Physical health monitoring in mental health settings: A study exploring mental health nurses' views of their role

Aims and objectives: To explore nurses' views of their role in the screening and monitoring of the physical care needs of people with serious mental illness in a mental health service provider.
Background: There is increasing awareness through research that people with serious mental illness disproportionately experience and die early from physical health conditions. Mental health nurses are best placed as front line workers to offer screening, monitoring and interventions; however, their views on physical care interventions are not studied often.
Design: Qualitative exploratory study.
Methods: The study was carried out in a mental health inpatient centre in England. Volunteer sampling was adopted for the study with a total target sample of (*n=20*) nurses from three inpatient wards. Semi-structured interviews were conducted with (*n=10*) registered mental health nurses who had consented to take part in the study. Inductive data analysis and theme development were guided by a thematic analytic framework.
Results: Participants shared a clear commitment regarding their role regarding physical health screening and monitoring in mental health settings. Four themes emerged: Features of current practice and physical health monitoring; perceived barriers to physical health monitoring; education and training needs; and strategies to improve physical health monitoring.
Conclusions: Nurses were unequivocal in their resolve to ensure good standard physical health monitoring and screening interventions in practice. However, identified obstacles have to be addressed to ensure that physical health screening and monitoring is integrated adequately in everyday clinical activities. Achieving this would require improvements in nurses' training, and an integrated multi-service and team-working approach.
Relevance to clinical practice: Attending to the physical health needs of people with serious mental illness has been associated with multiple improvements in both mental and physical health; nurses have a vital role to play in identifying and addressing causes of poor physical health to improve physical health outcomes in people with serious mental illness.

Keywords: monitoring, mental health nurses, physical health, screening, barriers

What does this paper contribute to the wider global clinical community?

- This paper contributes to the wider debate regarding the training needs of mental health nurses in relation to their knowledge, skills and understanding around physical healthcare and management amongst people with serious mental illness

- Recognition of wider systemic obstacles that frontline health care professionals face in practice with service users presents challenges and deters staff from successfully managing the healthcare needs of those in their care.

Introduction

People suffering from serious mental illness (SMI) such as schizophrenia or bipolar affective disorder have increased rates of physical health conditions, dyslipidemia, obesity and cardiovascular conditions than the general population (Robson and Gray, 2007). They also have higher than average rates of non-insulin-dependent diabetes, infectious diseases and certain types of cancer (Mutsatsa, 2015). This is due to several dynamics such as illicit drug abuse, poor diet, lack of exercise, inadequate seeking of physical care and side effects of medication. Even with increased uptake of health services, people with serious mental illness do not always get the support they require promptly and are likely to have their physical health needs ignored or attributed to their mental diagnoses (Mutsatsa, 2015).

Mortality and morbidity rates due to poor physical health are considerably higher in people with SMI compared to the general population (Brown *et al.*, 1999, Haddad, 2009, Mykletun *et al*., 2009). Life expectancy of those with SMI has been estimated to be up to 25 years shorter in comparison to the general population (Thornicroft, 2013; World Health Organization, 2013).

The physical healthcare needs of patients using mental health services are less routinely addressed. This may be because of healthcare professionals' poor attitudes, lack of awareness of physical health diseases, lack of skills, knowledge and abilities and stigmatisation (Nash, 2011). These dynamics hinder prompt screening, diagnosis and management of physical health conditions.

The National Institute for Health and Care Excellence guidelines (NICE, 2009) and the Commissioning Framework (Department of Health, 2009) stress the importance of good-quality physical health in people with serious mental illness and urge service providers to promote parity between physical and mental healthcare provision. The guidelines recommend that people with serious mental illness should have their physical health regularly assessed, monitored and managed by both primary and secondary care (NICE, 2009). NICE also acknowledges that health professionals need to be given the essential training to meet these needs in order to offer the necessary health interventions to patients.

In their study of screening and monitoring practices for metabolic risk factors for patients taking antipsychotic medication in both primary and secondary care, Hasnain *et al.* (2010) found that these were not robust enough and the services needed to integrate better. Similarly, in their study of treatment rates for diabetes and hypertension in people with serious mental illness, Nasrallah *et al*. (2006) found non-treatment rates for diabetes in people with schizophrenia to be as high as 30.2%.

Background

People with serious mental illness are two times more likely to die from coronary heart disease compared to the general population and four times more likely to die from respiratory diseases (Nocon *et al*., 2004). More so, they are at greater risk of suffering from ischaemic heart disease events, stroke, epilepsy and hypertension compared to the general population. The Disability Rights Commission (2005) analysed 1.7 million records in primary care and found that people with serious mental illness are twice as likely to have diabetes as other patients and, in spite of overwhelming evidence of the high prevalence of cardiovascular risk factors in people with mental illness, current evidence shows a lack of focus on the known modifiable risk factors (Mutsatsa, 2015).

Frequently, the challenge for frontline staff lies in the ability to plan and implement physical health interventions across a range of physical health conditions which often have underlying multi-causal factors (social, environmental and economic), beyond the staff control. Significantly, increased rates of morbidity and mortality resulting from physical illness among people with SMI, together with an unequal uptake of evidence-informed interventions are significant when matched against wider health inequality challenges (Marmot, 2010). There is evidence that people with SMI are disadvantaged by health inequalities and complex dynamics relating to poverty, unhealthy lifestyle, access to assessment and treatment (Phelan *et al*., 2001). Most people with mental health problems, in particular SMI, are likely to be unemployed; this impacts on their social-economic status. As a result, they may experience financial difficulties that affect their ableness to sustain themselves sufficiently when it comes to buying food, clothing or housing (Mutsatsa, 2015). Similarly, in several societies, most ailments are more likely to occur further down the social ladder (Marmot, 2004). Not surprisingly, poorer people usually have twice the risk of serious illness and die earlier compared to those at the top of the social strata (Marmott, 2010).

