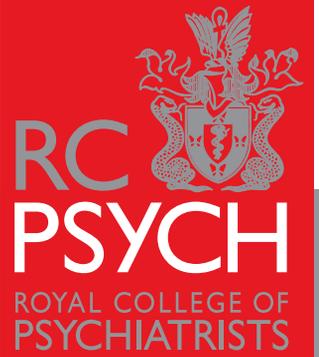


OP67



Physical health in mental health

Final report of a scoping group

January 2009

OCCASIONAL PAPER

Physical health in mental health

Final report of a scoping group

Occasional Paper OP67
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Royal College of Psychiatrists
London

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- Dr E. Palazidou and Dr J. Lynch, Psychopharmacology Special Interest Group, Royal College of Psychiatrists
- Dr E. Gilvarry and J. Marshall, Faculty of Addictions, Royal College of Psychiatrists
- Professor A. Howe, Royal College of General Practitioners
- Dr T. Berney, Child and Adolescent Psychiatrist
- All attendees of the Scoping Group Workshop held during the 2007 Annual Meeting of the Royal College of Psychiatrists in Edinburgh

ADDITIONAL MATERIAL AND/OR COMMENTS WERE CONTRIBUTED BY

- Secretariat, Forensic Psychiatry Faculty
- Secretariat, Perinatal Psychiatry Section
- Secretariat, Special Committee on Ethnic Issues
- Secretariat, General and Community Psychiatry Faculty
- Secretariat, Liaison Psychiatry Faculty (advice)
- Secretariat, Psychotherapy Faculty (advice)
- Women in Psychiatry Special Interest Group
- Psychopharmacology Special Interest Group
- Dr M. Launer (results of a critical incident inquiry)
- Drs G. Martin, D. Haslam and M. Ashworth and Professor T. Kendrick (the approach of the Royal College of General Practitioners to this area)
- Dr D. Yeomans, Wellbeing Support Project (account of group work)
- Disability Rights Commission Investigation into Health Care Inequalities in Mental Health and Learning Disabilities Health Care (Professor G. O'Brien gave evidence to the inquiry – the Commission gave the Scoping Group sight of its preliminary report)

ACKNOWLEDGEMENTS

The Scoping Group wishes to acknowledge the past-President of the College, Mike Shooter, who commissioned the work of our group, and our current President, Sheila Hollins, who has given invaluable help and guidance.

Part I

The Scoping Group, key
recommendations and overview
of physical health in mental
healthcare

1 Introduction and terms of reference

Gregory O'Brien

- General health morbidity among people with mental health problems is high.
- There is a need for good-quality general healthcare 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 healthcare, working in partnership and collaboration with primary healthcare and other specialist colleagues.

There is a growing body of evidence that many psychiatrists lack the skills required to provide for the general healthcare of people with mental health problems. This situation may have arisen for good reason – psychiatrists have sought to specialise in mental health matters, regarding physical healthcare as the province of other clinicians. However, as medical practitioners, psychiatrists clearly have a role to play in the management of the general health problems of people with mental health problems. This entails an 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.

OVERALL AIM

The overall aim of the Scoping Group was to explore a range of issues concerning the general health of people with mental health problems, with a view to making recommendations to the Council of the Royal College of Psychiatrists on matters concerning clinical practice, training and the identification of other priorities in physical healthcare.

CONDUCT OF THE SCOPING GROUP

The Scoping Group set out to:

- review a body of published and unpublished evidence, on such themes as it regarded relevant to the overall aim
- select certain high-profile themes, to be the subject of a series of meetings and discussions (see overleaf)
- consult widely within the College and with other authoritative and professional bodies, especially with clinicians who play key roles in the general healthcare of people with mental health problems

- invite other clinicians to participate in its discussions, as appropriate to the subject
- involve patient and patient-representative advocacy bodies in its work
- adopt a flexible approach to the subject matter for inclusion
- complete its work over the course of 1 year.

OUTPUT OF THE SCOPING GROUP

The Scoping Group will identify areas of clinical practice in which there is need for new publications such as clinical guidelines or other review material. These publications may be produced by the group or, more likely, the group might highlight areas of need, especially in terms of continuing professional development (CPD) and collaborative work on interdisciplinary protocols in healthcare and screening.

SUBJECT MATTER FOR CONSULTATIVE MEETINGS OF THE SCOPING GROUP

- Psychotropic medication and general health
- Lifespan perspectives on general health and mental health
- Lifestyle issues – alcohol and recreational drug use, smoking and infectious diseases such as HIV
- Primary care interface issues and general health screening
- Other issues such as may arise over the course of the Scoping Group's year.

An earlier College Working Party convened to explore the related issue of 'medical cover' for patients with mental health problems, made the following suggestions:

- 1 Patients of mental health services are entitled to expect emergency medical care when necessary, and continuity of medical care for as long as necessary.
- 2 Service providers are responsible for ensuring that an adequate level of competent medical cover is available. Doctors are responsible for maintaining the standards of patient care set out by the General Medical Council.
- 3 Primary medical responsibility for patients in the community, including patients who have been discharged from hospital, lies with the patient's general practitioner. Primary medical responsibility for hospital in-patients lies with the consultant.
- 4 Patients have an equal right to be admitted to a medical, surgical (or any other) ward if they are in-patients in psychiatric units or referred from the community by their general practitioner.'

KEY RECOMMENDATIONS: OBJECTIVES AND ACTIONS

CONTINUING PROFESSIONAL DEVELOPMENT

OBJECTIVE

That psychiatrists should be up to date on key issues concerning physical healthcare in mental health.

ACTIONS

- The College journal *Advances in Psychiatric Treatment* should continue and extend its programme of articles on physical health in mental health.
- A book to be prepared (based in part on *Advances in Psychiatric Treatment* articles) on this theme.
- The College website could be used to publish resources submitted by members on physical health matters such as audits, screening tools and patient information leaflets on physical health.

ROLES AND RESPONSIBILITIES OF THE PSYCHIATRIST/MODERN WAYS OF WORKING

OBJECTIVE

That psychiatrists should be aware of the extent of their own responsibilities in physical healthcare, and those of other physicians, especially general practitioners.

ACTIONS

- The College to publish sample protocols of physical healthcare in mental health practice.
- Such protocols to be specific for the psychiatric specialties (child, forensic in-patient, etc.).
- Such protocols should be shared/agreed with other medical specialists and other clinical disciplines: this requires contact with other medical Royal Colleges and the Academy of Medical Royal Colleges.

