POLICY BRIEF

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

THE ROYAL NEW ZEALAND COLLEGE OF GENERAL PRACTITIONERS

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Equally Well: Improving the physical health of people experiencing mental health and/or addiction issues

People experiencing mental health and/or addiction issues are at unacceptably greater risk for a range of chronic health conditions, have worse physical health outcomes, and are at risk of dying earlier than their general population peers. The influence of antipsychotics on weight gain and cardiovascular disease (CVD) is a major contributor to the inequitable rate of premature mortality. Diagnostic overshadowing, where clinicians attribute physical symptoms to a person's mental illness, also contributes to this inequity. Cancer outcomes are also inequitably worse, in part due to late diagnosis. This *Policy Brief* aims to provide GPs with information about why these health inequities occur and what they can do to help mitigate them.

Which patients are we talking about?

Researchers use a variety of definitions and groupings to define those with serious mental illness and addiction who are also at risk of poor physical health, with some using recorded diagnosis while others use contact with secondary mental health services as an indicator. A broad definition includes those who have been severely impacted by mental illness and/or diagnosed with schizophrenia, schizoaffective disorder, bipolar affective disorder (BAD), major depressive disorder (MDD), and/or addiction.[2] While research tends to focus on people with severe illness, as this is where the inequities are greater, it is worth noting that less severe mental illness (eg mild-to-moderate depression or anxiety) is also associated with chronic physical diseases, and patients may also face barriers to care.[3] Additionally, while research tends to focus on adults, children living with mental health and addiction are at greater risk of physical health problems and health risk behaviours.[4] It is also of note that children with parents affected by mental illness are at higher risk of adverse developmental outcomes and mental health problems.[5,6]

Importantly, while this resource does not address Alzheimer's or other diseases causing dementia, eating disorders, or intellectual disability, people with these conditions also face considerable challenges in accessing health care and staying physically well.

The physical health of people living with mental health and addiction issues

New Zealand research found that people who used mental health services were two times more likely to die prematurely than their general population counterparts, and people with psychotic disorder were three times more likely.[7] Additionally, in 2015, Cunningham et al. showed that those with a history of recent psychiatric service use or diagnosis with severe mental illness had considerably poorer survival after diagnosis with breast or colorectal cancer than those without such a history.[8] International evidence suggests that people experiencing challenges with mental health and/or addiction – particularly those on antipsychotic medications – have the following comorbidities:[7,9–15]

- Cardiovascular disease (particularly women)
- Metabolic syndrome, obesity
- Diabetes
- Respiratory disease
- Cancers (particularly bowel cancer and breast cancer with schizophrenia)
- Stroke under the age of 55

Key messages

- Significant physical health inequities exist for people living with mental illness or addiction, including a risk of dying younger. There are many complex drivers of this inequity that can be broadly categorised as lower socioeconomic status, higher exposure to risk factors, medication effects and side effects, and access to and quality of health care.
- Diagnostic overshadowing, where a clinician misattributes symptoms to the person's mental illness rather than seeing them as a separate physical complaint, is a particularly relevant driver for GPs to consider.
- GPs already provide care for people with mild to moderate mental illness and are envisioned to play and increasing role in caring for those living with stable severe mental illness (SMI).
- GPs can contribute positively to this issue by being aware of the inequitable health outcomes, taking on a model of wellbeing-focused prescribing, actively avoiding diagnostic overshadowing, empowering patients, and working closely with other health providers.

- Viral disease, including HIV
- Poor oral health
- Gastrointestinal disorders such as irritable bowel syndrome
- Other conditions, including chronic pain, high blood pressure, high cholesterol, fibromyalgia, chronic fatigue syndrome, and temporomandibular joint disorder.

These illnesses are also often present at a much earlier age than in the general population.