Lifestyle behaviours such as smoking, illicit drug use, unhealthy eating and sedentary behaviours are more common amongst people with serious mental illness. It has been suggested that poor mental health can lead to unhealthy lifestyle choices and increased appetite (Markowitz, 2008). A combination of increased stress resulting from the nature and severity of mental illness alongside unhealthy eating habits, negative thoughts, sedentary behaviour, substance misuse and reduced social support, makes it more likely for people with mental illness to experience poor physical health. There is evidence that people with chronic or repeated episodes of depression are at particular risk of subsequent obesity and sedentary behaviour (Kivimaki *et al.*, 2009).

The smoking rate amongst the psychiatric population is significantly higher than the general population by almost 80% (McNeill, 2004, Robson and Gray, 2007; Department of Health, 2009). It is unsurprising that heavy smoking in people with serious mental illness is

associated with higher risk of smoking-related illnesses than non-smokers or those who smoke less (NHS Information Centre, 2010). Chronic obstructive airway disease (COPD) is common among people with serious mental illness and, importantly, its prevalence amongst chronic and habitual smokers is clearly documented (Himelhoch *et al.*, 2004; Jochelson and Majrowski, 2006l Wade *et al.*, 2006). Results from a study of 200 outpatients showed that 15% of those with schizophrenia and 25% of those with bipolar had chronic bronchitis; similarly, 16% of people with schizophrenia and 19% of those with bipolar disorder had asthma. In comparison to the matched controls in the general population, these rates were significantly higher (Mutsatsa, 2015). Further results from this study showed that rates of emphysema were significantly higher in people with schizophrenia and bipolar disorder, even after the confounders for the effects of smoking were controlled.

Additionally, psychopharmacological interventions used in mental health settings contribute to greater metabolic risks, i.e. glucose intolerance, dyslipidemia, weight gain (De Hert *et al*., 2011). Weight gain amongst people with SMI is a direct side effect of antipsychotics, especially related to atypical antipsychotics. In a clinical antipsychotic trial of intervention effectiveness, 88% of patients with dyslipidemia, 62% of those with hypertension and 38% of those with diabetes were not offered interventions for their conditions (Nasrallah *et al.*, 2006). Also, compared to the general population, people with serious mental illness are less likely to be offered screening for blood pressure, diabetes checks, cholesterol, weight checks, exercise or drug and alcohol screening (Mutsatsa, 2015; Roberts *et al*., 2007; Phelan *et al*., 2001). Too often, physical health symptoms and concerns presented by people with SMI have been over-attributed to psychiatric symptoms (diagnostic overshadowing); these practices undoubtedly hinder and lower the uptake of physical health interventions and result in delayed assessment and treatment of conditions such as diabetes and hypertension (Buckley *et al.*, 2005; Hasnain *et al.*, 2010).

Rationale for the Study

There is limited research relating to mental health nurses' practices and views on their role regarding physical health monitoring (Shuel *et al*., 2010). In their survey of mental health nurses' views, McNally *et al.* (2006) found that the nurses were less encouraged about owning the role of supporting smoking cessation interventions in mental health settings compared to general nurses. Research by Nash (2005; 2011) found that mental health nurses possessed inadequate physical healthcare skills and while some nurses reported having physical care skills, their physical health practical skills and knowledge base was out of date (Rushforth, 1998). Similarly, a survey by Happell *et al*. (2013), which investigated Australian nurses' interest in training across aspects of physical health monitoring including lifestyle, cardiovascular disease and screening for health risks, found that 91.6% of participants perceived training nurses in physical health monitoring as of moderate significance in improving the physical health of people with serious mental illness.

However, findings from other studies suggests that nurses acknowledge the value of physical health training in mental health settings (Blythe and White, 2012; Happell *et al*., 2012). Proposed benefits by nurses of facilitating physical health monitoring have included enabling and engaging service users in health promotion activities, i.e. healthy eating advice and smoking cessation (Robson *et al*., 2013; Robson and Haddad, 2012). Likewise, Hyland *et al*. (2003), in their study of nurses' attitudes, found that mental health nurses recognise that physical health screening and monitoring is inadequate and not performed at a systematic level. How well these views are assimilated into nurses' daily practice is highly questionable. Robson and Gray (2007) argue that the rationale for this practice gap is usually due to staff shortages, resource shortages, training needs and confusion surrounding roles. A broader approach of strategies is necessary and essential to address challenges at both micro and macro levels within health settings if the physical healthcare of people with serious mental illness is to improve (Scott and Happell, 2011).

Turning to the patients' views on accessing physical health care interventions, a study by Mind (1996), a leading mental health charity in the UK, found that many people with serious mental illness reported that their general practitioners and other healthcare professionals possessed stereotypical views towards them. Such stigmatising attitudes could prevent people from accessing help and therefore prolong physical ill states. Mental health nurses are strategically placed to address the stigma of mental illness by challenging stereotypical attitudes of healthcare professionals and the general public towards people with serious mental illness.

Given this context, this exploratory study investigates mental health nurses' views regarding the screening and monitoring of physical health needs of people with serious mental illness under their care. Furthermore, the study examines whether nurses believe they are able to meet the physical health monitoring needs of servicer users and whether they view these clinical activities as integral to their roles.

Methods

Design

To provide a flexible environment for voicing opinions and to facilitate dialogue, a qualitative exploratory approach was adopted for this study. This methodology is described by Stebbins (2001) as a vehicle to support in-depth examination of a topic of interest where little research is available to facilitate knowledge. As a method, it involves studying a small sample of participants by reconstructing their reality and understanding lived experiences through extensive and prolonged engagement to develop a pattern and relationship of meaning (Niewiadony, 1993). Semi-structured interviews were used and provided participants with an opportunity to air their opinions openly and freely.

This study was carried out in a mental health centre that holds inpatient wards and community mental health teams. Mental health nurses in the centre are the first point of contact for service users and their role is to admit, assess and develop recovery care plans focused on mental and physical health well-being. Mental health nurses at this centre are expected to conduct physical health monitoring checks for the service users under their care as per local policy guidance. Physical health monitoring and assessment is also shared between secondary and primary care services. General practitioners in the locality in which this study was conducted are expected to conduct annual physical health checks for people with serious mental illness on the registers, as per national guidelines (NICE, 2009).

