

Mental Health in Scotland

Improving the Physical Health and Well Being of those
experiencing Mental Illness
December 2008

"We will improve the physical health of those with severe and enduring mental illness by ensuring that every such patient, where possible and appropriate, has a physical health assessment at least once every 15 months."



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Introduction

This guidance focuses on the need for all agencies to work together, in collaboration with services users, families and carers to improve the physical health of people experiencing mental illness. The guidance responds to the published commitment (2006):

“We will improve the physical health of those with severe and enduring mental illness by ensuring that every such patient, where possible and appropriate, has a physical health assessment at least once every 15 months.”

This guidance offers 7 deliverable recommendations for change and improvement; the context in which they are set; linked initiatives; some practice examples already underway; and the evidence base.

The guidance is aimed at clinicians and service providers from mental health and primary care (general practice), the wider NHS (general hospitals and others), local authority and voluntary sector organisations who regularly care for people with mental health problems.

Attention to the physical health of those with a mental health problem is driven by the need for systematic support for those with long-term conditions, a reduction in health inequality and better management of care. This applies across service user and carer contacts, in health, social services and other settings.

Successful delivery of the recommendations made rely on health, local authority and other agencies working together and on the ongoing participation and engagement of people experiencing mental illness and their carers. Engagement should recognise communication needs and information should be provided in accessible formats on request.

Clinicians and other care providers are invited to consider the full range of available therapies and other interventions for an integrated appropriate response to individual needs.

All approaches must take account of equality and diversity issues to ensure compliance with Disability Discrimination legislation. For example there may be specific issues to address with regard to disability, sensory need, language, cultural, ethnic or gender related issues, and the particular needs of socially excluded groups. All prevention care and support approaches should be designed and delivered in a non stigmatising, non discriminating way which values people, promotes equality and encourages the individual towards effective self management, better physical health and improved wellbeing.

Promotion and maintenance of physical wellbeing should ensure that approaches are tailored to individual need.

Recommendations

Recommendations for best outcomes are as follows:

1. Community Health Partnerships (CHPs) must; raise awareness among staff, Partner Organisations, service users and carers of the increased rate and poorer outcomes of common physical illnesses in people with severe mental health problems; and must provide this population group with lifestyle and other health promotion interventions within the context of their Health Promotion Strategies and local health improvement programmes.
2. General Practices on an annual basis should use existing processes to review and support improvements to the physical health of those with severe mental illness. Findings should be recorded and communicated to all interests to ensure appropriate follow up where required.
3. CHPs, Mental Health Services, Partner Organisations and acute care services should remove barriers to accessing care and ensure non-discriminatory delivery of care to people with severe mental health problems.
4. When following the standards for Integrated Care Pathways, Mental Health Services must make or co-ordinate arrangements for the additional screening of patients whose treatment requires that they receive more than an annual review, or lithium monitoring, in primary care.

5. The Scottish Government Mental Health Division will work with the 'Keep Well' programme to identify opportunities to integrate initiatives such as this with local Mental Health Services in order to widen opportunities for this population group during 2008 and beyond and will build on the work that will be taken forward by the Royal College of General Practitioners Living Better project in relation to diabetes, coronary heart disease and depression.
6. CHPs, Mental Health Services, acute services and Partner Organisations involved in health promotion and health screening activity for people with severe mental illnesses should be able to evidence improvement in physical health in those with mental health problems through robust monitoring and review arrangements including audit, Integrated Care Pathways (ICPs) or other means of validation and tracking of variances in care.
7. The training and education of all who provide care and treatment to people with severe mental health problems should embrace a holistic approach, with a focus on recovery, and reflect an understanding of the inherent interactions between the mind/brain and the rest of the body.

Successful implementation of the recommendations will be founded on the availability of the right response, at the right time, with appropriate follow up.

Background

Evidence Base

Research in Europe and the USA has shown that the mortality rate from physical illness for those with mental health problems is significantly higher than in the general population. Schizophrenia is generally acknowledged as a life shortening illness with sufferers dying on average 10 years earlier than the general population. Two thirds of this excess mortality is due to poor physical health.^{1,2,3}

Equal Treatment: Closing the Gap (2006)⁴ – a UK based study commissioned by the Disability Rights Commission (DRC) in England and Wales – describes an analysis of 8 million health records in primary care. It confirms that for people with schizophrenia and bipolar disorder the rates of ischaemic heart disease, stroke, high blood pressure and diabetes are higher than in the general population, with diabetes 2 to 3 times more common than expected. Bowel cancer is 90% more likely in someone with schizophrenia and women with schizophrenia are 42% more likely than other women to get breast cancer.

They also found that people with major mental health problems are developing these illnesses at a younger age and are dying from them earlier with 5 year survival rates reduced by up to 16%.

These and other studies of General Practice based populations in the UK and abroad have shown that increased mortality rates from cardiovascular disease in people with severe mental illness is a robust finding even when smoking rates and deprivation are taken into account.^{5,6} Similarly, a clear link between depression and cardiovascular disease has been established.^{7,8} There may be a range of factors contributing to elevated levels of obesity and diabetes including medication and related weight gain.^{9,10,11} These factors are likewise involved in the development of cardiovascular disease, the leading cause of excess mortality due to physical illness. Some causal factors are potentially amenable to change. These include lifestyle factors, in particular smoking (where rates among this care group are up to twice that of the general population), poor diet and lack of exercise.^{12,13,14,15}

People especially vulnerable to severe mental health problems include those who have suffered major trauma and adverse life events in childhood, such as physical and sexual abuse. A range of research has demonstrated that they have higher rates of some major physical conditions, of medically-unexplained symptoms, and of damaging lifestyle issues such as heavy smoking, obesity and substance use, largely due to attempts to self-medicate and block out disturbing post-traumatic stress symptoms.^{16,17}

As medications (such as anti-psychotics, mood stabilisers and antidepressants) used to treat mental illness can lead to a number of significant side effects⁹ their impact and the need for their use should be regularly reviewed with service users.¹⁸

Where the presence of cardiovascular disease or other physical illnesses have been established there is evidence that those with additional mental health problems are less likely to receive quality interventions which could improve outcomes.^{4,19} Clearly there are barriers to access which must be overcome.