Although there is currently limited New Zealand–based research, the available studies and data from the The New Zealand Mental Health Survey 2006 strongly suggest that these inequities are very much in existence in our country.[16]

Cultural inequities

Patterns of disease inequity faced by Māori and Pacific peoples seen in other areas of health are also seen in the prevalence of serious mental health conditions.[16–18] Māori age-sex-standardised rates of hospitalisation for a mental disorder were 80% higher than those of non-Māori.[18] For the inpatient population, Pacific peoples are three times more likely to have a diagnosis of schizophrenia or a psychotic illness than European people.[19] A recent study by Loan et al. suggests that diagnosis and management of depression in Tokelauan populations (and probably other Pacific populations) may be particularly complex and underreported due to cultural norms of 'masking' negative feelings.[20]

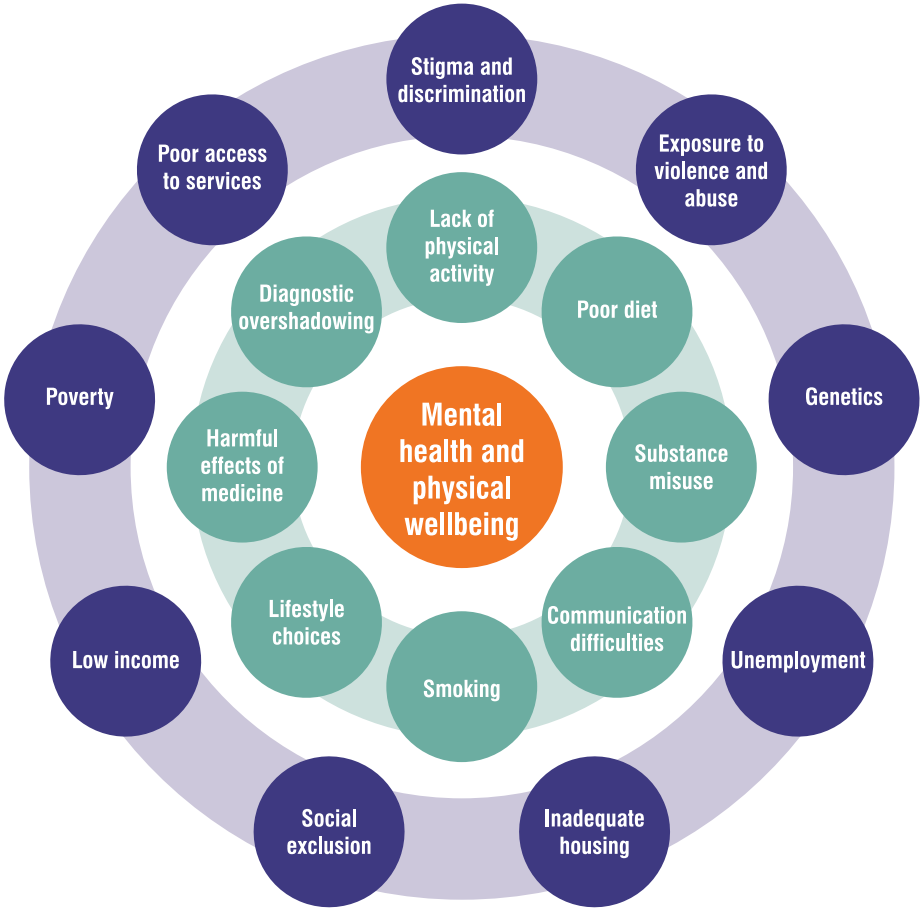
Drivers of inequity

The drivers of physical health inequities for those living with mental health and addiction issues are illustrated in Figure 1. Drivers are complex, but broadly speaking, can be categorised as lower socioeconomic status, higher exposure to risk factors, medication effects and side effects, and access to and quality of health care.[4]

An important driver, not explicitly illustrated in the diagram, is the artificial separation of mental health services from physical health services. Notably, integration of physical and mental health services is more aligned with Māori and Pacific concepts of holistic health care. Differential service design perpetuates the separation and inequity, with different systems used for writing notes for mental health patients. Often, GPs and other clinicians cannot see the patient's mental health record, and discharge summaries from mental health units have not traditionally included physical health problems on the diagnostic list.

Diagnostic overshadowing is one driver, noted in the diagram, that is particularly relevant to GPs, where the clinician misattributes symptoms to the person's mental illness rather than seeing them as a separate physical complaint.[21] This can lead to reduced or absent diagnosis and treatment of physical illnesses and symptoms. A recent case highlighting this issue can be found in **Coroner K Grieg's report to the court** on Richard Thompson, who died from complications of acute subdural haematoma after his GP judged his presentation to be driven by his schizophrenia diagnosis (and medication), rather than head injury (case number: CSU-2014-AUK-001182).