Prospective participants had to be professionally registered with the UK Nursing and Midwifery Council (2015) and were expected to be working at bands 5, 6 or 7. Voluntary sampling was adopted for the study with a total target sample of 20 nurses from three inpatient wards. Emails were sent to nurses informing them of the study and inviting them to take part. In addition, two ward managers publicised (ward notices) detailing the study of the nurses in order to encourage participation. A study information sheet was forwarded to those who expressed interest 48 hours prior to the first semi-structured interviews taking place in the mental health centre. Of the 20 nurses, 11 expressed interest and gave consent in line with the protocol set by the National Research Ethics Service (NRES, 2007). So as to maintain confidentiality, participants were not expected to disclose professional/personal information other than length of service. Therefore, details for non-participation and representativeness were not recorded.

Table 1: Mental health nurses participants (*n=11*)

	(n)
Registered professional (MH nurse and seniority level as reflected by banding number)	
Band 5 (Newly registered nurse/primary nurse)	9
Band 6 (Charge nurse/assistant ward manager)	2
Band 7 (Ward manager/team manager)	0
Total	11
Length of service	
0-10 years	8
10-20 years	3
Over 20 years	0

Data collection

Interviews were conducted by the lead researcher who is a registered mental health specialist nurse with over 12 years of experience. Each participant was interviewed in a pre-allocated assessment room away from their work settings to maintain anonymity. Some of the participants agreed to be interviewed after their working schedules, so they felt at ease and more relaxed. During the interview, some structure was essential to compare narratives between participants and to ensure that the study objectives were addressed. A reflexive approach was employed throughout the interview, which allowed the participants to raise issues they felt were relevant to the study, and questions were rephrased to enable clarity and fluidity in the participants' responses. Physical health monitoring was a key discussion point during the interviews. The content of the interview questions was informed by the gaps identified in the literature review. Furthermore, in formulating the questions, the lead researcher was guided by and reflected upon informal feedback received from mental health nurse colleagues in both primary and secondary care services regarding current physical care monitoring practices. Table 2 shows a list of topics covered in the interview process

Table 2

Current practice and nurses' attitudes towards involvement in physical health monitoring
Importance of physical health monitoring in mental health settings
Perceived barriers to physical healthcare delivery and monitoring
Level of training, knowledge and skills to facilitate physical health monitoring
Level of service integration, multi-team working in facilitating physical health monitoring

After 10 interviews, the lead researcher decided that the information obtained had reached a saturation point with no new opinions or perceptions/insights arising in further interviews.

The interviews were recorded and transcribed verbatim after they were conducted in order to maintain a rich recount of the participants' narratives.

Ethical issues

Ethics committees of the university and Mental health service provider reviewed and granted approval for this research. Informed consent from prospective participants was obtained and recorded for the research before conducting the interviews. Participants were given assurance in relation to their anonymity and confidentiality being upheld (RCN, 2004), and participant number identifiers were used instead of names. The participants were informed that they were free to withdraw their consent at any time, at which point the recorded interview would be deleted.

Data analysis

A thematic framework used for data analysis was based upon Benner (1994) and Munhall (2007) to ensure that a detailed data analysis process was followed. The analytical framework focused on coding to derive the meaning of common experiences shared by the participants, followed by thematic development, whereby the lead researcher carefully used the framework to pinpoint, examine, compare and record patterns (or 'themes') within the data collected. The first stage of the analysis involved the lead researcher examining data from the audio recording and written transcript form. Throughout this procedure, the lead researcher manually coded emerging similar patterns of the data and inductive analysis. Emerging data was reviewed, compared codes and a sub- thematic structure was developed. To ensure the accuracy of the analysis and the themes derived, in the second stage of analysis, the lead researcher re-read the transcribed scripts against the codes identified and carefully checked against the audio recordings; changes were made to ensure trustworthiness and accuracy of the participants' narratives. Four final overarching themes reflecting commonalities to the sub-themes identified in stage one were identified in the last stage.

Results

The analysis of the data collected illustrated a clear commitment and overall support for physical health monitoring. The nurse participants surveyed recognised that physical health care has become and should be an essential element of their practice, whilst concerns about different barriers were raised. The four key themes were: (1) Features of current practice and physical health monitoring; (2) perceived barriers to physical health monitoring; (3) perceived education and training needs; (4) strategies to improve physical health monitoring. These themes will be discussed further.

Features of Current practice and physical health monitoring

The participants' views show a clear and definite role for mental health nurses in relation to physical health monitoring. The participants in the study recognised the importance of meeting the physical, mental and psychological health needs of service users, identifying that all healthcare professionals, including mental health nurses, have a significant role to play in the provision of and facilitating access to appropriate health interventions. Turning to their day-to-day role, participants confirmed that this involved the screening and monitoring of mental and physical health problems, including adverse effects of neuroleptic medications as well as opportunistic health promotion activities relating to healthy eating, smoking and illicit substance use. One participant stated that:

> I am aware that I should be conducting weekly physical health monitoring checks for the patients and I often do so, but sometimes I do not do it, especially when patients

> are asked but show no interest or refuse. I think the follow up in such situations is poor (Part N.2).

A similar view was echoed by another participant, including concerns around patients' low uptake of health promotion activities related to lifestyle choices and behavioural change that nurses often try to implement.

> I feel that sometimes nurses give up too easily when patients refuse to participate in physical health monitoring. I remember, one time I had to approach the patient so many times for blood sugar monitoring, eventually he agreed (Part N.1).

Participants identified common physical health conditions amongst the psychiatric population, which is a major cause of morbidity and mortality in this patient group. One participant recounted an experience in the past in which she acted quickly by making a sugar drink for a diabetic patient who was experiencing low blood sugar, but at the same time felt poorly confident in relation to having the necessary up-to-date skills and knowledge to intervene when she did. In a similar account, another participant described how:

> Any delays in screening of physical health problems and poor monitoring practices expose patients to ill-health. I think this is because nurses lack the appropriate skills and current knowledge of physical health conditions, how to assess and support patients who present to us with such … (Part N.5).

Some participants suggested that the monitoring of physical health appears to be provided in an ad hoc manner depending on a number of factors, including the competence and attitude of nurses, inter-service partnerships, resource availability and severity of patients' mental illness.

