Holistic health care for patients with severe mental illness

– collective responsibility for all professionals

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Psychiatry has come a long way over the decades. Public mental asylums were established in Britain after the passing of the 1808 County Asylums Act. It was only in 1845 that the Lunacy Act changed the status of the mentally ill to have the status of patients who require treatment. In the 1900's the asylums had thousands of patients, and the institutionalization was not far from custodial institutions. From the 1960's deinstitutionalization started, community services started developing and asylums were gradually closed over the next few decades. This was a huge acknowledgement that mental disorders were health problems; patients who had mental disorders should be treated as members of society and not be placed for years in institutions.

Currently in England, we have psychiatry units often away from general hospitals, and this has led to a different type of segregation, both of mental health patients and mental health professionals. The recent developments in England to develop core 24 and enhanced liaison service 26[(1)] is a welcome move where we now have more mental health professionals based at general hospitals and the need for looking after the mental health of a person who presents with physical health problems or at accident and emergency with mental health problems. In addition the extra funding for perinatal psychiatry[(2)] has led to close working of perinatal mental health professionals with primary care and obstetric departments.

The NHS Mental health implementation [(2)] has assured an extra £2.3 billion investment fund which is ringfenced and be available year on year to help provide mental health care to an additional 2 million people, and also has specific targets for patients with severe mental illness, to ensure they have integrated care and increased number of people (390,000) to receive health checks by 2023/24.

In terms of physical health care of patients with mental health problems there have been great initiatives over the years including national and local commissioning for quality and innovations (CQUINs), Quality outcome framework targets , to name a few. The importance of intervening and not just screening was repeatedly emphasised. All these initiatives were brought about to help reduce the inequalities faced by patients with severe mental illness, where the mortality is around 15 to 20 years earliar than the general population[(3)] .

In a research and analysis briefing paper published by Public Health England titled " Severe mental illness and physical health inequalities" in September 2018[(3)] ; the major causes of death for patients with chronic mental illness included cardiovascular disease, respiratory disease, diabetes and hypertension. The main findings were as follows-

- Confirmation that compared to all patients, SMI patients have a higher prevalence of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), stroke and heart failure and similar prevalence for hypertension, cancer and atrial fibrillation.
- demonstrate that the differences are more pronounced for younger age groups with the highest health inequality in ages 15 to 34 for asthma, diabetes, hypertension and obesity
- demonstrate that SMI patients are more likely (1.3 for female and 1.2 for male) to have one or more of the physical health conditions examined in the analysis than all patients
- demonstrate the health inequality between the SMI and all patients is almost double for multi-morbid (2 or more) of the physical health conditions
- demonstrate that SMI patients aged 15 to 34 are 5 times more likely to have 3 or more physical health conditions and this health inequality reduces with age
- demonstrate that patients living in more deprived areas have a higher prevalence of SMI
- confirm that SMI patients living in more deprived areas have a higher prevalence of physical health conditions

- demonstrate that SMI patients experience inequalities in physical health for obesity, asthma, diabetes, COPD, CHD and stroke after standardising for deprivation as well as age and sex
- The need for all health professionals to acknowledge the need and their role

Whilst all the strategies to look at ways to address these are commendable, it is also important for the health and care community to acknowledge and understand the extent of the inequality these patients face; and also consider the commitment and faith we have in ourselves and each other to help these patients to make a real difference. For all chronic illnesses, the benefit of small changes are often seen over time, and in the fast paced environment of our working lives, the time we need to take to invest in this area can be a challenge. We often hear of individuals and teams who are passionate and committed to make the change.

There has also been a gradual change of moving people on from secondary care to primary care therefore reducing the length of time a patient is with services; and loss of key relationships and prompts from a familiar person can affect the attendance for health checks and subsequent interventions as required. The transitioning between services needs responsibility shared on both sides. We have to find ways to bridge these gaps and also ensure the integrated care models will surely work for patients and carers in the best way.

Understanding patients and carers

Having more than one health condition is a challenge. For a patient with severe mental illness, the journey with health can be very varied, with some patients having outpatient and other having inpatient contact. Some may have been detained under the mental health act. All these experiences along with the illness as well can be quite an emotional and intense experience for them and their loved ones. When they then hear they have an additional physical health diagnosis this can again cause further emotional reactions. Patients may be searching for explanations within themselves and others. It is not uncommon for mental health prescriber to be blamed for the additional diagnosis of diabetes, obesity, high triglyceride levels. It is true there are significant side effects related to psychotropic medications and it is necessary to explain about the need for looking after the physical health from the start of any treatment. Patients if diagnosed with additional conditions may be recommended further medication to manage the comorbid condition and their status as a patient becomes more pronounced. They often have to go for additional tests, appointments and see more health professionals, often who talk to them on the condition the professional is qualified in.

