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Article

The Northampton Physical Health and Wellbeing Project: the views of patients with severe mental illness about their physical health check

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ABSTRACT

Background Annual health checks are recommended for people with severe mental illness, as they are at high risk of cardiovascular disease. We trained practice nurses from six primary care centres in Northampton, in the UK, how to deliver health checks for this population.
Aims The purpose of this study was to examine patients' views about the physical health check delivered by a nurse trained in the Northampton Physical Health and Wellbeing (PhyHWell) project.
Method We interviewed five patients from three primary care centres using a topic guide.
Results From a total of 29 patients who were invited, five attended. They had a good understanding of the importance of a healthy diet and taking regular exercise, but did not appear to be aware of the risk of cardiovascular disease. Being treated consistently by the same healthcare professional and/or by a nurse was cited as a helpful factor in managing their physical health. Most of the patients were glad to be invited for a health check and thought that it was worthwhile. They would have liked more information about blood tests and medication. All of the patients reported that they had started to make changes to their lifestyle since the health check.
Recommendations Training for practice nurses to provide physical health checks for people with severe mental illness should emphasise the patients' views of what will make them effective.

Keywords: health check, patients, physical health, primary care, severe mental illness

Introduction

People with severe mental illness (SMI) have a high incidence of cardiovascular disease (CVD) leading to premature death.[1, 2] This is due to a combination of lifestyle factors and the side-effects of antipsychotic medication.[3, 4] It is important that these patients have an annual physical health check in order to identify and manage their risk factors for CVD.[5,6]

There is little evidence to demonstrate that these health checks are routinely taking place[7] or that health education is a common feature of consultations with the SMI group of patients in primary care.[8] This may be because people with SMI do not consider themselves at risk of physical health problems, and therefore do not attend for screening.[9]

However, one audit demonstrated that these patients will attend for a physical health check when invited to an appointment at a specific time and date with a named person.[10] In addition, a qualitative study from the perspective of individuals with a mental illness established that this group of patients considered that it would be advantageous if primary healthcare providers focused on prevention and early detection of physical health problems.[11]

Two studies concluded that people with SMI give less attention to their lifestyle and physical health needs as a result of lack of knowledge rather than poor motivation.[9,12] In fact, other research has shown that people with SMI had a very positive attitude towards their physical healthcare, but that lack of support and negative staff attitudes were possible barriers to their participation in lifestyle interventions.[13,14] People with schizophrenia consider it important that healthcare professionals have the ability to inspire their confidence, and that they are kind and patient.[15] They also want to know what services are available to help them to make informed decisions as well as proactive health choices.[11] In addition, peer and staff support, knowledge, personal attributes and the participation of staff have been identified as possible incentives for improving the health of this group.[14] For example, Campion and colleagues reported that one-third of patients with SMI in their study stated that they would increase their physical activity following advice to do so from a doctor.

A qualitative study examining personal (or holistic) care of all patients in general practice reported that, regardless of their diagnosis, patients wanted to be treated as a 'whole person' rather than just receiving treatment of the presenting illness.[16] The patients referred to the importance of professionals knowing about them and their family history. The nurses in this study described themselves as specialists in this respect. A mental health service user with a diagnosis of schizophrenia responded to this study,[17] and emphasised that personal care is very important to mental health service users who are trying to cope in the community.

There is no evidence-based education for healthcare professionals with regard to the physical health of patients with SMI.[18] We envisaged that specific training in this subject could influence the nurses' role and as a result improve patient outcomes. Consequently, we developed a training package for practice nurses (the Northampton Physical Health and Wellbeing (PhyHWell) project), with funding from a primary care service provider in the Midlands, UK. This training was effective in modifying practice nurses' misconceptions about physical health in people with SMI.[19]

The education took place in each individual practice, and the community mental health worker linked to each centre was also invited. The major part of the training involved the use of a manual (the Health Improvement Profile for Primary Care or HIP-PC) and a website (http://physicalsmi.webeden.co.uk). The manual provides practice nurses with clear guidance and a rationale to help them to make decisions about individual patients. The website includes useful tools (e.g. letters, care plans, scales, HIP-PC), relevant information about SMI (e.g. medication, the Mental Capacity Act, schizophrenia, bipolar disorder) and helpful links (e.g. leaflets, further information for healthcare professionals, charities). In addition, the practice nurses were taught the definition, signs and symptoms, and epidemiology of SMI, the impact of SMI on physical health (particularly the increased risk of CVD), how to enter the data into the computer template, and how to liaise with relevant healthcare professionals and agencies.