> … There is still confusion between services on who does what … for example, last week, we admitted a patient and we asked the GP to send us their current list of their medication; however, the list they sent us differed from what the community mental health team has, also the patient had missed their annual physical health check and he did not know where to attend for this … (Part N.10).

Analysis of nurses' understanding of health beliefs from their patients' perspective varied considerably:

> I think patients know the difference between right and wrong, so they can choose to smoke or not to. I think it is always safer and easier for patients to receive smoking cessation interventions when they are discharged (Part N.9).

> Patients are just like all of us, they have good and bad habits. If they choose not to eat healthily, why should we tell them otherwise? Also, sometimes patients don't

want to be advised, and for some who are too unwell, often lack understanding to engage in health promotion activities (Part N.10).

Perceived barriers to physical health monitoring

While most of the participants acknowledged that physical health monitoring is a necessity in practice, factors such as resource allocation, local culture and staff attitudes were identified as barriers. In the UK, smoking in public places was made illegal in 2007 and a year later, the smoking ban was applied to mental health units (Mallett, 2013). A few participants reported that they had not been entirely convinced about the usefulness of the ban relating to people with mental illness. The participants viewed smoking as a social activity for patients within the mental health units and felt the ban was a form of social control taking away patients' freedoms and that the nurses very often are faced with real challenges to police the ban.

> I did not totally agree with the smoking ban in 2008 because most of our patients have been smoking a long time and I felt that it would be pointless to try to get them to stop (Part N.1).

> I have approached and spoken to patients who smoke about cutting down or quitting but I often feel like I am hitting a brick wall. This has happened so many times and now I don't bother… (Part N.7).

Other participants reflected on the positive benefits of the smoking ban on the wards, including the creation of smoke-free spaces and limiting the effects of passive smoking for non-smokers. But the nurses generally reported ongoing challenges to implementing cessation programmes on the wards.

In some cases, participants reported challenges in trying to decipher physical health symptomatology manifesting as either psychological or mental health symptoms in patients, for example, one participant reported that:

> I remember a case where a patient with a mood disorder returned from leave and she reported that she had fallen. She was initially screened by the doctors and we were asked to monitor her. However, a few days after, her behaviour escalated. Most of my colleagues thought it was down to her mood disorder but we later discovered that she had broken a bone during the fall (Part N.9).

Participants' views also suggest that a more integrative-collaborative approach between primary and secondary health providers is required to improve physical health outcomes.

> Some patients we admit appear not to have had annual physical health checks from their GPs. While this always presents us with an opportunity to intervene, I don't

> think it is always fair for the patient. Only two weeks ago, we admitted a man who was later assessed to have type 2 diabetes (Part N.9).
>
> I feel that as patients spend more time in the community, primary care services need to do more to screen patients for diabetes and metabolic effects of the medication. At times, even when the patient is hospitalised, sharing information between wards and the patient's GP has its challenges and difficulties, though the system is gradually improving … (Part N.12).

Participants expressly noted concerns relating to lack of clarity around referral pathways and their role. A participant recounted that, 'sometimes we get patients who require podiatrist referral. I do struggle to know who to refer to as there is not a clear referral pathway identified' (Part N.11). This view was echoed by other participants in relation to referrals to general hospitals.

More than half of participants expressed a view that patients' variable mental health states had a major impact on whether they are able to participate in nurse-led interventions. One participant recounted that:

> Most of our patients are often too acutely unwell to participate in health interventional activities. It is very challenging for nurses to alter this state of being; we sometimes have to treat their mental health and wait for them to stabilise … (Part N.9).

Perceived education and training needs

Participants acknowledged that a lack of up-to-date skills and knowledge was a hindrance for them to fully engage in physical health care in practice. One nurse noted how her knowledge of conditions like diabetes and cardiovascular conditions was limited in comparison to her knowledge of mental health conditions. Similarly, two other participants recognised that they lacked confidence in using manual blood pressure machines, and that they felt that their knowledge of physical health conditions was limited.

While some participants acknowledged that the delivery of physical health training updates had improved in the health service provider, the participants felt that in-house communication regarding physical health training opportunities was poor, and some participants reported not having attended a physical health course in the last two years or more:

> I attended an update three years ago, I think; I am not sure whether there have been any further updates in the last year. I also think there should be a link physical health clinician in our team who can keep us informed of such news and for staff to go to them for advice or support (Part N.8).

Participants acknowledged that it was their professional as well as personal responsibility to keep their skills and knowledge up to date so as to provide the right care for service users (Nursing Midwifery Council, 2015).

Strategies to improve physical health monitoring

Despite barriers identified by participants in this study, all participants acknowledged that more can be done to address these barriers. Participants also stressed the need to improve resources such as staffing levels, availability of medical equipment and consideration for specialist roles in practice, such as physical health lead practitioner to provide in-house advice and support. One participant noted that:

> …We have link clinicians for drugs and alcohol, health and safety, infection control; why not one for physical health? Although the 'GP encounter letter' approach is currently in use when we admit patients, it would be more helpful if information we request from GPs is promptly received and likewise when we discharge patients … sending discharge information to GPs (Part N.8).

The participants commented and reported that newer evidence-based interventions currently used in clinical practice have achieved some success, including Modified Early Warning Scale (MEWS) (Subbe *et al.*, 2001), which is now routinely used in most inpatient sites as a monitoring assessment tool to screen/monitor for sudden changes in the physical health status of service users.

> … The MEWS monitoring tool is a useful tool. I often use it to assess and record vital signs when I admit patients, also in monitoring of patients with suspected underlying physical health conditions. I think the traffic light system helps the nurses to know when to involve the doctor … (Part N.3).

Discussion

Participants in this study viewed the monitoring and screening of the physical health needs of service users as vital in practice. Results from this study make an important contribution to the limited literature available that focuses on the role of mental health nurses in facilitating physical health screening and monitoring (Blythe and White, 2012; Brunero and Lamont, 2010; Deans and Meocevic, 2006; Happell *et al*., 2012a; Happell *et al.*, 2013b; Nash, 2005; De Hert *et al.*, 2009; 2011). Participants argued that, in order for mental health nurses to take up their role fully, investment and time are needed to enable them to build their expertise and confidence so as to deliver sound evidence-based interventions. As demonstrated in the findings, lack of training and inadequate skills development were identified by participants as a hindrance for mental health nurses to fully engage in physical healthcare. This is consistent with the results from research conducted by Nash (2005; 2011).