Engagement and building trust

Patients with severe mental illness can often have experiences that are very unique to that individual. For a health care professional to be able to truly make an impact, the element of trust is key. One requires a huge amount of perseverance and patience it can take months to years even to engage some patients. Many mental health professional have mastered this art over a long period of time. Specialist teams including early intervention in psychosis teams that provide a bespoke service to patients and carers from their time of diagnosis; and assertive outreach teams that help engage patients who have chronic, severe and enduring mental illness, are difficult to engage, often requiring lengthy admissions and may have comorbid substance misuse were created in 1999 to help provide an intensive service in the community[4]. These teams worked alongside community mental health teams. Several areas have now reorganised and these teams are not universally present at all areas. It is vital to preserve the expertise of these professionals and continue their role in all services and remember the need for the time and effort to help these patients to trust and engage with the care for all their conditions.

Other ways of engaging patients to work on health and wellbeing

Accompanying patients for appointments- if a patient with severe mental illness is supported to attend their appointments for health clinics such as diabetes, cardiac and respiratory clinics etc the health professional seeing them can have a more comprehensive understanding of their mental health and social situation. In addition the patient can feel valued and cared for and is likely to take the advice more seriously due to the combined effort of two or more professionals. This includes services such as smoking cessation, lifestyle changes. This does mean more time from the professionals however the impact of benefits on individuals cumulatively and to society far outweighs the risks.

Doing blood tests and ECG's from the mental health teams and having a good transition plan if this changes- Many teams have the ability to provide blood tests and ECG's in places familiar to patients , there are teams who have also trained mental health staff who can do phlebotomy and ECG's at home. This has improved the uptake of blood tests, and also been especially beneficial during covid times.

Consideration of cultural, religious and spiritual actors

It is so important to understand the cultural factors of each individual, and not make any assumptions. Culture can play a significant role in how a person responds to a diagnosis of mental illness and their subsequent engagement.

Many patients go to religious and spiritual leaders and working alongside them so that they can also reinforce the need to take treatment for their mental health can provide patients and carers multiple avenues of support and further build collaborations.

Medication and interethnic differences and genetic differences

Medication is only one aspect of treatment of severe mental illness and we must be used in conjunction with other psychological, social and cultural interventions as needed for the patient. Medications for mental health are perceived differently in different cultures and also within sub cultures.

It is important to consider genetic and environmental factors and how these may affect a patient. In a study[5] it was noted that there were differences in the plasma proteins that transport medications among ethnic groups. The plasma concentration of α1-acid glycoproteins, which provide binding sites for psychotropic drugs in the blood, was found to be significantly lower among Asians than among whites and African Americans . In addition the activities of conjugating enzymes (transferases) that are involved in the metabolism of most psychotropic medications are now known to be genetically determined. Furthermore the CYP system has been found to demonstrate genetic polymorphism and to exist in a bimodal distribution; individuals may be classified as extensive, poor, or slow metabolizers. The genetic polymorphism and subsequent functional expression of CYP enzymes, particularly CYP2D6 and CYP2C19, may

contribute to differences in rates of psychotropic medication metabolism. In addition to these genetic differences between ethnic groups, interethnic differences in enzyme activity may exist, partly resulting from a variety of environmental factors, such as diet, use of herbal medicines, and other lifestyle factors.[5]

Socioeconomic factors, housing, support for employment

One should not underestimate the socioeconomic factors for patients who have severe mental illness, as this can affect education and employment. Supporting patients in these areas when they are stable will hugely help improve their quality of life and give society a valuable contribution. Examples include individual placement support and recovery colleges. Many patients have taken on roles of peer support workers and this has been a huge success. Whilst we talk to patients about their health it is so important to consider their social and environmental aspects. Supporting a person to do the form to get their benefits, apply for housing, having access to a bus pass, having a package of support from social care makes a huge difference. These cannot be underestimated at all and the only way to achieve this is for health, social care, housing and other agencies to work collaboratively. The impact of severe mental illness for many people also means interrupted education due to episodes of illness, varying IT skills and vulnerability to be taken advantage of by others such as providing them with illicit drugs in return for money or prostitution as examples. Having substance misuse services working in collaboration and similar approach from other agencies such as police to help protect patients from exploitation are other examples.

Ask the patient what they think

It is important for clinicians to be able to ask the patients views, there are patients who believe they have an illness, but prefer not to take medication. On the other hand some patients may not believe they have a mental illness however they take prescribed medication to help sleep, or feel relaxed. When clinicians ask patients' their views genuinely and are able to convey the reason for the question to be to help the patient, they may hear the most important aspects that are relevant to the patient clinician relationship, and to work on the treatment plans together for the long term.