Figure 1. Interrelated dynamic elements affecting people's physical health.[4]



The role of the GP

As concisely phrased by the NHS, "Physical and mental health are inextricably linked, and it is detrimental to a person's overall wellbeing to regard these as two separate entities".[4]

For almost everyone, GPs are the first point of contact with the health system and the earliest opportunity to identify and treat physical health issues.[22] As well as providing care and information to patients, GPs are in a position to engage with the patient's support network (family, whānau and friends) who can help the person sustain a healthy lifestyle and deal with the physical health impacts of medications.

Recent government strategic documents, including the new **Health Strategy**, have identified general practice's pivotal role in mental health and addiction and seek to shift more of these services into the community and primary care.[23] The PHO-led project, **Closing the Loop**, also articulates a future vision of primary care–based mental health services.[24] GPs already provide care for people with mild to moderate mental illness and are envisioned to play an increasing role in caring for those living with stable severe mental illness (SMI).

Galletly et al. provide some clarity as to the roles that different health practitioners have to play:[25]

- **Specialist mental health clinicians**
  - work in partnership with primary care physicians and NGOs to ensure physical health and non-clinical needs are adequately addressed.
  - conduct regular follow-up to ensure continuity of treatment for people with schizophrenia or related disorders, who have significant ongoing symptoms and disability and a history of serious severe psychotic relapses.
  - are sometimes able to transfer the mental health care of people with schizophrenia to general practice. For these individuals, the specialist mental health clinician's role is to contact the primary care practice to discuss the follow-up needs and to provide clear written information regarding the treatment plan.
- **GPs**
  - play an important role in managing physical health conditions as part of a multidisciplinary team
  - receive appropriate clinical information, including the treatment plan, and have regular communication with mental health clinicians.
  - may be the main medical contact for people with schizophrenia rather than a psychiatrist in rural regions. This is because the resources for the care of people with mental illness are scarce, the number of psychiatrists per population is less than in urban regions, and distances from hospitals are greater. Telemedicine services can be useful in enabling ongoing specialist assessment and advice.
- **All medical professionals**
  - While aimed primarily at mental health specialists, the following statement by The Royal Australian and New Zealand College of Psychiatrists (RANZCP) on the role of the clinician also has relevance for primary care physicians: "The clinician's role is to establish a mutually respectful therapeutic relationship and optimise the management of potentially treatable factors such as unrecognised depression, inadequate psychosocial rehabilitation, poor adherence to prescribed medicines, substance use, medication side effects, differential responses to medicines, drug interactions and suboptimal drug therapy."

Driver	Mitigating policies and systems-level action	Actions GPs can take
Socioeconomic status		
Physical and mental illness does not take place in isolation but in the context of our environments and living situation. Oakley-Browne et al. found that people living with mental illness and/or addiction were more likely to be living in more deprived areas (NZDep2001 Decile 1–3), have a lower household income and fewer or no educational qualifications.[16] Regardless of the direction of the association between socioeconomic status and mental health, low socioeconomic status reduces access to health resources (such as dry, safe, warm housing) and increases the likelihood of health risks.	Government policy around creating healthy living environments will always lay the foundation for health – that is urban design, the food environment, housing conditions, minimum wage etc. The WHO advocates a proportionate universalism approach to government policy to address social inequalities.[26] Such policy would sit alongside a continued effort and progress towards Smokefree New Zealand 2025 and to reduce the harm caused by alcohol and other drugs (eg Selman et al.'s approach: raising price, raising age, reducing accessibility, reducing advertising and sponsorship, and increasing drink-diving countermeasures[27]).	■ **GPs can ask about and record information relating to deprivation.** Data can then be used to highlight areas of need, and build cases for targeted programmes and funding.[28] ■ **GPs can continue to help patients in need to access available services and support options.** For example, low-income patients in rental houses or with a respiratory condition (certified by the GP's letter) may be eligible for insulation subsidies.[29]