In this study our primary objective was to examine the patients' view of the physical health check that was delivered to them by a practice nurse who had received PhyHWell training. We hoped to use these observations to refine and enhance the intervention.

Method

As people with SMI often have cognitive problems, we decided to use interviewing as the method of obtaining data.[20,21] This allowed for some flexibility in administration, clarification of questions and the use of follow-up questions.[22]

Recruitment

We intended to interview 12 patients from three of the participating practices who had had a health check by a nurse trained in the PhyHWell project. We aimed to build a sample that was representative of the population who had had a health check. It was planned that this would be achieved by using purposive non-random sampling by selecting a distribution of gender and diagnosis (three men and three women with bipolar disorder, and three men and three women with schizophrenia), age (three patients from each of the following age groups: 18–28 years, 29–39 years, 39–49 years, and over 50 years) and ethnicity (one patient belonging to the black minority ethnic sector diagnosed with bipolar disorder and one diagnosed with schizophrenia). These

characteristics would reflect the diversity and breadth of the sample population.

Each practice was asked to identify one male and one female patient with schizophrenia, and one male and one female patient with bipolar disorder. They were requested to include one patient from each age group. The practice that had the highest percentage of patients belonging to the black minority ethnic sector was requested to include a patient of either sex from this group. A member of the administrative team from each participating practice generated a list of eligible patients using these criteria. The first patient listed in each category was then selected. The names of the identified patients were checked by one of the healthcare professionals to ensure that they had the mental capacity to consent to participate in the study. As we recognised that it was unlikely that everyone who was invited would attend, we aimed to invite eight people from each of the three identified practices.

Conduct of Interviews

One of the authors (SH) followed a topic guide that included the following questions:

- How do you think you look after your physical health?
- How would you describe your physical health (e.g. good, poor)?
- Have you got any concerns about your physical health?
- Where would you go if you had a physical illness?
- How often do you visit your GP?
- What did you think about the health check you had (interventions, nurse delivering the health check)?
- Has the health check encouraged you to make any lifestyle changes? If so, what are they?

Open-ended questions were asked in order not to lead the patient into giving a particular response. Tape recorders were not used because, after consultation with patients with schizophrenia, we ascertained that this could be unacceptable to some participants because of paranoid symptoms, and therefore might restrict their involvement. The Regional Ethics Committee gave approval on condition that there was an assistant present to take notes.

SH made her own notes immediately after the interviews in order to record some of her observations about the patients.

Analysis

Thematic analysis was conducted on the notes from the interviews. We have driven some of the themes by using a topic guide.

Results

From a total of 29 patients who were invited, five attended. The first practice identified eight patients using the criteria, and one patient turned up. As they had many eligible patients they were able to invite a further eight, and again one patient attended. The second practice was very small and only had five eligible patients. They were all invited, and one patient came to the interview. The third practice invited eight patients, and two of them attended.

Table 1 shows the demographic data for the participants. None of them were working, and the majority had no regular support from secondary care services.

Observations

Although all of the patients were willing to take part in the interviews, their answers were on the whole very brief, and it was difficult to get them to elaborate on the points they had made.

All of the patients arrived on time for their interview. Most of them were clean, neat and tidy in appearance. The majority of the patients were initially a little guarded until they had listened to the verbal explanation of the study. Finding out that the interviewer (SH) was a nurse seemed to be a reassuring factor.

One patient lived with her husband, who was present during the interview. She responded to all of the questions, but looked to her husband for confirmation of her answers. This patient stated that she was very happy with all of the care that she received, both now and in the past. Only one patient declared the opposite.

The other four patients, who all lived alone, indicated that life could often be rather difficult.

Understanding of physical health

All of the patients appeared to have a good understanding of the importance of a healthy diet and taking regular exercise. Some were managing to engage in regular physical activity and eat well, but others reported that this was not so easy. Two

Table 1 Demographic data for participants

Patient number	Ethnicity	Gender	Age (years)	Diagnosis	Year of diagnosis	Living arrangements	Occupational status	Social support
1	White British	Female	52	Bipolar disorder	2005	Lives alone	Unemployed	None
2	White British	Male	48	Schizophrenia	2002	Lives alone	Unemployed	CPN for injection
3	White British	Female	47	Psychotic episode	2002	Lives alone	Unemployed (carer for son)	None
4	White British	Female	76	Bipolar disorder	2010	Lives with husband	Retired	CPN annually
5	White British	Male	25	Paranoid schizophrenia	2002	Lives alone	Unemployed	Weekly visit from support agency

patients reported that their lifestyle had improved now that their mental state was better. Only one patient smoked, and he was trying to give up. None of the patients were currently drinking alcohol or taking illicit drugs, although one reported a past habit.