OBJECTIVE

That any prescribing physician, including the psychiatrist, has key responsibilities concerning the physical effects of medication, and that these include clarity regarding responsibility for physical health monitoring in long-term therapy.

ACTIONS

- Protocols and intercollegiate interdisciplinary agreements (above) need to take special note of physical effects of prescribed medication and physical health monitoring.

- The syllabus for the College's Membership examinations (the MRCPsych) to include physical health monitoring in psychiatric practice, in addition to knowledge of the side-effects of prescribed medication.

COMPETENCIES

OBJECTIVE

That psychiatrists should be competent in physical healthcare as it affects the physical health of their patients – with particular reference to their own patient group (e.g. child/old age/long-term secure care).

ACTIONS

- Core competencies in psychiatry should include physical healthcare monitoring skills, as applied to the respective psychiatric specialties.
- Postgraduate Medical Education and Training Board (PMETB) specialist training scheme inspection visits should consider whether services have sufficient resources for physical healthcare monitoring, and whether required training is taking place.
- The College should consider the creation of an accreditation service, to approve the facilities required in services to support physical healthcare monitoring in mental health practice; this should be analogous to the Electroconvulsive Therapy Accreditation Service (ECTAS).

CONCLUSIONS

- The Scoping Group's report should be a brief account of the work of the group, expanding on these key recommendations, including a full account of contributions and sample protocols for physical healthcare in the psychiatric specialties.
- The electronic files submitted to the Scoping Group, and the PowerPoint files prepared by the group for its meetings and presentations, should be made available on the College website, appropriately indexed and signposted.
- The members of the Scoping Group are committed to contributing to any educational material that might follow, especially articles for *Advances in Psychiatric Treatment*, and to a handbook on physical healthcare in mental health.
- Implementation of these recommendations will entail consultation/consideration with the Chief Examiner, Dean, Faculty Committees and Specialty Advisory Committees of the Royal College of Psychiatrists, and with PMETB, other medical Royal Colleges, the Academy of Medical Royal Colleges and other professional bodies.
- In view of the extent of these recommendations, the Scoping Group considers that a concerted College campaign on physical healthcare in mental health is now required, with the theme 'Healthy Bodies for Healthy Minds'.

2 Physical health of people with mental disorder and disabilities

Irene Cormac

People with mental disorders and disabilities have a higher risk of poor physical health and premature mortality than the general population (Phelan *et al*, 2001). Ten years ago, a meta-analysis of 27 studies showed 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 disorder (Harris & Barraclough, 1998).

In schizophrenia, standardised mortality ratios are increased 3–4 times compared with 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 metabolic syndrome for those with schizophrenia is 2–4 times greater than for 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 intellectual disability (commonly known as learning disability in UK health services) (Hollins *et al*, 1998; Lyndsey, 2002; Ouellette-Kuntz *et al*, 2004; Disability Rights Commission, 2006). In the Netherlands, one study reported 2.5 times more physical health problems in those with intellectual disability than in the general population (van Shrojenstein Lantman-de Valk *et al*, 2000).

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. A study in the USA found 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).

THE ROLE OF THE PSYCHIATRIST

As doctors, psychiatrists have a responsibility to provide their patients with good standards of practice and care (General Medical Council, 2001). 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, 2004), 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' (p. 15).

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 mentioned 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.

The level and range of expertise in physical healthcare that 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 have schizophrenia and are living in a long-stay institution.

In many psychiatric in-patient services, psychiatrists continue to provide routine and emergency physical healthcare. 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). High rates of physical comorbidity were found in a population of long-stay psychiatric patients, and recommendations were made to provide a primary healthcare service to meet their health needs (Cormac *et al*, 2005).

PRIMARY HEALTHCARE

Primary healthcare services deliver acute medical care, management of chronic disease, 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 general practitioners (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 in the community recommends that active links be made between primary care services and psychiatric services (National Institute for Mental Health in England & Mentality, 2004). It suggests 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 and searching, for example, by diagnosis, medication and history of contact with mental health services. It also outlines the need for regular and appropriate physical health checks for patients in psychiatric services. A training package is available for GP educators on the physical healthcare of psychiatric patients (Cohen & Hove, 2001). People with intellectual disability (commonly known as learning disability in UK healthcare services) should have a health action plan to facilitate appropriate physical healthcare (Department of Health, 2002).

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

OTHER HEALTH SERVICES

Comprehensive physical healthcare 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 helping 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 healthcare as other citizens.

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3 Special considerations

Gregory O'Brien

MINORITY ETHNIC GROUPS

Psychiatrists should be aware that, as is the case with mental health, there are marked ethnic differentials in the incidence of physical illness as well as in access to and use of health services. The Fourth National Survey of Ethnic Minorities (Berthoud *et al*, 1997) found that people from Black and minority ethnic (BME) groups were consistently more likely to report very poor health and registered disability. Facilities developed to support physical healthcare monitoring in mental health practice should be sensitive to the needs of ethnic minorities.

WOMEN'S HEALTH

INITIAL PHYSICAL ASSESSMENT

All women of reproductive age should be offered a pregnancy test on admission.

A gynaecological and obstetric history is recommended to ensure that women's reproductive health is assessed. Often documentation of medical history excludes a reproductive history. Areas for consideration include the following:

- past pregnancies, uncompleted pregnancies
- menstrual irregularity or amenorrhoea and risk of osteoporosis as a result
- history of unprotected intercourse or sexual assault prior to admission
- use of contraception and pregnancy plans
- psychosexual history.

HEALTH PROMOTION

- Health promotion should include facilitating women's access to national screening programmes, including smear tests and mammograms for women over 50 years of age.
- Health information should be available on issues including the menopause and symptoms facing women in later life.

- It is important that staff be made aware of local care pathways and how to access local primary healthcare services.
- The physical health needs of women with eating disorders require careful attention in clinical practice.

SPIRITUALITY AND HEALTH

- For many people, including psychiatric in-patients, adherence to personal spirituality and faith is an integral element of general health: commitment to a religious faith or other personal spirituality can be an important contributor to positive health.
- Certain aspects of religious adherence – notably diet, fasting, pilgrimage and other spiritual exercises – can, if carried out in their more committed forms, have implications for metabolic balance and general health.