The participants also emphasised the benefits from such training with regard to equipping them with the right skills and knowledge and enabling them to be in a position to provide the right care to service users. A survey by Happell *et al*. (2013b), which investigated Australian nurses' interest in training across aspects of physical health monitoring including lifestyle, cardiovascular disease and screening for health risks, found that 91.6% of participants perceived training nurses in physical health monitoring as of moderate significance in improving the physical health of people with serious mental illness. Similarly, results from other studies show that mental health nurses acknowledge the value of physical health training to equip them with the necessary skills and knowledge (Happell *et al*., 2012a).

Early detection and management of physical health conditions in people with serious mental illness and initiation of preventative approaches improves their mental and physical well-being. Participants acknowledged that the Modified Early Warning Score (MEWS) and Glasgow antipsychotic side effects (GASS) monitoring tools (Hynes *et al.*, 2015) are vital for early screening, detection of adverse physical health effects of antipsychotics and physical health symptoms. The objective of preventative strategies across all services should be aimed at reducing health inequalities (Marmot and Bell, 2012) and appropriate use of evidence-informed measures to tackle and monitor disease states amongst service users.

Participants identified knowledge transfer strategies to enhance their confidence, and also emphasised that better structured inter-service working approaches were crucial to the patient journey and warranted improvement. In this context, improvements are needed and also need to be sustained in effective working partnerships between general practice and inpatient wards, as well as to ensure clarity around referral pathways for physical health concerns. This is consistent with findings in the literature related to effects on health outcomes and inefficient inter-service working partnerships (Morrato *et al*., 2009; De Hert *et al.*, 2009; 2011).

It is important to consider service users' readiness to engage in screening and monitoring, i.e. therapeutic nihilism (Bermanzohn and Siris 1994), a term often used to denote ambivalence by service users to engage in care interventions. Within this context, the participants shared the view of many others that bureaucracy, staff shortages, clarity around roles, lack of skills and knowledge around physical healthcare presented major distraction for them to readily provide the right care to service users. While the participants reported that monitoring approaches were improving in practice, they felt that there is still a need to strengthen partnerships between provider services, carers and health professionals involved in the care of service users with mental illness. Robson *et al*. (2013) in there study examining attitudes of nurses in practice towards physical health monitoring found that clinicians perceived that screening and monitoring should be routine and emphasised several benefits such as empowering and supporting patients in decision-making processes and engaging them in health promotion activities. However, some participants questioned how well these views/attitudes are easily translated into

practice by nurses when faced with various work-related challenges (low morale, lack of staffing and funding, increasing workload).

Similarly, there is growing restlessness that the National Health Service (NHS) is facing challenges as a result of austerity. For example, in November 2015, the chairperson of St George's Hospital Trust in London warned that the NHS faces 'wide-scale financial collapse' if the government did not provide at least a further £4 billion each year – twice as much as expected in the NHS (Kings Fund, 2013). Already, some hospitals are unable to pay staff, and patients are facing increasing delays for treatment with the burden of increasing workloads on staff. While the NHS's annual budget has been increasing by 0.8% (the smallest budget increases in its history), costs have risen by over 4% (Crawford *et al.*, 2014), and although the NHS has provided 'miracles' in extra productivity, it cannot continue to do so – the system has reached tipping point (Smallwood, 2015). Given this delicate political and economic climate, the challenges reported by the participants and findings from other studies are unsurprising (Mutsatsa, 2011).

The gap between policy and practice in relation to barriers to physical health monitoring has been evidenced (Buckley *et al.*, 2005; Mutsatsa, 2015; Robson and Gray, 2007). For example, diagnostic overshadowing is evident when a large proportion of people with serious mental illness are not offered tests to assess metabolic risk factors for conditions such as diabetes and obesity (Buckley *et al*., 2005). This mirrors the views of participants in our study who acknowledged that physical health symptoms were too often attributed to patients' mental health diagnoses. This underestimation of the importance of physical health problems because of significant psychiatric symptomatology is called diagnostic overshadowing. Similarly, participants noted obstacles to physical health monitoring (resource shortages, organisational culture and staff attitudes). These findings are supported by findings in other studies (Robson and Gray, 2007; Marder *et al*., 2007; Nash, 2011; Robson and Haddad, 2013). The consistency of the findings from these aforementioned studies emphasises that there are systemic shortcomings in the delivery of physical healthcare practices. Therefore, mental health providers must ensure that mental health professionals are equipped with the right skills and knowledge to be able to recognise signs of poor physical health and promptly offer screening and monitoring interventions. Participants in this study showed enthusiasm and eagerness to learn and develop new skills and were able to note areas in which physical healthcare can be improved in practice. Evidence suggests that the physical health and well-being of people with serious mental illness can be improved (Muir-Cochrane, 2006; Royal College of Psychiatrists, 2012).

The strength of the findings of this study is that it captured the rich narratives of the participants' views and their role in relation to physical health monitoring in clinical practice. However, given the limits to generalisability, it could be relevant for researchers in the United Kingdom (and other countries) to explore research activities to include other members of the multidisciplinary team given that all health professionals share a common responsibility and role in addressing

signs of poor physical, psychological and mental health in people they care for (social workers, psychologists) and seek their views on physical healthcare practices in mental health services. In the UK, psychologists and social workers caring for people with serious mental illness are usually offered professional developmental training on physical health conditions such as long-term conditions (diabetes, COPD).

In the UK, nurse training is based on three pathways (adult, mental health, child); hence, future prospective UK research could explore the views and attitudes of pre-registration nurses on dual (adult and mental health) training as a prerequisite for pre-registration. Participants in this study felt that a dual nurse training programme (adult and mental health combined) would equip nurses with the necessary physical health as well as psychiatric skills and knowledge to meet the diverse needs of patients. Prospective studies could explore the views of registered mental health nurses on role expansion and creation of a physical health lead practitioner to support in-house training around physical healthcare to improve physical health outcomes. At the time of this study, there was no such role in the centre in which the study was conducted.