Other common mental health problems are also associated with poorer than average physical health. Eating disorders are often associated with physical illness²⁰. Dementia in the middle aged and elderly can be accompanied with poor physical health²¹. Again, there is a higher incidence of cardiovascular disease with other physical conditions seen more commonly also. People with substance misuse disorders, especially if co-morbid with other mental health problems, will tend to have poorer than average physical health²².

There are numerous recommendations as to what to include in a regular physical review for people with schizophrenia,^{23,24,25} bipolar disorder,^{26,27} learning disability^{28,29} and dementia.³⁰ Annex A gives some practice examples of how services across Scotland are working to improve the physical health of people with mental illness.

Given this evidenced context it is important that the health needs of individuals with major mental health problems are responded to in a targeted way, with reasonable adjustments for disability status and with clearly communicated responsibilities. Where depression, severe life traumas and poor self esteem have contributed to intractably unhealthy lifestyles, it is important that services address the underlying issues. There is also a clear imperative for all health, social services, voluntary sector and other partners to promote general health and well being.

Other Considerations

In Primary Care the Quality and Outcomes Framework (QOF) Mental Health indicators provide incentives for General Practices to offer regular reviews with, 'routine health promotion and prevention advice appropriate to age, gender and health status for people with a diagnosis of schizophrenia, bipolar disorder or other forms of psychosis'. (see Annex B *GMS Contract for Primary Medical Services*). Though delivery is entirely voluntary, encouragingly, the uptake is high. Participating Practices have developed registers for psychosis, dementia and learning disabilities. In due course this should improve the care delivered to these individuals.

Additional attention is needed for people who may not absorb the public health and other initiatives targeted at the wider population through established mediums and approaches.³¹ The shortcomings of such blanket approaches have been highlighted by the initial reports from the Keep Well, Anticipatory Care Initiative- *Have a Heart Paisley*³². Specific support for health behaviour change and service user involvement in the design of approaches to optimise physical health and wellbeing might help improve their relevance, uptake and outcome.

Consideration must be given to the importance of opportunistic brief health promotion and screening interventions, for example at routine GP or outpatient appointments. Social care providers are also ideally placed to contribute to the promotion of general health and wellbeing to service users. Unfortunately it is clear that even for those in contact with services opportunities are being missed.

Service Users and Carers

When asked, many service users will confirm they want attention paid to their general health and wellbeing including smoking cessation input, dietary and other lifestyle advice and physical screening³³. They are also becoming increasingly aware of the potential for improved mental health if their physical health is optimal, and of the relevance of including good physical health in a wellness recovery action plan³⁴.

Service users, carers and families must be given more opportunities to learn of the importance of maintaining and improving their physical health and the beneficial effects on mental health. They must also be encouraged to express their own views about any underlying reasons, such as low self esteem, depressed mood or previous trauma experience, as to why they may be unable to take advantage of this knowledge. Information should be provided in accessible formats (on request) to help illustrate ways to reduce possible risks to health. All will have a role in promoting and supporting access and uptake.

Carers play a key role in supporting, motivating and encouraging uptake of healthier lifestyles and recognising physical health problems at an early point.

*Better Health Better Care*³⁵ and the *Care 21 Report*³⁶ recognise this significant contribution and underline the need for appropriate involvement of the Carer and Service Users in the design and delivery of individual care plans.

The emotional and physical needs of carers themselves must not be overlooked, especially in the case of young carers and those looking after the more severely ill, or relatives with dementia.

Stigma and Discrimination

Legislation requires that all Agencies dealing with the public remove discrimination and promote equality, yet (current) “See Me” survey reports that some people with mental health problems still feel stigmatised.³⁷ They have found that when it comes to their physical health needs they can be subject to unequal access to services and can feel stigmatised and discriminated against when they try to access general health care services. They feel their physical health concerns are too often put down to their mental health problem³³, especially if their symptoms are medically unexplained, a common issue for survivors of sexual and physical violence.¹⁶ Research has confirmed that they do not always receive the same medical treatments as the rest of the public⁴ and consequently outcomes can be worse.³⁸

Legislation is in place to counteract and deal with discrimination on the grounds of age and disability. There is also now a legal duty on all public agencies including the NHS to be proactive in supporting the rights of people with disabilities. The responsibility of local authorities and social services in this respect are outlined in the Scottish Social services Code of Practice³⁹ and “With Inclusion in Mind”.⁴⁰

Management and Treatment of Physical Health and Wellbeing

Everyone potentially will benefit from access to relevant health promotion advice and information.

Improving the management of physical health and wellbeing for people with a mental illness should be embedded within existing health improvement policies and practice, and health promotion, screening, self management and recovery initiatives must be equally available to all. (See page 16).

Of the guidance available there are a number of core good practice elements common to each including:

General health and wellbeing:

- A review should take account of lifestyle choices such as smoking, diet, physical activity, and risk behaviours such as alcohol and drugs, with appropriate health promotion advice and interventions offered;

Additional health promotion activity:

- Attention to immunisation needs, sexual and reproductive health, or dental and eye checks;

Medication management:

- A review of any side effects with action where appropriate;

Physical screening:

- Primarily for cardiovascular risk factors such as weight and blood pressure; and

Investigations:

- primarily for cardiovascular risk factors such as glucose and cholesterol.

Keep Well

Ultimately there are many factors which can affect physical health, including: poverty, inequalities, disability, deprivation, unemployment and childhood trauma. There are a range of initiatives addressing these factors within Scotland.