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Part II

Examples of physical standards in four services

4 Physical health standards: the West London Mental Health Trust

Michael Phelan

INITIAL PHYSICAL ASSESSMENT OF IN-PATIENTS

PHYSICAL EXAMINATION

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

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
 - review of all current medication
 - health promotion history (including smoking, diet and 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 the patient's notes.

APPROPRIATE MEDICAL EQUIPMENT AVAILABLE ON WARDS (SEE APPENDIX)

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

ON-GOING PHYSICAL HEALTHCARE OF IN-PATIENTS

- Patients' weight and blood pressure should be 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, a dietician, physiotherapy, sexual healthcare and an optician.

MANAGEMENT OF LONG-TERM PHYSICAL ILLNESS OF IN-PATIENTS

- 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 general practitioner (GP) or hospital specialist at least every 6 months.

HEALTH PROMOTION FOR IN-PATIENTS

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

ENVIRONMENT FOR IN-PATIENTS

- 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 is mandatory.
- Access to appropriate, clean washing and toilet facilities should be maintained at all times.

EMERGENCY CARE FOR IN-PATIENTS

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

COMMUNITY PHYSICAL HEALTH STANDARDS (ENHANCED CPA)

- Discharge summaries should include a section on physical health.
- Care programme approach (CPA) care coordinators should liaise with patients' GPs every year to confirm that an 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

Recommended medical equipment for psychiatric wards (Garden, 2005)

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

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5 Physical health standards: psychiatry of intellectual disability

Glyn Jones

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

Despite an extensive evidence base, the healthcare needs of people with intellectual 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 intellectual disability are also less likely to access generic health promotion initiatives (Beange *et al*, 1995; Lennox & Kerr, 1997; Webb & Rogers, 1999) and do not access primary care services at a level commensurate with their physical needs (Howells, 1986; Wilson & Haire, 1990; Whitfield *et al*, 1996; Lennox & Kerr, 1997). 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 intellectual 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 healthcare needs, there are concerns that people with intellectual disability are being unnecessarily exposed to unpleasant and potentially harmful medication side-effects (Ahmed *et al*, 2000).

The healthcare system in the UK 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, whose healthcare 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 intellectual disability are not a homogeneous group and that personal characteristics must be considered when offering health services. For example, patients with mild intellectual disability will have difficulty negotiating systems that assume competence in areas such as literacy.

Even if the individual and/or carers seek assistance from primary healthcare 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 healthcare professionals are not trained to work with people with intellectual disability and are often unaware of the range of their healthcare needs (Howells, 1986; Lennox & Kerr, 1997; Melville *et al*, 2005). Surveys have shown that many general practitioners (GPs) lack confidence in treating people with intellectual disability (Stein, 2000) and are unsure about legal issues such as capacity to consent to medical treatment (Minihan & Dean, 1990). People with intellectual disability may need longer or additional consultations (Chambers *et al*, 1998) and consideration must be given to environmental stressors as well as examination difficulties, including behaviour that is, or is perceived to be, challenging (Minihan & Dean, 1990; Lennox *et al*, 1997). It is also important to obtain consistent information from appropriate informants, as high staff turnover in residential services can mean that carers with inadequate knowledge accompany 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.

ADDRESSING HEALTHCARE DEFICITS

Various models have been suggested for addressing 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 seems that carrying out such checks on an opportunistic basis is ineffective even if they are backed up by prompts and educational aids such as information leaflets (Jones & Kerr, 1997). Clinical studies have confirmed the need for systematic healthcare screening (Martin *et al*, 1997; Webb & Rogers, 1999), and further studies have confirmed not just the ability of screening to uncover high levels of unmet need (Baxter *et al*, 2006), but that the benefits of subsequent treatment 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 that is actively followed. Experience shows that omissions are likely to occur and that a fail-safe system for checking completion is to be recommended.

Even after health problems have been identified and investigations recommended, the practical barriers to accessing secondary healthcare services are similar to those in primary care, and these must be anticipated and addressed. Specialist learning disability services have skills in facilitation but, even though GPs generally value these teams (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 coordination is essential to ensure that people with intellectual disability have effective access to healthcare services at both primary and secondary levels (McConkey & McAteer, 1999).

REPORTS AND GUIDANCE

Reports from various bodies in the fields of intellectual 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 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 intellectual 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 intellectual disability with a GP. In Scotland, *A Partnership for a Better Scotland* (Scottish Executive, 2003) advocated piloting of a health screen for people with intellectual disability, and a subsequent report on the assessment of health needs of this population (NHS Health Scotland 2004) recommended written antidiscrimination policies backed up by widespread staff training on their needs. 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(1) Local Authority Social Services Act 1970 guidance issued by the Welsh Assembly Government (2002) also recommended that the multidisciplinary unified assessment process, coordinated by the local authority, should identify a plan for health needs as well as social care needs.

The intellectual disability component of the Royal College of Psychiatrists' curriculum for basic specialist training (2007) emphasises the importance of recognising the influence of physical disorders on psychological presentation. Psychiatrists must therefore be aware not just of the high rates of, and atypical patterns of, health deficits in people with intellectual 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 are 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 intellectual disability (as outlined in sections Ga11, Ga13 and Wc11). Epilepsy is a common comorbidity in this group and the presentation is more complex and frequently more intractable than in the general population. An awareness of the potential neuropsychiatric sequelae and familiarity with the use of regular and rescue medication is essential.

CONCLUSION

A comprehensive systems enquiry and investigation of potential healthcare problems are core components of the psychiatric assessment of any person

with intellectual disability, whether an in-patient or living in the community. 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 healthcare setting, where psychiatric services have, in effect, assumed the role normally carried out by the individual's primary healthcare team.

The discharge of any patient back to the primary healthcare system must involve the transfer of good-quality information regarding 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 healthcare both before (Lennox *et al*, 2006) and after discharge (Jones & Kerr, 1997) has been shown to be beneficial to effective healthcare provision.

Responsibility for the healthcare of all people with intellectual disability in the community lies with primary care services. Specialist intellectual (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 healthcare pathways and the completion of statutory healthcare initiatives. However, the temptation for these specialist services to take over responsibility for the healthcare needs of people with intellectual disability should be resisted.

Appendix 1 sets out physical health standards for people with intellectual disability. These are based on the model outlined earlier by Michael Phelan (pp. 21–23) 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 2) is a clinical and research tool used extensively in primary care and specialist intellectual disability services both in the UK and internationally (Kerr *et al*, 1996; Webb & Rogers, 1999). Within its directed enhanced services initiative (National Assembly for Wales, 2006), the Welsh Assembly Government has funded a Learning Disabilities Scheme in primary care to carry out annual health checks using the Welsh Health Check since April 2006.