Seeing patients with chronic mental illness in physical health care clinics

As a clinician who is not an expert on mental illness, one may consider how best to approach a patient with regards to their health condition. Some patients may have residual or treatment resistant conditions such as hallucinatory experiences or delusional beliefs. It is best to talk to the patient just as you would to any other patient, and ask them if they have a clinician who they see for their mental health who they would consent for you to liaise with. For patients on medication such as clozapine, even a simple symptom such as tachycardia should be taken seriously as over several years it can cause significant cardiac problems. Similarly for a patient with COPD, all professionals should consider ways to advice on smoking cessation. This should be specific to the patient at the stage they are at. An expert advising a patient and showing they really care can have a genuine impact on the patient.

Joint clinics with psychiatrists and experts in physical health conditions

Having a one stop clinic with multiple professionals will be a great way to ensure all chronic conditions are given equal importance, and to show the patient that all professionals are keen to improve their overall health and wellbeing, and in doing so can gain several years of their life. This also helps professionals learning from one another on their area of expertise.

Corresponding with other clinicians seeing the patient and with patients' consent ask for copies of letters and sharing of information between various systems is key to know the opinions of experts in these areas and how strategies that work for the individual can be used by others.

Recovery

Recovery is defined as "A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. Recovery from mental illness involves much more than recovery from the illness itself."[6]

A recovery framework that has been developed from a systematic review and narrative synthesis of the literature[8], has found that the areas most relevant to clinical research and practice are connectedness, hope and optimism, identity , meaning in life and empowerment (also called CHIME framework)[7]. In patients from ethnic minority groups there was a greater emphasis on spirituality and stigma, culture specific factors and collectivist notions of recovery.

Conclusion

This article has tried to look at how we can collectively reduce health inequalities for patients with severe mental illness. It explains the importance of acknowledging our own ability to help; and really understanding the patients. Taking time to build trust can give a huge benefits over time. Every opportunity a professional has must be used in the best way, and collaborating with other specialists and general practitioner who is also seeing the patient can make a positive difference for the patient, help share medical information directly without using the patient as the messenger and make the patient feel valued. The use of preventative techniques should always be considered , and lifestyle advice should be given regularly .The impact of a small change in parameters such as pulse, BP, small increments in weight and HbA1C to name a few must be taken seriously for this group of patients. Understanding the patient, taking time to engage them, taking into account their cultural aspects and individual views will help to foster a good patient clinician relationship. Doing joint clinics with psychiatrists and other disciplines for example cardiology, diabetes and endocrinology, respiratory can be a way forward for the future to help treat all conditions the patient has collaboratively, increase expertise across the conditions and reduce the health inequalities that patients with severe mental illness face. Patients who are on long term psychotropic medication need to have the optimal care not only for their mental health, but also their physical health. Recovery is more about quality of life and not absence of symptoms, and the need for patients to be able to connect, have hope, identity and meaning in life and empowerment are key factors that support and help a person to achieve recovery.

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Obituary: **Prof Julian Leff** (1938-2021)

Prof Julian Leff was Professor of Social Psychiatry at Institute of Psychiatry (IoP), London. He was regarded as an original thinker who developed and translated research ideas to lives of people who suffer from Schizophrenia. His work led to improvement in understanding the impact of social factors in patients suffering from Schizophrenia. I did not have an opportunity to meet him personally but read his work with interest as a young trainee psychiatrist in India in the early 1990s and later in U.K. A few years back at Royal College of Psychiatrists International Congress in Birmingham in 2018 I had the opportunity to watch a documentary regarding his life and work and also meet his son, Adriel.

One of Prof Leff's key research work demonstrated that family interventions aimed at reducing high expressed emotions (high EE) resulted in reducing relapse of Schizophrenia from 50%to less than 10%. In another study, Prof Leff showed that that higher incidence of Schizophrenia in Black Caribbean population in U.K. was likely to be due to social factors. He was involved in International studies of incidence of Schizophrenia co-ordinated by the World health Organisation (WHO). During one such visit to India he was impressed by how a supportive family environment is beneficial to individuals suffering from Schizophrenia.

Prof Leff also invented "Avatar therapy" in 2008. It is an innovative therapy in which people who hear voices have a dialogue with a digital representation (avatar)of their presumed persecutor voiced by the therapist, so that the avatar responds by becoming less hostile and concedes power over the course of therapy.


Credit: Matthew Lewin HAM HIGH

Prof Leff received several national and International awards during his distinguished psychiatric career including the Burgholzli award from University of Zurich in 1999, The Royal College of Psychiatrists, London conferred on him it's highest award, "Honorary Fellowship" in 2015. Prof Leff was awarded Yves Pelicier Lifetime Achievement Award by World Association of Social Psychiatry in 2017.

On behalf of Swasthya Editorial team I convey sincere condolences to Prof Leff's family.

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Chief Editor, Mental Health section, Swasthya