Keep Well is a 3 year anticipatory care programme that focuses on tackling the main risk factors associated with the early onset of cardiovascular disease within areas of multiple deprivation.⁴¹ The programme represents a key component of the Scottish Government's drive to reduce health inequalities. The initiative is already piloted across 7 NHS Board areas with a stated aim to increase the rate of health improvement, with a particular focus on early intervention for those at a high risk of coronary heart disease and its main risk factors in the age group 45-64 years.

Communities selected for the initial stage involve Community Health Partnership (CHP) populations in North Glasgow, East Glasgow, Edinburgh, Dundee and North Lanarkshire.

Currently 166 practices are proposed for Wave 2. This would provide the opportunity for up to 44,000 individuals to go through the Keep Well process. Health Checks commenced in November 2007.

The Keep Well Health Check includes 3 main assessment areas; clinical (e.g. Height, Weight, Blood Glucose and Cholesterol), lifestyle (e.g. Smoking, Physical Activity and Diet) and life circumstance (Learning, Employability and Income Maximisation). Based on assessed need a range of NHS and non-NHS treatments, services and supports are offered thereafter.

There are clear overlaps between the clinical and lifestyle content of the Keep Well check and the Quality and Outcomes Framework (QOF) based review for people on general practice based mental health registers. (See example in Annex C of QOF related guidance for GP's).

In developing planned and tailored interventions for individuals, the Keep Well approach takes account of the importance of co-morbidity, which often involves both physical, wellbeing and mental health elements, and therefore the need to take account of the mental health issues in tackling risk factors for physical diseases.

To support the objective of improving the physical health of those with mental illness it is proposed that a logical set of actions are considered between national representatives, Keep Well Wave 1 & 2 areas and local Mental Health services. This consultative process would be facilitated via the Keep Well Delivery Infrastructure.

This process would not only inform health check plans for individuals with an enduring mental illness within the Keep Well target populations, but might also assist in establishing a way forward for this work for the population served by Community Mental Health Services as a whole.

It is important to ensure that referral pathways are clear, and that areas without "Keep well" are still inclusive of people with mental health problems.

Equity of access for delivery of care

Among people with mental health problems there are those for whom special considerations may apply. Specific examples are set out below.

Age - Younger

Young people can be difficult to engage in health care or influence with health promotion. Creativity may be required in meeting their particular needs.

Services delivering early intervention for psychosis must be particularly vigilant when recommending drug treatments with the potential for “metabolic” side effects such as weight gain and glucose irregularities. Full discussion of potential side effects and frequent monitoring from the outset, coupled with appropriate action if side effects emerge - which might include a recovery based discussion about treatment options - are necessary to prevent an insidious slide into obesity and poor physical health at a young age and for the longer term.

Age - Older

Those in the over 65 population are more prone to falls, confusion regarding medication regimes, nutritional neglect and co-morbid physical health problems. In addition, they may have fewer (or older) carers and they may experience physical, cognitive or sensory barriers to health care. The introduction of registers for dementia and associated reviews in General Practice is a positive development.

Social care, health and voluntary sector services may need to contribute more to the enabling of older people with mental health problems such as schizophrenia, bipolar disorder, depression and dementia to access regular health and wellbeing input.

Learning Disabilities

For people with a learning disability, having a mental illness can add to the health inequalities gap. Factors include lack of self-reporting of symptoms and barriers to access such as physical, cognitive and overt discrimination. People with learning disabilities have a different pattern of health need and a broader pattern of leading causes of death. They have a higher prevalence of schizophrenia and can develop dementia at an earlier age.⁴²

Targeted work should take account of the specific needs of this group and the individuals within it, including the needs of the carers. This is best done in consultation with specialist learning disabilities services or in keeping with arrangements in place under the GMS Local Enhanced Services, (see Annex B *GMS Contract for Primary Medical Services*). A number of organisations have websites which offer guidance.^{29,43}

Autism spectrum disorders (ASD)

People with ASD are more vulnerable to mental health problems, and depression, anxiety, obsessive compulsive disorders and other psychiatric conditions are not uncommon particularly among adolescents and adults with ASD. However, people with ASD may also have difficulty in communicating unrelated physical and mental health needs.

Black and minority ethnic groups

For some in this population there is an even higher risk of diabetes and other physical problems.

There is a need therefore to ensure that the delivery of care reflects particular considerations. These considerations will include cultural, gender and other relevant aspects.

There may also be stigma issues for some associated with mental ill health, culturally different distinctions between mental and physical health, language barriers and problems with evidence bases and monitoring systems not accounting for race.

Disability

Where an individual has a suspected or established physical sensory or communication disability, steps must be taken to ensure that their needs are clarified and responded to appropriately.

Action is required to remove or overcome physical barriers. Sensory and communication impairment must not be allowed to contribute to further health inequality. Awareness raising, providing information in appropriate formats and wider availability of staff competent in British Sign Language, and providing communication, including Augmentative and Alternative Communication support (AAC) should help improve wider health care to these individuals.⁴⁴

Inpatients

Individuals admitted to psychiatric inpatient care have a review of their physical health which should include health promotion advice. People who are inpatients for more than a year should be offered an appropriate annual review of their health promotion, prevention and physical care needs. This is in addition to any specific requirements associated with their treatment or co-morbid illnesses.

Medication Treatment

Extra monitoring is required for those whose treatment includes medication at high dosage or with special monitoring requirements (e.g. Clozapine). This may involve extra contacts with general practice or acute services when ECGs (electrocardiograms) or extra blood tests are required. Monitoring for side effects and advice about the effects of nicotine, caffeine and illicit drugs on medication effectiveness is the responsibility of prescribers.

Sexual Health

Contraceptive needs, pre pregnancy counseling and safe prescribing in pregnancy requires consideration in addition to education about the risks of sexually transmitted diseases.

Sexual dysfunction can be directly attributed to some medications and when problematic can lead to some people deciding to stop their treatment with associated risks to their mental health.

Anyone recommending or prescribing drug treatments with the potential for causing sexual dysfunction should ask about the presence of this or other side effects and consider the need to organise a review of an individual's prolactin levels with appropriate follow up.

