknowledgements**

The above Forensic Physical health standards are based on the work of Dr Michael Phelan and with his permission have been adapted by Dr Irene Cormac and Dr Mary Walsh, Consultant Forensic Psychiatrists, at Rampton Hospital, in consultation with Dr Emmet Larkin and the Medical Staff Committee at Rampton Hospital, Retford, Notts. DN22OPD. They are being used in the forensic services in Nottinghamshire.

## **APPENDIX 2:**

### **Medical Alert Card**

The Medical Alert Card has been developed at Rampton Hospital by Drs P Bendall, I Cormac and M Walsh and others. It has been reproduced with kind permission of Dr Emmet Larkin, Associate Medical Director at Rampton Hospital.

The Medical Alert Card is normally printed on 2 sides of a yellow card and is filed in each patient's clinical record. It is completed by the Clinical team and is intended to contain the basic medical information that might be required in an emergency situation.

<b>MEDICAL ALERT CARD</b>		Name:
Please read with medication card		DOB:
		Hospital no.
		Ward
		<b>Give Details</b>
<b>ALLERGIES:</b> Medication Food eg. Nuts Bee/Wasp stings, Latex		
<b>BLOOD BORNE VIRUSES</b> Hepatitis B, carrier, HIV status Hepatitis C, carrier	Yes/No/Nk Yes/No/Nk	
Immuno-compromised Steroids	Yes/No/Nk Yes/No/Nk	
<b>MEDICATION</b> Lithium Anti-coagulants Clozapine Insulin Anti-epileptics	Yes/No/Nk Yes/No/Nk Yes/No/Nk Yes/No/Nk Yes/No/Nk	
Heart disease	Yes/No/Nk	
Hypertension / CVA	Yes/No/Nk	
Diabetes	Yes/No/Nk	
Respiratory/Asthma	Yes/No/Nk	
Renal /Urinary	Yes/No/Nk	
Liver disease	Yes/No/Nk	
Epilepsy/Organic brain disorder	Yes/No/Nk	

		Give details
<b>PAST MEDICAL HISTORY OF ANYTHING SIGNIFICANT eg. Operations, TB</b>		
Glaucoma/ Blind / Deaf	Yes/No/Nk	
Mobility problems	Yes/No/Nk	
Medical device in situ Foreign bodies	Yes/No/Nk Yes/No/Nk	
Hyperlipidaemia	Yes/No/Nk	
Other metabolic / blood disorders	Yes/No/Nk	
Blood abnormality Sickle Cell Disease / other	Yes/No/Nk	
<b>IMMUNISATION</b> Tetanus Hepatitis B BCG	Yes/No/Nk Yes/No/Nk Yes/No/Nk	
Needs prophylactic antibiotics for invasive/dental procedures	Yes/No/Nk	

Name .....(print) ..... (sign)

Date: ...../ ...../ .....(D/M/Y)

## **Section 2.4 - Physical Healthcare Standards - The Physical Health of Children and Young People with Mental Health Problems**

**Dr Margaret Murphy**

By contrast with adults far less is known about the physical health care needs of children and young people referred to mental health services and there has been little research in this area. Furthermore, as there are significant differences in the pattern and nature of physical and psychological morbidities and in the organization of mental health services for children and young people it is not possible to simply extrapolate from the findings for adults.

### **Organization and Functions of Child and Adolescent Mental Health Services**

Across the UK, Northern Ireland and the Irish Republic child and adolescent mental health services (CAMHS) are strategically organized into tiers (although there are some differences in organization of services in the Republic of Ireland). Tier 1 CAMHS or their equivalent are provided by professionals such as General Practitioners, health visitors, teachers, youth workers, paediatricians and social workers whose main role and training is not in mental health.

Tier 2 CAMHS refers to services provided by specialist mental health professionals, working primarily on their own, rather than in a team- although in the majority of cases such workers are based within multi-disciplinary specialist teams and may work with other agencies such as local authority looked- after childrens' teams or general hospital liaison services on an outreach basis. Tier 3 CAMHS refers to specialist mental health teams which may include psychiatry, psychology, individual and family therapists, nurses and social workers. Tier 4 CAMHS refers to highly specialized services usually provided on a regional basis such as in-patient units.

The majority of children and young people referred to CAMHS services will not be seen by a psychiatrist and much of the care is provided by clinicians who may not have either experience or training in physical health care. Data from the National CAMHS mapping exercise in England and Wales (2004) shows that emotional disorders and disruptive behaviour disorders are the commonest reasons for referral to CAMHS with severe mental illnesses such as psychosis, bipolar disorder and severe eating disorders being relatively rare. Very few children and people referred to CAMHS require in-patient care. The majority of children and young people in contact with CAMHS have a treatment duration of less than 6 months.

Thus as the vast majority of CAMHS patients are living in the community with parents or carers and may have only a relatively brief or time-limited contact with CAMHS services they are much more likely to be in longer term contact with primary care services such as GPs, school nurses, community paediatrics etc than with CAMHS services and to rely on these other services to meet physical health care needs. Many consultant child and adolescent psychiatrists will thus only rarely

carry out a physical examination of a child and have very little involvement themselves in the treatment of physical illnesses. Nevertheless, it is important for CAMHS clinicians to be aware of the complex relationship between physical health and mental health/emotional well-being for several reasons: -

1. mental health problems may be the presenting manifestation of underlying physical illness.
2. children and young people who are experiencing physical illnesses particularly chronic illnesses and/ or severely impairing or life-threatening illnesses especially those which involve the brain are at higher risk of developing co-morbid mental health problems (Rutter et al .1970. Seidal et al 1975).
3. in order to safely prescribe the medications used in the management of some child and adolescent psychiatric disorders it is vital that practitioners are aware of any potential impact on physical health/well-being and of the need to carry out adequate monitoring of physical health parameters as well as monitoring of the effect upon the child or adolescents mental state and behaviour.
4. there is evidence of the benefit of exercise in the treatment of depression in children and young people (NICE Guidelines on The Treatment of Depression in Children , 2005). There is also some evidence of the positive effects of exercise on the self-esteem of children and young people ( Ekeland et al, 2004). There is also a growing interest in the role of diet and life-style factors in relation to the mental health of children and young people.
5. it could be argued that as professionals coming into contact with children and young people at what is thought to be an important life-stage in the development of attitudes to health and in particular "health-risk" behaviours, Royal College of Paediatrics and Child Health (2003) CAMHS professionals have a responsibility for general health promotion. Moreover, children and young people at risk of developing mental health problems may also be at increased risk of 'high-risk' health behaviours such as smoking and poor sexual health (Resnick et al. 1997).