The patients gave very few details about whether or not they thought they were healthy. Two patients described joint problems or stiffness caused by the medication they were taking. One patient stated that the medication had made her gain weight. Another patient was unaware that his medication might increase his weight or cause other problems.

> Sometimes I comfort eat, though it doesn't help me feel better.
>
> Patient 1 (52-year-old woman)

> I try to exercise [cycle], sometimes I'm a bit lazy.
>
> Patient 2 (48-year-old man)

> Look after health better now – didn't give a t**s before when ill, as didn't care whether I lived or died.
>
> Patient 3 (47-year-old woman)

> My health is better since I started to look after myself.
>
> Patient 4 (76-year-old woman)

> My health is bad. I'm not a healthy eater, I smoke.
>
> Patient 5 (25-year-old man)

Patients' concerns about their physical health

The patients voiced some concerns about their physical health, although they did not display an awareness of the risk of CVD. One patient felt that everything that could be done with regard to keeping her healthy was in place. Another patient stated that they were not worried at the moment, but would probably need to consider their health in the future. Two patients mentioned the side-effects of medication.

> My health could be better. I haven't looked after myself so well since my mental illness. I would rather have side-effects [from the medication] than symptoms of bipolar disorder.
>
> Patient 1 (52-year-old woman)

> I worry about the stiffness.
>
> Patient 2 (48-year-old man)

Seeking help for a physical illness

The majority of the patients stated that they would attempt to resolve minor ailments themselves, and only attended the surgery when it was absolutely necessary (e.g. for reviews for medication and diabetes or more severe illness). One patient stated that this was because she was brought up not to go to the doctor, but when her mental health was poor it was because she did not trust anyone. She thought that

seeing the same person each time she went to the surgery would help. Two other patients stated that they had no confidence in doctors. One said that he found it easier to talk to the community mental health nurse, but she did not know about physical health, and the other patient said she might be happier seeing a nurse. Another patient said that seeing a nurse would be OK if they were not too young and they had some understanding of the patient's situation.

> [The] system at this doctor means you see [a] different doctor or nurse each time. Not good when you have mental illness and cannot trust people.
>
> Patient 3 (47-year-old woman)

> I stopped coming [to the GP surgery] because [the] doctors would just read [the] notes and say 'will write to CPN.' My physical illness is overlooked because I have a mental health problem. They treat me like a child. I would be more willing to come if this changed.
>
> Patient 5 (25-year-old man)

Patients' thoughts about the health check

Most of the patients expressed the view that they were glad to be invited and thought that the health check was worthwhile. They were happy to be offered advice about diet and exercise. Only one patient said that he thought it did not matter, but he was unaware that he had had a health check. The majority of the patients said that they had not been told what the blood tests were for and would have liked an explanation. Four patients wished that they could have discussed their medication and its effects on their health. Generally the patients wanted more information (both verbal and written).

> I don't know what to ask for, so would like to be offered more information about services available to me.
>
> Patient 3 (47-year-old woman)

Patients' thoughts about the effect of the health check

All of the patients reported that since the health check they had started to make changes to their lifestyle. Three of them reported that they had increased the amount of regular physical exercise they took, and made changes to their diet. The fourth patient was improving her diet, and the fifth patient (who was unaware that he had had a health check) was working with the nurse to decrease his smoking.

> It made me focus on my weight problem. I would like to see nurse weekly, but they can only do once a month, so my parents are paying for a diet class.
>
> Patient 1 (52-year-old woman)

> I'm seeing the nurse every 6 weeks for my diet. I've lost 2 stone!
>
> Patient 4 (76-year-old woman)

Discussion

The purpose of this study was to examine patients' views about the physical health check delivered by a nurse trained in the PhyHWell project.

It was disappointing that we only managed to recruit five patients to our study. It is recognised that recruitment can be the most challenging part of a clinical research study, and our potential participants shared most of the characteristics often associated with poor response rates.[23,24] Given this and the fact that patients with SMI are often not forthcoming in presenting themselves with physical ailments, the response rate is not surprising.[20,25] However, despite the small number of participants, we still managed to obtain a cross-section of patients with regard to gender, age and diagnosis.

All of the patients arrived on time for their interview. It could be argued that this provides a picture of good organisation, which is a characteristic often described as lacking in people with SMI.[20,21] However, we should take into account that of the patients who did not attend, only a small number telephoned to say they would not be coming. We do not know whether those who did not inform us of their non-attendance made a conscious decision not to participate, or whether they were too disorganised to come.

