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Improving the physical health of people with mental health problems:

Actions for mental health nurses

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Contents

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- Royal Pharmaceutical Society
- UNITE - Mental Health Nurses Association

Foreword

The *Five Year Forward View for Mental Health* (2016) has once again highlighted that people with mental health problems have poorer physical health than the general population, often they are unable to access the physical healthcare they need and experience unnecessary health inequalities.

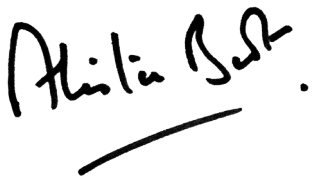
People with severe mental illness are particularly at risk and die on average 15-20 years earlier than the general population. Being in contact with mental health services does not necessarily mean that people will have a physical health assessment, have their physical health monitored, or receive the information and support they need to adopt a healthier lifestyle.

Mental health nurses have unparalleled opportunities to help people improve their physical health alongside their mental health, both in inpatient settings and in the community. Building on their skills and knowledge this resource will assist mental health nurses to identify the key risk factors that are known to adversely affect the physical health of people with mental health problems. By following the activities to achieve change, and learning from the good practice examples in this resource, they can build up their confidence and expertise and make improvements to people's health outcomes.

The Government is committed to putting healthcare for people with mental health problems, including people with co-existing learning disabilities, on an equal footing with people with physical problems. This means reducing unwarranted variation, so that individuals are supported to live healthy lives, and are empowered to make real progress towards bringing their life expectancy in line with the rest of the population.

NHS England has agreed that by 2020/21 at least 280,000 more people living with severe mental health problems should have their physical health needs met. Mental health nurses are crucial to making these improvements, and to the Government's goal of parity of esteem. Nurses must capitalise on the opportunities they have and make sure that people with whom they have the most contact have their physical health needs met by early detection and access to evidence based care and interventions.

This resource is a significant step forward encouraging mental health nurses to take an active role to ensure people's physical health needs are assessed and responded to. Drawing on the available evidence it will improve the monitoring of and reduction of the risk factors that have a detrimental effect on people's physical health and ultimately reduce health inequalities.



Alistair Burt

Minister of State for Community and Social Care
Department of Health

Improving physical health and wellbeing … a new resource

This resource is for mental health nurses, wherever they work, to take positive action to improve the physical health of people living with mental health problems. It builds on work to ensure parity of esteem between mental and physical health by giving equal attention to the physical health of people with mental health problems as is given to the general population. People with mental health problems should be supported to live healthy lives, and should be empowered to make real progress towards bringing their life expectancy in line with the rest of the population.

The resource supports the Government's commitment to ensure that people living with mental health problems have the same access to health checks and healthcare as the general population. It provides evidence based information about ways in which mental health nurses can improve the physical health and wellbeing of people living with mental health problems by tackling some of the key risk factors for physical health problems.

It complements other programmes of work underway to address the physical health needs of people with mental health problems within Health Education England (HEE), NHS England, Public Health England (PHE), Royal Colleges of Nursing, Midwifery, Physicians, Psychiatrists and Pharmacology and within national charities.

While this resource focuses primarily on adults with mental health problems including common mental illnesses, severe mental illness (SMI) and personality disorder, it is important to recognise that over half of all mental ill health starts before the age of 14 and 75% (excluding dementia) develops by the age of 18[1]. Children with mental health problems are at greater risk of physical health problems, just like adults they are more likely to smoke, drink alcohol and take drugs, undertake little physical activity and have poor diets, which contributes to poor physical health. The life chances of these individuals are significantly reduced in terms of their physical health, educational and work prospects and life expectancy.

A holistic approach to physical and mental health

A holistic approach to managing mental and physical health is needed. Physical and mental health are inextricably linked and it is detrimental to a person's overall wellbeing to regard these as two separate entities. There is strong evidence that having a long term mental health condition can be a significant risk factor for the development of physical ill health[2]. Conversely long term physical health conditions can lead to people suffering poor mental health.

People with SMI die on average 15 to 20 years earlier than other people[3]. This is mostly due to physical health problems which are often not diagnosed or managed efficiently and lifestyle factors which negatively affect physical health.

Key facts

- Mortality among mental health service users aged 19 and over in England was 3.6 times the rate of the general population in 2010/11.
- People in contact with specialist mental health services per 100,000 service users, compared with 100,000 in the general population, had a higher death rate for most causes of death, in particular:
  - nearly four times the rate of deaths from diseases of the respiratory system at 142.2, compared with the general population at 37.3
  - just over four times the rate of deaths from diseases of the digestive system at 126.1, compared with the general population at 28.5
  - nearly three times the rate of deaths from diseases of the circulatory system at 254, compared with the general population at 101.1.
- Within these disease areas specific conditions that accounted for a high proportion of deaths among service users (under the age of 75) were:
  - diseases of the liver at 7.6% of deaths (1,430 in total)
  - ischaemic heart diseases at 9.9% of all deaths (1,880 in total)[4].
- The relative difference in mortality rates was largest among people aged 30 to 39: almost five times that of the general population[5].
- People with severe and enduring mental health problems have the lowest employment rate of all groups of people with a disability at just 7%.
- There were 198 deaths of people detained under the Mental Health Act in 2013/14, the majority of which were due to natural causes, including preventable physical ill health[6].

Challenges across the system have contributed to the unacceptably large 'premature mortality gap'[7,8]. It is therefore imperative that people with mental health problems receive the physical healthcare that they require and have help in accessing support to have more healthy lifestyles.

The Government has identified a national priority to join up services across primary, secondary and crisis care in order to promote equal access, early intervention, choice, and recovery based on NICE quality standards of access for people with mental health problems.

Better partnership between primary and secondary care can help share expertise, instil confidence and also help overcome barriers to high quality care. Good communication between all healthcare professionals involved in the care of those with mental health problems helps to avoid duplication or fragmentation of care. While many NHS mental health and independent providers have already begun to implement programmes to improve the physical health of people living with mental health problems, there is still unwarranted variation across the country.

A commitment to action

This resource is part of the Government's commitment to a wider programme of work to improve the physical health of people living with mental health problems.

- The NHS *Five Year Forward View*[5] commits the NHS to take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. It recognises that:
  - over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together.
- The report from the Independent Mental Health Taskforce to the NHS in England[6] has made a number of recommendations.
  - NHS England should undertake work to define a quantified national reduction in premature mortality among people with severe mental illness, and an operational plan to begin achieving it from 2017/18. NHS England should also lead work to ensure that by 2020/21, 280,000 more people living with severe mental illness have their physical health needs met by increasing early detection and expanding access to evidence based physical care assessment and intervention.
  - PHE should prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes. This includes primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. As part of this, NHS England and PHE should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018.
  - By April 2017, HEE should work with the Academy of Medical Royal Colleges to develop standards for all prescribing health professionals that include discussion of the risks and benefits of medication, and take into account people's personal preferences, including preventative physical health support and the provision of accessible information to support informed decision making.

A commitment to action *cont*

- NHS England is committed to working with PHE and a range of partner organisations to provide a clear steer to commissioners about the evidence base relating to clinical interventions and service developments which are likely to have the greatest impact.
- *Achieving Better Access to Mental Health Services by 2020*[1], sets out a clear vision to ensure mental and physical health services are given equal priority in terms of timely access to high quality services. It emphasises that *'the physical needs of people with mental health conditions need to be assessed routinely alongside their psychological needs and vice versa'.*
- The Commissioning for Quality and Innovation (CQUIN)[9] payment framework enables commissioners of services to reward excellence among providers of mental health services through the achievement of quality improvement goals. The CQUIN 2016/17 indicator 3a – Cardio metabolic assessment and treatment for patients with psychoses, aims to ensure that patients with SMI have comprehensive cardio metabolic risk assessments, have access to the necessary treatments/interventions and the results are recorded in the patient's record and shared appropriately with the patient and the treating clinical teams. The cardio metabolic parameters based on the Lester Tool (see Appendix 1) include smoking status; lifestyle (including exercise, diet alcohol and drugs); body mass index; blood pressure; glucose regulation; blood lipids.
- HEE's workforce transformation programmes will include training in supporting the physical health needs of users of mental health services in the children and young people, mental health, learning disabilities and early interventions in psychosis.
- HEE will continue to support a wide range of training opportunities and resources developed at a local level by HEE local teams, in conjunction with higher education partners and academic health science networks.

Improving outcomes for people living with mental health problems

There is overwhelming evidence from the Marmot Review[10] on health inequalities that addressing lifestyle factors alone will not increase the life expectancy of people with mental health problems. Mental health nurses have an important role in addressing all determinants of health through assessing, referring, delivering and facilitating psychosocial, psychological and physical interventions. Recovery oriented services and peer-led approaches that address underpinning factors of health inequalities will help individuals to maintain social relationships, access good housing, employment and improve wellbeing and resilience, which will have a major impact on physical and mental health.

There is also evidence to suggest that diagnostic overshadowing can lead a practitioner to misattribute a physical health symptom as an expression of mental illness rather than a genuine physical complaint[11]. Interventions that optimise physical, mental and social elements of health and wellbeing include health promotion to maximise prevention and reduce the risks associated with the onset of illness, and ultimately lead to a reduction in premature mortality.

The reasons why people with mental health problems experience an increased burden of physical health needs are complex. These are identified in the diagram on page 11.

Eight key areas for action to improve health outcomes have been identified*. Each of these areas is associated with particular risk factors that can have a detrimental effect on physical health and reduce life expectancy.

The action areas are:

- **Support to quit smoking**
- **Tackling obesity**
- **Improving physical activity levels**
- **Reducing alcohol and substance use**
- **Sexual and reproductive health**
- **Medicine optimisation**
- **Dental and oral health**
- **Reducing falls**

These action areas are addressed in more detail in the following sections with a focus on the main headlines associated with each risk, why mental health nurses need to take action, activities to achieve change, examples of good practice and a review of the evidence base for practice.

* The Department of Health carried out a survey of mental health providers about improving the physical health of people living with mental health problems in 2014. The survey identified a number of successful interventions that can improve the physical health of people who receive mental health services. Interventions included offering physical health screening, promoting healthier lifestyles and inpatient services becoming smoke free in compliance with NICE recommendations.

Interrelated dynamic elements affecting people's physical health

Metabolic syndrome and people with mental health problems

People with mental health problems are likely to be exposed to a combination of different risk factors and have a higher level of metabolic syndrome and co-morbidities than the general population.

The physical health conditions making up metabolic syndrome include:

- obesity
- high blood pressure
- raised blood sugar levels
- abnormal cholesterol levels.

Individually, these health conditions can cause damage, but three or more together are particularly dangerous, and increase the risk of serious and life threatening illnesses including heart disease, stroke and diabetes[12].

Metabolic syndrome is particularly common amongst Asian and African-Caribbean people and women with polycystic ovary syndrome (PCOS). People with metabolic syndrome have a 3-6 fold increased risk of mortality due to coronary heart disease and a 5-6 fold increased risk of developing type 2 diabetes[13].

Many psychiatric medicines, antipsychotics in particular, are associated with increased risk of metabolic syndrome. Despite this, the majority of patients receiving antipsychotic treatment in psychiatric hospitals or general healthcare clinics are not monitored for metabolic risk factors, even those that are simple to measure, such as obesity and high blood pressure[14]. The lack of monitoring and interventions often means metabolic syndrome is underdiagnosed and undertreated among people with SMI.

People with long term physical conditions such as diabetes, high blood pressure and obesity are also likely to experience mental ill health, such as anxiety and depression, as well as social isolation, low self-esteem, stigma and discrimination[8].

Cardiovascular disease

Cardiovascular or circulatory diseases (CVD), such as heart disease and stroke, accounted for just over a quarter (27%) of all deaths (135,904) registered in 2014 in England and Wales, with ischaemic heart disease accounting for 60,509 (12.1%) deaths and stroke for 34,157 deaths[15].

The risk factors associated with CVD are smoking, high blood pressure (hypertension), high cholesterol, diabetes, lack of exercise, being overweight or obese, a family history of heart disease, and ethnic background. The amount of alcohol people drink and how they deal with stress are also thought to be linked[16].

Diabetes

Diabetes is one of the most common long term health conditions. In the UK there are 3.3 million people diagnosed with diabetes and an estimated 590,000 people who have the condition, but are unaware of it. In 2014, there were 5,314 deaths from diabetes registered in England and Wales.

The prevalence of diabetes has been reported to be 2–3 fold higher in people with schizophrenia than the general population[17].

Increasingly, brief psychotherapeutic interventions are being integrated as part of diabetes treatment and education, supporting treatment adherence among service users of all ages and helping to prevent some of the suffering associated with the condition.

Regular physical health checks

Regular physical health checks, which include lifestyle and family medical history and routine tests such as weight, blood pressure, glucose and fats or lipids, can identify potential problems before they develop into serious conditions, such as those described above.

Several tools have been developed to provide clear physical health monitoring standards for people with severe mental illness, such as the Lester tool (see Appendix 1). Some NHS trusts have also developed their own tools to undertake appropriate health checks.

Health screening

Health screening is an effective way to diagnose certain conditions which can benefit from early diagnosis. The NHS provides a range of population health screening programmes to identify people who appear healthy, but may be at increased risk of a disease or condition. Information on current screening programmes is available on the Public Health England website[18].

Mental health nurses should support people with mental health problems, who are eligible, to access these screening programmes (see Appendix 1). For example, they can provide information about the screening programmes for breast, cervical and bowel cancer; and abdominal aortic aneurysm, including the eligibility criteria and screening frequency.

Taking action: the role of mental health nurses

The person-centred, holistic nature of the therapeutic relationship between mental health nurses and service users means that nurses are ideally placed and have a vital role to play in prevention of physical ill health, increasing early detection of illness and reducing premature morbidity, enabling people to live healthier and longer lives.