This chapter will focus on the areas themes identified in points 3, 4 and 5 and in particular the physical health impact of some of the treatments used in CAMHS and the relationship between mental health and physical health/ health behaviour. Readers interested in the issue of physical disorders presenting in routine child and adolescent mental health practice are directed towards the comprehensive review of physical examination and investigation in general child and adolescent psychiatric practice by Bailey (2002 ).

There are also a number of excellent reviews of the emotional needs and mental health of children and young people experiencing physical illnesses (Mrazek, 2002; Rauch and Jellinek ,2002 ). In addition readers should be aware that there is an

increasing emphasis in the training of paediatricians in the skills and competencies needed to meet the emotional health care needs of child and adolescent patients via. Initiatives such as the Child in Mind training programme developed jointly by the Royal Colleges of Paediatrics and Child Health and the Royal College of Psychiatrists.

## COMPETENCIES IN THE BASIC PHYSICAL EXAMINATION AND ASSESSMENT OF CHILDREN AND YOUNG PEOPLE

**1. It is recommended that all child and adolescent psychiatrists are competent in the basic physical assessment of children and young people (measurement of height, weight, head circumference, pulse, blood pressure, the assessment of the physical stigmata of drug misuse and neurological examination) that there are adequate physical examination facilities in clinics and that there are good working links with general practice and paediatrics.**

**Child and Adolescent Psychiatrists also need skills in the interpretation of basic physical investigations particularly those required for on-going monitoring of medication. In order to develop and maintain these skills it is likely that there will need to be active training links with paediatrics for both training of trainees in child and adolescent psychiatry and CPD for consultant child and adolescent psychiatrists.**

**2. In CAMHS in-patient settings where there is a need to be able to carry out a more comprehensive physical examination as part of the routine admission procedure and where there may be a need to meet basic medical needs on an on-going basis as in-patients may not have access to routine primary care a higher level of competency will be required. Thus there will need to be a doctor or doctors in the team who are competent in the general physical assessment of children and young people and are able to carry out basic physical investigations ( e.g routine blood tests, basic interpretation of ECGs), treat minor ailments, refer to other medical services as appropriate and alongside appropriate specialists monitor longer term medical conditions.**

**3. Similarly for nurses, particularly those in in-patient settings, it is important that there is adequate training in the physical health care needs of children and adolescents as many nurses working in CAMHS in-patient settings may not have either training or experience in this area.**

## ***PHYSICAL TREATMENTS IN CHILD AND ADOLESCENT MENTAL HEALTH***

### General issues.

In the UK and Ireland medication plays a much less important role in the management of child and adolescent mental health problems than is the case in adult mental health partly because of the lower prevalence of illnesses which require physical treatment and a more cautious approach towards the use of psychotropic medications with this age range.

With the exception of treatment of ADHD when medication is used this is often on the basis of extrapolation from the findings with adults. In a review of paediatric prescribing in the USA Jensen et al (1999) estimated that around 80% of prescribing was off-label and that with the exception of ADHD there was little association between frequency of use and clinical trial evidence of efficacy. Whilst it is known that there are marked UK-USA differences in prescribing with a generally more conservative approach to the use of psychotropic medication in the UK, the situation may not be that different as very few drugs are licensed for use in children and adolescents and prescribing may be done on the basis of small efficacy studies in children or extrapolated from studies on adults without the benefit of developmentally specific data on either efficacy or safety.

Despite these concerns there may be little choice but to use medication in disorders such as bipolar disorder and schizophrenia where there is relatively little research because of the severely impairing and high risk nature of these illnesses. Where this is the case it is important to be aware of the developmental differences in response to medication.

There are developmental differences in pharmacokinetics. Hepatic metabolism is greatest between the ages of 1 and 6 and declines thereafter so that it is roughly twice the adult rate prepubertally and reaches the adult rate in adolescence, although in the months prior to the onset of puberty the metabolism of some drugs may decline ( Bourin & Couetoux du Terre, 1992). Glomerular filtration rate is generally much faster in children and young people than in adults. Children and teenagers tend to have lower proportions of body fat and a higher proportion of water than adults and there are differences in protein binding .All of these factors can affect bioavailability. There are also developmental differences in the permeability of the blood brain barrier. All of these differences combine to potentially lead to developmental differences in drug handling. The net effect of these differences may vary from one drug to another depending upon its metabolism, distribution etc.

Much less is known about developmental differences in pharmacodynamics although it is known that developmental differences can exist for example, the maturation of autonomic cardiac control during childhood and adolescence means that there are developmentally specific drug effects on this system which may be important in the case of psychotropic drugs such as tri-cyclics. There may also be developmental variation in side-effects for example, children and young people appear more likely than adults to experience disinhibition with benzodiazepines

(Paton, 2002), extrapyramidal side-effects on antipsychotic medication (Findling and McNamara, 2004) and adolescent girls may be more vulnerable to developing polycystic ovary disease on valproate (Isojarvi et al 1993).

Unfortunately there has been very little research into the longer term effects on children and young people of most of the psychotropic medications currently in use. Thus it is difficult to assess whether there may be longer term side-effects associated with the use of particular medications in the child and adolescent population.