Relevance for clinical practice

Meeting the varying needs of people with serious mental illness requires that both physical healthcare and health promotion become integral aspects of their care planning. The promotion of healthy lifestyles and well-being in people with serious mental illness is a central component of the recovery process (Mutsatsa, 2015; Silverstein and Bellack, 2008). Smoking, in particular, is one of the most identifiable factors of poor health amongst this patient cohort. In comparison to the general public, the smoking rate amongst the SMI population is three times higher (McNeil, 2001). Participants in this study expressed mixed views about their role regarding facilitating smoking cessation activities and screening.

Many mental health professionals still regard smoking as an important coping strategy and means of self-medication for patients (Lawn and Condon, 2006). Smoking remains a frequently used strategy of reward or punishment for adherence to treatment, Lawn and Pols (2005) found that smoking acts as the machinery for many of the rules of communication and social interactions and staff in mental health settings. A survey of clinical staff in one National Health Service mental health provider found that Staff who smoked were more likely to have reservations about the significance of the smoke free policies and the success of smoking cessation interventions (Ratschen et *al.,* 2009). The lack of staff motivation to promote cessation interventions is likely to have an impact on advice offered to patients, training is vital to ameliorate entrenched staff attitudes; commissioners and providers should support staff to stop smoking. This provides benefits for their own health and also assists staff in challenging the culture that normalises smoking in mental health settings.

To ameliorate nurses' perspectives and attitudes around supporting behavioural change interventions, there ought to be a focus in their training on individual and systemic social

determinants of health that contribute to poor physical health in people with mental illness. Hence, a more inclusive and robust system is required in practice and clear guidance on information around referral pathways, and support for nurses in working with people presenting with complex diverse needs. Physical care monitoring policies in provider services should be easily accessible and clear, stating the functions and roles of mental health professionals in addressing service users' physical health and health promotion needs.

Some of the participants proposed the identification of a physical health lead practitioner who would act as a 'go to' resource for support to staff that might require guidance around physical health issues in practice. Mandatory training, as well as continuing professional development courses, should be reflective of physical health skills and not only training relating to mental care practice (Nash, 2005). It is vital that mental health nurses are knowledgeable about physical health conditions amongst people with serious mental illness; the Department of Health (2006) puts emphasis on the importance of widening mental health nurses' knowledge and skills to better assess poor physical health in service users and provide health promotion activities and education on unhealthy lifestyle behaviours.

Health promotion is a vital aspect of care in mental health settings (Robson *et al*., 2013). Smoking and diet were identified by participants as areas of concern; therefore, training should be prioritised in these areas, as well as nurse training focused on screening for adverse physical health effects of antipsychotic therapy. Health promotion strategies in mental health should address dynamics that make people unwilling to have healthier lifestyle; for example, access to information, poverty, life skills and prospects for making healthy life choices. People may not be able to attain their full potential unless they are able to take control of the dynamics that determine their health. Thus, health promotion is everyone's' responsibility and must address broader determinants on health, including biological, environmental and social factors. Mental health nurses can incorporate health promotion interventions for people with serious mental illness through a combination of health protection, education and policy (Mutsatsa, 2015).

Conclusion

People with mental illnesses such as bipolar, schizophrenia or depression are at increased risk of suffering from cardiovascular disease, diabetes, infections and respiratory disease and are prone to higher levels of obesity (Mutsatsa, 2015). Mental health nurses are at the forefront of service provision and are better placed to offer opportunistic screening and monitoring of physical health needs. However, there are barriers identified in this study and other studies that hinder mental health nurses in effectively providing meaningful care interventions. These and other wider societal and individual dynamics require everyone (health professionals, politicians, patients, health and social care services and carers) to work together to improve the health outcomes of people with mental health problems. Participants emphasised the importance of physical health monitoring and their views are consistent with other research findings in that the

integration of physical and mental health is vital to bring about improvements in the way patients are cared for. The participants acknowledged that both physical and mental health needs are equally important and must receive the same attention from health professionals. In addition, a robust approach that must incorporate the patient, their environment and clear working partnerships of the services involved is a crucial aspect of the patient journey to recovery.

References

Benner, P. (1994). *Interpretative Phenomenology: Embodiment, Caring and Ethics in Health and Disease*. California: Sage Publications.

Bermanzohn, P. C. and Siris, S. G. (1994). Battle against therapeutic nihilism in caring for patients who exhibit the negative symptoms of schizophrenia. *Comprehensive Psychiatry,* 35(6), p.478.

Blythe, J. and White, J. (2012). Role of the mental health nurse towards physical health care in serious mental illness: An integrative review of 10 years of UK Literature. *International Journal of Mental Health Nursing*, 21, pp.193–201.

Brown, S., Birtwistle, J., Roe, L. and Thompson, C. (1999). The unhealthy lifestyle of people with schizophrenia. *Journal of Psychological Medicine*, 29, pp.697–701.

Brunero, S. and Lamont, S. (2010). Health behaviour beliefs and physical health risk factors for cardiovascular disease in an outpatient sample of consumers with a serious mental illness: a cross-sectional survey. *International Journal of Nursing Studies*, 47, pp.753–760.

Buckley, P. F., Miller, D. D., Singer, B., Arena, J. and Stirewalt, E. M. (2005). Clinicians' recognition of the metabolic adverse effects of antipsychotic medications. *Schizophrenia Research*, 79(2–3), pp.281–288.

Deans, C. and Meocevic, E. (2006). Attitudes of registered psychiatric nurses towards patients with borderline personality disorder. *Advances in Contemporary Mental Health Nursing*, 21(1), pp.102-120.

De Hert, M., Cohen, D., Bobes, J., Cetkovich-Bakmas, M., Leutcht, S., Ndete, D. M., Newcomer, J. W., Uwakwe, R., Asai, I., Moller, H. J., Gautma, S., Detraux, J. and Correll, C. U. (2011). Physical illness in patients with severe mental disorders. II. Barriers to care, monitoring and treatment guidelines, plus recommendations at the system and individual level. *World Psychiatry*, 10, pp.138–151.