Making Every Contact Count[19] involves tailoring nursing activities and interventions to an individual's needs. This includes providing practical advice, support and solutions to empower individuals to make positive health choices and changes to their lifestyle, and ensuring that they receive the relevant physical health assessments and care that they need.

Working in partnership

Working in partnership with other health professionals and drawing on local knowledge, mental health nurses can identify key areas of support and resources for recovery across health and social care. They can make connections and manage referrals to ease transition from one service to another, across inpatient and community care, health and social care, specialist and community services, with appropriate guidance and support. For example, mental health nurses can collaborate with pharmacy teams, both in hospitals and in the local community to improve people's health, focusing on areas such as smoking, alcohol and substance misuse, sexual and reproductive health and medicine optimisation.

Some trusts employ registered adult nurses to work alongside mental health nurse colleagues as part of the multidisciplinary team on acute mental health wards. This is proving valuable in supporting staff and service users to raise the physical health agenda. Some trusts have also set up physical health link nurse meetings, to discuss areas of practice and enhance shared learning.

Knowledge and skills

Mental health nurses must make sure that people's physical, social and psychological needs are assessed and responded to[20]. They must also recognise and work within the limits of their competence.

There should be opportunities through continuing professional development to acquire the knowledge and skills needed to carry out the activities identified in this resource.

To help identify their own development needs mental health nurses will need to ask themselves 'Do I feel competent to do this?' – 'Do I need further training in additional skills, such as motivational interviewing, or do I need to access specialist help?'

Mental health nurses may need to identify how they secure additional support and training if they lack confidence in particular areas, for example, to discuss and address concerns or issues with individuals regarding their sexual activity, or refreshing skills and knowledge associated with monitoring and recording physical observations and conditions, as well as the physical side effects of medicines.

The Department of Health has commissioned Skills for Health, Health Education England and Skills for Care to develop a Mental Health Core Skills, Education and Training Framework[21] for the mental health workforce. The framework includes supporting the physical health needs of people with mental health problems, and will be published in 2016.

RightCare programme

The RightCare programme[22] aims to demonstrate, through using a range of tools, where unwarranted variation exists and how to address it. RightCare includes the Atlas of Variation series, which demonstrates that it is possible to achieve better outcomes by looking at local data, and asking whether the outcomes being achieved are as good as those achieved by the best.

The 2015 Atlas of Variation has more than 100 maps covering a wide range of care including mental health, which enable local comparisons between clinical commissioning groups, NHS trusts, local authorities or NHS area teams, depending on the nature of the subject.

RightCare shares best practice by providing local examples of innovations that demonstrate the philosophy behind RightCare, and has a three-stage approach to drive improvement.

Step one: 'Where to look'

Because of the variety and comprehensiveness of its data, the Atlas of Variation represents an ideal starting point for making comparisons and identifying quickly which local services are outliers. It indicates where more detailed investigation should be focused to increase value.

Step two: 'What to change'

Identifies exactly which aspects of services can be improved locally. This typically involves a 'deep dive' into a particular care pathway to gain more detailed insight into what is working well, and what is not. This additional information informs the case for change.

Step three: 'How to change'

Proving the credibility and viability of the proposed change and then implementing it. This requires the disciplined use of reliable processes, including programme management, stakeholder engagement, analysis of the potential impact on service providers and a sound business case.

The RightCare programme can support mental health nurses to identify and reduce unwarranted variation. Addressing unwarranted variation can help to narrow the gaps in relation to health and wellbeing, care and quality, and funding and efficiency.

A framework for action

- **Review the eight action areas identified in this resource.**
- **Use the RightCare methodologies to identify and reduce unwarranted variations in practice, in your area.**
- **Follow the relevant NICE guidelines for each action area.**
- **Consider the activities to achieve change for each action area in relation to the needs and care of individuals and the development of their care plans.**
- **Develop a person-centred action plan for each individual to address their physical health needs.**
- **Use the Making Every Contact Count (MECC)[19] toolkit to focus on 'change behaviour'.**
- **Use the stages of care planning: 'assess', 'plan', 'implement' and 'evaluate' as a cycle to achieve improvements in individuals' physical health and wellbeing.**

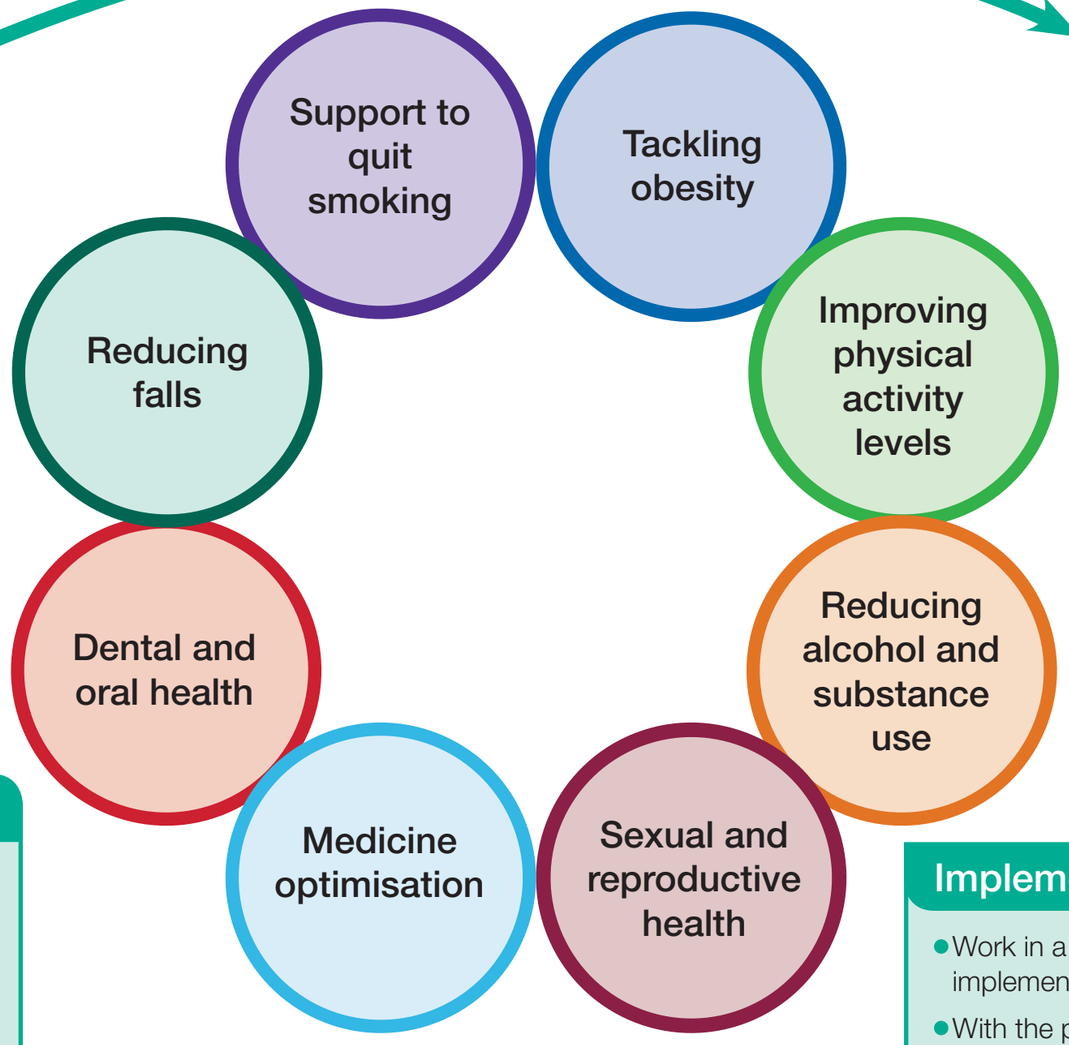
Care planning: exploring the potential for individual change and improving physical health

Assess

- Use a person centred approach to assess the individual's current physical health
- Listen to the person, their preferences and concerns
- Identify what is important to the person, how they live their life and what they want to change
- Acknowledge and address the individual's fears and anxieties
- Use an appropriate physical assessment tool

Plan

- Work with the individual to create a shared care plan for improving their physical health and wellbeing
- Identify key goals and aspirations, set dates and times that are realistic and manageable for achieving measurable outcomes
- Identify local health, social care and/or voluntary services that can provide particular types of support
- With the person's consent, work in partnership with other healthcare professionals to promote equal access to all appropriate healthcare
- Agree what will be in the care plan and give a copy to the individual



Implement

- Work in a person centred, integrated, holistic way to implement the plan of care
- With the person's consent, involve carers and other healthcare professionals if appropriate
- Make sure the individual receives treatment for their physical health problems
- Use the activities to achieve change outlined under each action area
- Continually encourage individuals to take care of their physical health

Evaluate

- Monitor and review progress with the individual and refine and adjust care plans if necessary
- Discuss and record outcomes of specific actions and interventions with the individual
- Gather evidence on the impact of any changes, for example by repeating assessment tool measures
- Review priorities and action areas and negotiate with the individual to update their care plan
- Repeat the care planning cycle

1 Action on… Support to quit smoking

The headlines

- **Smoking is the largest cause of preventable ill health and premature mortality.**
- **Smoking is a proven risk for cancer, respiratory disease and circulatory disease, which are all major causes of premature mortality.**
- **Smoking significantly increases the complication rate for diabetes.**
- **Half of all long term smokers will die from a smoking related illness.**
- **40% of all tobacco is smoked by people living with mental health problems.**
- **In some mental health inpatient settings, smoking rates are as high as 64%.**
- **A third (33%) of people with mental health problems and more than two thirds (70%) of people in psychiatric units smoke tobacco[23].**
- **An average of one in six people admitted to hospital is a current smoker, this figure is three times higher among people with mental health problems, over half of whom are smokers.**

Why mental health nurses need to take action

Smoking is the main cause of preventable illness and premature death in England. People with a longstanding mental health problem are twice as likely to smoke as those without mental health problem. Not only is smoking more common in this group but the degree of addiction is greater. Mortality among people with SMI is substantially higher than among the general population, and smoking is one of the factors contributing to this outcome[24].

A variety of drugs can be smoked, e.g. cannabis, synthetic cannabinoids, crack cocaine, heroin, which also have an adverse effect on the respiratory system and exacerbate any pre-existing respiratory problems. Tobacco smoking is also highly prevalent in alcohol and substance users (see Action on Reducing alcohol and substance use).

Supporting people with mental health problems to quit smoking is the single largest, most effective intervention to reduce physical ill health and premature death. Quitting smoking also has a positive impact on mental wellbeing and can make a big difference to an individual's financial welfare, lifting many out of poverty.

People with a mental health condition are just as likely to want to stop smoking as other smokers but they face more barriers to quitting and are more likely to be dependant and therefore need more support. Respondents to the ASH survey[25] reported that smoking was not being routinely discussed with them in health and social care settings. Of those who smoked, 43% said they had not been spoken to by any health professional about their smoking in the past year. Of those who had been asked, 23% said they were not always advised to stop, while 37% said they were advised to stop but not always offered any help to do so.

Quitting smoking does not exacerbate poor mental health, and actually has a positive impact on anxiety and depression, similar to taking antidepressants. Quitting smoking may also provide an opportunity to reduce the dose of some psychotropic medicines, which may also result in fewer side effects (see Action on Medicine optimisation).

The Report from the Independent Mental Health Taskforce to the NHS in England, recommended that NHS England and PHE should support mental health inpatient units and facilities (for adults, children and young people) to be smoke free by 2018[6].

Activities to achieve change

- Routinely ask people if they smoke.
- Advise people that the best way to quit smoking is with a combination of support and medication and that this help is available.
- Offer brief advice and information to encourage people to quit smoking.
- Support people who wish to cut down or quit smoking to get access to smoking cessation services.
- Develop skills and confidence to administer nicotine replacement therapy.
- Support people who wish to cut down or quit smoking using e-cigarette devices, which are considered to be 95% safer than smoking[26].
- Support people who experience smoking withdrawal symptoms.
- Engage with local smoking cessation services in planning and delivering community activity for people living with mental health problems and to support those in transition from inpatient to community services.
- Support and lead activities within trusts to become completely smoke free and compliant with NICE recommendations.

NICE Guidelines	Supporting tools
Smoking cessation in secondary care: acute, maternity and mental health services, NICE guidelines [PH48] November 2013 Smoking: harm reduction, NICE quality standard [QS92] July 2015 Smoking: harm reduction, NICE guidelines [PH45] June 2013 Smoking: reducing and preventing tobacco use, NICE quality standard [QS82] March 2015 Stop smoking services, NICE guidelines [PH10] February 2008 Psychosis and schizophrenia in adults: prevention and management, NICE guidelines [CG178] February 2014	The Lester tool Integrated Physical Health Pathway JBS3 Risk calculator Primary Care Guidance on Smoking and Mental Disorders

Examples of good practice to quit smoking

West London Mental Health NHS Trust: Working towards smoke free

West London Mental Health developed an inpatient quit smoking service to support nicotine withdrawal, cutting down to quit and quitting smoking. The service focuses on addressing individuals' wellbeing, physical activities and mental health medication use. Initially they worked with staff to create a positive approach to quitting smoking. There were challenges as staff felt that they were taking something away from people. However, staff started to observe reduction in cigarette use among service users and how nicotine replacement could be beneficial during admission leading to a positive attitude among staff. Training was rolled out for staff to support care plans.

To engage service users, a weekly psycho-education lesson was offered to improve their knowledge about smoking in mental health, the benefits of quitting, and the psychological and physiological effects of smoking. This was supported by a nicotine withdrawal programme. There is no limit to how many times patients can attend the programme which is tailored to service users' needs and incorporates techniques like cognitive behavioural therapy, motivational interviewing and the international treatment effectiveness project (ITEP) mapping. This intervention uses maps as a way of creating a visual 'hook' for the discussion together with other psycho-educational materials and handouts. This is very effective with service users, as it challenges and changes the way they think about smoking.