## RECOMMENDATIONS

1. **There is a need for greater research into the use of psychotropic medication in children and adolescents and in particular a need to consider developmentally specific effects including longer term effects.**
2. **It is accepted that there are instances, such as young people suffering from severe illnesses such as schizophrenia, when the impact of the illness is so great that it is reasonable to prescribe on the basis of the existing limited evidence base. In such circumstances the following principles should be applied which are adapted from the Maudsley Prescribing Guidelines (2005/6) :-**
  - a. **Target symptoms and not diagnosis- diagnosis can be difficult in children and co-morbidity is very common. Treatment should target key symptoms and where possible systematic ratings of symptom severity and impairment should be used . Whilst a working diagnosis is useful to facilitate communication and frame expectations it should be remembered that this is provisional as particularly in this age group it may take some time for the illness to evolve.**
  - b. **Begin with less, go slow and if necessary be prepared to end with more- in outpatient care, dosage will usually commence lower in mg/kg per day than with adults, in in-patient settings whilst this may still be advisable as there can be closer monitoring and patients may be more severely impaired higher starting doses may be possible. The final dose may be higher in mg/kg terms (because of children's faster excretion) if titrated to the point of maximal response. (Although the adult dose should not generally be exceeded.)**
  - c. **Multiple medications may be required in the severely ill although monotherapy is ideal. Early onset illnesses can be very severe and thus multiple medications may be required alongside psychosocial interventions.**

- d. **Allow time for an adequate trial of treatment – children are often more severely ill than their adult counterparts and will often require longer periods of treatment before responding. An adequate trial of treatment for those who require in-patient care will therefore involve 8 to 12 weeks for most major conditions.**
- e. **Where possible change one drug at a time.**
- f. **Patient and family medication education is essential – and where medications are used off-license it is important to explain this.**

The recommendations regarding the indications for prescribing, the choice of medications and the required monitoring are those found in the Maudsley prescribing guidelines (2005/2006). These guidelines have the advantage of being regularly updated and of being based upon a rigorous review of the relevant literature and expert consensus.

### **Health Behaviour in Children and Young People**

A number of key themes have emerged in recent research and government initiatives in relation to the physical health and health behaviour of children and young people in Britain and the USA. These relate partly to the identified major causes of morbidity and mortality in this age group and to what are regarded as 'high-risk' health behaviours.

The major causes of death in the child and adolescent population in the UK and Ireland are accidents and self-harm (Office of National Statistics, Mortality Data 2005). There is however increasing concern about 'high-risk' health behaviours such as poor diet, lack of exercise, obesity, cigarette smoking and poor sexual health ('The health of children and young people', 2004; National Service Framework Children and Young People and Maternity Services' 2004). This is partly because of the impact upon health and quality of life in childhood and adolescence but also because of the longer term consequences of such behaviours and the evidence that persistent smoking in adult life is associated with early initiation of smoking (Thomas et al. 1998) and that obesity/ being overweight in childhood and adolescence are associated with obesity and a range of poor health outcomes in adult life (Office of National Statistics, 2004).

There is unfortunately very little research on the relationship between child and adolescent mental health problems and health behaviour but what research there is does point to an overlapping pattern of risks for emotional distress, suicidality, substance misuse, smoking and early initiation of sexual activity (Resnick et al, 1997) and to the protective effects of family and school-connectedness. To date there has been virtually no published research on the physical health and health behaviour of children and young people referred to CAMHS.

There is a growing literature on interventions aimed at improving the health status and health behaviour of children and young people and a wide range of initiatives

although many of these are based upon examples of good or innovative practice rather than on empirical research evidence. The majority of UK evaluations measure the process of programmes themselves rather than outcomes. In addition much of the existing research evidence comes from the USA and may not be transferable to UK practice. For a comprehensive review of this area see 'The health of children and young people', 2004 and the 'Evidence to inform the National Service Framework for Children and Young People and Maternity services-standard 4 growing Up into Adulthood.' 2005.

To date much of this research has focused upon the general population rather than 'at-risk' populations such as children and young people with mental health problems, young offenders and young people in secure care, 'looked- after' children etc. There has also been little attention paid to the role of CAMHS professionals, although there are examples of good-practice in some in-patient units for children and young people which promote healthy eating and exercise.

## **RECOMMENDATIONS**

- 1. There is a need for research into the relationship between physical and mental health in children and young people and between mental health and health behaviour. Such research should include interventions to improve the physical health and health behaviour of potentially 'at-risk' populations such as children and young people with mental health problems.**
- 2. CAMHS clinicians should consider to what extent they can actively promote more positive physical health and health behaviour. This could include advice and information on health promotion being available within CAMHS settings; ensuring that due regard is paid to the physical health and lifestyle of children and young people referred to CAMHS and that advice on exercise, diet, smoking etc is given where this is appropriate. The latter is especially important for particularly vulnerable young people such as those experiencing severe mental illness, young people in in- patient settings, young offenders who have mental health problems. Services should ensure that there links with and access to services/facilities such as exercise referral schemes, smoking cessation, sexual health services and more general medical services.**
- 3. Staff who work in in-patient settings should ensure that children and young people are provided with good quality healthy food, that there is access to appropriate exercise, that where necessary children and young people can access services usually provided in either primary care or more specialist physical health settings ( including advice on sexual health) and that there are appropriate policies and practices to discourage smoking and in particular the initiation of smoking.**

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## **Section 3 - Examples of Interventions in Physical Health Care**

### **3.1 Psychotropic Prescribing**

**Dr David Osborn and Dr Michael Phelan**

#### **Overview**

Psychotropic medications confer wide ranging benefits to people with mental health problems in the short and long term. They can alleviate suffering, promote recovery and prevent relapse of mental illnesses. Consideration of physical health is an essential component of all prescribing. The potential physical effects of psychotropic agents are wide-ranging and beyond the scope of this report.

This section outlines general principles relating to physical health and psychotropic prescribing. Some specific areas of current concern are highlighted, including comments regarding physical monitoring for atypical antipsychotics (Appendix A).

Specific up-to-date drug information is available elsewhere and is updated more frequently. Recent references and websites are suggested at the end (Appendix B).

#### **Principles of prescribing – benefits and risks**

Prescription of any medication is sometimes associated with risks as well as benefits and this sometimes includes unwanted physical effects. The prescription of any psychotropic agent should be based on the balance of these benefits and risks.

Psychiatrists are familiar with this equation and routinely monitor physical effects of agents such as lithium and typical antipsychotics. The new generation of antipsychotics have shifted focus to a different cluster of side effects including weight gain and metabolic disturbances. Each prescriber has a duty to engage in CPD activity to ensure his/her current knowledge relating to the physical consequences of psychotropics he/she prescribes is up to date.

#### **Physical risks of psychotropic prescribing**

Physical side effects can arise in previously healthy individuals. Pre-existing physical conditions may be worsened by certain psychotropic agents. The chronic nature of some mental illnesses requires long term prescribing. This chronicity may expose people with mental illnesses to a greater risk of developing physical complications. Prescribers should therefore actively monitor for physical side effects of psychotropics in the short and long term.