People who experienced childhood sexual abuse trauma

Survivors of childhood sexual abuse are a group at above-average risk for both physical and mental ill health. Survivors of childhood sexual abuse are found among sufferers of all types of mental illness and mental health problems, including severe and enduring conditions. They are also vulnerable to unhealthy lifestyles. For instance many have used alcohol, tobacco, food, and both legal and illicit drugs to self-medicate, to block out disturbing memories, nightmares and flashbacks. Sexual violence itself damages health. Severe loss of self-esteem undermines people's motivation to care about their physical health. Many with poor mental health will also have suffered side effects of medication. Often, survivors of sexual abuse fear medical checks, especially in sexual and reproductive health and in dental care, because of their intrusive past experiences.

Before this particularly vulnerable group can be motivated to adopt healthier lifestyles and undertake preventive health checks, they need supportive and understanding services, to help them address their trauma issues. The appropriate training of staff to inquire sensitively where appropriate about an abuse history, must therefore be encouraged.

People in residential care

The Care Commission regulates a wide range of services providing care and treatment for people with mental illness, dementia and learning disabilities. There is a legal obligation on care providers to make provision for the health and welfare of service users.

People in prison

The prison population has high rates of mental illness and requires access to the same range of healthcare and health improvement initiatives.

Linked initiatives

The following examples are offered for consideration in advancing the aims set out in this guidance.

*Towards a Mentally Flourishing Scotland, (TAMFS)*⁴⁵

Mental health improvement and population mental health work is a key aspect of the Scottish Government National Programme for Improving Mental Health and Wellbeing⁴⁶. The TAMFS report outlines the proposed future direction for Local Authorities, NHS Boards and other partners in addressing health inequalities. The report emphasises the links between physical and mental health and improved quality of life.

*Gaun Yersel- Being Human*⁴⁷

The Long Term Conditions Alliance Scotland has developed a strategy for self management with the aim that people living with a long term condition have access to the support they need to successfully manage their condition. The strategy raises the importance of a person centred empowering approach to help people make changes and identify areas where they need support, and outlines specific aims for the NHS and statutory organisations.

*Living Better*⁴⁸

In keeping with the Commitment published in 2006, to improve assessment and treatment models for those with depression and anxiety, work is underway in partnership with the Royal College of General Practitioners, and others to evaluate the effectiveness of local stepped care pathways (such as training; skills development; service improvements; partnership working etc) in reducing co-morbid depression and anxiety in coronary heart disease and diabetes.

*Closing the Gap*⁴⁹

National policy on the treatment of those with substance misuse problems is firmly directed toward addressing not only the immediate needs of addiction but also the underlying difficulties, often present, which include physical and mental health.

*The National Quality Standards for Substance Misuse (2006)*⁵⁰

These standards make it clear that clients need to be involved at all stages of assessment and care planning and that Services should work with a wide range of partners, including other services, to ensure that client needs are met.

*National Strategy for Survivors of Childhood Sexual Abuse*¹⁷

The Strategy, Survivor Scotland is a Scottish Government initiative. It sets out a way forward to improve services for male and female survivors, to ensure greater priority and joined-up working in national and local mainstream services, and improve the lives of all who have suffered such trauma. The Strategy includes a number of initiatives to improve the physical and mental health of affected individuals.

Health Improvement – Key Policies and Evidence

Smoking Cessation

Around 25% (2005/6) of adults in Scotland smoke however, the prevalence is significantly higher among those with a mental illness.

Studies (in UK) have shown that 74% of people with schizophrenia spectrum and 70% of people with affective psychosis are smokers – a rate almost three times that of the general population. While people with mental illness are subject to the same smoking related diseases as everyone else, they are less likely however to be offered smoking cessation services and when they do, they may face additional challenges.

A study by ASH Scotland (2004)⁵¹ sets out why these challenges exist. A further study in 2005 maps services specifically offering support for smoking cessation to people with mental illness.⁵² References for these studies and key policies and guidance for the NHS and partners,⁵³ are provided in Annex E.

The Scottish Government consultation, in early 2009, on achieving smoke-free mental health services was born out of a need to help to inform the Scottish Government's future action on reducing exposure to second-hand smoke in psychiatric hospitals and psychiatric units, and this in turn will contribute to tackling broader health inequalities.

Reducing or stopping smoking is likely to make the greatest impact on reducing morbidity and mortality. It is important that discriminatory beliefs do not prevent access to safe behavioral and pharmacological approaches to smoking cessation.

Weight Management and healthy eating

Most adults in Scotland are already overweight and the prediction is that by 2050 60% of men and 50% of women could be clinically obese.

It is now estimated that one in three deaths from cancer and one in three deaths from coronary heart disease (CHD) are attributable to poor diet. Type 2 diabetes is 13 times more likely to occur in obese women than other women.

While data on BMI linked to mental health status are not known for Scotland, there is a general acceptance that the rates are higher both at the underweight and overweight/obese ends of the scale. Given the increasingly strong evidence that even a small weight loss (of 10% of body

weight) can reduce risks and improve health, there is a need to encourage all steps toward change⁵⁴.

Physical activity

Two thirds of adults in Scotland are relatively inactive, leading to twice the risk of dying from CHD compared to active people (independent of all other risk factors).

Physical activity also has a range of well evidenced benefits for mental wellbeing including improved physical self perception and self esteem, improved mood and reduced state and trait anxiety. Moderate activity also reduces physiological reactions to stress and can improve both the quality and quantity of sleep.⁵⁵

Evidence now shows that short bouts of activity (for example 10 minutes of brisk walking three times a day) are as effective as a single 30 minute session and activity need not be vigorous to confer benefits.

Given the reduction in risk of CHD, diabetes and some cancers together with the improvement in wellbeing, increasing short bouts of moderate physical activity has much to offer.

Inequalities in Health

Equally Well: The Report of the Ministerial Task Force on Health Inequalities (June 2008)⁵⁶ sets out the Scottish Government's commitment to reducing health inequalities in Scotland.