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Cygnet Hospital: Working towards a smoke free organisation

The journey to being a smoke free organisation involves staff and service users. At Cygnet Hospital Beckton, which provides care for women with complex mental health needs, part of Cygnet Health Care, Jennifer Beal, head of occupational therapy worked in partnership with four service users to develop and implement a training programme for both staff and service users.

The training included a 20 item pre-training smoking cessation quiz, information to build on existing skills and knowledge, scenarios to understand the inpatient experience of smoke free, and information to obtain further resources or access to higher level training. A list of activities to beat cravings helps patients to give up, together with products to manage withdrawal symptoms such as patches, nasal sprays, inhalers, and mouth sprays.

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The evidence base

There is a long standing assumption that smoking helps people deal with stressful situations, however, evidence contradicts this and reinforces the association between smoking and serious health conditions as well as poorer mental health. Nicotine mediates the release of neurotransmitters, e.g. dopamine, leading to enhanced arousal, increased vigilance, appetite suppression, mood changes, poorer memory, lowered attention and reduced cognitive functions.

There has been a steady reduction in the number of adults in Great Britain who smoke, from 82% in 1948, to 19% of adults currently smoking. However, for people living with mental health problems, there has been virtually no change in the smoking rate.

The 'smoking culture' within mental healthcare settings is one of the most important barriers to helping people quit smoking during inpatient stays. Lawn and Pols[27] saw smoking as representing an *'entrenched process that has been central to the history of mental institutions over the past three centuries'*. In some mental health settings smoking rates are as high as 64%[28].

A study[29] found that the vast majority of mental healthcare staff did not feel that addressing patients' smoking would have an adverse impact on the therapeutic relationship (86.7%), or that quitting smoking during treatment for their mental health problem would have a negative impact on their recovery (81.4%). However, this study also showed that only 48% of the respondents felt that addressing smoking was within their remit of responsibility as a mental health professional.

Smoking rates among adults with depression and anxiety disorders is 32%[30], among adults with psychosis is 60% and 88% of adults with substance use disorder[31] compared to 19% of the general adult population. There is an association between smoking and increased risk of having mental health problems[32].

Smoking cessation is associated with reduced feelings of depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke. The effects of quitting smoking are equal or larger than the effect of taking antidepressant treatment for mood and anxiety disorders[33].

Smoking causes or exacerbates many physical illnesses, but most of the mortality and morbidity caused by smoking at population level arise from effects on the risk of lung cancer, cardiovascular disease and chronic obstructive pulmonary disease [34, 35].

Studies highlight the ability of people living with mental health problems to quit smoking successfully, without detriment to their longer term mental health[36, 37].

2 Action on… Tackling obesity

The headlines

- **There has been a marked increase in the proportion of adults that are obese in England between 1993 and 2013 - from 13.2% to 26% for men, and from 16.4% to 23.8% for women.**
- **People that were overweight, including obese, increased from 57.6% to 67.1% in men and from 48.6% to 57.2% in women[38].**
- **People who are overweight have a higher risk of getting type 2 diabetes, heart disease and certain cancers.**
- **Excess weight can also make it more difficult for people to find and keep work, and can affect self-esteem and mental health.**
- **Most people in England eat and drink too many calories, too much fat, sugar and salt, and not enough fruit, vegetables, oily fish and fibre. This together with low activity leads to an increase in obesity levels.**
- **A healthy diet has been shown to help reduce the risk of both physical and mental illness.**

Why mental health nurses need to take action

People with mental health problems are more likely to have weight fluctuations related to their mental health and associated dietary habits, resulting in either obesity or undernourishment associated with anorexia, and as a side effect of medicines (see Action on Medicine optimisation). Either of these extremes of diet can lead people with mental health problems to have an increased risk of major physical health problems.

NICE recommends baseline measures, such as waistline and body mass index (BMI), are taken prior to starting medication and are monitored (depending on the medication) at regular intervals throughout treatment. Most weight interventions amongst individuals with mental illness use BMI as an outcome measure, although many recommend simply using a waist circumference measure as it is a stronger predictor for complications such as diabetes and heart disease[39].

Weight management programmes have been shown to help people change their behaviour, to reduce their energy intake and be more physically active. Even small reductions in weight and slight increases in physical activity (see Action on Improving physical activity levels) are proven to reduce the risk of the main diseases associated with obesity, for example: coronary heart disease, stroke, hypertension, osteoarthritis, type 2 diabetes and various cancers (endometrial, breast, kidney and colon)[40].

Healthy eating is not about being on a diet, it is about eating a balanced diet with a wide variety of foods in the right proportions. This helps to maintain a healthy body weight that provides people with the energy and nutrients they need to be healthy. Eating well requires making good dietary choices. This can be challenging for some people, but can be more difficult for people with mental health problems. Consideration should also be given to individuals' lifestyle, for example, do individuals have basic cooking skills, access to cooking implements (some in hostel accommodation may not have this), adequate finances and budget management etc. given that most adults with mental health problems are treated in the community.

Interventions to improve diet (and reduce energy intake) should include dietary modification, targeted advice and support, family involvement and goal setting, tailored to the individual person's needs, culture and beliefs.

Activities to achieve change

- Routinely ask people about their diet when undertaking a nursing assessment, explaining why it is important to eat and drink healthily.
- Regularly monitor the weight of individuals by use of ongoing measurement, e.g. BMI/girth and weight.
- Ensure care plans focus on the individual's needs, and address their nutrition and weight management.
- Offer advice on eating a healthy balanced diet, healthy food choices, meal preparation, eating habits and how to use food labels and the Eatwell Guide.
- Advise people to limit consumption of energy dense food and drinks prepared outside the home, particularly 'fast' or 'takeaway' foods.
- Refer people to lifestyle weight management programmes. This should be offered as routine care for anyone prescribed antipsychotic medicines.
- Particular emphasis should be given to first episode patients to focus on prevention rather than cure.
- Work in conjunction with other partners, e.g. dieticians, catering departments, to increase access to healthier food choices within mental healthcare settings.
- Review medication, if it is contributing to weight gain.

NICE Guidelines

Preventing excessive weight gain, NICE guidelines [NG7], March 2015

Obesity in adults – prevention and lifestyle weight management programmes, NICE quality standard [QS111], January 2016

Obesity: identification, assessment and management, NICE guidelines [CG189], November 2014

Obesity prevention, NICE guidelines [CG43], December 2006

Type 2 diabetes in adults: management, NICE guidelines [NG28], December 2015

Weight management: lifestyle services for overweight or obese adults. NICE Guidelines [PH53], May 2014

Supporting tools

The Lester tool

Integrated Physical Health Pathway

JBS3 Risk calculator

Malnutrition Universal Screening Tool (MUST)

Eatwell Guide

Examples of good practice to tackle obesity

CAMEO: Developing nutritional advice to support physical fitness

CAMEO is an early intervention service assessing and treating clients having first episode psychosis. CAMEO offers basic nutritional advice to individuals and access to external smoking cessation clinics for support.

It is part of Cambridge and Peterborough NHS Foundation Trust. Richard De Rosa, the support time recovery worker is undertaking an advanced qualification in physical health which will enable him to offer support to CAMEO service users with a more advanced and holistic programme, incorporating nutritional advice alongside physical fitness programme if required.

Strong links with community-based organisations have been developed and staff work in partnership with these organisations to help deliver both individual and group based interventions. These partnerships mean that service users can continue to access these physical health environments and programmes on an independent level.

Work is also ongoing in developing a healthy eating and smoking cessation clinic to run alongside the physical health clinic which will allow service users to access both healthy eating and smoking cessation support.

Contact: Richard De Rosa, Support Time Recovery Worker, CAMEO North, 53 Thorpe Road, Peterborough PE3 6AN

Email: Richard.derosa@cpft.nhs.uk

Oxleas NHS Foundation Trust: Early intervention in psychosis

Mental health nurses worked with the trust to commission a bespoke package of activities for early intervention psychosis clients from Charlton Athletic community trust. The main aims of the programme are to increase confidence and self-esteem, to develop new social networks and to increase physical wellbeing as part of the recovery process. Each individual has a programme of activities and a nominated clinician is responsible for supporting the activity to help improve an individual's physical health and wellbeing including their diet by encouraging healthy eating.

The initiative began when the Charlton Athletic football club returned to The Valley in 1992. It started with just one member of staff, a bag of footballs and a telephone and has now grown into an organisation that employs over 120 members of staff and has a pool of over 100 casual coaches and engages with approximately 10,000 young people on a weekly basis.

Contact: Early Intervention in Psychosis Service, Oxleas NHS Foundation Trust, Pinewood House, Pinewood Place, Dartford, Kent DA2 7WG

Email: Gordon.McKay@oxleas.nhs.uk

The evidence base

People with severe mental health problems, such as schizophrenia and bipolar disorder have higher rates of obesity than the general population, which is often confounded by the side effects of medicines[41].

Evidence suggests combining a healthy diet with physical activity has the potential to improve the quality of life, including improved self-esteem and wellbeing. A randomised controlled clinical trial on behavioural interventions for antipsychotic medication-associated obesity, suggests that behavioural interventions are effective in SMI patients. The treatment intervention, which included food and exercise diaries, weekly classes, individual counselling for eight weeks, rewards, caregiver consultations, and monthly booster classes and counselling for one year, was found to be more effective than usual care control in treating medication-associated obesity, independent of SMI diagnosis, antipsychotic medication, and knowledge gained[42].

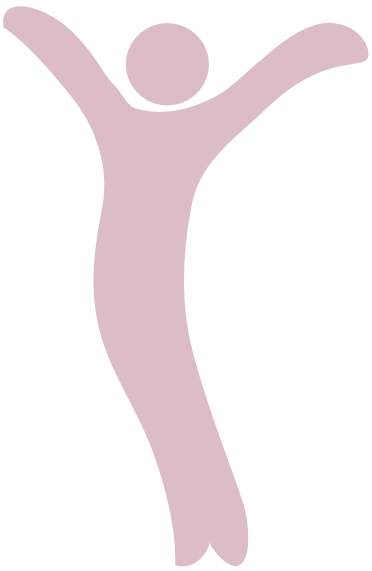
Evidence shows that using labels on food packages can help provide the information needed to make healthier choices when buying food. The front-of-pack nutrition labelling is colour-coded red, amber and green, showing if the food or drink has high, medium or low amounts of fat, saturated fat, sugars and salt. For a healthier choice people should go for more greens and ambers, and fewer reds.

The Eatwell Guide forms the basis of the Government's healthy eating advice to the general population. It makes healthy eating easier to understand by giving a visual representation of the types and proportions of foods that should be eaten to make a well-balanced, healthy diet. This includes snacks as well as meals. The Eatwell Guide[43] is intended as a guide to the overall balance of the diet over a day or a week rather than for any specific meal.

Losing 5-10% of body weight has been shown to decrease cholesterol, high blood pressure, insulin levels, diabetes, sleep apnoea and inflammation[44].

Weight maintenance is associated with an internal motivation to lose weight, social support, better coping strategies and ability to handle life stress, self-efficacy, autonomy, assuming responsibility in life, and overall more psychological strength and stability[45].

A study that reviewed the data on the prevalence of successful weight loss maintenance from the National Weight Control Registry in the USA, with more than 4,000 individuals registered, found there are several factors that lead to success. These were engaging in high levels of physical activity; eating a diet that is low in calories and fat; eating breakfast; self-monitoring weight on a regular basis; maintaining a consistent eating pattern; and catching 'slips' before they turn into larger regains. Moreover, individuals who had kept their weight off for two years or more had markedly increased odds of continuing to maintain their weight over the following years[46].



3 Action on… Improving physical activity levels

The headlines

- **Many people with mental health problems do not take enough physical exercise.**
- **Increasing physical activity can improve physical and mental health, enhance psychological wellbeing, reduce mortality and improve life expectancy.**
- **Regular physical activity reduces the risk of cardiovascular disease, type 2 diabetes, and depression, improves self-esteem and reduces stress and anxiety. Even small increases in physical activity have beneficial effects.**
- **Physical activity may improve some aspects of cognitive function and is also associated with a reduced risk of developing problems of cognitive impairment in old age.**
- **Introducing activities and encouraging people to undertake regular mild physical activity as part of their daily routine can see benefits in health and wellbeing over time[47].**

Why mental health nurses need to take action

Lack of physical activity and excessive sitting is linked to:

- being overweight and obese
- increased risk of cardiovascular disease
- type 2 diabetes
- some types of cancer, particularly colon and breast
- depression
- muscle wastage
- orthopaedic problems resulting from inactivity.

People with severe mental health problems, such as schizophrenia and bipolar disorder are more likely to be sedentary and have high rates of obesity, confounded by the side effects of medicines.

The 2011 report from the UK Chief Medical Officers[48] sets out physical activity recommendations for different groups. For adults:

- over a week, activity should add up to 150 minutes (2½ hours) of moderate-intensity activity, in bouts of 10 minutes or more. One way to approach this is to do 30 minutes on at least 5 days a week
- alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or combinations of moderate and vigorous intensity activity
- adults should also undertake physical activity such as gym work, yoga or carrying bags, to improve muscle strength on at least two days a week
- adults can improve their balance by activities such as tai chi, dancing and bowls
- all adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Interventions to increase physical activity should focus on activities that fit easily into people's everyday life (such as walking), and minimising sedentary behaviour such as watching TV and playing video games. Interventions should be tailored to people's individual preferences and circumstances and should aim to improve people's belief in their ability to change.

Activities to achieve change

- Include an assessment of a person's physical activity levels when undertaking a nursing assessment:
  - on average how many days a week do you engage in moderate to vigorous physical activity like a brisk walk?
  - on those days, on average, how many minutes do you engage in physical activity at this level?
- Encourage individuals to engage in the recommended 150 minutes of physical activity each week.
- Use the physical activity benefits guide (see Appendix 1) when discussing physical activity with individuals to assess their ability and suitability for increasing physical activity.
- Request additional support to assess the fitness of individuals and develop meaningful care plans if needed.
- Work with local partners and other agencies to ensure service users have access to leisure centres, gyms, and sports facilities.