#### **Prescribing when physical health is compromised: Comorbidity**

High levels of comorbidity between mental illnesses and physical illnesses are well established. This warrants specific screening for physical problems in users of mental health services, before prescribing psychotropic medication.

This demands awareness when choosing agents which have the potential to exacerbate pre-existing physical problems, for instance neurological or cardiac disease. The physical conditions pertinent to the psychiatric specialties are numerous. Examples include:

Extremes of age (e.g. renal and hepatic impairment, neuroleptic sensitivity)  
Learning disability (e.g. propensity to epilepsy).  
Alcohol and substance misuse (e.g. hepatic impairment; blood borne viruses)  
Severe mental illnesses including schizophrenia (e.g. increased coronary heart disease).

### **Pre-prescription physical assessments**

An appropriate assessment of physical health is required before prescribing agents which may precipitate or worsen a condition. This may involve a combination of physical history, relevant examination and investigations (e.g. for epilepsy, Parkinsonism or obesity).

In psychiatric emergencies it may not be safe to delay administration of medication until consent to the physical assessment is obtained. In these situations the minimum effective doses should be used, and vital signs must be monitored carefully subsequent to administration. Consent to physical investigation should be reviewed at regular intervals.

Cautions regarding physical side effects are familiar to most psychiatrists, and especially liaison psychiatrists. Psychotropic medications interact with many biological systems. Specific consideration must be given to the presence of cardiac, respiratory, gastrointestinal, neurological, hepatic and renal disease. Presence of physical illness or risk factors may affect the required intensity of monitoring for adverse effects.

Each practitioner should be aware of specific risks associated with treatments s/he uses regularly and have a broader appreciation of the risk of comorbidity in people with mental health problems.

### **Physical assessments**

Relevant baseline physical information should be obtained before prescribing. This should include:

#### **1. Physical history**

- Current physical symptoms of relevance  
eg symptoms of hypothyroidism, hepatic impairment or diabetes
- Current physical signs including relevant examination  
eg. Obesity or Parkinsonian symptoms
- Past medical history  
eg. Chronic conditions which may affect choice or dose of agent:

Cardiac, hepatic, renal, neurological, gastrointestinal or endocrinological conditions.

- Results of any screening by another practitioner eg Abnormal thyroid function, lipids, glucose or liver function
- Current drug history to include prescribed, over the counter, alternative and illicit substances
- Pregnancy.
- Is a pre-prescription test and counselling required?
- Previous adverse effects from psychotropic medications eg Dystonias, neutropaenia, sexual side effects
- Risk factors for physical illness including family medical history, smoking, obesity, sedentary lifestyle, poor diet.

## **2. Physical Examination**

Examination may not always be necessary, but should be tailored to positive findings from the physical history.

## **3. Investigations**

These will depend on the agent to be prescribed and the physical health of the individual Blood tests. Consider renal, hepatic, haematological and endocrinological (thyroid) baseline measures.

Non-fasting (or fasting if possible) glucose and lipids (including LDL & HDL cholesterol) where relevant. Electrocardiogram, Weight and height. Body Mass Index and/or waist/hip circumference.

## **Information regarding the physical effects of medications**

In non-emergency situations, a prescription should be founded on a collaborative, informed discussion between the doctor/prescriber and the service user. This should include consideration of possible physical adverse effects or the risk of exacerbating existing physical problems.

The discussion requires provision of accurate information in an appropriate form that can be understood by service users and their carers. Such information can facilitate the service user's active participation in monitoring for adverse effects. The information should be proportionate to the risks, and neither exaggerate nor minimise health benefits and side effects.

In some circumstances the service user may not be well enough to contribute meaningfully to decisions about medications. In these cases, prescription will be decided either by the doctor alone or ideally with input from a carer. For the prescriber the overall principle remains one of maximising psychiatric benefits while minimising any risks to physical health posed by medication.

This requires up to date knowledge of the adverse effects of psychotropic medications and their ability to affect established physical health problems.

## Psychotropics requiring specific vigilance

The following psychotropic medications require special attention to physical health over and above awareness of common physical adverse effects. The list is not exhaustive and further references are included in appendix B

### First generation antipsychotics

Movement disorders; QT prolongation; hyperprolactinaemia,

### Second generation atypical antipsychotic agents

Weight gain. Possible dyslipidaemia, hypertriglyceridaemia, impairment of glucose metabolism and diabetes mellitus. Hyperprolactinaemia. QT prolongation.

### Clozapine

Neutropaenia and agranulocytosis. More rarely myocarditis. Monitoring mandatory.

### Sodium valproate:

Weight gain

### Lithium

Risk of toxicity. Renal impairment. Hypothyroidism. Monitoring mandatory.

Weight gain also common.

## Psychotropic prescribing in pregnancy

The following notes indicate the level of vigilance which needs to be followed in prescribing psychotropic medication in pregnancy.

- Women should have a pregnancy test before starting on **Clozapine**.
- **Sodium valproate** should not be used in women of reproductive age unless they are clearly informed of the risks associated with sodium valproate both in the first trimester and during later pregnancy. There should be evidence of effective contraception (not the combined oral contraceptive pill or condoms) and probably should have a negative pregnancy test before starting it. The NICE guidelines on the management of bipolar disorder and on epilepsy do not recommend the use of sodium valproate in pregnancy.
- Other **anticonvulsant mood stabilisers** are also associated with a substantially elevated risk of major congenital malformations, although not as high as sodium valproate. Full documentation of a risk benefit analysis should take place when **lithium** is prescribed and women need to be fully aware of the risks associated with taking lithium during pregnancy.
- There is increasing concern about the safety of **SSRIs** in pregnancy. The Department of Health and the manufacturers advise against the use of Paroxetine in pregnancy but there are concerns emerging about all SSRIs and about Venlafaxine.

Overall, for a wide variety of psychotropic medications, counselling is required in women of reproductive age.

## **Appendix A – Physical health Monitoring and second generation antipsychotics**

Emerging international consensus recommends monitoring body mass index, lipids, and glucose before prescribing atypical antipsychotics. Such agents *may* exacerbate a patients' cardiovascular risk through weight gain or metabolic disturbance. The high rates of coronary heart disease in people with severe mental illnesses warrant risk factor screening in its own right.