The report challenges public services to develop a more anticipatory and proactive approach to working with those whose health is at greatest risk and acknowledges that people with mental illness are at significantly increased risk of poor health outcomes.

While the report acknowledges the provision of universal health services including health promotion can be a gateway, it calls on local delivery agents to tailor and target services to ensure engagement and support for specific populations.

This general approach to health improvement (more proactive and tailored to those at greatest risk) now offers a significant opportunity to invest in health promotion services for people with mental ill health thereby increasing the likelihood of successful referral and engagement as part of the planned health checks.

Health Improvement Initiatives for People with Mental Health Problems

Although the evidence base for successful health improvement interventions for people with mental health problems is in its infancy, there is considerable expertise among allied health professionals, clinical and health psychologists, health improvement practitioners and others engaged in general health promotion, which could be tapped into to improve effectiveness.

As part of the response to perceived needs Health Scotland is:

- (i) Undertaking a review of evidence based approaches to tailored and targeted interventions for smoking cessation support, weight management and physical activity tailored for people with mental health problems;
- (ii) Undertaking to provide a suite of user and carer led health information for smoking cessation, weight management and physical activity again tailored for people with mental health problems; and
- (iii) Working with NHS Education for Scotland to identify how this evidence and patient information support for consultations can be used to help build capacity and capability amongst the wider workforce in the delivery of health checks and the support provided as a consequence.

Performance Management and Delivery

Current performance management arrangements are producing data generated from NHS Boards and CHPs using established QOF and primary care systems. This is being reinforced and built on by the following range of initiatives:

- The Mental Health Collaborative;
- The Standards for Integrated Care Pathways;
- Mental Health Benchmarking;
- Developing the psychological therapies infrastructure;
- Scottish Patients at Risk of Readmission and Admission (SPARRA);
- The infrastructure to support the implementation of the Mental Health Nursing Review; and
- The Mental Health Leadership Programme – Leading for Change.

The Single Outcome Agreements offer the opportunity for exploring and expanding information sharing and service improvement across NHS Boards and Local Authorities.

Further work is required on improving electronic recording and sharing of information.

For their part NHS Boards will be expected to demonstrate:

- Priority given to health improvement initiatives for *hard to reach* care populations, particularly those with mental health problems and those service users with a co-occurring condition e.g. sensory loss, alcohol, or substance issues;
- Ongoing collaboration between primary and secondary care for appropriate coverage for this care population;
- Ongoing liaison with local health improvement practitioners to facilitate and/or design evidence based health improvement interventions for this care population;
- Evidence in secondary care, of a physical health assessment as outlined in the standards for ICPs or confirmation that a review in primary care under QOF is adequate for individual needs;
- Evidence in inpatient care that the same standards are met for those in hospital for more than 12 months and more frequently where the care or other need so indicates;
- That consideration has been given to the QOF exclusion and exception reporting data available from ISD⁵⁷ to review practice performance as well as to ensure that appropriate high quality care is being delivered; and
- Evidence of the use of audit or other initiatives at a local level to help reduce the health inequalities described in this group.

Annex A

PRACTICE EXAMPLES

The following good practice examples offer insights to approaches for better outcomes for this care group and their families.

NHS Grampian

Additional developments have arisen including a walking group and smoking cessation interventions. Clinic staff also suggests local opportunities for men and women looking to take part in organised sport.

Community Mental Health Teams (CMHTs) in Fraserburgh and Peterhead have introduced annual Lifestyle Clinics for patients known to be suffering from Schizophrenia or Bipolar Affective Disorder. The clinics have been running for over three years and have been well attended.

Fraserburgh and Peterhead CMHTs created registers of patients with the relevant diagnoses. Following a team “away day” and wide consultation a protocol for screening measurements was developed.

Blood pressure measurement, urinalysis, ECG, BMI calculation, side effects screening and a series of blood tests are performed at an annual clinic to which every patient on the register is invited.

Clinics are run jointly by CMHT staff and practice nurses. All clinics are held in the GP surgeries. CMHT members facilitate attendance for their outpatients.

Where lifestyle screening highlights a risk factor further input is arranged (community dietician, exercise groups or smoking cessation advice etc). CMHT members also help with follow up appointments with GPs if abnormal results are shown from tests.

Outcomes to date:

- Attendance rate over 70% in year one in one centre indicated the feasibility of the initiative;
- Joint working between general practice and CMHT staff has consolidated shared care for this vulnerable patient group;
- Many treatable physical illnesses have been highlighted and brought to the attention of the primary care team; and
- Introduction of health screening to a group of patients who traditionally do not attend for such opportunities.

More details available from:

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Greater Glasgow and Clyde

Glasgow and Clyde experience – GMS contract/Mental Health interface

In Glasgow, GPs from the GMS contract group helped determine what can be most usefully achieved for patients under the current Mental Health Indicators. Evidence based guidance notes for GPs around the mental health indicators have been produced.

This guidance was circulated to all GPs in Glasgow and Clyde in January 2007, following the approval of the GMS contract group, the Mental Health Partnership and the CHCP Clinical Directors group.

Relevance to Mental Health Services Staff

Glasgow and Clyde recognises the importance of Mental Health Services staff sharing relevant clinical information with primary care colleagues.

This includes:

- Details and results of any physical reviews carried out on patients with severe and enduring mental illness;
- Care Plans, including those completed as part of the Integrated Care Pathway (ICP) and Care Programming (CPA);
- Other clinical information relevant to patients' care plans – which may include outpatient arrangements, Key worker details etc, as is standard for Community Mental Health Team contacts; and
- Collaboration in maintaining the accuracy of mental health registers in general practice under QOF.

Benefits

More focussed sharing of information regarding patients' care plans;
Improved communications between primary and secondary care;
Reduced likelihood of patients missing out on follow up;
Reduced likelihood of inaccurate information; and
Patients receiving improved health assessments in Primary Care.