REFERENCE

- Welsh Assembly Government & NHS Cymru Wales (2002) *Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care. Guidance for Local Authorities and Health Services*. National Assembly for Wales.

APPENDIX 1 PSYCHIATRY OF INTELLECTUAL DISABILITY: PHYSICAL HEALTH STANDARDS

INITIAL PHYSICAL ASSESSMENT OF IN-PATIENTS

PHYSICAL EXAMINATION

- All patients should have a comprehensive physical examination within 24h 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:
 - details of medical history (or request made for information from relevant agencies)
 - a comprehensive systems/symptom review
 - current medication.
- Within 1 week of admission additional information should be obtained in relation to:
 - health promotion history
 - details of health screening
 - any relevant medication history.
- For any patient with epilepsy, information should be gathered on:
 - seizure type
 - seizure frequency and stability
 - 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 IN-PATIENTS

- Patients should have their weight and blood pressure recorded at least monthly.

- A 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 1 month and 3 months of treatment and thereafter every 6 months.
- Patients with epilepsy should have seizure type and frequency recorded on standardised charts.
- Patients should have continued access to appropriate primary and secondary healthcare 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.

MANAGEMENT OF LONG-TERM PHYSICAL ILLNESS OF IN-PATIENTS

- 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.

HEALTH PROMOTION FOR IN-PATIENTS

- 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 dietary advice.

ENVIRONMENT FOR IN-PATIENTS

- 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 is now mandatory.
- Access to appropriate clean washing and toilet facilities should be maintained at all times.

EMERGENCY CARE FOR IN-PATIENTS

- 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.

DISCHARGE ARRANGEMENTS

- All patients should receive a comprehensive systems review and physical examination before discharge.
- Discharge summaries should include a section on physical health.

COMMUNITY PHYSICAL HEALTH STANDARDS

- Care programme approach (CPA) care coordinators/case managers should be aware of the health needs of patients, include these in any statutory reviews and liaise with each patient's primary healthcare team in accordance with relevant statutory guidelines.
- Responsibility for the healthcare of all people with intellectual disability in the community lies with primary care services. Specialist intellectual (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 healthcare pathways and the completion of statutory healthcare initiatives.

MEDICAL EQUIPMENT

Recommended minimum medical equipment for intellectual disability units:

- Height measure
- Ophthalmoscope/auroscope
- Sphygmomanometer
- Stethoscope
- Tendon hammer
- Thermometer
- Video camera (for monitoring of seizures and movement disorders)
- Weighing scales.

APPENDIX 2

WELSH HEALTH CHECK FOR PEOPLE WITH INTELLECTUAL DISABILITY

Date: _____ Name: _____
 Marital status: _____ Ethnic origin: _____
 Principal carer: _____ Date of birth: _____ Gender: _____
 Address: _____
 Tel: _____

Weight (kg/stone) _____ Height (metres/feet) _____
 Blood pressure _____ Urine analysis _____
 Smoking (cigarettes per day) _____ Alcohol (units per week) _____
 Cholesterol/serum lipids _____
 Body mass index (weight in kg/height in m²) _____

Immunisation *People with an intellectual disability should have the same regimes as others and the same contra-indications apply.*

Tetanus vaccine in past 10 years? Yes No
 If no, has vaccine been given? Yes No
 Tetanus in past 10 years? Yes No
 Has influenza vaccine been given? Yes No
 Is hepatitis B status known? Yes No Result? _____

Cervical screen *People with an intellectual disability have the 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

Continued

CHRONIC ILLNESS – Does your patient have any chronic illnesses?

Diabetes Yes No
Asthma Yes No

SYSTEMS ENQUIRY – answers 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 No
Faecal incontinence Yes No
Feeding problems Yes No

CNS – for epilepsy see overleaf

Faints Yes No
Parasthesia Yes No
Weakness Yes No Where? _____

Continued

Genito-urinary

- Dysuria Yes No
- Frequency Yes No
- Haematuria Yes No
- Urinary incontinence Yes No
- If yes, has MSU been done? Yes No
- Would you consider other investigations? Yes No

Gynaecological

- Dysmenorrhoea Yes No
- Intermenstrual bleeding Yes No
- Vaginal discharge Yes No
- Is patient post menopausal? Yes No
- Contraceptives Yes No
- Other _____

EPILEPSY

- Type of fit _____ Yes No
- Frequency of seizures (fits/month) _____/_____
- Over the past year have the fits: Worsened
- Improved
- Remained the same

Anti-epileptic medication		
<i>Drug name</i>	<i>Dose/frequency</i>	<i>Levels (if indicated)</i>

Side-effects observed in the patient _____

Continued

BEHAVIOURAL DISTURBANCE *Behavioural disturbance in people with an intellectual 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

Yes More than once a month Less than once a month Very infrequently

Self-injury:

No

Yes More than once a month Less than once a month Very infrequently

Overactivity:

No

Yes 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

Cardiovascular system

Pulse (beats/min) _____ Blood pressure _____

Heart sounds (describe) _____

SOA (stimulus onset asynchrony) Yes No

Respiratory system

Respiratory rate (beats/min) _____

Breath sounds Yes No

Wheeze Yes No

Tachypnoea Yes No

Additional sounds Yes No

(describe)

Continued

AbdomenMasses Yes No Liver Yes No Spleen Yes No Rectal examination indicated Yes No

Results _____

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

VisionNormal vision Minor visual problems Major visual problems Is the carer/keyworker concerned? Yes No

When did your patient last see an optician? ___/___/____

Is there a cataract? Yes No

Result of Snellen chart _____

Any other data _____

HearingNormal hearing Minor hearing problem Major hearing problem Is the carer/keyworker concerned? Yes No Does your patient wear a hearing aid? Yes No Any wax? Yes No Does your patient see an audiologist? Yes No

Other investigation _____

CommunicationDoes 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 *Continued*

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 _____

Breasts

Any lumps? Yes No
Any discharge? Yes No
Nipple retraction? Yes No

Other investigations

Are further investigations necessary? Yes No
If yes, which? _____

SYNDROME-SPECIFIC CHECK – Certain syndromes causing intellectual disabilities are associated with increased morbidity for this reason it is important to record:

Is the cause of intellectual disability known? Yes No

If yes, what is it? _____

Has your patient had a chromosomal analysis? Yes No

Result _____

Degree of intellectual disability:

Mild Moderate Severe Profound

All patients with Down syndrome should have a yearly test for hypothyroidism.