Most of the participants were clean, neat and tidy in appearance. This might be interpreted as demonstrating that they wanted to look after themselves and were therefore responsive to advice given by the nurse during the health check. These participants may not be typical of the SMI group as a whole.

The majority of the patients were initially a little guarded, until they had listened to the verbal explanation of the study. This may have been due to concerns about confidentiality, which may be experienced by any person who is being interviewed.[26]

These anxieties are usually allayed following assurance that the patients' privacy will be respected.[27] In addition, some people with SMI have an element of suspicion related to their diagnosis, which could increase their feelings of apprehension in this situation.[28] They could have been reassured by the knowledge that the interviewer (SH) was a nurse, because they would then expect to be approached from a perspective of understanding.[29]

The majority of the patients who attended had no regular support from secondary care. This may be because they were well and so were able to make the decision to participate. Perhaps the patients who were receiving support were less well and that was one reason why they did not attend.

Most of the participants answered the questions during the interviews very succinctly. This may be a reflection of the cognitive problems associated with SMI, rather than indifference.[20,21]

The patients did not show any awareness of the risk of CVD. We cannot be sure whether they were given this information during the health check and did not remember it, or whether they were never given the information. Providing relevant written information could be helpful, and was suggested by some of the participants.

A number of the patients said that they would delay seeking help for a physical illness due to their lack of confidence in their doctors and the need to see a different person each time they visited the surgery. One of them illustrated his reluctance to attend was due to the negative attitude of his general practitioner. This concurs with the findings of Roberts and Bailey with regard to possible barriers.[14] However, the patients were willing to see a nurse. The reason for this may be that generally nurses have more time than doctors and therefore appear more patient, a trait that is considered important by people with schizophrenia.[15] Having one nurse in the practice responsible for providing these health checks offers the opportunity to build an ongoing relationship. However, as was mentioned by one of the participants, this nurse would need to have a positive manner and relevant skills. Training nurses will help to achieve this outcome.[19]

Most of the patients expressed the view that they were happy to be invited for a health check and thought that it was worthwhile. Their views are consistent with those of the participants in the study by McCabe and Leas,[11] who thought that it would be beneficial if primary healthcare providers focused on preventive health. The patients in our sample wanted to know more about the blood tests that they were having and the effects of their medication. This demonstrates a highly positive attitude towards their physical healthcare, which is consistent with the results of the study by Brunero and Lamont.[13] Patients with SMI may pay more attention to their lifestyle and physical health needs if they have this knowledge.[9,12]

Despite the apparent lack of knowledge of CVD risk factors, the patients were making lifestyle changes. In fact, one patient was unaware that he had had a health check. It could be argued that this is not important if the desired outcomes are achieved (i.e. he was tackling the toughest lifestyle change, namely smoking). It appears from the interviews that lifestyle changes were implemented after the health check. This is consistent with the findings of Campion *et al*.[9] However, as we do not have a knowledge of the participants' previous behaviour, we cannot claim conclusively that this was the case.

The King's Fund report on long-term conditions and mental health[30] suggests that developing more integrated support for people with mental and physical health problems could improve outcomes and play an important part in helping the NHS to meet the quality, innovation, productivity and prevention challenge. Providing education based on the views of patients with SMI is only one but very important step towards meeting this challenge and improving the service that is received by this group with regard to their physical health needs. There needs to be a coordinated intervention at the level of the whole system, which includes policy makers, health and social care leaders and organisations, academics and educators.

Recommendations

Training for practice nurses to provide physical health checks for people with SMI should emphasise the patients' views of what will make these effective. This study has found that these include the importance of explaining why the health check has been offered, describing what each blood test is for, discussing the potential side-effects of antipsychotic medication, giving relevant verbal and written information, and providing the opportunity to see the same healthcare professional wherever possible. Finding out how patients think current service delivery arrangements could be improved, by asking them about this directly, could help to provide them with a less intimidating environment. Commissioning leads need to take heed of their suggestions and then resource long-term sustainable pathways of care in the NHS. Access to relevant training should be part of this process, and is one of the regulations in the Care Quality Commission workforce outcomes document.[31]

Limitations

We only managed to obtain the views of five patients. They are therefore not representative of the whole population of patients with SMI, but their voices are nevertheless important.

Some of the quotations may not correspond to the exact wording used by the patients. As we were limited by funding, the person who made the notes during the interviews was a healthcare professional, not a researcher.

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