Next Steps

Ongoing work with colleagues in General Practice to ensure application of the QOF Mental Health Indicators helps to improve the health and well-being of patients with severe and enduring mental health problems.

Reviewing related practice in mental health care to ensure there is good accordance with the evidence based approach adopted in primary care. (E.g. ICP reviews, health and wellbeing clinics).

Consideration of training and I.T. needs.

More details available from:

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NHS Lothian

NHS Lothian has published a series of " Don't Panic" guides (currently on issue 7) keeping GPs and others up to date with changes to the QOF indicators and related issues.

The latest guide is available at:
<http://www.rcgp.org.uk/pdf/Lothian%20Dont%20Panic%20Guide%207.PDF>

Further details from:

GMS.contract@lpct.scot.nhs.uk (with "Don't panic!" in the title line)

NHS Lanarkshire

Guidance has been prepared to support the development of pro-active primary mental health care and assist practices to meet the requirements of GMS (NGMS). The guidance followed local discussion with primary and secondary care practitioners and is designed to facilitate a co-ordinated approach to delivering the indicators in a consistent, efficient and effective way, inline with appropriate guidelines.

The guidance focuses on the Mental Health, Depression and Dementia indicators.

Separate guidance will be prepared for the learning disability indicators.

The clear systematic guidance offered includes relevant flow charts, read codes and a range of appendices. Links to further information are also included.

The guidance focuses on approaches to improve the health of people with severe/ enduring mental health mental care needs, depression and dementia living in Lanarkshire while also addressing the needs of their carers.

Liaison

Liaison is offered from secondary care services to support practices to implement the Mental Health indicators where the practice has identified a named person within the practice to lead on the mental health indicators.

The liaison focuses on the development of accurate mental health and dementia registers, which the practice can then use to meet the various indicators. The level of liaison will vary but includes:

Each Practice will have a named mental health professional from the community mental health team (CMHT) as liaison to the practice;

The CMHT will provide a list to each practice, of clients known to them who meet the criteria for inclusion on the mental health register;

The named mental health professional will offer to meet with the practice a minimum of twice a year to update the registers and share information with the practice;

The named mental health professional will also liaise with the practice to advise that they should also request patient lists from older people services, forensic services; and Psychiatric outpatients, resettlement teams and rehabilitation services, amongst others, to identify people for inclusion on the register.

Patient Reviews

Face-to-face reviews focus on support needs of the patient and their carer. In particular the reviews address:

- An appropriate physical and mental health review for the patient;
- The carer's needs for information commensurate with the stage of the illness and his or her and the patient's health and social care needs (if applicable);
- The impact of caring on the care giver and co-ordination arrangements with secondary care (if applicable); and
- Communication and co-ordination arrangements with secondary care (if applicable).

Available Documentation

1. Guidance on putting the primary care registers together
2. Example patient review letter
3. Example annual review questionnaire.
4. Example summary care plan
5. Patient Health Questionnaire – PHQ9 for depression
6. Secondary Care List pro-forma

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NHS Tayside

In keeping with the National Programme for Improving Mental Health and Wellbeing and the growing evidence base for excess cardiovascular and metabolic problems in people with mental health problems, the Dundee Health Screen Clinic was established in 2002 in a Community Resource Clinic within the city. The Clinic has adopted an integrated Multidisciplinary team approach consisting of medical input along with community nurses, occupational therapists, dietetics and physiotherapy. The initial objectives of the clinic were as follows:

- To provide at least annual health checks to the population prescribed antipsychotic medication;
- To offer advice on healthy lifestyle interventions including diet and exercise; and
- To offer education on mental health issues and medication management.

A pilot was conducted to assess the feasibility of health screening and define best practice. The results confirmed that this population had increased rates of modifiable risk factors and co morbid physical health problems. (Diagram 1).

<u>Modifiable risk factors</u>	<u>Prevalence</u>	<u>Compared to Normal</u>
<u>Population</u>		
Obesity	66% (n= 54/81 BMI > 30)	X
1.5-2		
Smoking	71% (n = 108/152 with 90%>20/day)	X 2-3
Elevated Random Glucose	7%* (n=8/108)	X2
Hypertension	32% (n=49/152)	
Elevated Total Cholesterol	60% (n=36/60)	X5

(dyslipidaemia)

*Previous history of DM/Impaired Glucose

Davidson S et al. *ANZ J Psych.* 2001;35(2):196-202. Allison et al. *J Clin Psychiatry.* 1999; 60(4):215-20. Dixon et al. *J Nerv Ment Dis.* 1999; 187(8):496-502. Herran et al. *Schizophr Res.* 2000; 21;41(2):373-8. Allebeck. *Schizophr Bull.* 1999;15(1)81-89.

The Health Screen is now a coordinated Healthy Lifestyle Programme with clear pathways for care in keeping with the UK Consensus guidance:

Minimising metabolic and cardiovascular risk in Schizophrenia (2007)²⁴ and the recently released Standards for Integrated Health Care Pathways for Mental Health (2007)²⁷.

A database has been set up to record clinical measurements and investigations conducted at the clinic to monitor for Metabolic Syndrome. Results are collected and relevant information fed back to General Practices and specialists to ensure appropriate follow-up. (Diagram 2).

Diagram 2

Blood results

- Full Blood Count
- Urea & Electrolytes
- Liver Function Tests
- Thyroid Function
- Prolactin
- Fasting Lipid Profile
- Fasting blood glucose level

Other Investigations

- Waist Circumference
- BMI (Wgt/hgt (kg/m²))
- ECG
- Vital signs
- Medical History/Lifestyle History
- Rating scales/cardiovascular risk

Of the first 100 patients audited 33% were identified with metabolic syndrome. This figure reflects similar studies conducted in the US and Europe identifying this population as high risk in terms of cardiovascular and metabolic problems such as Diabetes.