If appropriate, has this test been done within the past 12 months? Yes No

Continued

Other medication			
<i>Drug name</i>	<i>Dose</i>	<i>Side-effects</i>	<i>Levels (if indicated)</i>

THANK YOU

The Welsh Health Check for People with Learning Disability is very closely modelled on the Cardiff Health Check for People with a Learning Disability developed by Professor M. Kerr, Welsh Centre for Learning Disabilities ([http://www.cardiff.ac.uk/medic/subsites/learningdisabilities/\[hidden\]resources/cardiff_health_check_for_people_with_a_learning_disability.pdf](http://www.cardiff.ac.uk/medic/subsites/learningdisabilities/[hidden]resources/cardiff_health_check_for_people_with_a_learning_disability.pdf)). Reproduced here with the author's permission.

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6 Physical healthcare standards: forensic psychiatric services

Irene Cormac and Mary Walsh

The following physical healthcare standards are the minimum expected for the care of 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 medical or legal reasons not to do so. It is recommended that all patients have access to a primary healthcare service.

INITIAL PHYSICAL ASSESSMENT OF IN-PATIENTS

PHYSICAL EXAMINATION

- All patients should have a comprehensive physical examination within 24h 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 might 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 (CPA) 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)
- record of all forms of medication and allergies.

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

A medical alert card (Appendix 1) should be completed and stored at the front of the clinical record.

PHYSICAL INVESTIGATIONS

- Appropriate physical investigations should be completed during the first week of admission.
- Results of physical investigations 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 (below) must be available and accessible on each ward.

Equipment must be maintained in working order.

CONTINUING PHYSICAL HEALTHCARE

- Patients should have their weight and blood pressure measured and recorded monthly.
- Physical health review, examination and investigations should be repeated as necessary, and at least annually.
- Patients should have access to dental care, chiropody, physiotherapy, dietetics, hearing tests and 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.

MANAGEMENT OF CHRONIC PHYSICAL ILLNESS OF IN-PATIENTS

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

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 units, emergency medical services must be able to gain rapid access and, if necessary, be able to transfer a patient to a general hospital, while maintaining the appropriate level of security.

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

MANAGEMENT OF A POTENTIALLY VIOLENT OR VIOLENT PATIENT

- The standards in the NICE Clinical Guideline 25 (National Institute for Health and Clinical Excellence, 2005) should be applied for clinical observations and for rapid tranquillisation.
- 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 appropriate Mental Health Act Code of Practice (e.g. in England – Care Programme Approach).

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.

ENVIRONMENT

- Patients should be provided with fluids and a diet that is nutritious and sufficient to meet their needs.
- Patients should have access to fresh air and exercise facilities.
- A smoke-free environment is now mandatory.
- 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.

CARE PROGRAMME APPROACH (CPA) 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 healthcare needs.
- Patients should have access to support and encouragement to promote good physical health.

DISCHARGE PLANS FOR COMMUNITY CARE

- Discharge summaries should contain a section on physical health.

- Arrangements for future plans for physical healthcare should be included.
- Community patients should have access to appropriate community services that support and encourage good physical health, for example weight management and healthy living groups.
- All patients should have access to primary healthcare services and a review of physical health at least annually.

DISCHARGE PLANS FOR TRANSFER TO PENAL ESTABLISHMENTS

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

APPROPRIATE MEDICAL EQUIPMENT

Recommended medical equipment for psychiatric wards (adapted from Garden, 2005).

ESSENTIAL EQUIPMENT

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

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

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, UK. They are being used in the forensic services in Nottinghamshire.

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APPENDIX 1

MEDICAL ALERT CARD

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

The Medical Alert Card is normally printed on two sides of a yellow card and is filed in the 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.

MEDICAL ALERT CARD		Name:
Please read with medication card		DOB:
		Hospital no.
		Ward:
		Give details
Allergies		
Medication		
Food, e.g. nuts		
Bee/wasp stings, latex		
Blood-borne viruses		
Hepatitis B, carrier	Yes/No/Nk	
HIV status	Known?	
Hepatitis C, carrier	Yes/No/Nk	
Immuno-compromised	Yes/No/Nk	
Steroids	Yes/No/Nk	
Medication		
Lithium	Yes/No/Nk	
Anticoagulants	Yes/No/Nk	
Clozapine	Yes/No/Nk	
Insulin	Yes/No/Nk	
Anti-epileptics	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	
Medical history of anything significant, e.g. operations, TB		
Glaucoma/Blind	Yes/No/Nk	
Deaf	Yes/No/Nk	
Mobility problems	Yes/No/Nk	

Medical device <i>in situ</i>	Yes/No/Nk	
Foreign bodies	Yes/No/Nk	
Hyperlipidaemia	Yes/No/Nk	
Other metabolic/blood disorders	Yes/No/Nk	
Blood abnormality: sickle cell disease/other	Yes/No/Nk	
Immunisation		
Tetanus	Yes/No/Nk	
Hepatitis B	Yes/No/Nk	
BCG	Yes/No/Nk	
Needs prophylactic anti-biotics for invasive/dental procedures?	Yes/No/Nk	

Nk, not known.

Name _____ (print) _____ (sign)

Date: _____ (D/M/Y)

7 Physical healthcare standards: children and young people with mental health problems

Margaret Murphy

By contrast with adults far less is known about the physical healthcare 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 organisation of mental health services for children and young people it is not possible simply to extrapolate from the findings for adults.

ORGANISATION AND FUNCTIONS OF CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Across the UK, Northern Ireland and Ireland child and adolescent mental health services (CAMHS) are strategically organised into tiers (although there are some differences in organisation of services in Ireland).

Tier 1 CAMHS or their equivalent are provided by professionals such as general practitioners (GPs), health visitors, teachers, youth workers, paediatricians and social workers, whose main role and training is not in mental health.

Tier 2 CAMHS are 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 multidisciplinary specialist teams and may work with other agencies such as local authority looked-after children's teams or general hospital liaison services on an outreach basis.

Tier 3 CAMHS involve specialist mental health teams which may include psychiatrists, psychologists, individual and family therapists, nurses and social workers.

The highly specialised Tier 4 CAMHS such as in-patient units are usually provided on a regional basis.