Driver	Mitigating policies and systems-level action	Actions GPs can take
Exposure to risk factors		
As well as social and physical environmental influences, the nature of many mental illnesses and addiction can cause reduced ability for, or interest in, self-care. Living with a mental illness or addiction increases the likelihood of engaging in risk factors such as: ■ **Tobacco smoking**, although Jun et al. found that a high proportion of people with a serious mental illness were either seriously considering or actively trying to stop smoking[30] ■ **Poor nutrition**, such as inadequate fruit and vegetable intake (affected by produce affordability)[31,32] ■ **Physical inactivity** can be due to a lack of confidence, medication effects, and lack of motivation (eg from depression)[33,34] ■ **Alcohol and drugs**,[33,34] which are sometimes used as a form of self-medication. Consequently, the rates of diseases and outcomes associated with these risk factors are higher among this group. Importantly, evidence from the Marmot Review[23] on health inequalities suggests that addressing lifestyle factors alone will not increase the life expectancy of people with mental health problems.[34]	**Policies that remove barriers to health care** and that make healthy choices easy promote the health of the whole population. As well as universal policies, some targeted policies for patients with SMI might include funding for extended appointments, weight-loss clinics, and health promotion programmes that support positive behaviour changes. At all levels, actions can be taken to **empower patients** (and their whānau and friends) to stay involved in their own care and to self-manage. This can be through the provision of resources and information about their condition, how it is likely to impact on their physical health, the use of care plans, and proliferation of tools like patient portals. For example, in mid-2016, Taranaki DHB launched a Recovery Action Plan and Health Passport for people experiencing mental illness and addiction.	■ **GPs can institute annual wellness check-ups for at-risk patients in their practice.** There is evidence to suggest that assessment tools and regular check-ups of SMI patients is an effective mechanism for identifying unmet need.[35] The Northampton Physical Health and Wellbeing Project developed a useful guide to physical health checks for people with SMI in a primary care setting (paraphrased in Box 1).[36] ■ **GPs can aid patient empowerment** by setting up a care plan with patients and by discussing their illness(es), current risk factors, medication options, side effects, and health implications. When addressing risk factors like weight gain or smoking, it is suggested that GPs should have the same expectation for those with mental illness or addiction but, "be realistic and accept that some things might take longer".[37] Family/whānau involvement in addressing risk factors can be pivotal to sustained success. ■ Practices can improve access to services for those with mental illness and/or addiction by **partnering with health promotion programmes**. That is, ensuring practice staff are able to easily refer and engage patients in nutrition, exercise, or other support programmes. ■ GPs can **raise awareness** of the risk factors and physical health outcomes of those with mental illness and addiction by referring patients, whānau, health professionals, and policy makers to Equally Well resources and other works relating to this issue (some key resources are listed on page 8).

Driver	Mitigating policies and systems-level action	Actions GPs can take
Medication effects and side effects		
Antipsychotic medications are associated with a range of side effects including weight gain, sedation, hyperglycaemia, and anticholinergic effects.[25,38,39] It is important that both the patient and health professional understand why side effects are occurring to avoid blame being placed on the individual. For example: ■ Weight gain is a possibility as antipsychotics often supress satiation. ■ Respiradone can cause overproduction of prolactin, leading to difficulty conceiving, among other physical health impacts.[38] **Polypharmacy** increases the risk of adverse drug events, which contribute to ill health, disability, hospitalisation and death. Refer to the College's **Policy Brief Issue 7: Problematic polypharmacy and deprescribing** for more information on this issue.[40]	DHBs can "ensure models of care and contractual agreements provide equitable access to medicines management services targeted towards people receiving high-risk medicines and/or polypharmacy."[41] Those with mental illness and/or addiction are a key group to consider in the implementation of this action. Prescribing practice is part of the recovery paradigm which centres on the importance of the lived experience of the person with mental illness.[42] This paradigm should be understood and promoted across all levels of care. Personal recovery draws on constructs of hope, self-identity, meaning and personal responsibility (rather than a focus on a reducing symptoms).[43] "Recovery is a key goal in real terms and not merely in the sense of acceptance of persistent illness or adapting around it to have a meaningful life (critical though this is for many people)."[25]	■ **Health professionals can take on the model of wellbeing-focused prescribing.** That is, at the point of prescribing as well as on an ongoing basis, the GP (or other doctor) also talks with the patient about the effects of medications, what can be done to mitigate the physical health impacts (principles to prescribing for first episode psychosis, many of which are broadly applicable, are included in Box 2).[44] This model also stops perpetuating the thinking that adverse effects are inevitable. ■ **Planning and monitoring of medication withdrawal** should be considered at the time a prescription is initiated as the side effects of changing medication or reducing dosage can be very unpleasant, persistent, and/or mistaken as a relapse.[45] These decisions should be made in partnership with the patient as far as possible. ■ **GPs (and other health professionals) can help prevent and manage metabolic syndrome**, which is a major risk factor for CVD and a common physical health impact of psychotropic medications (obesity, CVD, oral health, Type 2 diabetes). A useful resource in this area is the positive cardiometabolic health early intervention framework for patients on psychotropic medication, developed by Curtis et al.[46] ■ Where patients are on multiple medications or experiencing side effects, GPs can initiate a **Medications Management Service** (a collaborative process between the patient, their clinical pharmacist, and the GP). There is evidence to show that collaboration with community pharmacies in metabolic risk management can be effective.[47]