### Suggested measurements for those prescribed atypical antipsychotics

BMI/ Waist circumference, Blood Pressure, current and previous smoking status, lipids (including LDL HDL), random or fasting glucose.

### Suggested frequencies for monitoring

Recommended frequencies for monitoring those commencing an atypical antipsychotics vary internationally. The practicalities of the treatment setting (including equipment availability) and frequency of contact will determine appropriate intervals for monitoring.

As a good practice guideline, weight/ waist circumference, (fasting or non-fasting) glucose and lipids including cholesterol, HDL cholesterol, LDL and triglycerides should be monitored at the following time points:

Baseline, 10-16 weeks, six months, then annually.

A baseline ECG is desirable.

### Responsibility for screening

Most practitioners agree that physical health monitoring is best performed in primary care. Local agreements and the treatment setting ( for instance inpatient or community) will determine the best arrangement for physical health monitoring after prescribing. However the prescriber should ensure that physical screening has taken place. Where physical problems are detected (eg obesity), the prescriber should select psychotropic treatments with optimal mental health benefits but minimal effects on the condition (weight gain).

### Acting on abnormal physical findings.

Psychiatrists are medically trained doctors. Some remain highly involved in physical health care throughout their careers and other specialise into areas where physical assessments are performed less frequently. All prescribers must remain competent to detect and minimise physical consequences of prescribed drugs. However not all psychiatrists will feel competent to interpret abnormal tests (such as abnormal glucose measurement) and to manage them. Liaison with colleagues from primary and secondary care is essential when results of physical assessments fall beyond an individual's current level of competence.

## **Appendix B - References and Resources**

There are many guidelines available worldwide. Some are independent and some produced or sponsored by the pharmaceutical industry. Psychiatrists should be aware of benefits and biases intrinsic to reviews sponsored by pharmaceutical industry.

### **Adverse effects of psychotropic medications**

The British National Formulary: <http://bnf.org/bnf/>

British Medical Association and Royal Pharmaceutical Society of Great Britain (2005). British National Formulary 50. London: British Medical Association Books.

The Maudsley 2005-2006 Prescribing Guidelines. Edited by: David Taylor, Carol Paton, Robert Kerwin. London. Taylor and Francis Group Ltd. ISBN: 1841845000.

### **Relative adverse effects and prescribing in problem areas eg cardiovascular disease:**

Bazire S. (2003). Psychotropic Drug Directory. 120. C2.2 p180. Bath: The Bath Press. ISBN 0-9544839-60

### **Antipsychotic monitoring**

Marder, S.R., Essock S.M., Miller A.L., et al. (2004) Physical Health Monitoring of Patients With Schizophrenia. American Journal of Psychiatry. 161:1334-1349.

Anonymous. (2004). Which atypical antipsychotic for schizophrenia? Drug and Therapeutics Bulletin. 42 (8) 57-62.

### **Groups**

Royal College of Psychiatrists psychopharmacology Special Interest Group.  
<http://www.rcpsych.ac.uk/college/sig/phar/index.asp>

United Kingdom Psychiatric Pharmacy Group  
<http://www.ukppg.org.uk/>

## Section 3 - Examples of Interventions in Physical Health Care

### 3.2 Promoting healthy lifestyles in psychiatric services

Dr Irene Cormac

#### Introduction

Health and longevity are influenced by genetics, socio-economic status and circumstances, the presence of disease or disability, lifestyle and access to health care (The Surgeon General, 2006). The main modifiable causes of morbidity and premature mortality are inactivity, smoking tobacco, poor diet, and obesity, addiction to alcohol and illicit drugs, and sexual health risks (Department of Health, 2004a). The presence of these factors increases the likelihood of developing physical conditions such as cardiovascular and respiratory disease, diabetes mellitus, hypertension hypercholesterolaemia, the metabolic syndrome and some forms of cancer. These risks combine with age to shorten and reduce the quality of life.

The World Health Organization (WHO) identified that health promotion works by enabling people to establish control over their physical health and involves creating health policies, providing health promotion and health education to people (WHO, 2005). They recommend that health promotion, disease prevention and health interventions should be tailored to each person's needs according to their gender, age, socio-economic circumstances, as well as their physical and mental health.

#### Physical health of psychiatric patients

The poor physical health of people in psychiatric services cannot be explained solely by the presence of a mental disorder or disability. Lifestyle factors and preventable health risk factors are important too (Connolly *et al*, 2005). Psychiatric patients are known to have high rates of obesity and smoking (Brown *et al*, 1999, Cormac *et al*, 2005a). People with schizophrenia in the community have been found to have a poor diet, with less than the recommended intake of fruit and vegetables, and high risks of cardiovascular disease (McCreadie *et al*, 2003).

Health improvement can be achieved through exercise, smoking cessation, a healthy diet, weight management, together with the detection, treatment and prevention of co-morbid physical disorders. This paper applies mainly to the physical health of adults including older people. More information on ways to improve the physical health of children and young people is available in the white paper 'Choosing health' (Department of Health, 2004a), and in the documents 'Choosing Activity' (Department of Health, 2005a) and 'Choosing a better diet' (Department of Health, 2005b). Tobacco smoking is a major cause of premature mortality and morbidity and is addressed elsewhere in this report.

#### Health promotion

In people with mental disorders or disabilities, physical health may be a low priority, motivation to change may be low or absent, and patients may have more difficulty in gaining access to physical health care. Mental health professionals can promote physical well-being by the following process which also applies to the

general population; identifying the physical health needs of the patient population, raising awareness of physical health issues, and assisting patients to adopt ways to improve their physical health (Warrell *et al*, 2005).

As in the general population, a person may choose not to have a healthy lifestyle and to ignore advice about ways to improve their health. However, patients receiving psychiatric care should have access to health promotion information on topics such as; men's health, women's health, oral health, sexual health, ageing, infectious diseases, looking after your heart, healthy eating/cooking, weight management, alcohol and addictions.

A multi-professional approach should be taken to delivering health promotion by involving members of the clinical team. Health promotion can be provided in various settings such as daycare, rehabilitation and in-patient facilities. Psychiatric facilities should comply with relevant smoking policies and in-patient services should provide a healthy diet, access to exercise, and health education, which is relevant and understandable.