The majority of children and young people referred to CAMHS will not be seen by a psychiatrist, and much of the care is provided by clinicians with neither experience nor training in physical healthcare. Data from the National CAMHS mapping exercise in England and Wales (Barnes *et al*, 2005) shows that emotional disorders and disruptive behaviour are the most common reasons for referral to CAMHS; referrals for severe mental illnesses such as psychosis, bipolar disorder and severe eating disorders are relatively rare.

Very few children and young people referred to CAMHS require in-patient care. The majority in contact with CAMHS have a treatment duration of less than 6 months.

Thus, the vast majority of CAMHS patients are living in the community with parents or carers and have only a relatively brief or time-limited contact with CAMHS. They are much more likely to be in longer-term contact with primary care services such as GPs, school nurses, community paediatricians and so on than with CAMHS and to rely on these other services to meet their physical healthcare needs. Many consultant child and adolescent psychiatrists only rarely carry out a physical examination of a child and have very little involvement in the treatment of physical illnesses. Nevertheless, it is important for all 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 and those that involve the brain, are at higher risk of developing comorbid mental health problems (Rutter *et al*, 1970; Seidel *et al*, 1975);
- 3 for the safe prescription of 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 on the patient's mental state and behaviour;
- 4 research on children and young people shows evidence of the benefit of exercise in the treatment of depression (National Collaborating Centre for Mental Health, 2005) and of its positive effects on self-esteem (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 this population;
- 5 it might be argued that CAMHS professionals have a responsibility for general health promotion to the children and young people who come into contact with them at what is thought to be an important stage in the development of attitudes to health and in particular 'health-risk' behaviours (Royal College of Paediatrics and Child Health, 2003); 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 unprotected sex (Resnick *et al*, 1997).

This chapter will focus on the areas identified in points 3, 4 and 5 above, 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 physical disorders presenting in routine child and adolescent mental health practice are directed to the comprehensive review by Bailey (2002). Excellent reviews of the emotional needs and mental health of children and young people experiencing physical illnesses have been published by Mrazek (2002) and Rauch & Jellinek (2002).

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 (www.rcpch.ac.uk/Education/Education-Courses-and-Programmes/Child-In-Mind), are placing increasing emphasis on the training of paediatricians in the skills and competencies needed to meet the emotional healthcare needs of child and adolescent patients.

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

RECOMMENDATIONS

- 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. To develop and maintain these skills it is likely that there will need to be active training links with paediatrics both for training of trainees in child and adolescent psychiatry and continuing professional development (CPD) for consultant child and adolescent psychiatrists.
 - A higher level of competency will be required in CAMHS in-patient settings, where a more comprehensive physical examination may be needed as part of the routine admission procedure and where the ongoing basic medical needs of any in-patients who have no access to routine primary care have to be met. Thus, the team will need to include at least one doctor who is competent in the general physical assessment of children and young people and is able to carry out basic physical investigations (e.g. routine blood tests, basic interpretation of electroencephalograms), treat minor ailments, refer to other medical services as appropriate and, alongside appropriate specialists, monitor longer-term medical conditions.
 - It is similarly important that nurses, particularly those in in-patient settings, have adequate training in the physical healthcare needs of children and adolescents, as many nurses entering work in CAMHS in-patient settings have neither training nor experience in this area.
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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 mental health problems of children and adolescents than it does for adults, partly because of the lower prevalence of illnesses that require physical treatment and partly because of a more cautious approach towards the use of psychotropic medications for this age range.

With the exception of treatment of attention-deficit hyperactivity disorder (ADHD), when medication is used this is often on the basis

of extrapolation from the findings for adults. In a review of paediatric prescribing in the USA, Jensen *et al* (1999) estimated that around 80% was off-label and that, with the exception of ADHD, there was little association between frequency of use and clinical trial evidence of efficacy. Although there are marked UK–USA differences in prescribing (Riddle & Walkup, 2008), with a generally more conservative approach to the use of psychotropic medication in the UK, the situation regarding prescribing to children and adolescents may not be that different between the two countries: 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 for 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. If this is the case it is important to be aware of the developmental differences in response to medication.

DEVELOPMENTAL DIFFERENCES IN PHARMACOKINETICS

There are known developmental differences in pharmacokinetics. Hepatic metabolism is greatest between the ages of 1 and 6 years, and declines thereafter, so that it is roughly twice the adult rate prepubertally and reaches the adult rate in adolescence, although in the months before 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 bio-availability. There are also developmental differences in the permeability of the blood–brain barrier. All of these differences combine to lead potentially to developmental differences in drug handling. The net effect of these differences may vary from one drug to another depending on its metabolism, distribution, etc.

DEVELOPMENTAL DIFFERENCES IN PHARMACODYNAMICS

Much less is known about developmental differences in pharmacodynamics although it is known that they 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 tricyclic antidepressants. 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) and extrapyramidal side-effects on antipsychotic medication (Findling & 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. It is therefore 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

- 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.
- It is accepted that there are instances, for example the presence of 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, which are adapted from the *Maudsley Prescribing Guidelines* (Taylor *et al*, 2005), should be applied.
 - Target the symptoms not the diagnosis – diagnosis can be difficult in children and comorbidity is very common. Treatment should target key symptoms and, where possible, systematic ratings of symptom severity and impairment should be used. Although a working diagnosis is useful to facilitate communication and frame expectations, it should be remembered that this is provisional: in this age group in particular it may take time for the illness to evolve.
 - Begin with less, go slow and, if necessary, be prepared to end with more: in out-patient care, dosage will usually commence lower in mg/kg/day than with adults; this may also be advisable in in-patient settings, but 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.)
 - 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.
 - 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 8–12 weeks for most major conditions.
 - Where possible change one drug at a time.
 - Patient and family education about medication is essential – and where medications are used off-licence it is important to explain this.

Recommendations regarding the indications for prescribing, the choice of medications and the required monitoring can be found in the *Maudsley Prescribing Guidelines* (Taylor *et al*, 2005). These guidelines have the advantage of being regularly updated and of being based on a rigorous review of the 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 concern both the identified major causes of morbidity and mortality in this age group and 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 (data from the Office for National Statistics). There is, however, increasing concern about high-risk health behaviours such as poor diet, lack of exercise, obesity, cigarette-

smoking, alcohol and substance misuse, and poor sexual health (Office for National Statistics, 2004; Department of Health & Department for Education and Skills, 2004). This is partly because of their impact on 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 being overweight or obese in childhood and adolescence is associated with obesity and a range of poor health outcomes in adult life (Office for 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 engagement in school life. There has been virtually no published research to date 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 on examples of good or innovative practice rather than on empirical research evidence. The majority of UK evaluations measure the process of programmes rather than their 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 Office for National Statistics (2004) and Department of Health & Department for Education and Skills (2005).