De Hert, M., Dekker, J. M., Wood, D., Kahl, K. G., Holt, R. I. and Möller, H. J. (2009). Cardiovascular disease and diabetes in people with serious mental illness position statement from the European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (ESC). *European Psychiatry*, 6, pp.412–24.

Department of Health (2006). Choosing Health: Supporting the Physical Health Needs of People with Severe Mental Health Illness. *Commissioning Framework*. London: Department of Health.

Department of Health (2009) Analysis of General Household Survey/General Lifestyle Survey Data, Office for National Statistics. London: Department of Health.

Disability Rights Commission (2005). Disability Briefing, DRC.

Haddad, M. (2009). Depression in adults with a chronic physical health problem, Treatment and management. *International Journal of Nursing Studies*, 46, pp.1411–1414.

Happell, B., Scott, D., Platania-Phung, C. and Nankivell, J. (2012). Should we or shouldn't we? Mental health nurses' views on physical health care of mental health consumers. *International Journal of Mental Health Nursing*, 21, pp.202–210.

Happell, B., Platania-Phung, C. and Scott, D. (2013). Physical health care for people with mental illness: training needs for nurses. *Nurse Education Today*, 33(4), pp.396–401.

Happell, B., Platania-Phung, C. and Scott, D. (2014). Proposed nurse-led initiatives in improving physical health of people with serious mental illness: a survey of nurses in mental health. *Journal of Clinical Nursing*, 23 (7-8), pp.1018–1029.

Hasnain, M., redrickson, S. K., Vieweg, W. V. and Pandurangi, A. K. (2010). Metabolic syndrome associated with schizophrenia and atypical antipsychotics. *Current Diabetes Reports*, 10, pp.209–216.

Himelhoch, S., Lehman, A., Kreyenbuhl, J., Daumit, G., Brown, C. and Dixon, L. (2004). Prevalence of chronic obstructive pulmonary disease among those with serious mental illness. *American Journal of Psychiatry*, 161(12), pp.2317–9.

Hoang, U., Stewart, R. and Goldacre, M. J. (2011). Mortality after hospital discharge for people with schizophrenia or bipolar disorder: retrospective study of linked English hospital episode statistics, 1999-2006. *British Medical Journal*, doi: http://dx.doi.org/10.1136/bmj.d5422, BMJ 2011;343:d5422.

Hyland, B., Judd, F., Davidson, S., Jolley, D. and Hocking, B. (2003). Case managers' attitudes to the physical health of their patients. *Australian and New Zealand Journal of Psychiatry*, 37, pp.710–714.

Hynes, C., Keating, D., McWilliams, S., *et al*. (2015). Glasgow Antipsychotic Side-effects Scale for Clozapine Development and Validation of a Clozapine-specific Side-effects Scale. *Schizophrenia Research*, 1, pp.505–513.

Jochelson, J. and Majroswki, B. (2006). Clearing the Air. Debating Smoke-free Policies in Psychiatric Units: Kings Fund.

Kings Fund. (2013). Leading health care in London Time for a radical response. [ONLINE] Available at: http://www.kingsfund.org.uk/publications/leading-health-care-london?gclid. [Accessed 23 August 2016].

Kivimaki, M., Lawlor, D. A., Singh-Manoux, A., Batty, G., Ferrie, J. E. and Shipley, M. J. (2009). Common mental disorder and obesity: Insight from four repeat measures over 19 years: Prospective Whitehall II cohort study. *British Medical Journal*, 339 (7726), no pagination specified.

Lawn, S. and Pols, R. (2005) Smoking bans in psychiatric inpatient settings, A review of the research. *Australian and New Zealand Journal of Psychiatry*, (39), pp. 866–85.

Lawn, S. and Condon, J. (2006) Psychiatric nurses' ethical stance on cigarette smoking by patients: determinants and dilemmas in their role in supporting cessation. *Internal Journal of Mental Health Nursing,* 15: 118.

Lawrence, D., Holman, C. and Jablensky, A. (2001). Duty to Care: Preventable Physical Illness in People with Mental Illness. University of Western Australia, Perth.

Mallett, C. (2013) Smoking and mental health: NHS confederation-Mental health network (267) Available at: http:// www.nhsconfed.org [Accessed 23 March 2015].

Marder, S. R., Essock, S. M., Miller, A. L., Buchanan, R. W., Casey, D. E., Davis, J. M., Kane, J. M., Lieberman, J. A., Schooler, N. R., Covell, N., Stroup, S., Weissman, E. M., Wirshing, D. A., Hall, C. S., Pogach, L., Pi-Sunyer, X., Bigger, J. T. Jr, Friedman, A., Kleinberg, D., Yevich, S. J., Davis, B. and Shon, S. (2004). Physical health monitoring of patients with schizophrenia. *American Journal of Psychiatry*, 161(8), pp.1334–49.

Markowitz, S., Friedman, M. A. and Arent, S. M. (2008). Understanding the relation between obesity and depression: Causal mechanisms and implications for treatment. *Clinical Psychology: Science and Practice*, 15(1), pp.1–20.

Marmot, M. and Bell, R. (2012). Fair society, healthy lives. *Journal of Public Health,* 126(1), pp.1–242.

Marmot, M. (2004). *The Status Syndrome; How Social Standing Affects Our Health and Longevity*. New York: Henry Holt and Company.

Marmot Review (2010). Fair Society, Healthy Lives: The Marmot Review. London: The Marmot

Review. Available at: www.instituteofhealthequity.org/projects/fair-society-healthy-lives-themarmot-review (accessed on 27 April 2015).

McNally, L., Oyefeso, A., Annan, J., Perryman, K., Bloor, R. and Freeman, S. (2006). A survey of staff attitudes to smoking-related policy and intervention in psychiatric and general health care settings. *Journal of Public Health*, 28(3), pp.192–6.

McNeill, A. (2004). *Smoking and Patients with Mental Health Problems*. Health Development Agency.