General Practitioners (GPs) and nurse specialists should be able to advise patients and staff on the optimum management of medical conditions such as asthma and diabetes. Health information is also available at NHS Direct; on the telephone, Internet and digital television. NHS Direct links with health approved lifestyle programmes, both local and national and is available 24 hours per day without charge. Psychiatric patients may be at a disadvantage in arranging physical healthcare if they do not have access to a telephone or Internet facilities.

NIMHE has published a health promotion guide for people with mental health problems containing information and advice on 10 health promotion topics (NIMHE, 2004a). The Health Events calendar (Department of Health, 2006) has a list of health promotion events and awareness days which can be used to inform patients, carers and staff, about physical health.

### ***Exercise***

The Chief Medical Officer (Department of Health, 2004b) recommends for general health that children should exercise for 60 minutes of exercise daily and:

**'Adults should exercise for a total of 30 minutes of at least moderate intensity physical activity a day on at least 5 or more days of the week.'**

For adults, shorter '10 minute' periods of exercise interspersed throughout the day have been shown to be as beneficial as longer periods of exercise. Physical activity does not have to be vigorous to be beneficial. Walking is one of the safest forms of exercise for those who are obese or have health risk factors and for older people.

### ***Benefits of physical exercise***

40-50% reduction in the risk of cancer

33-50% reduction in the risk of developing diabetes

27% reduction in the risk of strokes

Reduction in blood pressure of between 3.8 -2.6 mm Hg

Reduction in the risk of coronary heart disease  
Reduction in mortality and morbidity associated with obesity  
Increase in energy expenditure and reduction in weight gain  
Improvement in the chance of long-term success with weight loss  
'Improvement in psychological well-being'

The benefits of taking exercise have to be weighed against the potential risks of physical exertion. If there are concerns about a person's physical health, it is best to seek the advice of a GP before exercising. Patients can be referred through their GP to an exercise professional with a 'GP Referral' qualification or other relevant qualifications, to undertake a fitness assessment, before creating an exercise plan to suit the patient's needs and abilities.

Exercise should be varied and delivered at the appropriate level for the patient's standard of fitness and can increase a person's flexibility, strength and aerobic capacity. Aerobic exercises, such as swimming, walking and using cardiovascular gym equipment can result in weight loss of about 0.5 – 1 kg per month (Department of Health, 2004b). However, more effective weight loss can be best achieved by combining aerobic exercise and a calorie-restricted diet. During dieting, exercise reduces the loss of lean body tissue and tends to preserve weight loss for an extended period of time.

Physical activity should be promoted in those admitted to in-patient psychiatric services. Opportunities for exercise should be made available for patients to exercise for at least 30 minutes at least 5 times per week, bearing in mind their mental health needs. A range of exercise options should be provided to suit the needs of the patient population. Whenever possible, outpatient psychiatric services should promote fitness and create exercise opportunities for their patients.

### ***Diet and nutrition***

Good nutrition is essential for good health. Malnutrition can occur at any age and result from deficiencies in macronutrients and/or micronutrients. Patients should ideally consume a diet with the characteristics outlined below but this may not be possible or what they wish to do. In the community, patients with psychiatric disorders and disabilities may have a limited budget or pension with which to buy food and have basic cooking skills.

The catering department in in-patient psychiatric facilities should provide a diet that meets the estimated average requirement for food energy and the appropriate intake of micronutrients. The menu should contain healthy options, be varied and meet the cultural, religious, social and health needs of patients (Department of Health, 2000).

Patients may need advice and support to make healthy choices and to control portion size. The elderly and those with a physical disability may need assistance with feeding. Dysphagia is prevalent in psychiatric patients and may require treatment by Speech and language therapists and a texture modified diet.

### ***A healthy diet***

5 portions of fruit or vegetables per day	
Dietary fibre	> 18 g per day
Saturated fat	< 11 % of food energy
Reducing total fat	< 35 % of food energy
Sugar added	< 11 % of food energy
Salt	< 6 g per day

### **Choosing a better diet: a food and health action plan (Department of Health, 2005b)**

The *Food Standards Agency* provides information on healthy diets, with tips for eating well ([www.eatwell.gov.uk/healthydiet/8tips](http://www.eatwell.gov.uk/healthydiet/8tips)) and the 'balance of good health' plate (Food Standards Agency, 2001). The diet of children should be sufficient to meet their needs for growth and development. Older adults tend to require fewer calories and will benefit from good nutrition to prevent diabetes, coronary heart disease and the prevention of skin damage and fractures

### ***Weight management***

There is a worldwide obesity epidemic in adults and children. In England, 24% of men and women are now obese. Obesity is more prevalent in the lower socio-economic groups and causes premature death and ill health. It is caused by excess dietary consumption, inactivity and by certain forms of psychotropic medication with side effects of weight gain. Jung (1997) highlighted the benefits of losing weight intentionally. By losing 10 kg in weight, there can be a 20% fall in premature mortality, a 30% reduction in deaths due to diabetes, a 40-50% reduction in cancers due to obesity and up to a 30% fall in serum triglycerides (ibid).

NICE (2006) and the National Heart Forum (2007) have produced guidance on the treatment of obesity and prevention of weight gain. Their recommendations include dietary modification, reduction in calorie consumption and regular exercise. Advice is given for both adults and children. Health professionals play a key role in helping patients to obtain dietary advice and weight management interventions. At Rampton Hospital, a successful weight management programme has been developed especially for patients with mental disorders (Cormac et al, 2005 b).

### ***Infectious diseases and sexual health***

In the general population in the UK, infectious diseases (such as hepatitis and tuberculosis) and sexually transmitted diseases (for example syphilis, human immunodeficiency virus and clamidyia) cause a wide range of illnesses and are a significant cause of long term and serious disability ([www.dh.gov.uk/Policy](http://www.dh.gov.uk/Policy)). Psychiatric patients should have the opportunity to receive suitable advice and immunization as needed.

Mental health professionals should not ignore their patients' sexual health and fertility. The sexual side effects of psychotropic medication should be explained to patients. Lactation, gynaecomastia, amenorrhoea and impotence are distressing side effects of certain forms of psychotropic medication. Psychiatrists and mental

health professionals must be aware of the teratogenic risks of certain forms of psychotropic medication and the possible risk of transmission of medication to breast milk.