Much of this research has focused on the general population of young people rather than at-risk populations such as children and young people with mental health problems, young offenders and young people in secure care, and looked-after children. 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 that promote healthy eating and exercise.

RECOMMENDATIONS

- 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.
- Clinicians in CAMHS should consider to what extent they can actively promote more positive physical health and health behaviour. This might include making advice and information on health promotion available in CAMHS settings; and ensuring that due regard is paid to the physical health and lifestyle of individuals referred to CAMHS and that advice on exercise, diet, smoking and so on is given where this is appropriate. The latter is especially important for particularly vulnerable young people such as those experiencing severe mental illness, those in in-patient settings and young offenders who have mental health problems. Services should ensure that there are links with and access to services/facilities such as exercise referral and smoking cessation schemes, sexual health services and more general medical services.
- 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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Part III

Examples of interventions in physical healthcare

8 Psychotropic prescribing

David Osborn and Michael Phelan

Psychotropic medications confer numerous benefits on people with mental health problems in the short and long term. They can alleviate suffering, promote recovery and prevent relapse. 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 chapter. Here we outline general principles relating to physical health and psychotropic prescribing. Some specific areas of current concern are highlighted, including comments regarding physical monitoring for second-generation (atypical) antipsychotics (Appendix 1).

Specific up-to-date drug information is available elsewhere and is updated more frequently. Recent references and websites are suggested in Appendix 2.

PRINCIPLES OF PRESCRIBING – BENEFITS AND RISKS

Prescription of any medication may be associated with risks as well as benefits and they sometimes include unwanted physical effects. The prescription of a 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 first-generation (typical) antipsychotics. The new generation of antipsychotics, the atypicals, have shifted focus to a different cluster of side-effects, including weight gain and metabolic disturbances. All prescribers have a duty to engage in continuing professional development (CPD) to ensure that their knowledge relating to the physical consequences of the psychotropics they prescribe 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 patients 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 and physical illnesses are well established. This warrants specific screening for physical problems in users of mental health services, before psychotropic medication is prescribed. Clinicians must be particularly aware when choosing agents that 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, antipsychotic sensitivity)
- intellectual 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 that 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 a physical assessment is obtained. In such situations the minimum effective doses should be used, and vital signs must be monitored carefully after 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.

All practitioners should be aware of specific risks associated with treatments they use 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 the following.

PHYSICAL HISTORY

- Current physical symptoms of relevance, e.g. symptoms of hypothyroidism, hepatic impairment or diabetes

- Current physical signs, including relevant examination, e.g. obesity or Parkinsonian symptoms
- Past medical history, e.g. chronic conditions that may affect choice or dose of agent: cardiac, hepatic, renal, neurological, gastrointestinal or endocrinological conditions
- Results of any screening by another practitioner, e.g. abnormal thyroid function, lipids, glucose or liver function
- Current drug history, including prescribed, over-the-counter, alternative and illicit substances
- Pregnancy
- Consideration of whether a pre-prescription test and counselling are required
- Previous adverse effects from psychotropic medications, e.g. dystonias, neutropaenia, sexual side-effects
- Risk factors for physical illness, including family medical history, smoking, obesity, sedentary lifestyle, poor diet.

PHYSICAL EXAMINATION

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

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 low-density and high-density lipoprotein cholesterol) where relevant
- Electrocardiogram
- Weight and height
- Body mass index and/or waist/hip circumference.

INFORMATION REGARDING THE PHYSICAL EFFECTS OF MEDICATIONS

In non-emergencies, 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 2.

- First-generation (typical) 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 (monitoring mandatory): neutropaenia and agranulocytosis; more rarely myocarditis
- Sodium valproate: weight gain
- Lithium (monitoring mandatory): risk of toxicity; renal impairment; hypothyroidism; weight gain also common.

PSYCHOTROPIC PRESCRIBING IN PREGNANCY

The following notes indicate the level of vigilance needed 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 the drug 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 in most cases a negative pregnancy test should be a requirement before starting the drug. The National Institute for Health and Clinical Excellence (NICE) guidelines on the management of bipolar disorder (National Collaborating Centre for Mental Health, 2006) and on epilepsy (National Collaborating Centre for Primary Care, 2004) recommend that sodium valproate is not used in pregnancy.
- Other anticonvulsant mood stabilisers are also associated with a substantially elevated risk of major congenital malformations, although not as high as for 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 selective serotonin reuptake inhibitors (SSRIs) in pregnancy. 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 1 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 SECOND-GENERATION ANTIPSYCHOTICS

- Body mass index and/or waist circumference
- Blood pressure
- Current and previous smoking status
- Lipids, including low-density lipoprotein (LDL) and high-density lipoprotein (HDL)
- Random or fasting glucose.

SUGGESTED FREQUENCIES FOR MONITORING

Recommended frequencies for monitoring those commencing an atypical antipsychotic 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 and/or waist circumference, fasting or non-fasting glucose, lipids (including cholesterol, HDL and LDL cholesterol) and triglycerides should be monitored at: baseline, 10–16 weeks, 6 months, then annually.

A baseline electrocardiogram is desirable.

RESPONSIBILITY FOR SCREENING

Most practitioners agree that most physical health monitoring is best performed in primary care. Local agreements and the treatment setting (for instance in-patient 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 (e.g. 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 healthcare throughout their careers and other specialise in 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 level of competence.

APPENDIX 2 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 the pharmaceutical industry.

ADVERSE EFFECTS OF PSYCHOTROPIC MEDICATIONS

British Medical Association & Royal Pharmaceutical Society of Great Britain (2008) *British National Formulary March no. 55*. BMJ Publishing Group & RPS Publishing.

Taylor, D., Paton, C. & Kerwin, R. (eds) (2007) *The Maudsley 2005–2006 Prescribing Guidelines (9th edn)*. Taylor & Francis.

RELATIVE ADVERSE EFFECTS AND PRESCRIBING IN PROBLEM AREAS SUCH AS CARDIOVASCULAR DISEASE

Bazire, S. (2007) *Psychotropic Drug Directory*. 120. C2.2 p180. Bath Press.