NICE Guidelines	Supporting tools
Physical activity: brief advice for adults in primary care, NICE guidelines [PH44], May 2013 Physical activity: encouraging activity in all people in contact with the NHS, NICE quality standard [QS84], March 2015 Physical activity: exercise referral schemes, NICE guidelines [PH54], September 2014 Service user experience in adult mental health, NICE quality standard [QS14], December 2011	The Lester tool Integrated Physical Health Pathway JBS3 Risk calculator Physical Activity Benefits Guide

Examples of good practice to increase physical activity

Somerset Partnership NHS Foundation Trust: Healthy lifestyle officers

The role of the healthy lifestyle officer is to encourage inpatients to become more physically active and live a healthier lifestyle. They offer a variety of activities including using the gym facilities, basketball, table tennis, local walks and cycling. People are offered education on the benefits of physical activity, which include a reduced risk of cardiac disease, increased ability to carry out daily tasks, increase in confidence, lower blood pressure, and the ability to help maintain a healthier weight. Healthy lifestyle officers also facilitate a healthy lifestyle cooking group, which allows people to choose healthy meals to cook from scratch and on a budget. These meals are low calorie and the aim is to emphasise portion size control as well as providing a healthy balanced meal.

They also undertake weekly basic observations and blood pressure checks to monitor if anyone has a sudden increase in weight or blood pressure and discuss ways of losing weight and maintaining a healthier lifestyle.

Within two of the adult acute wards and psychiatric intensive care unit the team employ a fitness instructor who provides two sessions a week for inpatients. Each session consists of a combination of activities including easy exercise, gym induction and health promotion strategies. People moving on from hospital will be provided with links to local leisure facilities, which they can access after leaving the inpatient service.

Contact: Timothy Young, Deputy Head of Division, Adult Mental Health Inpatient and Crisis Services, Somerset Partnership NHS Foundation Trust, 2nd Floor, Mallard Court, Express Park, Bristol Road, Bridgwater TA6 4RN

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Cumbria Partnership NHS Foundation Trust: Football group

Cumbria Partnership NHS Foundation Trust ventured into partnership with Carlisle United Football Club (CUFC) and the Cumberland FA in 2013, to develop a weekly football group aimed specifically at promoting social inclusion and physical health outcomes for people living with mental health problems in the area.

The sessions are co-facilitated by Hadrian Unit's Activity Coordinator and CUFC coaching staff. The group has gone from strength to strength with at least 15 people attending each week, participating in a local weekly league, as well as taking part in the North West Mental Health League twice a year. Audit results show significant improvement in the confidence and physical health of attendees.

Contact: Laura White, Occupational Therapist, Hadrian Unit, The Carleton Clinic, Cumwhinton Drive, Carlisle CA1 3SX

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The evidence base

A systematic review of randomised controlled trials[49] concluded that exercise improved depressive symptoms in people with a diagnosis of depression (including mild to severe clinical symptoms) when compared with no treatment or a control intervention, e.g. sedentary social activity.

The research evidence suggests that physical activity has the potential to improve the quality of life of people with severe mental health problems. Reviews of randomised controlled physical activity interventions found exercise improves negative symptoms of schizophrenia compared to standard care, small increases in physical activity could have important physical health benefits, as well as enhancing quality of life. More recent systematic reviews and meta-analysis show conflicting results. Exercise therapies led to a modest increase in levels of exercise activity, but symptoms varied from no noticeable changes to marked reduction, no change was noted in body mass index, and body weight[50].

Among older people, physical activity can be of benefit to maintaining mental health, with one study of women aged 70–81 showing those in the highest physical activity quintile to have a 20% lower risk of cognitive decline (including tests of general cognition, verbal memory and attention)[51].

Evidence suggests that physical activity can improve sleep and reduce the risk of major illnesses, such as heart disease, stroke, type 2 diabetes and cancer by up to 50% and lower risk of falls (among older adults) and early death by up to 30%[52,53].

Research suggests that remaining seated for too long is bad for your health, regardless of how much exercise you do. Prolonged sitting is thought to slow the metabolism, which affects the body's ability to regulate blood sugar, blood pressure and break down body fat[54].

Significant proportions of adults report sitting for more than five hours a day (including work and leisure-time), and adults report spending between 3-4 hours a day sitting during their leisure-time[55].

One of the largest pieces of research to date[56] involving almost 800,000 people, found that, compared with those who sat the least, people who sat the longest had:

- 112% increase in risk of diabetes
- 147% increase in cardiovascular events
- 90% increase in death caused by cardiovascular events
- 49% increase in death from any cause.

A systematic review and meta-analysis that looked at the relationship of non-vigorous physical activity and all-cause mortality, suggests that reaching the recommended minimum level of physical activity compared with no activity was found to lead to a reduction in all-cause mortality of 19% – and this rises to 24% if an hour a day is spent in physical activity[57].

4 Action on… Reducing alcohol and substance use

The headlines

- **Co-existing substance use (alcohol and/or drug use) is common in people with mental health problems.**
- **30-50% of people with severe mental illness have problems with substance or alcohol misuse or both.**
- **The prevalence of alcohol dependence among people with psychiatric disorders is almost twice as high as in the general population.**
- **In 2013/14 there were 1,059,210 alcohol-related NHS hospital admissions in England, based on primary and secondary diagnoses[58].**
- **People with alcohol dependency have higher levels of depressive and affective problems, schizophrenia and personality disorders[59].**
- **54% of service users who committed suicide had a history of alcohol or drug misuse (or both)[60].**
- **In 2014/15 there were 74,329 NHS hospital admissions in England with a primary or secondary diagnosis of drug related mental health and behavioural disorders[61].**

Why mental health nurses need to take action

People with mental health problems are more likely to use alcohol and substances than the general population. They are more likely to lead chaotic lifestyles, neglect their physical health, have a poor diet, be homeless, and be involved in sex work to fund use. They may also be at risk of accidents due to the consequences of use, or place themselves in risky situations when intoxicated.

People with co-existing alcohol, drug and mental health issues are often unable to access the care they need, with mental health problems being insufficiently severe to meet access criteria for mental health services. Some individuals may find it difficult to engage with primary care services, while some do not see their substance use as a problem so are unwilling to access specialist substance misuse services.

Although historically, alcohol and substance use has been thought of as a specialist area of practice, mental health nurses need to view such work as a core part of their practice. Alcohol and substance use problems can develop at any stage of life, and the levels of dependence may fluctuate, so it is important to consider them across the lifespan and respond appropriately to individuals' needs. Unless alcohol and substance use is identified, opportunities for offering appropriate interventions or referring to specialist services will be missed. Substance use on inpatient wards is also a significant issue that can compromise patient safety.

Alcohol, the substance most commonly used by people with mental health problems, is associated with liver disease, cancers, CVD, cognitive problems, pancreatitis, ulcers, oesophageal varices and nutritional deficits that can result in peripheral neuropathy and Wernicke's encephalopathy. Physical dependence can develop with withdrawal symptoms being potentially life threatening (seizures, delirium tremens). Alcohol may also interact with prescribed medication (see Action on Medicine optimisation). Combinations of central nervous system depressants can be life-threatening.

Most drugs can be smoked, e.g. cannabis, synthetic cannabinoids, crack cocaine, heroin) and this can have an adverse effect on the respiratory system and exacerbate any pre-existing respiratory problems. Injecting drugs carries health risks including local and systemic infections, e.g. abscesses, septicaemia, deep vein thrombosis, blood borne viruses (HIV, hepatitis), and vein damage.

Stimulant drugs, e.g. cocaine, crack cocaine, amphetamine, are associated with CVD and seizures. Prolonged use can produce adverse effects on physical health due to loss of sleep, weight loss and neglect of personal wellbeing. GHB/GBL is physically dependence forming and withdrawals can be life threatening. It is a CNS depressant. Ketamine can cause serious bladder problems. Synthetic cannabinoids, e.g. Spice, Black Mamba, can trigger a range of physical symptoms including seizures, vomiting, breathlessness, tight chest, or collapse.

Chemsex is sex that occurs under the influence of drugs to enhance sexual arousal. Physical health risks include those associated with the drugs, (typically crystal meth, mephedrone and GHB/GBL), but also with unsafe sexual practices (see Action on Sexual and reproductive health).

People that are physically dependent on alcohol and substances risk serious physical health consequences and even death if withdrawal or substitute prescribing are poorly managed. Nurses need to ensure that NICE guidance for alcohol and opiate detoxification is followed.

Activities to achieve change

- Building a respectful, trusting, non-judgemental, collaborative relationship is a pre-requisite for working effectively with people with substance use issues.
- Assess alcohol and drug use as a core component of mental health assessment.
- Screen everyone aged 16 or above for alcohol use disorders, using a validated tool, and offer appropriate interventions.
- Offer verbal and written information about the effects of substances on physical and mental health and the way in which they may interact with prescribed medications.
- Offer information about local substance misuse services and self-help/mutual aid groups, e.g. Alcoholics Anonymous, UK SMART Recovery.
- If an individual is not ready to stop using, offer information and treatment options that can help reduce the harms associated with use, e.g. using a needle exchange, prescribing thiamine/pabrinex.
- Follow evidence based protocols to safely assess and initiate substitute prescribing or detox (alcohol, opioids, GHB/GBL, benzodiazepines).
- Work in partnership with substance misuse services to develop referral pathways and treatment options that are accessible and tailored to the needs of different individuals with mental health problems. Offer advocacy as needed.
- Know how to manage physical emergencies associated with substance use, e.g. withdrawal seizures, delirium tremens, Wernicke's encephalopathy, opiate overdose, collapse following the use of synthetic cannabinoids.
- Be aware of new drugs and changing patterns of substance use, e.g. new psychoactive substances, drugs used in chemsex.
- Ensure people assessed as having co-existing alcohol and drug misuse problems are referred to services to address both areas of need.

NICE Guidelines

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, NICE guidelines [CG115], February 2011

Alcohol-use disorders: diagnosis and management, NICE quality standard [QS11], August 2011

Alcohol-use disorders: diagnosis and management of physical complications, NICE guidelines [CG100], June 2010

Drug misuse: psychosocial interventions, NICE clinical guideline [CG51] July 2007

Nalmefene for reducing alcohol consumption in people with alcohol dependence, NICE technology appraisal guidance [TA325], November 2014

Psychosis and co-existing substance use, NICE guidance [CG120], March 2011

Methadone and buprenorphine for the management of opioid dependence, NICE technology appraisal [TA114], January 2007

Naltrexone for the management of opioid dependence, NICE technology appraisal [TA115], January 2007

Supporting tools

PHE Alcohol Learning Resources

Public Health England, Drug and Alcohol information

Drugwise

Frank

Leeds Dual Diagnosis Capability Framework

Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances

Examples of good practice to reduce alcohol and substance use

Blue Light Project: Alcohol Concern

The Blue Light Project shows that there are positive strategies that can reduce harmful drinking. The project is Alcohol Concern's national initiative to develop alternative approaches and care pathways for treatment resistant drinkers, including those with mental health problems. It is supported by Public Health England and 23 local authorities across the country.

Drawing on both motivational and harm reduction approaches it provides non-specialist and specialist workers with tools and pathways which help to manage the risk and directly reduce associated problems.

Tools include understanding why clients may not engage; harm reduction techniques workers can use; advice on crucial nutritional approaches which can reduce alcohol related harm; questions to help non-clinicians; management frameworks; guidance on legal frameworks; and training materials to disseminate the techniques.

It offers a positive message that change is possible. Research shows that these clients are not as unmotivated as they seem, with at least 40% of higher risk and dependent drinking clients trying to change each year.

Website: www.alcoholconcern.org.uk/training/training-and-expertise-for-your-organisation/alcohol-concerns-blue-light-project-working-change-resistant-drinkers/

Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust: Non-medical prescriber

Rob Smithies is a specialist substance misuse non-medical prescriber in the Liaison Psychiatry Department part of Cambridgeshire and Peterborough Foundation Trust, working at Addenbrooke's Hospital, Cambridge. He aims to see every patient who comes into the hospital with a substance misuse problem. Rob and his colleagues provide specialist treatment for patients' drug or alcohol dependence problems. He can provide immediate substitute prescriptions for opiate dependence and prescribe benzodiazepines to prevent alcohol withdrawal. Typically, he sees people who have injecting injuries, complications from alcohol withdrawal or alcoholic liver disease. For patients admitted with alcohol dependence, Rob can start alcohol detoxification regimes.

When the patient is ready for discharge, Rob liaises with the community alcohol nurses who continue the detoxification medication. He also supervises the detoxification. Rob can independently prescribe opioid substitution medicines.

Having an independent prescriber has enabled the hospital to provide much faster access to opioid substitution treatment. Many of the opiate-dependent patients are known to their local community drug teams and Rob ensures that their treatment is transferred to the community team or to their GP when they leave Addenbrooke's Hospital.

Contact: Rob Smithies, Specialist Substance Misuse Non-medical Prescriber, Cambridge University Hospitals NHS Foundation Trust, Cambridge Biomedical Campus, Hills Road, Cambridge CB2 0QQ

Email: Rob.Smithies@cpft.nhs.uk

The evidence base

The 2011 No Health without Mental Health strategy[3] acknowledged the link between mental health problems and alcohol and drugs. It emphasised the issues likely to be experienced by individuals with co-existing alcohol and/or drug and mental health, which include an increased risk of a range of other factors such as homelessness, offending behaviour, social isolation, unemployment and financial exclusion.

Harmful use of alcohol is a component cause of more than 200 disease and injury conditions, most notably alcohol dependence, liver cirrhosis, cancers and injuries[62]. In January 2016, the UK Chief Medical Officers published proposed new guidelines, for 'lower risk' alcohol consumption[63]. The new levels, which are the same for men and women, were particularly influenced by evidence on the increased risk alcohol use can have on developing cancers.