Of 100 User satisfaction questionnaires distributed, 46 % were returned by patients who had attended the clinic. 100% agreed the Quality of the Health Screen Clinic was very good to excellent and that the checks were important. 65% agreed to look at lifestyle changes as a result of their assessment.

The Future of the Health Screen Clinic Programme

The future plan is to develop further individualised lifestyle programmes to target high risk individuals identified with metabolic syndrome. The programme will include specialist dietary advice and a specific quantifiable exercise regime which will be monitored and supervised by a key worker along with a dietician and physiotherapist.

The aim of the programme is to improve the outcome for this high risk population by improving their physical wellbeing, life expectancy and their overall quality of life.

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NHS Western Isles

The concept of Psychiatric Annual Review Clinics (PARC) for patients with a severe and enduring mental illness was introduced in response, initially, to the targets and outcomes required from the NHS QIS *Standards for Schizophrenia*.

The diagnostic criteria was extended to include patients with either bi-polar or schizo-affective disorders.

These arrangements have been introduced for Lewis and Harris with a view to wider roll out soon to the Uists and Barra.

Procedure

Three weeks prior to the clinic, pro-forma letters are sent to both the patient and their GP. The patient letter explains the format of the clinic, asks the patient to make an appointment with their GP and encourages them to bring their principal carer to the clinic.

The GP letter and a form inviting a written up-date of their contacts with the patient, and current opinion covering any concerns around the patient's physical, mental or psychosocial needs and includes a list of tests that the GP is invited to perform (e.g. Prolactin, U & E's, Blood Lipids, LFT's, TFT's, FBC, B.P and ECGs).

This information is to be returned to the administrator with an up-to-date list of the patient's medication.

At the clinic, the patient has three consecutive appointments, in sequence, with

- A Community Psychiatric Nurse;
- A Specialist Social Work Practitioner in Mental Health; and finally with
- A Consultant Psychiatrist.

The CPN will have the returned pro-forma from the GP and will complete their section to include any outstanding concerns of the patient and/or their carer together with any presenting problems or areas of unmet need.

The CPN will carry out a global rating using the Health of the Nation Outcome Scales (HoNOS), will assess side-effects using the Autonomic Involuntary Movement Scale (AIMS) and measure weight.

The patient and their carer will then have an assessment by the Specialist Social Worker, again recorded on the same pro-forma.

Finally, the patient will be seen by the Consultant who will have the completed reports from the other professionals. The consultant will be able to access all of the results of the blood tests that were performed electronically from SCI store

At the end of the clinic the Consultant, CPN and Specialist Social Worker will meet to discuss findings. The completed pro-forma will form the main outcome record for the clinic.

Outcomes

To date, following 6 of these quarterly clinics, a number of positive results are shown.

- 3 patients have had under-active thyroids detected;
- 2 patients have had elective admissions for major changes in medication prompted by side-effects;
- A number of others have had changes made in the community and onward referrals to Social Work, Dietetics and the Mental Health Occupational Therapy Service; and
- Feedback from patients and carers has been very positive with carers, in particular, expressing satisfaction with what they describe as their “MOT Clinic”.

Challenges

The main challenge has been securing sign up by all practitioners. Many are now more responsive and we are hopeful for comprehensive engagement soon.

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General Medical Services Contract for Primary Medical Services⁵⁸

Since 2004 additional resources have been provided to deliver high quality and consistency of primary care healthcare services.

These have been made through the General Medical Services (GMS) contract by setting standards to address the management of illness, undertake health promotion and health protection, ill health prevention and improvement of health and public health. The expectation is that individuals' health is managed in the social context of their families/carers and the community in which they live.

The impact is monitored through the Quality and Outcomes Framework (QOF), which is published annually.

The contract includes; the provision of essential services; additional services; QOF and enhanced services. The first two are largely compulsory. The QOF and some enhanced services are optional. Enhanced services are commissioned at the discretion of NHS Boards and depend on local prioritisation. The Directed Enhanced Services are compulsory but are for NHS Boards to commission.

Encouragingly participation in the directed enhanced services and the QOF, which have to be offered by the NHS Boards, has been very high among the GMS Practices in Scotland. Practices not on the GMS contract have also attempted to deliver services to at least the level of the GMS contract.

GP Practices are resourced to provide primary health care to all individuals registered with the practice, as appropriate, whether they have mental ill health, physical ill health or are generally in good health. Therefore anyone with a mental health condition should receive similar attention and monitoring to those with physical ill health, and for co-existing physical conditions identified through the appropriate registers.

The following synopsis, gives some indication of the way in which GP Practices are supported to provide care to people They include:

Essential Services

These require the management of patients who are ill or believe themselves to be ill, including health promotion advice and referral as appropriate, reflecting patient choice wherever possible. Health promotion advice includes advice regarding life style issues such as weight management diet, smoking cessation, regular physical activity and moderation in alcohol intake.

Additional services

These include: Cervical screening; Child Health Surveillance; Maternity services; and Contraceptive services.

Quality and Outcomes Framework of the General Medical Services contract,

Indicators include the development of a register and specified clinical management of patients with a number of conditions.

The following QOF indicators are particularly relevant to the published commitment on physical and mental health:

- *Mental health* - register of people with schizophrenia, bipolar disorder and other psychoses; annual review to include routine health promotion and prevention advice appropriate to their age, gender and health status; monitoring lithium therapy; comprehensive care plan agreed with patients and their family/carers recorded; active follow up by the practice team, within 14 days, of people who fail to attend;
- *Dementia* - register of people with dementia; annual review of care;
- *Depression* - annual review of patients with diabetes and/or Coronary Heart Disease to check for depression; patients with a new diagnosis of depression have an assessment of severity using a tool validated for use in primary care;
- *Learning Disabilities* - register of patients with learning disabilities;
- *Obesity* - register only of patients 16 years and over with a BMI equal to or over 30 in the previous year; and

- *Smoking* - smoking cessation in patients with coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, asthma, and schizophrenia, bipolar disorder and other psychoses.