Driver	Mitigating policies and systems-level action	Actions GPs can take
Access to, and quality of, health care at all levels		
Systemic: There is consistent separation of physical and mental health services (eg isolated psychiatric wards in hospitals) and often a lack of clarity around who is responsible for the ongoing care management. The resulting fragmentation of care is detrimental and can understandably reduce consumer trust in the health system. Another frequently reported issue is the chronic underfunding of mental health and addiction-related services and contracts. **Provider:** As well as the time and resource constraints caused by underfunding, discriminatory behaviour can be a significant barrier to accessing health care (whether intended or not). The RANZCP refers to the "culture of hopelessness and low expectations that pervades the health system in relation to people with a serious mental illness".[3] For primary health care professionals, a barrier to providing quality care can be a lack of support systems in place for complex cases, eg a mental health/addiction expert available to take calls. Diagnostic overshadowing is another common barrier to care at all provider levels, whereby the diagnosis and treatment of physical ailments and illnesses are overlooked.[21] **Individual:**[3] SMI patients can often have reduced awareness of physical issues, suffer from self-neglect and lack motivation, have limited social and communication skills, and low expectations of health services. All of these factors individually and cumulatively impact on their ability to seek medical assistance. Health professional attitudes (eg stigmatisation and assumptions), a lack of knowledge and training, and late diagnosis or misinterpretation of physical symptoms further compound these barriers to care.	**Integrated care models**, including **shared care plans**, with clear, communicated responsibility for care areas are increasingly being considered as the solution to patients with complex needs,[48,49] eg **Closing the Loop** and the **Mental Health Liaison Programme**. Solutions also include more comprehensively integrated primary and secondary mental health and alcohol and other drug treatment services. Integration comes in a variety of forms, including colocation of psychiatric and primary care services and GP visits to mental health inpatient wards.[50] Generally, the College considers a shared patient management system (PMS) to be a critical element of true integrated care. Integration is also enabled by other innovative information-sharing technologies and applications, such as the **eMedicines** programmes. These tools help with coordination and continuation of care plans and reduce the burden on the patient to repeat information. **(Funded) training** would be beneficial at all levels of a stepped care approach:[51] ■ Some specialist mental health clinicians would benefit from training in physical health monitoring and proactive communication with primary care providers. What tends to be missing from a stepped-care approach is the process for patient care transfer back down the steps. That is, the referral and communication from the tertiary and secondary carers back to primary care (eg fom the psychiatrist back to the GP). ■ Meanwhile, GPs, nurses and other primary care staff would benefit from increased mental health and addiction training to increase confidence and ability to take responsibility for care of those with mental illness and/or addiction. Fully funded, free or heavily subsidised physical health check-ups for patients with an addiction, on antipsychotics or with an SMI diagnosis would reduce the cost and time barriers associated with care.	■ While GPs aim to attend to all aspects of their patients' health and wellbeing, it is easy for an appointment to be 'hijacked' by discussion and treatment of SMI. **Increased GP (/primary care) awareness and active avoidance of diagnostic overshadowing** can eliminate this barrier to care. Practice nurses and other clinicians in the general practice team with enhanced skills (eg a postgraduate qualification in Advanced Nursing Practice in Mental Health) can also provide input. ■ **Better communication** in general between health care professionals and across all levels will improve continuity and comprehensiveness of care; that is, between primary care, secondary care and community workers, and within primary care teams. This could be as simple as the provision of specialist mental health telephone advice to GPs. The RANZCP provides some **resources on communication and referral between GPs and psychiatrists** and the 'Find a psychiatrist' tool available in Australia may be extended to New Zealand in the near future.[52] ■ **GPs can also investigate what health care funding** is available for patients. Some options that might be available include: – **CarePlus** or long-term conditions funding – **Community Services and High Use Health Card** – **ACC claims for mental injuries, sensitive claims, and counselling** (from an event) – **WINZ Disability Allowance** for free counselling sessions – **Employment Assistance Programmes** – **Green Prescriptions** (GRx)