Older people are particularly susceptible to the effects of alcohol because of physiological and metabolic changes. Common acute presentations like confusion, falls and delirium can be alcohol and drug related and these need to be considered in the differential diagnosis[64].

There is a robust evidence base for the effectiveness of delivering brief interventions to people that are drinking alcohol at hazardous or harmful (increasing risk or higher risk) levels in a variety of settings[65]. There is some limited evidence that this is also effective for people in mental health settings[66].

The effectiveness of well delivered, evidence based treatment for drug misuse is well established. UK and international evidence consistently show that drug treatment – covering different types of drug problems, using different treatment interventions, and in different treatment settings – impacts positively on levels of drug use, offending, overdose risk and the spread of blood-borne viruses. The National Treatment Outcomes Research Study showed that, for a significant proportion of those entering treatment (between a quarter and a third), drug treatment results in long term sustained abstinence[67].

There is some evidence that when working with people with co-morbid mental health and substance misuse problems a long term perspective is required. Although some people will respond positively, and readily make significant changes others will find this difficult. Realistic, small goals are needed to maintain optimism regarding future change.

Although abstinence from substances may be the ideal outcome, given that many people with co-morbid mental health and substance misuse problems are not ready to stop using substances[68], harm reduction approaches are appropriate as a first step[69].

There is some evidence that delivering motivational interventions focused on substance misuse during psychiatric admission increases the likelihood of engagement with substance misuse treatment following discharge[70].

5 Action on… Sexual and reproductive health

The headlines

- **Of the 439,243 new sexually transmitted infections (STIs) diagnoses made in England in 2014, the most commonly diagnosed STIs were chlamydia 206,774 (47%), genital warts first episode 70,612 (16%), gonorrhoea 34,958 (8%) and genital herpes first episode 31,777 (7%). Between 2013-14 diagnosis of syphilis increased by 33% and gonorrhoea by 19%.**
- **People with mental illness are more likely to be infected with blood borne viruses (and STIs) than the general population. These risks increase further where substance misuse is also involved[71].**
- **Compared to the general population, patients with SMI are at substantially increased risk of domestic and sexual violence, with a relative excess of family violence and adverse health impact following victimization[72,73].**
- **Women with SMI are more likely to have an unintended pregnancy than women in the general population.**
- **People with extensive experience of physical and sexual violence against them are five times more likely to have a mental illness than those without such experiences. They are also 15 times more likely to have multiple (three or more) mental disorders[74].**
- **Unintended pregnancy is associated with an increased risk of mental health problems[75].**

Why mental health nurses need to take action

Good sexual health is important for physical, mental and social wellbeing. Some mental illness can have an impact on sexual behaviour and activity, e.g. individuals' judgement may be impaired and may become sexually disinhibited, especially if they are dependent on alcohol and other substances.

Strong links are made between sexual health and other key determinants of health and wellbeing, such as alcohol and drug misuse, smoking, obesity, mental health and violence (particularly violence against women and girls), contributing to a reduction in health inequalities.

Engaging in certain sexual behaviour can put people at risk of poorer sexual health outcomes, coercion, exploitation, unplanned pregnancies, STIs and HIV. It is important to bear in mind that some people fund their substance use by sex work – sex for drugs, or sex for money for drugs (also known as sex trading).

People with SMI are at risk of abuse and exploitation both in the community and in an inpatient ward setting. Mental health nurses have a responsibility under the Care Act 2014 to identify and respond to abuse and victimisation (including sexual abuse and domestic abuse), implementing their local safeguarding procedures. Inpatient staff can work with service users to improve safety within the ward setting. Single sex accommodation wards have been instigated to prevent sexual exploitation and abuse but it should also be recognised that abuse and sexual violence can also occur between same sex patients. A 'zero tolerance' to sexual violence and abuse should be clearly communicated, with messages about how to safely report such abuse to staff, should it occur.

Some people can become sexually disinhibited with increased libido when they are in an acute phase of an illness (such as hypomania) and will engage in acts that they would not normally do when more stable e.g. inappropriate touching and unprotected sex with other patients. Conversely, some people experience lower engagement with sexual activity than normal due to the side-effects of medications such as antipsychotics. These increase prolactin levels and cause sexual dysfunction such as inability to get aroused and reach orgasm, erectile dysfunction, and general loss of libido[76].

Talking about sexual matters can be embarrassing and so people who are experiencing sexual health problems may not always broach the subject with healthcare professionals. This can be exacerbated as mental health nurses can find it difficult to raise the subject, leading to the sexual health needs of people with mental health problems being ignored.

Mental health nurses are in a prime position to engage in discussions around sexual health and function. People should be offered screening as part of routine assessment and should include issues including: contraception, sexual partners, use of condoms, sexual health check-ups (including smear tests), violence and abuse in relationships, and issues with sexual identity.

Activities to achieve change

- Include sexual health as part of comprehensive nursing assessment and identify the individual's level of understanding.
- Take a non-judgemental approach, understanding the impact of own attitudes and those of others and treat people with privacy, dignity and discretion.
- Be able to offer clear and understandable information on what types of activities may increase risk of an STI or blood borne virus and what can help to prevent infections, e.g. consistent condom use; regular testing.
- Ask about sexual dysfunction.
- Actively support women with pre-existing mental health problems to reduce the risk of unintended pregnancies, e.g. providing guidance and information about contraception, particularly the more effective long acting methods as well as supporting their access to family planning services.
- Ensure that all women are aware of the availability of emergency contraception from local pharmacists.
- Provide information on local sexual health services and if required support people in attending such services.

NICE Guidelines	Supporting tools
Domestic violence and abuse multi-agency working, NICE guidelines [PH50], February 2014 Sexually transmitted infections and under-18 conceptions: prevention. NICE guidelines [PH3], February 2007.	Social Care Institute for Excellence, Sexual, reproductive and mental health resource The Care Act (2014): safeguarding adults

Examples of good practice to improve sexual and reproductive health

Social Care Institute for Excellence: Sexual, reproductive and mental health – an introductory module

A free interactive web-based learning programme: Sexual health matters – for mental health, covering sexual health and sexuality as part of life, sexual history and sexual risk assessment, sexual violence, abuse and trauma, and making a difference.

This resource was commissioned by the Department of Health in the context of a wider agenda for the sexual safety of people with mental illness in services. This came about through recognition of the often overlooked importance of sexual and reproductive health for the wellbeing of people with mental illness, and through the ongoing work of the Sexual Health Initiative at the Centre for Women's Mental Health (CWMH) at the University of Manchester and Manchester Mental Health and Social Care Trust.

Website: www.scie.org.uk/assets/elearning/sexualhealth/Web/Object1/main.html

Manchester Mental Health and Social Care Trust in Partnership with Manchester Social Care Services

Resources for sexual health include leaflets on contraception and sexually transmitted diseases, a sexual health directory of local services, and other resources including sexual health for those over 50 years old, information for male prisoners, and on HIV and pregnancy.

Website: http://goodhealth-manchester.nhs.uk/sexualHealth/index.html

The evidence base

The evidence base for the promotion of sexual health is limited. Two recent reviews identified trials of (mainly) group interventions that focused on education about HIV and sexual health risks, developing motivation to adopt safer sexual practices and build social skills such as assertiveness and condom negotiation. Some studies demonstrated that sexual risk behaviour decreased after intervention compared with control group, although this effect diminished over time[77,78,79].

Some people with severe mental health problems have been found to be more likely to engage in high risk sexual behaviours such as unprotected intercourse, having multiple partners and involvement in sex-trading. These behaviours place people at increased risk of sexually transmitted infections as well as being more vulnerable to abuse and violence and in the case of women, unplanned pregnancies[80].

Women whose pregnancy is unplanned present later for antenatal care, and are more prone to prenatal and postnatal depression and relationship breakdown. Children born of unplanned pregnancies have been shown to have a lower birth-weight, have poorer mental and physical health during childhood, and to do less well in cognitive tests[80].

The MBRRACE-UK Saving Lives, Improving Mothers' Care report affirms that women remain at high risk throughout the first year after giving birth, of death due to mental illness. Almost a quarter of women who died between six weeks and one year after pregnancy died from mental health related causes, and one in seven women died by suicide[81].

A recent study found that men and women with SMI who are under the on-going care of psychiatric services are 2–8 times more likely to experience sexual and domestic violence than the general population, with a high relative burden of family violence. Women with SMI are more likely than women in the general population to suffer psychological ill health and attempt suicide following sexual assaults, but most do not disclose violence to healthcare professionals[82].

There is a concern that sexual health is overlooked in mental health settings. A survey of mental health staff in London[83] found that whilst staff felt confident in raising issues, they rarely did so in routine care. In addition there was a wide range of responses to scenarios related to sexual health which indicates a lack of consistency in practice.

A qualitative study of nursing practice related to sexual health in mental health found that there was a genuine reluctance to raise the topic of sexual heath for fear of causing discomfort for the person, as well as being unsure what to do about sexual health problems if they emerged. However, increasing awareness amongst mental health nurses of the impact of mental health problems on sexual health concerns of patients and service users contributes to substantial and sustained positive changes in practice[84].

Some people may be a risk of experiencing sexual dysfunction as an adverse effect of psychotropic medicines including reduced libido, erectile dysfunction, ejaculatory difficulties and impaired orgasm in men and menstrual irregularity/ amenorrhoea, reduced libido, impaired orgasm and decreased vaginal lubrication in women[85].

Stigma and discrimination associated with poor sexual health, including the experience of being judged, or feelings of embarrassment, can stop people from getting the help and information that they need. It can also have an effect on quality of life and mental health[76].

6 Action on… Medicine optimisation

The headlines

- **Estimates show that 30-50% of medicines are not taken as intended by patients with long term conditions and 55% of people are not aware that they are not taking their medicines correctly.**
- **NHS England has estimated that 5-8% of unplanned hospital admissions are due to medicine related issues.**
- **Medicines plays a key role in managing symptoms of mental health, however adverse effects associated with psychotropic medicines play a contributory role in the poor physical health outcomes in severe mental illness.**
- **The adverse effects of medicines include an increased risk of metabolic syndrome, cardiovascular adverse effects, weight gain, sexual dysfunction and poor oral hygiene.**
- **Screening and monitoring physical health helps identify risk factors for individuals on medicines.**

Why mental health nurses need to take action

Medicines remain the primary treatment in most mental health conditions either as monotherapy or in combination with psychological or psychosocial interventions.

Studies show that medicine noncompliance, failure to take medicine as prescribed, precedes an overwhelming number of hospitalisations. For certain mental illnesses, such as schizophrenia and bipolar disorder, medicine compliance may be the single, most important factor in recovery and/or maintenance of a person's level of functioning[86].

Medicine compliance is often linked to what individuals can tolerate in terms of side effects. Mental health nurses are able to monitor and support individuals, providing reviews to reduce the impact of medication side effects[87].

Use of psychotropic medicines and associated adverse effects contribute to physical health problems for people with SMI. In people with schizophrenia, between 15-72% of people experience weight gain due to the use of antipsychotics with the sedative adverse effects being a potential contributor. The evidence for similar effects in those with bipolar disorder is growing. Weight gain and obesity contribute to stigma and discrimination increasing the risk of discontinuation of medicines and hence risk of relapse. Mental health nurses should be aware of the interactions between alcohol and certain substances and prescribed medication.

Other psychotropics such as tricyclic antidepressants increase the risk of adverse cardiac events. The adverse effects of medicines contribute to other physical health problems such as sexual dysfunction (by elevating prolactin levels) and poor oral hygiene (by causing dry mouth). Mental health nurses can educate patients; monitor side effects of medicines, screen and monitor physical health and identify individual risk factors. They can act to increase monitoring, alert the prescriber about abnormal physical health tests or exercise judgement to withhold medicines in the context of the person's condition. For example, some psychotropic medicines will need to be reduced if a person has reduced or quit smoking and will need to be monitored in case smoking is taken up again.

Mental health non-medical prescribers are responsible and accountable for the assessment of patients with undiagnosed and diagnosed conditions and for decisions about the clinical management required, including prescribing. They are able to provide information and advice to patients to help them understand the decisions made about their health and care, benefiting the patient's experience and attitude to their illness and treatment, improving medicine management and the likelihood that medicines are taken correctly[88].

Activities to achieve change

- Be aware of the medicines the individual is receiving including medicines for physical problems. Understand the reasons for all medicines being taken, and be aware of the benefits, indications, interactions including with alcohol and illicit drugs, and side effects of medicines.
- Ensure that your technical competency related to drug calculations and administration is assessed and approved, particularly in relation to administration of drugs by injection.
- Provide information to patients and their carers to ensure they know the therapeutic use, dose, side effects, precautions and contraindications to prescribed medicines.
- Monitor the impact of all medicines and particularly antipsychotic and other psychotropic medicines in accordance with relevant NICE guidelines.
- Regularly ask patients if they experience any side effects with their medicines using approved side effect rating scales and take appropriate actions as required.
- Ensure prevention and controls of infection measures are maintained to safeguard service users.
- Work collaboratively with pharmacists on issues related to medicines.
- Where services have a dedicated pharmacy service, encourage joint working with the pharmacists and ensure all nursing staff have an induction with the pharmacy team.
- Advocate on behalf of the patient for medicines to be changed or stopped if there is little or no perceived benefits or the side effects are intolerable.
- Consider the role of medicines in falls and seek the advice of a pharmacist where appropriate.

NICE Guidelines	Supporting tools
Bipolar disorder: assessment and management, NICE guidelines [CG185], September 2014 Depression in adults: recognition and management, NICE guidelines [CG90], October 2009 Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence, NICE guidelines [CG76], January 2009 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE guidelines [NG5], March 2015 Psychosis and schizophrenia in adults, NICE guidelines [CG178], February 2014	The Glasgow Antipsychotic Side-effect Scale (GASS) Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) Abnormal Involuntary Movement Scale (AIMS)

Examples of good practice of medicine optimisation

Central and North West London NHS Foundation Trust: Clozapine booklet

The Pharmacy Department at Central and North West London NHS Foundation Trust have developed a range of services and supporting material to support medicine optimisation.