There are additional service related indicators.

Enhanced Services

These are essential and additional services delivered to a higher specified standard or those services not provided through essential and additional services.

- *Directed Enhanced Services* - minor surgery; childhood and influenza immunisations.
- *National Enhanced Services* - specialised drug and alcohol misuse services; specialised depression services; specialised services for sexual health; minor injury services; enhanced care of the homeless; contraceptive fitting (IUCD); specialised services of multiple sclerosis; and others.
- *Scottish Enhanced Services Programme* - NHS Boards can choose areas for development.

EXAMPLE GUIDANCE FOR QUALITY AND OUTCOMES FRAMEWORK MENTAL HEALTH INDICATORS (FOR GPs IN NHS GREATER GLASGOW AND CLYDE 2007)

Suggested Actions	Potential Responses
SUGGESTED HEALTH PROMOTION and PREVENTION ADVICE (MH9)	
1. Note CVD medical history, family history and systems enquiry (Chronic Disease Register Status)	1. Pursue any suspicious symptoms identified on systems enquiry
2. Health related behaviours <ul style="list-style-type: none"> ▪ Smoking; record if current smoker (quantity), ex-smoker or never smoked ▪ Diet; record if problematic ▪ Physical activity; ask if thinking about becoming more active <p>COMPLETE HEART HEALTH RISK SCORE</p>	2. Health related behaviours-intervention advice <ul style="list-style-type: none"> ▪ If wishes to discontinue offer referral, e.g.; local groups, community pharmacies ▪ Offer general dietary advice ▪ Aim to accumulate 30mins or more of moderate intensity physical activity over the course of most days per week. Can offer referral to Live Active or GCVS if appropriate
3. Risk behaviours <ul style="list-style-type: none"> ▪ Alcohol; record details and pattern of consumption ▪ Illicit drugs 	3. Risk behaviours <ul style="list-style-type: none"> ▪ If suspect hazardous drinking offer advice/referral ▪ If suspect hazardous illicit drug use discuss liaising with CMHT or CAT
4. Check if additional health promotion activity required <ul style="list-style-type: none"> ▪ flu /pneumococcal vac, sexual health including cervical smear and contraception, eye screening, dental check, etc 	4. Additional health promotion <ul style="list-style-type: none"> ▪ Discuss arrangements where indicated
5. Height/Weight/BMI <ul style="list-style-type: none"> ▪ Record details Plus waist circumference	5. Height/Weight/BMI <ul style="list-style-type: none"> ▪ If BMI is 25-30 (overweight) – offer advice ▪ If BMI > 30 (obese) – discuss referral to local weight management services
6. Pulse and blood pressure <ul style="list-style-type: none"> ▪ Record rate and regularity of pulse ▪ Record blood pressure 	6. Pulse and blood pressure <ul style="list-style-type: none"> ▪ If irregularly irregular refer to AF Guidelines ▪ If systolic >140 or diastolic >90 refer to hypertension guidelines and consider adding to the hypertension register
7. Investigations <ul style="list-style-type: none"> ▪ Glucose – it is good practice to check if; diagnosis in schizophrenia spectrum, or on any antipsychotic medication (cross check prescription with BNF), and no measurement recorded in the past 12 months (fasting lab sample preferred) CVD medication assessed ▪ Lipids – It is good practice to check if; on any antipsychotic medication (check BNF) and no measurement recorded in past 12 months. Total Cholesterol, High Density Lipids and Low Density Lipids. 	7. Investigations <ul style="list-style-type: none"> ▪ Repeat and/or refer to diabetes diagnostic criteria and diabetes MCN referral guidelines if abnormal result obtained ▪ Repeat and/or refer to cholesterol guidelines for management if abnormal result obtained and set cholesterol screening interval to annually.

MEDICATION MANAGEMENT (MH9, MH4, MH5)	
<p>8. Prescribing accuracy</p> <ul style="list-style-type: none"> ▪ Check if prescribed and taken medication matches recent CMHT communication ▪ Note any significant side effects ▪ Note willingness to continue on prescribed medication <p>9. If on Lithium;</p> <ul style="list-style-type: none"> ▪ Check level if no record of level in therapeutic range in past 6 months ▪ Check serum creatinine and TSH if no result recorded in past 15 months 	<p>8. Prescribing accuracy</p> <ul style="list-style-type: none"> ▪ Liaise with CMHT if significant problems identified <p>9. Action if levels/creatinine/TSH result unsatisfactory when on Lithium</p>
CARE PLANNING AND CO-ORDINATION WITH SECONDARY CARE (MH6, MH7) (refer to CPA and ICP documentation if in existence)	
<p>10. Determine current social care and occupational needs</p> <p>11. Review CMHT/voluntary sector/family input and co- ordination arrangements</p> <p>12. Discuss early warning signs (relapse signature) and action to be taken in the event of relapse</p> <p>Signposting and Referral Information Recorded</p>	<p>10. Discuss liaison with CMHT if significant problems identified</p> <p>11. Discuss liaison with CMHT/voluntary sector/family if significant problems identified</p> <p>12. Discuss liaison with CMHT/voluntary sector/family if significant problems identified</p>
PROACTIVE FOLLOW UP (MH7)	
<p>13. Recall within 14 days if fail to attend review appt.</p>	<p>13. If fail to attend three appts liaise with CMHT (if under their care) or send a fourth invite.</p>

Abbreviations

CMHT*	=	Community Mental Health Team
CAT	=	Community Addictions Team
CPA	=	Care Programming Team
ICP	=	Integrated Care Pathway
SW	=	Social Worker
AF	=	Atrial Fibrillation
BNF	=	British National Formulary
MCN	=	Managed Clinical Network
GCVS	=	Glasgow Council for Voluntary Services
MH	=	Mental Health Clinical Indicator Number from QOF

* Some CMHTs may not have an integrated Social Work team. In these circumstances liaison with Social Work colleagues may have to be done separately.

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