Box 1. Wellness checks

1. Identify a practice nurse to be responsible for carrying out the health checks.
2. Ensure they receive appropriate training to feel confident to carry out the health checks.
3. Check your patient list for accuracy.
4. Work out how you are going to set up your clinics, eg how do you run your diabetes clinic? How much time will the practice nurse realistically need (45 minutes recommended).
5. Identify your community mental health link worker (approximately half of your patients will be in contact with secondary care).
6. Prepare your templates.
7. Invite patients for a physical health check
   a. Inform their community mental health team worker if appropriate
   b. Send out letter 10–14 days before the appointment
   c. Possibly include a pre-assessment form
   d. Consider telephone reminders.
8. Carry out the health check
   a. Explain why they have been invited and the purpose of each procedure
   b. Use one of the various tools available, such as the **updated Lester Tool***
   c. Provide the patient with any relevant leaflets
   d. If they need a follow-up appointment, explain why.
9. After the health check, inform the patient of the results of the blood tests (and their community worker if appropriate) and check they have attended any follow-up appointments.
10. If they did not attend, send a second invitation and/or telephone the patient, carer, or community worker as appropriate.

* Developed by the Royal College of Psychiatrists' Centre for Quality Improvement, the Royal College of General Practitioners Clinical Innovation and Research Centre and the Royal College of Nursing as part of the National Audit of Schizophrenia.

Box 2. Principles of pharmacotherapy in First Episode Psychosis[42]

- **Principle 1.** Take side effect profiles into consideration
- **Principle 2.** Prevent and treat psychiatric emergencies
- **Principle 3.** Distinguish between affective and non-affective psychosis
- **Principle 4.** 'Start low, go slow'
- **Principle 5.** Avoid antipsychotic polypharmacy
- **Principle 6.** Monitor adherence and address non-adherence
  - Factors affecting adherence
  - Shared decision making to facilitate treatment adherence
  - Managing non-adherence
  - Long-acting injectable (depot) medications to address non-adherence
- **Principle 7.** Monitor and manage adverse events and side effects
- **Principle 8.** Treat comorbidities
- **Principle 9.** Identify failure to respond but provide a sufficient period for treatment response and remission
- **Principle 10.** Use special care when prescribing for specific populations
  - Children
  - Women of child-bearing age, and pregnancy
  - Breastfeeding mothers
  - Young people with diabetes.

Conclusion

Like many complex problems, there is no one single action that will eliminate inequities. However, a collective effort from GPs can contribute to the solution. At the broadest level, practices can:

- acknowledge the greater health needs by endorsing the Equally Well consensus statement like Island Bay Medical Centre has done
- monitor health outcomes on a population basis
- better integrate mental and physical health care
- put systems in place to ensure routine screening of patients with diagnosed mental health and addiction problems
- encourage patients with mental health and addiction problems to have regular physical health checks and routine screening
- provide health-promoting information to patients
- partner with appropriate nutrition, exercise, smoking cessation, or other health promotion programmes
- support patients' whānau and/or close friends in contributing to patients' health
- advocate (as always) on behalf of patients
- familiarise staff with the issue and the evidence, and discuss it with patients and colleagues.

At a practice level, it may also be possible to analyse the patient list to identify the particular needs of your population. This data can be used to develop a practice-level Equally Well plan of action to improve the physical health outcomes for those patients with mental illness and/or addiction.

Further information and resources

- **Te Pou o Te Whakaaro Nui:**
  - Equally Well consensus position paper
  - The physical health of people with a serious mental illness and/or addiction: An evidence review
  - Cardiovascular disease and mental health: An evidence review

- **The Royal Australian and New Zealand College of Psychiatrists (RANZCP):**
  - The economic cost of serious mental illness and comorbidities in Australia and New Zealand (2016)
  - Keeping body and mind together: Improving the physical health and life expectancy of people with serious mental illness (2015)
  - Clinical practice guidelines for management of people with schizophrenia and related disorders (2016)
  - The RANZCP also has some information and advice for patients that GPs might like to direct patients to. For example, a fact sheet on addiction and a New Zealand treatment guide for consumer and carers on coping with depression.

- **Australian Department of Health, Primary Health Network (PHN):**
  - Mental health tools and resources: Guidance material has been developed that provides clarity on core issues, sets out expectations of the PHN and provides best practice examples, where appropriate. The workforce support information and resources document provides information on resources currently available relevant to supporting the mental health workforce throughout the Australian mental health reform implementation process.