They implemented point of care testing and physical health monitoring for patients on clozapine. Wellbeing programmes were delivered with a focus on recovery and healthy lifestyle. The outcome measures showed:

- do not attend (DNA) rates compared to pre-implementation reduced from 22% to less than 1% in a comparable period
- monitoring for pulse, blood pressure and weight/BMI increased from 74%, 74% and 72% respectively to 96% for all parameters post-implementation with the remaining 4% refusing monitoring
- side effect monitoring increased from 4% to 96%
- patients and carers describe the service as 'efficient, caring and supportive'.

They produced a clozapine physical health monitoring booklet for patients and carers to highlight the physical health tests required to monitor people on clozapine and how results are recorded and used by healthcare professionals.

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The use of a shared electronic platform to promote self-management – True Colours

True Colours is a remote symptom monitoring system that was initially developed by Oxford University Department of Psychiatry and Oxford Health NHS Foundation Trust with funding from the National Institute for Health Research, to monitor mood in people with bipolar disorder. True Colours is a web-based service which facilitates self-management of mental health disorders, by allowing service users to record their symptoms and track a visual representation of symptoms over time, and is accessible to mental health staff to allow for care collaboration.

The service prompts individuals to answer questionnaires (usually once a week) by their preferred communication method (usually e-mail) and their answers are plotted on a graph, which can be viewed by logging into their on-line account. Participants can personalise their graph by adding notes, e.g. life events, and record medication details. Identifying and tracking medication changes can help side effect monitoring and self-management, in collaboration with mental health staff. Participants can also add personalised questions, based on their own assessment of the outcomes that matter to them, e.g. alcohol consumption, dietary habits.

Service users are accepting of True Colours, with 75% from a specialist bipolar disorder research clinic completing weekly questionnaires. True Colours has also been implemented across 11 community mental health teams in Oxford Health NHS Foundation Trust, among service users with a variety of mental health problems, such as bipolar disorder, unipolar depression, anxiety and psychotic disorders.

Over 2,000 service users have registered to use True Colours and currently there are approximately 1,500 active users.

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The evidence base

Many individuals stop taking their medicines in the first months following initiation, often without informing their provider, with further attrition over time. In addition, many people who continue their medicines do not consistently take it as prescribed. As a result, adherence rates average around 50% and range from 0% to over 100%, and there is no evidence for substantial change in the past 50 years[89].

Evidence shows that psychotropic medicines contribute to poor physical health outcomes including an increased risk of metabolic syndrome, cardiovascular adverse effects, weight gain, sexual dysfunction, reduced bone mineral density and poor oral hygiene. Constipation is also a common yet serious adverse effect associated with antipsychotics; with complications such as intestinal obstruction, faecal impaction and paralytic ileus being amongst those reported.

There is growing evidence that antipsychotic use increases the prevalence of adverse effects associated with an increased risk of long term health problems. Side effects are a common reason for poor adherence or discontinuation of treatment.

Studies looking at patients' perspectives on medicines indicated that people taking antipsychotic medicines do not see side effects and symptoms as separate issues. Instead, they describe medicines are 'good' or 'terrible' – an indication of the total impact of their treatment. Side effect rating scales can be used to assess the presence and (perceived) severity of side effects which can lead to a dialogue about adverse effects and patient-centred approach to improve adherence.

Recent research indicates that about a third of people with SMI were experiencing pain[90,91]. This contributes to behavioural problems, offending and interpersonal difficulties. It is also a signal that there is an underlying physical health problem. Early intervention is possible if pain is assessed routinely and nurses should be able to provide interventions that support adequate investigations for the causes of the pain and appropriate pain relief.

7 Action on… Dental and oral health

The headlines

- **Mental health service users have a high risk of poor dental and oral health leading to a greater risk of additional health problems.**
- **People with SMI are more likely to have lost all their natural teeth and have higher levels of tooth decay than the general population[92].**
- **Poor oral health does not just cause problems inside the mouth, it can reduce self-confidence.**
- **Periodontal diseases including gingivitis, periodontitis are associated with adverse pregnancy outcomes, cardiovascular disease, stroke, pulmonary disease, and diabetes[93].**
- **The British Dental Health Foundation survey 2013, found one in four adults do not brush twice a day, including a third of men, and one in ten admit they regularly forget to brush their teeth[94].**

Why mental health nurses need to take action

Good dental and oral health is essential to general health and wellbeing. There are inequalities in health between the improved dental hygiene of the general population and that of people living with mental health problems. Despite greater dental treatment need, dental services are underused by people with SMI.

Systematic reviews[92,95] show that people with SMI compared to the general population, are more likely to have lost their teeth, have poorer oral hygiene, and have higher rates of tooth decay and gum disease.

People with SMI are susceptible to oral disease for a number of reasons including: poor diet; side effects of psychotropic medications (especially dry mouth or reduced saliva); dental costs; they may neglect their oral health; problems may not be detected by mental health practitioners; and dental services may be more difficult to access.

In addition, people with SMI are more likely to experience other chronic diseases or long term conditions such as diabetes, cardiovascular disease, chronic lung disease and cancer, which can also impact on oral health. Therefore, tooth loss may be a consequence of both disease level and poor oral health management.

Substance misuse can also have a detrimental impact on teeth. Stimulant drugs are associated with teeth grinding, which can be damaging, and heroin appears to make people crave sweets or sugar. Methadone, an opiate substitute has a high sugar content (although sugar-free is available), and many people take this long term. Because of their lifestyle individuals are probably more likely not to look after their oral health and since methadone is an opiate it will mask tooth pain.

Activities to achieve change

- Include an assessment of a person's dental and oral health, including dry mouth, when undertaking nursing assessments.
- Monitor that people have access to a dental practice and that they attend for check-ups at the intervals their dentist recommends and in line with NICE guidelines. For adults NICE recommends intervals of between three and 24 months depending on oral health status.
- Ensure people have access to appropriate oral hygiene equipment for example, toothbrush and fluoride toothpaste and interdental cleaning aids.
- Encourage brushing twice a day using fluoride toothpaste, and the use of dental floss and mouthwash.
- Encourage people to chew sugar-free gum to stimulate saliva to help neutralize acids – especially for individuals who are unlikely to carry out routine oral hygiene.
- Encourage people to eat less sugary foods and drinks, including carbonated sugary drinks especially before bedtime.
- Encourage people to stop smoking.

NICE Guidelines	Supporting tools
Oral and dental health overview, NICE pathway Oral health promotion: general dental practice, NICE guidelines [NG30], December 2015	Public Health England, Delivering Better Oral Health: An evidence based toolkit for prevention

Examples of good practice to improve dental and oral health

The Cottages, Horton Rehabilitation Service, Epsom Dental Care

The Cottages is made up of a 16-bed psychiatric rehabilitation service based in Epsom, Surrey. It is part of the rehabilitation directorate with Central and North West London NHS Trust. Their work began over 10 years ago, as part of an overall assessment of the physical health of their service users.

The combined skills and patience of the nursing and the dental staff succeeded in encouraging people to visit the dentist. Longer appointment times were given and often the nursing staff went into the treatment room with the patient for reassurance.

Care plans were drawn up with the individual to include dental care. Self-care plans include oral hygiene and each person is helped to purchase the dental care products needed. Advice is sought from the dentist about these and individuals use specialised products used as dental tepees, floss, and electric toothbrushes. A number of people now use prescribed medicated toothpaste, in various strengths. Now such care is routine, The Cottages also include healthier eating and smoking cessation as part of the broad approach to improving dental care.

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The Barts Health Special Care Dental Service

The dental service aims to meet the oral health needs of people who have a range of medical and physical impairments, including those who suffer from mental health conditions. In primary care, community dentists provide dental care in clinics and mobile dental units for patients in the medium secure unit (for mental health) and at day centres who have registered mental health clients.

In their secondary care provision, the consultant and registrar in special care dentistry provide comprehensive care under conscious sedation or general anaesthesia for individuals with both learning disabilities and mental health conditions.

Their secondary care service is unique: they do not have a standalone department like other hospitals, but work within the department of restorative dentistry. This has meant that their focus is driven towards oral rehabilitation, not just treatment of dental disease by providing a range of comprehensive dental treatments. It has also promoted joint working with a variety of specialists who work within the department to provide the best dental care for patients.

They also ensure engagement with multidisciplinary teams for all patients undergoing dental treatment under conscious sedation and general anaesthesia by liaising with medical specialties (such as ophthalmology, ENT, gastroenterology, radiography, gynaecology) to coordinate where possible treatment at the same time as the dental treatment. This work is gaining recognition amongst medical divisions within the trust and the initiative has been recently published in peer-reviewed journals. The aim is to encourage other services to adopt the same approach for patients with mental health conditions and severe learning disabilities to: improve health outcomes; reduce time spent in hospital services; and provide cost effective care in line with national initiatives.

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The evidence base

Oral health in patients with a diagnosed mental illness is an under-researched area, however it is clear that it is important for maintaining good physical health as well as for self-esteem, self-confidence and overall wellbeing.

People with mental health problems, particularly SMI, are at greater risk of oral health problems because of poor nutrition and oral hygiene; the heavy consumption of sugary drinks; comorbid substance misuse including tobacco, alcohol, or psychostimulants; and financial or other barriers to accessing dental care. Dry mouth (xerostomia) is a major risk factor for oral health problems and is often compounded by opportunistic gingivitis as a result of nutritional deficiencies secondary to psychosis or anorexia nervosa. Changes in salivary secretion due to parotid gland pathology have been described in patients with bulimia. In addition, xerostomia may be a side effect of commonly used psychotropic medications, particularly those with anticholinergic effects[96].

A systematic review[92] found that people with SMI, were more likely to have lost their teeth (26% of people with SMI compared to 6% of the general population); had higher rates of tooth decay (1.9 decayed teeth compared to 0.8 in the general population); had poorer oral hygiene; and had higher rates of gum disease compared to the general population.

A further systematic review and meta-analysis[95], found that people with SMI were 2.8 times more likely than controls to have lost all their teeth, and had higher numbers of decayed, missing or filled teeth.

The British Society for Disability and Oral Health guidelines and recommendations[97] for people with mental health problems, published in 2000, includes screening, the provision of health advice, support, promotion and education. In spite of this, research shows people with SMI continue to have significantly worse dental health than the general population. A 2009 study[98] showed that combining motivational interviewing and oral health education could lead to significant improvements.

A 2010 meta-analysis[99] highlighted the need for better oral health training amongst mental health professionals. Systematic reviews[92,95] concluded that non-dental staff should undertake basic assessments of oral hygiene using standardised checklists. Interventions should include provision of dental equipment such as toothbrushes for people in hospital, with instructions for their use, along with encouragement to attend dental check-ups.

Kisely[96] advocates that nursing care plans for hospital admissions should include the recording of factors known to cause oral ill health, such as psychotropic medication and tobacco or substance use, as well as the supply of toothbrushes and denture baths. Following a patient's discharge to the community, case management should include the identification of and referral to dentists who are willing to see people with SMI. The contribution of psychotropic medication to xerostomia should be considered, monitored, and managed. Patients should be asked whether their saliva seems decreased and whether they have any trouble swallowing, speaking, or eating dry foods. Additional questions include the presence of lip dryness, cracking, halitosis, and mouth sores.

Studies have shown that chewing sugar-free gum following meals can help prevent tooth decay. The physical act of chewing increases the flow of saliva in the mouth and chewing after eating increases the salivary flow which helps neutralise and wash away the acids that are produced when food is broken down by the bacteria in plaque on teeth. Chewing gum therefore has a place as an additional mode of dental disease prevention to be used in conjunction with the more traditional preventive methods[100].

8 Action on… Reducing falls

The headlines

- **There were 28,178 reported falls in NHS mental health units in England in 2013 (National Reporting and Learning System), 105 of which resulted in severe harm to the patient and 13 deaths[101].**
- **Falls are the most commonly reported patient-safety incident in mental health settings for older people.**
- **Falls affect rehabilitation, physical and mental function: can increase length of stay in hospital settings, and the likelihood of discharge to long term care settings[102].**
- **The consequences of falls can range from distress and loss of confidence, to injuries that cause pain and suffering, loss of independence and sometimes, death[103].**
- **The causes of falls are complex and influenced by contributing factors such as physical illness, mental ill health, medicines, alcohol and substance misuse, problems with eyesight, balance, strength or mobility, as well as environmental factors, with older people accessing mental health services being particularly vulnerable.**

Why mental health nurses need to take action

Falls in hospitals often occur in people aged 65 and over. Most falls do not result in serious injury but can cause the person to lose confidence, become withdrawn and feel that they have lost their independence.

Falls have an impact on quality of life, health and healthcare costs accounting for over 4 million bed days at an estimated £2 billion a year[104], with the combined social and healthcare cost of all fragility fractures alone in the UK estimated to be £4.4 billion.

Promoting safety through reducing falls and associated health concerns is important for people with mental health conditions, especially amongst older people. Anyone over 65 years of age should be considered at risk of falling.

While some factors that increase risk of falling such as age cannot be changed, there are a number of interventions that can significantly reduce the number of falls. NICE recommends that all people over the age of 65 should be assessed for falls risk using a multidisciplinary risk assessment leading to a multidisciplinary intervention plan that includes: falls history, medication review, low blood pressure on standing, mobility, use of walking aid, presence of delirium and other cognitive impairment, vision, footwear and continence problems.

NICE also advises that patients aged 50-64 should be considered as a falls risk if they have any of the following: sensory impairment, dementia, previous falls, stroke, syncope, delirium and gait disturbances.

It is worth noting that medication review for falls risk can be extremely challenging for people with mental health problems. Many drug groups such as antipsychotics, sedatives, anticholinergics, and cholinesterase inhibitors, carry known potential fall provoking side effects that can include dizziness, drowsiness, low blood pressure (particularly on standing) and in some cases lowered heart rate leading to collapse (see Action on Medicine optimisation).