### ***Addictions and alcohol misuse***

The impact of alcohol and substance misuse not only affects the physical health and well being of a person but also third parties affected by the drinker's or user's behaviour (Royal College of Physicians, 2004). The report also highlights the benefits of early detection of hazardous drinking to reduce the risk of significant harm to health. The Healthcare Commission (2006) has set a target to increase participation of problem drug users in drug treatment programmes by 100% by 2008, from the 1998 baseline. Participation in a drug treatment programme, for 12 weeks or more, reduces drug use, morbidity and mortality. Needle sharing schemes are also an effective way to reduce harm. Psychiatrists working in addiction services require expertise in the detection and treatment of physical health problems associated with addictions.

### **Conclusion**

There are many ways in which psychiatrists and mental health teams can promote a healthy lifestyle in their patients by providing information and wherever possible, providing the opportunities to tackle the above modifiable health risk factors.

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## **Appendix 1**

The Royal College of Paediatrics and Child Health and National Obesity Forum have produced a leaflet entitled: Approach to Weight Management in Children and Adolescents (2-16 years) in Primary Care. Authors: Penny Gibson, Laurel Edmunds, David W Haslam and Elizabeth Poskitt.

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I would like to thank Dr Katherine Naylor, Ashworth Hospital, for her contribution to health promotion on the Scoping Group.

## **Section 3 - Examples of Interventions in Physical Health Care**

### **3.3 Action plan to improve the physical health of Patients in psychiatric services**

**Dr Irene Cormac**

#### **1. Identify physical health needs**

The physical health needs of people with a mental disorder or disability should be identified and quantified.

People with mental disorders or disabilities should be identified in the community and in-patients so that an attempt can be made to improve their physical health. This could be done using computer searches of primary care records for the diagnostic categories of mental disorders and disabilities, by searching for various forms of psychotropic medication, and by liaison between primary care, mental health professionals and carers, when appropriate.

The physical health needs of individuals with psychiatric disorders and disabilities, whether in primary care or in psychiatric services should be assessed and addressed at least annually by appropriately trained health professionals, which may include psychiatrists. A routine functional enquiry, annual physical examination and investigation should be undertaken on an annual basis.

#### **2. Primary healthcare services**

All patients with mental health disorders or disabilities should have the opportunity to register with and receive care from a general practitioner and a dentist.

Barriers to gaining access to primary care should be identified and addressed.

Support should be given to patients who have difficulty in the practicalities of making appointments or visiting the health centre/surgery.

Homeless patients should be offered a physical health check and assistance with gaining access to physical healthcare.

#### **3. Access to diagnosis, treatment and monitoring of physical health**

Health professionals should enable people with mental disorders and disabilities to have the same standard of physical health care as other citizens.

Health professionals should develop and promote positive attitudes towards people with disabilities (see Leaflet for health professionals: 'You can make a difference' booklet ([www.drc-gb.org/makeadifference](http://www.drc-gb.org/makeadifference).)

Psychiatrists and mental health professionals should advocate that their patients should receive the same standard of treatment as other citizens.

#### **4. Health promotion**

Patients should be offered information and advice on health promotion, which is relevant and easily understood.

Patients should have access to health promotion material at the beginning of their contact with psychiatric services and at regular intervals thereafter.

Advice and information should be provided on safe sexual behaviour, avoidance of infectious diseases and accidents, risks of smoking tobacco and addictions, Information should be provided on how to access local healthcare services.

Patients should be empowered to identify and address their own health priorities and health choices e.g. by using health action plans.

Health professionals should provide health promotion.

#### **5. Choosing a healthy lifestyle**

Patients should have the same opportunities as other citizens to lead a healthy lifestyle, as far as practicable.

Exercise opportunities should be available for all patients to have at least 30 minutes of moderate exercise, at least 5 times per week.

Patients should be advised about the benefits of eating a healthy diet with at least 5 portions of fruit or vegetables per day and 2 portions of oily fish at least twice a week. They should be advised about reducing the content of fat, sugar and salt in the diet to current recommended levels.

In institutional care, a healthy and varied diet should be provided sufficient to meet the patients' nutritional requirements and other needs.

Advice should be given on the safe limits of consumption of alcohol.

Wherever possible, services should be available to assist with the withdrawal from addictions to drugs, smoking and alcohol.

Patients should be provided with information on the potential side effects of the psychotropic medication prescribed. Appropriate monitoring and preventative measures should be provided to minimise or limit the potential side effects.

Quit or cut down smoking tobacco.

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## Section 3 - Examples of Interventions in Physical Health Care

### 3.4 Developing a Smokefree NHS - smokefree grounds and buildings

Dr Rosalind Ramsay

National guidance

- *Smoking Kills* (White Paper on tobacco, 1998)
- *Where do we go from here? Tobacco Control Policies within Psychiatric and Long-stay Units. Guidance on Development and Implementation* (HDA, 2001)
- *Case for a Completely Smokefree NHS in England* (PharmacyHealthLink and HDA, 2004), a briefing paper giving the case for a smokefree policy across the NHS
- *Guidance for Smokefree Hospital Trusts* (HDA, 2005) which sets out the steps for NHS Trusts to become smokefree
- *Choosing Health: Making Healthier Choices Easier* (White Paper, November 2004) which states that the NHS will be smokefree by the end of 2006
- *Consultation on the Smokefree Elements of the Health Improvement and Protection Bill* (DH, 2005) following publication of *Choosing Health*

#### Rationale

##### Duty of care to smokers

There are the health risks of smoking which is the single greatest cause of preventable illness and premature death in the UK. Half of all smokers die prematurely of a smoking related ailment (approximately 120,000 deaths a year). The decrease in life expectancy for regular smokers under 35 who do not subsequently quit is approximately 8 years. The annual cost to the NHS of treating patients with smoking related disease is £1,500 million.

*Smoking and Patients with Mental Health Problems* (HDA, 2004) reported that smoking rates are much higher among people with mental health problems than in the general population. A national survey of psychiatric morbidity found that in people with neurotic disorders the rate is double that in the general population and around two thirds of those with a psychotic disorder smoke compared with 29% of the general population. More people with a psychotic disorder were heavy smokers than in the general population. In 1996 Meltzer and colleagues found rates of between 70 and 74% for residents in psychiatric institutions. Over 50% of these smokers wanted to stop smoking.