- **Mental Health Professionals Network** Webinar Library: This online library is filled with webinars on a variety of mental health issues. Of particular relevance to Equally Well are:
  - Mental health and diabetes
  - A collaborative approach to supporting people with coronary heart disease and depression
  - Chronic pain and mental health: An interdisciplinary case study panel discussion for general practitioners
  - Chronic pain and mental health issues

- **NSW Department of Health resources:**
  - The physical health mental health handbook (2009)
  - Linking physical and mental health care... it makes sense (2009)

- **Alcohol misuse: How to help patients in primary care:**
  - bpac^{NZ} article: Alcohol misuse: How to help patients in primary care
  - RNZCGP Clinical effectiveness module (developed with the Alcohol Advisory Council of New Zealand) on Implementing the ABC alcohol approach in primary care.

- **UK Resources:**
  - NHS: Improving the physical health of people with mental health problems: Actions for mental health nurses (2016)
  - Kings Fund: Bringing together physical and mental health: A new frontier for integrated care (2016)
  - HM Government, Department of Health: No health without mental health: A cross-government mental health outcomes strategy for people of all ages (2011)

- **DHB and PHO resources:**
  - Closing the loop – A person-centred approach to primary mental health and addictions support: This PHO-led project articulates a future vision of primary care–based mental health services that draw together the skills and resources of all the relevant agencies to transform a reactive, transactional system of treatment to a holistic, person-centered, responsive system of care and support.
  - Waitemata DHB Metabolic Screening and Physical Health Clinical Pathway policy
  - Taranaki DHB Recovery Action Plan and Health Passport
  - Compass Health's Mental Health Liaison Programme

- **Guidelines on managing/monitoring antipsychotic medications:**
  - bpac^{NZ} guidelines for monitoring medicines used in bipolar disorder[43]
  - Royal Australian and New Zealand College of Psychiatrists' clinical practice guidelines for the management of schizophrenia and related disorders: Table 8. Management strategies for side effects of antipsychotic drugs

- **Health Improvement Profile [HIP]**
  - The HIP is a brief pragmatic tool, which enables mental health nurses to work together with patients to screen physical health and take evidence-based action when variables are identified to be at risk. Piloting has demonstrated clinical utility and acceptability.
  - White J, Gray RJ, Swift L, et al. The serious mental illness health improvement profile [HIP]: Study protocol for a cluster randomised controlled trial. Trials. 2011;12(167).
  - Shuel F, White J, Jones M, Gray R. Using the serious mental illness health improvement profile [HIP] to identify physical problems in a cohort of community patients: a pragmatic case series evaluation. Int J Nurs Stud. 2010;47(2):136–145.