Activities to achieve change

- Adopt a holistic and person-centred approach to the individual, and offer older people or those judged to be at risk, a multifactorial falls risk assessment.
- Ensure referrals are made to appropriate services as required, e.g. optometry/ ophthalmology, physiotherapy, occupational therapy and encourage the person to engage with prescribed interventions, e.g. wear spectacles, hearing aid, use walking aids appropriately.
- Ensure service users have appropriate footwear: check footwear for secure fit, non-slip sole, no trailing laces.
- Review medication that can increase the risk of falls or request a medical and/or pharmacist review.
- Ensure falls are an integral part of the organisation's improvement agenda.
- Work with facilities staff to create a safer environment.
- Encourage individuals to be physically active, use walking aids as prescribed, and where appropriate engage in exercise programmes to improve posture and balance.

NICE Guidelines	Supporting tools
Falls in older people: assessing the risk and prevention, NICE guidelines [CG161], June 2013 Falls in older people, NICE quality standard [QS86], March 2015 Falls in older people. NICE Pathway	Royal College of Physicians: Falls quality improvement resources

Examples of good practice to reduce falls

Princess Alexandra Hospital NHS Trust: Falls coordinator

The falls coordinator based at the Princess Alexandra Hospital in Harlow has developed some strategies and actions to reduce fall rates. Their action plan includes:

- implementing a new multifactorial falls assessment and intervention plan for all those over 65 years
- engaging all health professionals within the trust to move away from falls being seen as primarily a nursing problem
- developing falls training for junior and student doctors
- setting up an optometry referral pathway to address the risks associated with visual problems
- developing new ward based roles of 'mobility assistants' who will work with patients to counteract the acute deconditioning that occurs due to patients being sedentary for the majority of their inpatient admission
- producing a falls welcome pack for patients containing information around falls and community falls prevention services so they can self-refer
- producing 'dementia friendly' falls information flyers to provide to patients.

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Kent and Canterbury Hospital: Quality improvement approach to falls

East Kent Hospitals University NHS Foundation Trust covers three acute sites and has a team of falls nurses and consultants. It includes a dual inpatient service with outpatient roles. The trust has used a quality improvement approach to prevent falls in hospital and currently have a rate of falls consistent with the national average (despite having a high elderly population). The injurious fall rate is lower than average. Kent and Canterbury Hospital have a falls policy, post fall protocols and education package which provide consistent expectations of staff in a supportive environment. There is easy access to equipment, such as movement alarms and low profiling beds, assisted by medical equipment libraries.

The service is about to implement a ward based quality improvement programme called 'Fallstop!' which involves a 'knowing where we are' module, planned weekly educational sessions incorporating risk assessment and care planning, head injury management and simulation training, audit and evaluation. Each stage will go through plan, do, study, act (PDSA) cycles and will be implemented collaboratively with the manual handling team and dementia team. The organisation's aim is to embed the prevention of falls and post fall actions further within their wards to enhance the safety of the care provided.

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The evidence base

More than 250,000 falls are reported each year within NHS hospitals across England. In 2013, 28,178 occurred in mental health facilities, with 1,292 resulting in moderate harm, 105 in severe harm, and 13 deaths.

It is well established that people who fall, even without a resulting physical injury, can have a compromised quality of life, limiting factors such as reduced mobility, and may be affected by anxiety and depression, commonly resultant from fear of further falls.

The risk of falling can be exacerbated by mental health problems, such as dementia, depression, mania and anxiety. Treatments of mental health conditions, for example, with psychotropic medication and electroconvulsive therapy can also increase fall risk[105]. People with dementia are twice as likely to fall than those without, and have a four times increased risk of sustaining a hip fracture. Recovery from hip fracture is also worse with a three times increase in mortality at six months compared to their peers[106].

Alcohol and medicines can be associated with an increased risk of falls in older people. The increased effects of alcohol on our bodies as we age due to changes in metabolism can exacerbate or even mask other risk factors for falling. Many medicines in common use for the treatment of mental health conditions contraindicate the use of alcohol which can magnify their effect and increase risks of falls[107].

A report by the former National Patient Safety Agency[108], states that preventing patients from falling is a particular challenge in hospital settings. Patients' safety has to be balanced against their right to make their own decisions about the risks they are prepared to take, their dignity and their privacy. A range of interventions can be used together and tailored to reduce an individual's specific risks, including: reviewing medication associated with a risk of falling; detecting and treating causes of delirium; detecting and treating cardiovascular illness; detecting and treating or managing incontinence or urgency; detecting and treating eyesight problems; providing safe footwear; physiotherapy, exercise and walking aids.

A systematic review with meta-analysis of randomised controlled trials that compared fall rates in older people who undertook exercise programmes with fall rates in those who did not exercise, concluded that exercise can prevent falls in older people. Greater relative effects are seen in programmes that include exercises that challenge balance, use a higher dose of exercise, and do not include a walking programme[109].

Various aspects of the hospital environment can impact on the risk of falls or injury, many of which can be modified by simple adjustment of the person's immediate surroundings. These include: flooring and lighting; the layout of wards, toilets and bathrooms; the distance and spaces between handholds, beds, chairs and toilets; the line of sight for staff observing patients; trip hazards including steps, clutter and cables; furniture and medical equipment.

Falls prevention studies[110] have shown that introducing evidence based care bundles with multifactorial assessment and intervention within a quality improvement approach, has resulted in significant reductions in fall rates, but not necessarily in injurious fall rates. Other recent research has found that nursing only interventions without input from the multidisciplinary team are not effective in reducing falls or injury[111].

A 2014 systematic review[102] concluded that NICE recommendations relating to falls in older people are also applicable to older people with mental health conditions. In particular these include: strength, gait and balance mobility training, home hazard assessment, vision assessment, and medication review.

Appendix 1 Assessment tools

1. The Lester Tool

The Lester tool also known as the Positive Cardiometabolic Health Resource provides practitioners with a simple intervention framework to assess the cardiovascular and metabolic health of patients with SMI and recommends the best course of intervention and treatment – including thresholds for intervention. It brings together advice from a number of NICE guidelines and is also designed to take into account the impact of anti-psychotic medication on an increased risk of CVD in people with SMI. The tool was developed by the Royal College of Psychiatrists and the Royal College of General Practitioners, supported by the National Audit of Schizophrenia. It was adapted to fit the NHS context with NHS England and Public Health England, and supports the current NHS mental health CQUIN.

As part of their work to implement actions from the CVD Outcomes Strategy, the NHS England Sustainable Improvement team (previously NHS Improving Quality) launched a pilot study that aimed to improve the cardiovascular health of people with SMI. The team worked with four mental health trusts to test different ways of incorporating the Lester tool 2014 Update, into clinical practice to assess service users' risk of developing CVD and intervene where necessary to prevent deterioration.

The Royal College of Psychiatrists carried out an external evaluation of the pilots, which identified a range of contextual factors that influence whether quality improvement can be achieved at a local level. NHS England has published a toolkit which offers practical advice and useful documents to NHS trusts working to improve the physical health of service users. The toolkit will help mental health nurses to assess the cardiovascular health of their patients, and their risk of developing type 2 diabetes.

Lester UK Adaptation | **2014 update**

Positive Cardiometabolic Health Resource

An **intervention framework** for people experiencing **psychosis** and **schizophrenia**

Don't just SCREEN – INTERVENE

for all patients in the "red zone"

Lester UK Adaptation: Positive Cardiometabolic Health Resource

This Cardiometabolic Health Resource supports the recommendations relating to monitoring physical health in the NICE guidelines on psychosis and schizophrenia in adults (www.nice.org.uk/guidance/cg178) and young people (www.nice.org.uk/guidance/cg155). In addition it also supports the statement about assessing physical health in the NICE quality standard for psychosis and schizophrenia in adults (www.nice.org.uk/guidance/qs80).

National Institute for Health and Care Excellence, November 2015

This clinical resource supports the implementation of the physical health CQUIN https://www.england.nhs.uk/wp-content/uploads/2015/03/9-cquin-guid-2015-16.pdf (page 13) which aims to improve collaborative and effective physical health monitoring of patients experiencing severe mental illness. It focusses on antipsychotic medication for adults, but many of the principles can be applied to other psychotropic medicines given to adults with long term mental disorders, e.g. mood stabilisers.

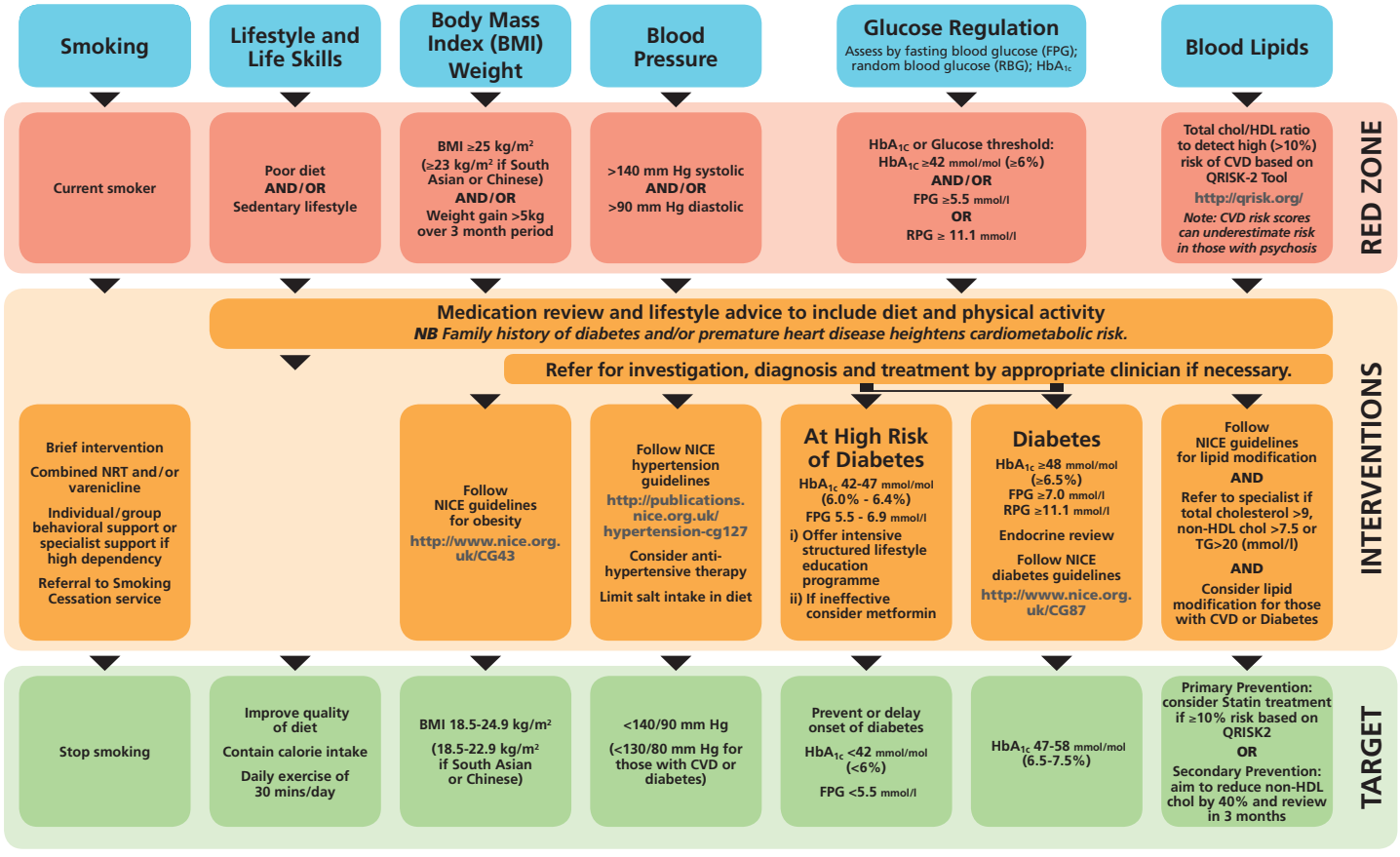
For all patients in the "red zone" (see center page spread): The general practitioner, psychiatrist and patient will work together to ensure appropriate monitoring and interventions are provided and communicated. The general practitioner will usually lead on supervising the provision of physical health interventions. The psychiatrist will usually lead on decisions to significantly change antipsychotic medication.

Download Lester UK Adaptation: www.rcpsych.ac.uk/quality/NAS/resources

Lester UK Adaptation | **2014 update**

Positive Cardiometabolic Health Resource

An **intervention framework** for people experiencing **psychosis** and **schizophrenia**



FPG = Fasting Plasma Glucose | RPG = Random Plasma Glucose | BMI = Body Mass Index | Total Chol = Total Cholesterol | HDL = High Density Lipoprotein | TRIG = Triglycerides

History and examination following initiation or change of antipsychotic medication

Frequency: Normally supervised by the psychiatrist. As a minimum review those prescribed a new antipsychotic at baseline and at least once after 3 months.

Weight should be assessed weekly in the first six weeks of taking a new antipsychotic, as rapid early weight gain may predict severe weight gain in the longer term.

Subsequent reviews should take place annually unless an abnormality of physical health emerges. In these cases, appropriate action should be taken and/or the situation should be reviewed at least every 3 months.

At review

History: Seek history of substantial weight gain (e.g. 5kg), especially where this has been rapid (e.g. within 3 months). Also review smoking, exercise and diet. Ask about family history (diabetes, obesity, CVD in first degree <55 yrs male relatives and <65 yrs female relatives) and gestational diabetes. Note ethnicity.

Examination: Weight, BMI, BP, pulse.

Investigations: Fasting estimates of plasma glucose (FPG), HbA1c, and lipids (total cholesterol, non-HDL, HDL, triglycerides). If fasting samples are impractical then non-fasting samples are satisfactory for most measurements except for triglycerides.