ANTIPSYCHOTIC MONITORING

Anonymous (2004) Which atypical antipsychotic for schizophrenia? *Drug and Therapeutics Bulletin*, **42**, 57–62.

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.

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>).

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9 Promoting healthy lifestyles in psychiatric services

Irene Cormac

Health and longevity are influenced by genetics, socio-economic status and circumstances, the presence of disease or disability, lifestyle and access to healthcare (US Department of Health and Human Services, 2005). The main modifiable causes of morbidity and premature mortality are inactivity, smoking tobacco, poor diet, 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, metabolic syndrome and some forms of cancer. These risks combine with age to shorten and reduce the quality of life.

The World Health Organization identified that health promotion works by enabling people to establish control over their physical health and it involves creating health policies and providing people with health promotion and health education (World Health Organization, 2005). It recommends that health promotion, disease prevention and health interventions should be tailored to each person's needs according to their gender, age and 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 & Kelly, 2005). Psychiatric patients are known to have high rates of obesity and smoking (Brown *et al*, 2000; Cormac *et al*, 2005). People with schizophrenia living 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, 2003).

Health improvement can be achieved through exercise, smoking cessation, a healthy diet and weight management, together with the detection, treatment and prevention of comorbid physical disorders. This chapter 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 from the Department of Health (2004a, 2005a,b). Tobacco smoking is a major cause of premature mortality and morbidity.

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 healthcare. 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 of improving their physical health (Warrell *et al*, 2005).

As in the general population, patients receiving psychiatric care may choose not to have a healthy lifestyle and to ignore advice about ways to improve their health. Nevertheless, they 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 the heart, healthy eating/cooking, weight management, alcohol and addictions.

A multiprofessional 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 day care, rehabilitation and in-patient facilities. Psychiatric facilities should comply with relevant smoking policies and legislation and in-patient services should provide a healthy diet, access to exercise, and health education that 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 from NHS Direct via telephone, the internet and digital television. NHS Direct links with health-approved lifestyle programmes, both local and national, and is available 24h a 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.

A health promotion guide for people with mental health problems containing information and advice on 10 health promotion topics has been published by the National Institute for Mental Health in England in collaboration with Mentality (2004). The Health Events calendar (<http://www.equip.nhs.uk/staffwm/healthevents.html>) has a list of health promotion events and awareness days that can be used to inform patients, carers and staff about physical health.

EXERCISE

The Chief Medical Officer (Department of Health, 2004*b*) recommends for general health that children should exercise for 60 min a day; the recommended minimum for adults is a total of 30 min of moderate-intensity physical activity a day on at least 5 days a week.

For adults, shorter periods (10 min) of exercise interspersed throughout the day have been shown (Department of Health, 2004*b*) to be as beneficial as longer periods. 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

Benefits of physical exercise include (Department of Health, 2004*b*):

- 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 3.8–2.6 mmHg
- 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 exercise is undertaken. Patients can be referred through their GP to an exercise professional with a GP-referral or other relevant qualification to undertake a fitness assessment, before the exercise professional creates 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. It 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, 2004*b*). 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 longer.

Physical activity should be promoted for individuals admitted to in-patient psychiatric services. Opportunities should be made available for patients to exercise for at least 30 min at least 5 times per week where there are no contra-indications to this, such as physical or mental health problems. A range of exercise options should be provided to suit the needs of the patient population. Whenever possible, out-patient 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 macro- and/or micro-nutrients. 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 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 micro-nutrients. 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. Elderly patients 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

The Department of Health (2005b) recommends the following:

- five portions of fruit or vegetables per day
- dietary fibre: >18g per day
- saturated fat: <11% of food energy
- total fat consumption: <35% of food energy
- added sugar: <11% of food energy
- salt: <6g per day

The Food Standards Agency provides information on healthy diets, with tips for eating well (www.eatwell.gov.uk/healthydiet/eighttipssection/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, 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 (Department of Health, 2008). Jung (1997) highlighted the benefits of losing weight intentionally. A general weight loss of 10kg can lead to a 20% fall in premature mortality, a 30% reduction in deaths due to diabetes, a 40–50% reduction in cancers due to obesity and a fall of up to 30% in serum triglycerides.

The National Collaborating Centre for Primary Care and the Health Development Agency (2006) and the National Heart Forum (Swanton & Frost, 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). The Royal College of Paediatric and Child Health has produced useful guidelines for weight management and healthy living in children (RCPCH, 2002).

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, HIV and chlamydia) cause a wide range of illnesses and are a significant cause of long-term and serious disability (Department of Health, 2007). Psychiatric patients should have the opportunity to receive suitable advice and immunisation 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 psychotropic medications. 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

Alcohol and substance misuse affect not only the physical health and well-being of the individual but also third parties, through the drinker's or user's behaviour (Royal College of Physicians, 2004). Early detection of hazardous drinking is of great importance in reducing 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, including the provision of information and, wherever possible, the opportunities to tackle modifiable health risk factors.

ACKNOWLEDGEMENT

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

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10 Action plan to improve the physical health of patients in psychiatric services

Irene Cormac

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 in the community and in residential and hospital care should be identified 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, who may include psychiatrists. A routine functional enquiry, physical examination and investigation should be undertaken on an annual basis (Connolly & Kelly, 2005).

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 with the practicalities of making appointments or visiting a health centre or surgery.
- Homeless patients should be offered a physical health check and assistance with gaining access to physical healthcare.

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 healthcare as other citizens (Beecroft *et al*, 2001).
- Health professionals should develop and promote positive attitudes towards people with disabilities (Department of Health, 2006).
- Psychiatrists and mental health professionals should advocate that their patients receive the same standard of treatment as other citizens.

HEALTH PROMOTION

- Patients should be offered information and advice on health promotion that 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, for example by using health action plans.
- Health professionals should provide health promotion.

CHOOSING A HEALTHY LIFESTYLE

- Patients should have the same opportunities as other citizens to lead a healthy lifestyle, as far as is practicable (Disability Rights Commission, 2006).
- Opportunities should be available for all patients to have at least 30 min of moderate exercise, at least 5 times per week.
- Patients should be advised about the benefits of eating a healthy diet containing at least five portions of fruit or vegetables per day and two portions of oily fish at least twice a week (i.e. four portions per week). They should be advised about reducing the content of fat, sugar and salt in the diet to current recommended levels (see chapter 9, this report).
- 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 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 preventive measures should be provided to minimise or limit the potential side-effects.
- Patients should be encouraged to quit or cut down smoking tobacco.

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