Mind (1996). *Not just sticks and stones: A Survey of Stigma, Taboos and Discrimination Experienced by People with Mental Health Problems*. London: Mind.

Morrato, E., Newcomer, J. W., Kamat, S., Baser, O. and Cuffel, B. (2009). Metabolic screening after the American Diabetes Association's consensus statement on antipsychotic drugs and diabetes. *Diabetes Care*, 32, pp.1037–1042.

Muir-Cochrane, E. (2006). Medical co-morbidity risk factors and barriers to care for people with schizophrenia. *Journal of Psychiatric and Mental Health Nursing*, 13(4), pp.447–452.

Munhall, P. L. (2007). *Nursing Research: A qualitative perspective*. 4th ed. Massachusetts: Jones and Bartlett Publishers.

Mutsatsa, S. (2015). *Physical Healthcare and Promotion in Mental Health Nursing*. SAGE. London

Mykletun, A., Bjerkeset, O., Overland, S., Prince, M. and Stewart, R. (2009). Levels of anxiety and depression as predictors of mortality: The Hunt Study. *British Journal of Psychiatry*, 195, pp.118–125.

Nash, M. (2005). Physical care skills: a training needs analysis of inpatient and community mental health nurses. *Journal of Mental Health Nursing*, 9(6), pp.24–7.

Nash, M. (2011). *Physical Health and Well-Being in Mental Health Nursing: Clinical Skills for Practice*. Open University Press.

Nasrallah, H. A., Meyer, J. M., Goff, D. C., McEvoy, J. P., Davis, S. M., Stroup, T. S. and Lieberman, J. A. (2006). Low rates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia: data from the CATIE schizophrenia trial sample at baseline. *Schizophrenia Research*, 86(1-3), pp.15–22.

National Institute for Clinical Excellence (2009). Schizophrenia Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care (update). *National Clinical Practice Guidelines Number 8*. London: NICE.

National Research and Ethics Service (2007). Information sheets and Consent forms: NHS.

NHS Information Centre (2010). Statistics on Smoking: England. NHS Information Centre.

Nieswiadony, R. M. (1993). *Foundation for nursing research*. 2nd ed. Norwalk: Appleton Lange.

Nocon, A., Rhodes, P. J., Wright, J. P., Eastham, J., Williams, D. R., Harrison, S. R. and Young, R. J. (2004). Specialist general practitioners and diabetes clinics in primary care: a qualitative and descriptive evaluation. *Diabetic Medicine*, 21(1), pp.32–8.

Nursing and Midwifery Council (2015). *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives*. London: NMC.

Phelan, M., Stradins, L. and Morrison, S. (2001). Physical health of people with severe mental illness. *British Medical Journal*, 322, pp.443–444.

Ratschen, E., Britton, J., Doody, GA., Leonardi-Bee, J., and McNeill, A. (2009) Tobacco dependence, treatment and smoke-free policies: a survey of mental health professionals' knowledge and attitudes. *General Hospital Psychiatry*, 31 (6): 576-582

Roberts, L., Roalfe, A., Wilson, S. and Lester, H. (2007). Physical health care of patients with schizophrenia in primary care: A comparative study. *Family Practice*, 24, pp.34–40.

Robson, D. and Gray, R. (2007). Serious mental illness and physical health problems: a discussion paper. *International Journal of Nursing Studies*, 44, pp.457–466.

Robson, D., Haddad, M., Gray, R. and Gournay, K. (2013). Mental health nursing and physical health care: a cross-sectional study of nurses' attitudes, practice, and perceived training needs for the physical health care of people with severe mental illness. *International Journal of Mental Health Nursing*, 5, pp.409–417.

Royal College of Nursing (2004). *Research Ethics: Guidance for Nurses*. London: RCN.

Royal College of Psychiatrists (2012). *Report of the National Audit of Schizophrenia (NAS)*. London: Healthcare Quality Improvement Partnership.

Rushforth, H., Warner, J., Burge, D. and Glasper, E. (1998). Nursing physical assessment: implication for practice. *British Journal of Nursing*, 7(16), pp.965–70.

Scott, D. and Happell, B. (2011). The high prevalence of poor physical health and unhealthy lifestyle behaviours in individuals with severe mental illness. *Issues in Mental Health Nursing*, 32, pp.589–597.

Shuel, F., White, J., Jones, M. and Gray, R. (2010). Using the serious mental illness health improvement profile [HIP] to identify physical problems in a cohort of community patients: a pragmatic case series evaluation. *International Journal of Nursing Studies*, 47, pp.136–145.

Silverstein, S. M. and Bellack, A. S. (2008). A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clinical Psychological Review*, 28(7), pp.1108–24.

Smallwood, C. (2015). NHS facing financial collapse without more cash, warns London trust chief. *The Guardian (Health Supplement),* 8th November 2015. [Online] Available at: http://www.theguardian.com/society/2015/nov/08/nhs-facing-financial-collapse-warns-london-trust-chief.[Accessed 20 May 2016.]

Stebbins, R. A. (2001). *Exploratory research in the social sciences*. Thousand Oaks, California: Sage.

Subbe, C., Kruger, M., Rutherford, P. and Gemmel, L. (2001). Validation of a modified Early Warning Score in medical admissions. *Quarterly Journal of medicine*, 94, pp.521–526.

Shuel, F., White, J., Jones, M. and Gray, R. (2010). Using the serious mental illness health improvement profile [HIP] to identify physical problems in a cohort of community patients: a pragmatic case series evaluation. International Journal of Nursing Studies, 47, pp.136–145.

Thornicroft, G. (2013). Premature death among people with mental illness. *British Medical Journal*. [Online] Available at: http://dx.doi.org/10.1136/bmj.f2969. [Accessed 15 August 16.]

Wade, D., Harrigan, S., Edwards, J., Burgess, P. M., Whelan, G. and McGorry, P. D. (2006). Course of substance misuse and daily tobacco use in first-episode psychosis. *Schizophrenia Research*, 81(3), pp.145–50.

World Health Organisation (2013). Premature death among people with severe mental disorders: Informationsheet.[Online] Available at: http://www.who.int/mental_health/management/info_sheet.pdf. [Accessed 15 August 2016.]