ECG: Include if history of CVD, family history of CVD; where examination reveals irregular pulse (if ECG confirms atrial fibrillation, follow NICE recommendations **http://guidance.nice.org.uk/CG36**); or if patient taking certain antipsychotics (See SPC) or other drugs known to cause ECG abnormalities (eg erythromycin, tricyclic anti-depressants, anti-arrhythmics – see British National Formulary for further information).

Chronic Kidney Disease*: Screen those with co-existing diabetes, hypertension, CVD, family history of chronic kidney disease, structural renal disease (e.g. renal stones) routinely:

1. Monitor renal function: a) urea & electrolytes
   b) estimated glomerular filtration rate (eGFR)
2. Test urine: a) for proteinuria (dip-stick),
   b) albumin creatinine ratio (laboratory analysis)

*Presence of chronic kidney disease additionally increases risk of CVD: follow appropriate NICE guidelines on chronic kidney disease.

Monitoring: How often and what to do

Applies to patients prescribed antipsychotics and mood stabilizers.

	Baseline	Weekly first 6 weeks	12 weeks	Annually
Personal/FHx	■			■
Lifestyle Review[1]	■		■	■
Weight	■	■	■	■
Waist circumference	■			■
BP	■		■	■
FPG/HbA_{1C}	■		■	■
Lipid Profile[2]	■		■	■

[1]Smoking, diet, and physical activity [2]If fasting lipid profile cannot be obtained, a non-fasting sample is satisfactory

Monitoring table derived from consensus guidelines 2004, j clin. psych 65:2. APA/ADA consensus conference of 2004 published jointly in Diabetes Care and Journal of Clinical Psychiatry with permission from the Ontario Metabolic Task Force.

Specific lifestyle and pharmacological interventions

Specific lifestyle interventions should be discussed in a collaborative, supportive and encouraging way, taking into account the person's preferences:

- **Nutritional counselling:** reduce take-away and "junk" food, reduce energy intake to prevent weight gain, avoid soft and caffeinated drinks and juices, and increase fibre intake.
- **Physical activity:** structured education-lifestyle intervention. **Advise physical activity such as a minimum of 150 minutes of 'moderate-intensity' physical activity per week (http://bit.ly/Oe7DeS).** For example suggest 30 minutes of physical activity on 5 days a week.

If the patient has not successfully reached their targets after 3 months, consider specific pharmacological interventions:

Anti-hypertensive therapy: Normally GP supervised. Follow NICE recommendations **http://publications.nice.org.uk/hypertension-cg127**.

Lipid lowering therapy: Normally GP supervised. (If total cholesterol >9, non-HDL chol >7.5 or TG>20 (mmol/l), refer to metabolic specialist.) Follow NICE recommendations **http://www.nice.org.uk/nicemedia/pdf/CG67NICEguideline.pdf**.

Treatment of diabetes: Normally GP supervised. Follow NICE recommendations **http://www.nice.org.uk/CG87**.

Treatment of those at high risk of diabetes: FPG 5.5-6.9 mmol/l; HbA_{1c} 42-47 mmol/mol (6.0-6.4%) *Follow NICE guideline PH 38 Preventing type 2 diabetes: risk identification and interventions for individuals at high risk (recommendation 19)* – **http://guidance.nice.org.uk/PH38**.

- Where intensive lifestyle intervention has failed **consider a metformin trial** (normally be GP supervised).
- Please be advised that **off-label** use requires documented informed consent as described in the GMC guidelines, **http://www.gmc-uk.org/guidance/ethical_guidance/14327.asp**. These GMC guidelines are recommended by the MPS and MDU, and the use of metformin in this context has been agreed as a relevant example by the Defence Unions.
- Adhere to British National Formulary guidance on safe use (in particular ensure renal function is adequate).
- Start with a low dose e.g 500mg once daily and build up, as tolerated, to 1500–2000mg daily.

Review of antipsychotic and mood stabiliser medication:

Discussions about medication should involve the patient, the general practitioner and the psychiatrist. Should be a priority if there is:

- Rapid weight gain (e.g. 5kg <3 months) following antipsychotic initiation.
- Rapid development (<3 months) of abnormal lipids, BP, or glucose.

The psychiatrist should consider whether the antipsychotic drug regimen has played a causative role in these abnormalities and, if so, whether an alternative regimen could be expected to offer less adverse effects:

- As a first step prescribed dosages should follow BNF recommendations; rationalise any polypharmacy.
- Changing antipsychotic medication requires careful clinical judgment to weigh any benefits against the risk of relapse of the psychosis.
- An effective trial of medication is considered to be the patient taking the medication, at an optimum dosage, for a period of 4-6 weeks.
- If clinical judgment and patient preference support continuing with the same treatment, then ensure appropriate further monitoring and clinical considerations are carried out regularly.

It is advised that all side effects to antipsychotic medication are regularly monitored, especially when commencing a new antipsychotic medication **(GASS questionnaire http://mentalhealthpartnerships.com/resource/glasgow-antipsychotic-side-effect-scale/)**, and that any side effects, as well as the rationale for continuing, changing or stopping medication is clearly recorded and communicated with the patient.

The Psychiatrist should maintain responsibility for monitoring the patient's physical health and the effects of anti-psychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.

Discuss any non-prescribed therapies the patient wishes to use (including complementary therapies) with the patient, and carer if appropriate. Discuss the safety and efficacy of the therapies, and possible interference with the therapeutic effects of prescribed medication and psychological treatments.

Public Health England

NAS CCQI NATIONAL AUDIT OF SCHIZOPHRENIA

NHS

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Royal College of Psychiatrists (RCPsych)
Royal College of General Practitioners (RCGP)
Royal College of Physicians
Royal College of Nursing
Royal College of Surgeons (RC Surgeons)
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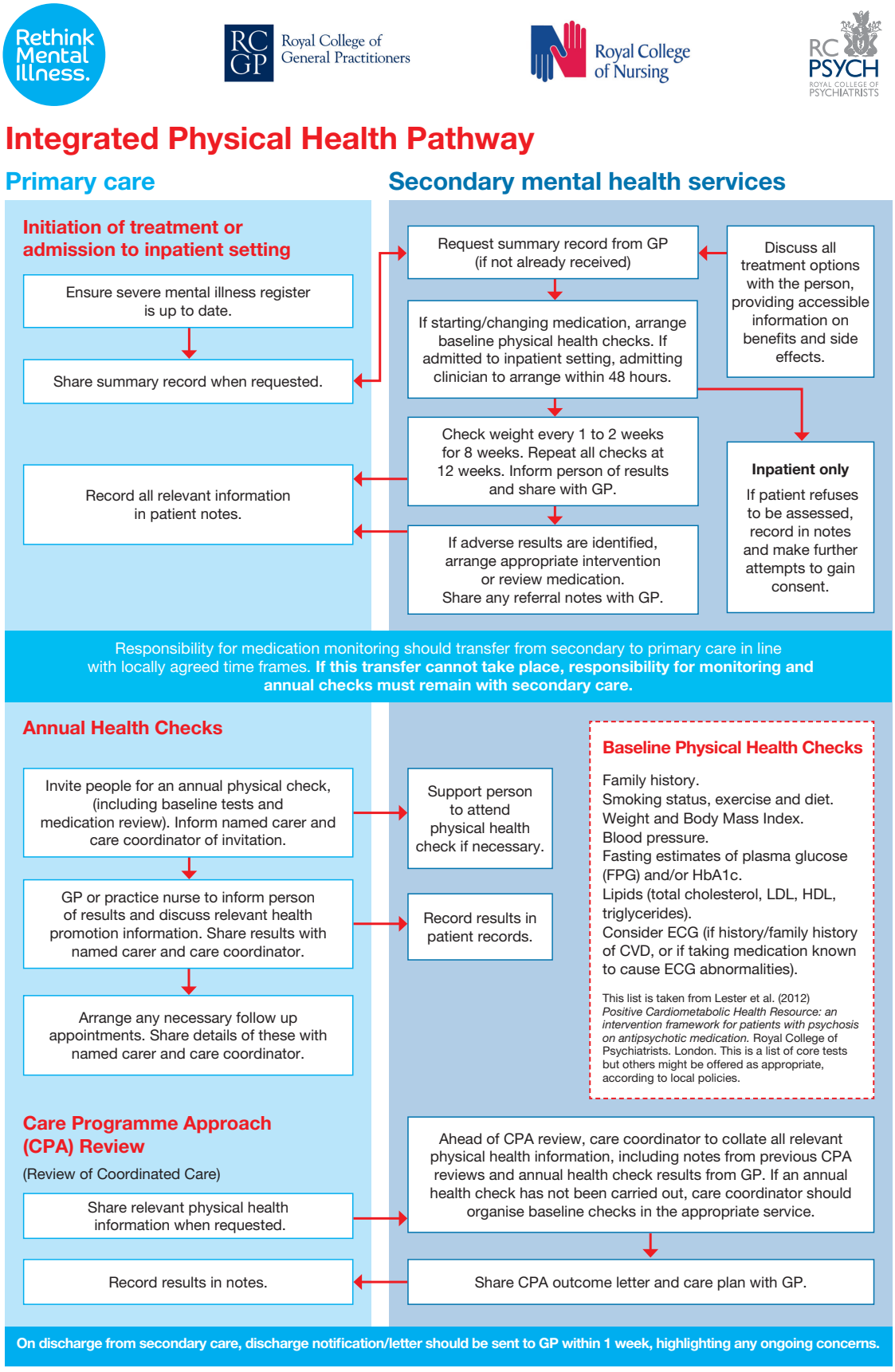
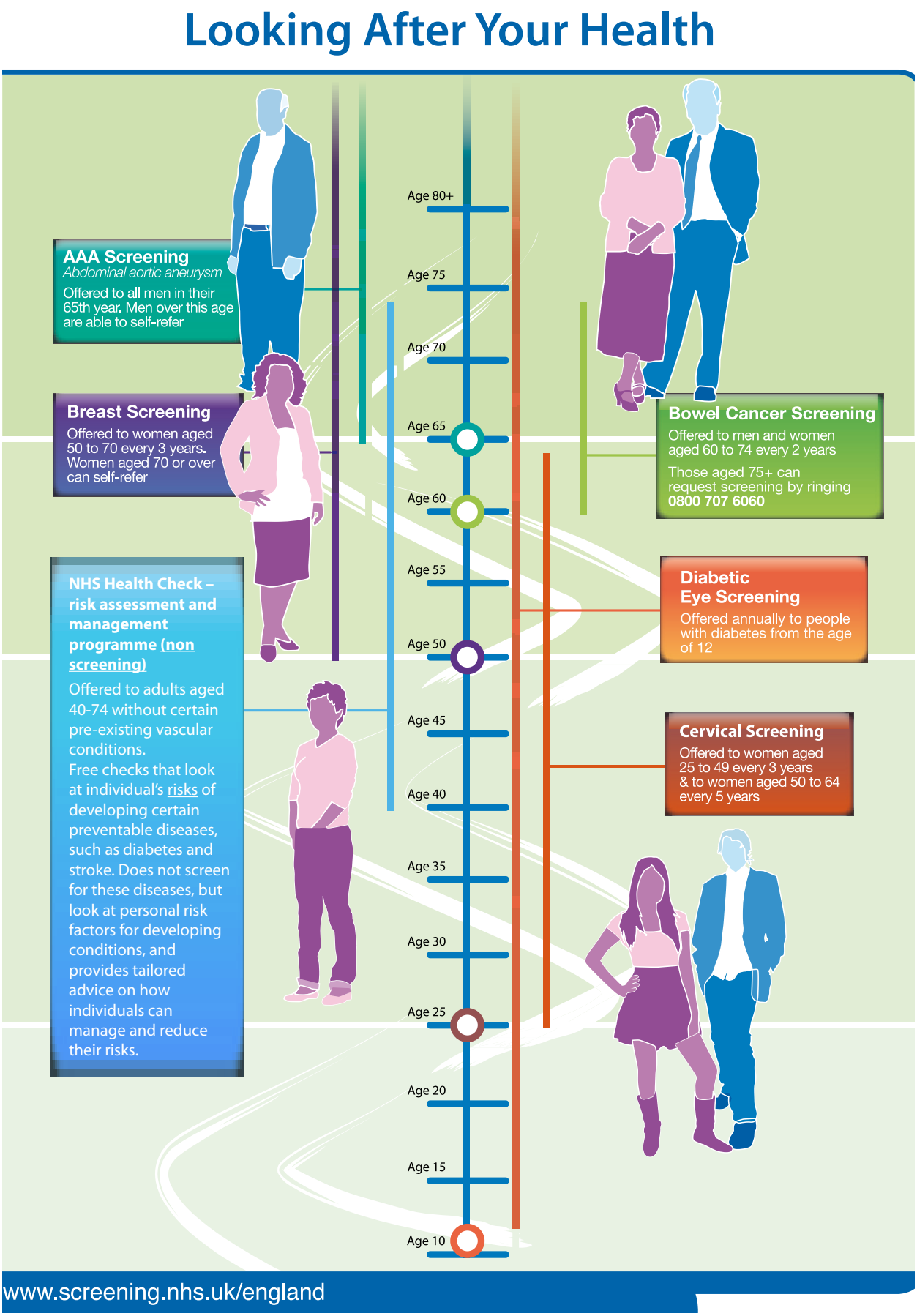
2. Integrated Physical Health Pathway

The Integrated Physical Health Pathway developed by Rethink Mental Illness, is a resource that supports health professionals to coordinate physical health monitoring for people affected by mental illness and ensure information is communicated effectively between services. It sets out a template for services across primary and secondary care to work together to ensure the physical health needs of people affected by mental illness are identified and addressed.



3. NHS screening

The NHS Screening time line is a visual representation of all national screening programmes available in the NHS in England.



4. Physical Activity Benefits for Adults and Older Adults

The Physical Activity Benefits for Adults and Older Adults: UK Chief Medical Officers' Guidelines (2011) provides a summary on the health benefits of being more active.

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