A survey of staff in a psychiatric unit showed that 22% were smokers (response rate 41%) (Stubbs et al, 2004).

It is estimated that 4 million smokers a year attempt to quit, but only 3-6% of these (1-2% of all smokers) succeed.

### **Passive smoking**

Tobacco smoke kills more than 1000 non-smokers a year – ‘in those with long-term exposure, the increased risk of lung cancer is in the order of 20-30%’ (*Report of the Scientific Committee on Tobacco and Health, 1998*); and there is an increased risk of ischaemic heart disease.

### **Litigation risks**

Employers have a duty under the Health and Safety at Work Act 1974 to provide and maintain a ‘safe working environment’, but there is no specific legislation in the UK or established case law. Exposing staff to tobacco smoke pollution in restricted smoking areas such as smoking rooms is a health hazard.

### **Support for smokers to quit**

Completely smokefree policies at work reduce the absolute prevalence of smoking by about 4%, and reduce the number of cigarettes smoked by those who continue to smoke.

Effective support to stop smoking is available through the NHS. Smoking cessation services can quadruple a smoker’s chance of successful quitting by using specialist support in combination with NRT/bupropion endorsed by NICE in 2002 while those who want to smoke can use NRT to control withdrawal symptoms.

### **Use of resources and fire risk**

Smokers take more time off sick, and also time for cigarette breaks. There are costs attached to the cleaning, ventilation and maintenance of smoking rooms which a smokefree policy reduces, and there is a reduced fire risk.

### **PPI issues**

The public favour smokefree public places in general, particularly in hospitals which 84% want to be smokefree (*Attitudes to smoking in public* (unpublished), MORI and Smokefree London, 2003). A patient centred service demands a smokefree service as the majority of NHS users are non-smokers.

### **Use in mental health services**

Trusts which have introduced smokefree policies have found few exceptions to the policy need to be made. In all cases where exceptions are made there should be demonstrable evidence that smoking cessation has been considered as part of the patient’s care plan in conjunction with the patient and carer. If exceptions are made there should be efforts to minimise staff exposure to smoke, meaning generally that smoking is only permitted outside, where staff and other patients are not in close proximity to the smoker.

## **Example of a case study: Norwich Mental Health Trust**

This became smokefree on 1.12.03. Smoking is generally not permitted on the site – although there may be some patient exceptions. Early experience shows that the level of smoking around the hospital sites has reduced, and the vast majority of staff accept the policy which has prompted staff to revise clinical protocols on the effects of smoking/quitting on medication levels.

In the US hospitalised patients have generally been required to abstain from smoking since a national policy banning smoking in all hospitals including psychiatric units was introduced in 1992. Some units though continue to provide patients with smoking passes, which may seem like a reward for good behaviour. Increasing numbers of prisons in the US are also smokefree. Most experience so far shows that feared difficulties around more assaults on staff have not materialised when facilities became smokefree (Lincoln et al, 2005).

### **Smoking cessation work**

Why do people with mental health problems smoke more?

*Smoking and Patients with Mental Health Problems* (HDA, 2004) and the Mental Health Act Commission *In Place of Fear? Eleventh Biennial Report 2003-2005* (2005) suggest there are a number of factors involved. In some cases people use nicotine through smoking as self-medication as it may seem to have some antidepressant and anxiolytic effects, although longer term it may exacerbate symptoms. It may seem to alleviate some of the negative symptoms of schizophrenia. It may also alleviate some of the EPS of anti-psychotic medication while increasing rates of akathisia and tardive dyskinesia. People with a mental disorder may find it harder to manage nicotine withdrawal symptoms of anxiety, depression and agitation.

Other issues include lax smoking policies with smoking behaviour being reinforced through the environment and patients' boredom. Smoking may also be a way of maintaining some control over their lives for detained patients. Smoking cessation strategies need to take account of concurrent cannabis use. In general health professionals have not addressed smoking cessation in patients with a mental illness and these patients receive little support when they want to quit.

### **Interactions between nicotine and psychotropic medication**

Cigarette smoke induces the enzyme CYP1A2, which is responsible for the metabolism of a number of psychotropic drugs including some anti-psychotic and some antidepressant drugs. For any of these drugs if a patient stops smoking, levels may rise and careful monitoring is needed for possible toxicity. This is particularly important with clozapine. Conversely if a patient has stopped and then starts to smoke previously therapeutic plasma levels of the drug may fall due to the enzyme induction. There may also be a decrease in smoking associated with clozapine.

### **Smoking cessation and smoking reduction in mental illness**

There is a little research in this area (*Smoking and Patients with Mental Health Problems* HDA, 2004). Specialised group therapy programmes and NRT may be

effective in people with schizophrenia. An alternative approach is harm minimisation, using nicotine patches while encouraging a reduction in the number of cigarettes smoked. Depressive and anxiety symptoms may get worse among people with a history of these disorders but otherwise there is not an exacerbation of mental health problems during attempts to stop smoking.

The Cochrane Tobacco Addiction Review group identifies and summarises the evidence for interventions to reduce and prevent tobacco use. It has found

- Advice from doctors, structured interventions from nurses and individual and group counselling are effective interventions
- Generic self-help materials are no better than brief advice but more effective than doing nothing; personalised materials are more effective than standard materials
- All forms of NRT are effective
- The antidepressants bupropion and nortriptyline increased quit rates in a small number of trials; the usefulness of the anti-hypertensive drug clonidine is limited by side effects
- Anxiolytics and lobeline are ineffective
- The effectiveness of aversion therapy, mecamlamine, acupuncture, hypnotherapy and exercise is uncertain

West et al (2000) published smoking cessation guidelines for health professionals which make recommendations for primary health care teams and hospital and community trusts as well as specialist smoking cessation clinics. The recommendations are graded according to the strength of the evidence.

Recent guidance has been published by NICE in Public Health Intervention Guidance 1 (2006) *Brief Interventions and Referral for Smoking Cessation in Primary Care and Other Settings* which includes mental health trusts. There is already guidance on the use of NRT and bupropion (Technology appraisal 39, *Guidance on the use of nicotine replacement therapy (NRT) and bupropion for smoking cessation*, 2002) while guidance on smoking cessation is currently in development by NICE.

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