References

1. Te Pou o Te Whakaaro Nui. Equally Well consensus position paper. Te Pou o Te Whakaaro Nui; 2014. Available from: http://www.tepou.co.nz/uploads/files/resource-assets/equally-well-consensus-position-paper-september-2014.pdf
2. Te Pou o Te Whakaaro Nui. The physical health of people with a serious mental illness and/or addiction: An evidence review. Te Pou o Te Whakaaro Nui; 2014. Available from: http://www.tepou.co.nz/resources/the-physical-health-of-people-with-a-serious-mental-illness-andor-addiction-an-evidence-review/515)
3. RANZCP. Keeping body and mind together: Improving the physical health and life expectancy of people with serious mental illness. Royal Australian and New Zealand College of Psychiatrists; 2015. Available from: https://www.ranzcp.org/Files/Publications/RANZCP-Keeping-body-and-mind-together.aspx
4. Nursing, Midwifery and Allied Health Professions Policy Unit. Improving the physical health of people with mental health problems: actions for mental health nurses. London: NHS; 2016. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/524571/Improving_physical_health_A.pdf?utm_campaign=new_comment&utm_medium=email&utm_source=thread_mailer
5. RANZCP. Position Statement 56: Children of parents with mental illness. Royal Australian and New Zealand College of Psychiatrists; 2016. Available from: https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-56-Children-of-parents-with-a-mental-illness-Ma.aspx
6. Rutter M, Quinton D. Parental psychiatric disorder: effects on children. Psychol Med. 1984;14(4):853–880.
7. Cunningham R, Peterson D, Sarfati D, et al. Premature mortality in adults using New Zealand psychiatric services. N Z Med J. 2014:127(1394):31–41. Available from: https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2014/vol-127-no.-1394/6126
8. Cunningham R, Sarfati D, Stanley J, et al. Cancer survival in the context of mental illness: a national cohort study. Gen Hosp Psychiatry. 2015;37(6):501–6.
9. Saha, S., Chant D., McGrath J. A systematic review of mortality in schizophrenia: Is the differential mortality gap worsening over time? Arch Gen Psychiatry. 2007;64(10):1123–31.
10. Fleischhacker WW, Cetkovich-Bakmas M, De Hert M, et al. Comorbid somatic illnesses in patients with severe mental disorders:clinical, policy, and research challenges. J Clin Psychiatry. 2008;69(4):514–9.
11. Bushe CJ, Taylor M, Haukka J. Mortality in schizophrenia: a measurable clinical endpoint. J Psychopharmacol. 2010;24(4_supplement):17–25.
12. Gilburt H. Cultural change is as important as funding in transforming mental health [blog article]. The Kings Fund, 2014. Available from: http://www.kingsfund.org.uk/blog/2014/09/cultural-changetransforming-mental-health
13. Disability Rights Commission (UK). Equal treatment: Closing the gap. A formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems. Stratford upon Avon: Disability Rights Commission, 2006. Available from: http://disability-studies.leeds.ac.uk/files/library/DRC-Health-FI-main.pdf
14. Goldacre MJ, Kurina LM, Wotton CJ, et al. Schizophrenia and cancer: an epidemiological study. The British Journal of Psychiatry, 2005;187:334–8.
15. Whitehead WE, Palsson O, Jones KR. Systematic review of the comorbidity of irritable bowel syndrome with other disorders: what are the causes and implications? Gastroenterology. 2002;122:1140–56.
16. Oakley-Browne M, Wells JE, Scott KM. Te Rau Hinengaro: The New Zealand Mental Health Survey. Wellington: Ministry of Health; 2006.
17. Nielssen O, Sara G, Lim Y, et al. Country of birth and hospital treatment for psychosis in New South Wales. Social Psychiatry and Psychiatric Epidemiology. 2013;48:613–20.
18. Robson B, Harris R, editors. Hauora: Māori Standards of Health IV. A study of the years 2000–2005. Chapter 5: Hospitalisations. Te Rōpū Rangahau Hauora a Eru Pōmare; 2007. Available from: http://www.otago.ac.nz/wellington/departments/publichealth/research/erupomare/research/otago019494.html
19. Gaines P, Bower A, Buckingham W, et al. New Zealand Mental Health Classification and Outcomes Study. Final report. Auckland, New Zealand: Health Research Council of New Zealand; 2003.
20. Loan I, Cunningham W, Jaye C. Understanding depression in Tokelauan people in New Zealand. J. Prim Health Care, 2016;8(2):67–74. Available from: http://www.publish.csiro.au/?act=view_file&file_id=HC15046.pdf
21. Nash M. Diagnostic overshadowing: a potential barrier to physical health care for mental health service users. Journal of Mental Health Nursing. 2013;17(4):22–6.
22. NSW Department of Health. Linking physical and mental health care... it makes sense. Australia: NSW Department of health; 2009. Available from: http://www.health.nsw.gov.au/mentalhealth/publications/Publications/pub-phmh-gp.pdf
23. Ministry of Health. New Zealand Health Strategy 2016. Wellington: Ministry of Health; 2016. Available from: http://www.health.govt.nz/publication/new-zealand-health-strategy-2016
24. Thompson. Closing the loop. Wellington: Network 4; 2016. Available from: http://www.closingtheloop.net.nz/#closing-the-loop
25. Galletly C, Castle D, Dark F, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. Australian and New Zealand Journal of Psychiatry. 2016;50(5):1–117. Available from: https://www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/CPG_Clinician_Full_Schizophrenia-pdf.aspx
26. Marmot, M. Review of social determinants and the health divide in the WHO European region: Executive summary. World Health Organization Regional Office for Europe. Report prepared by UCL Institute of Health Equity; 2013.
27. Sellman JD, Connor JL, Robinson GM. Will brief interventions in primary care change the heavy drinking culture in New Zealand? N Z Med J. 2010;125(1354).
28. Honeyford K. Data and performance: Can education and health learn from each other? Br J Gen Pract. 2016;66(646):e365–7.
29. EECA. Warm Up New Zealand: Healthy Homes [Internet]. [cited 2016 June]. Available from: https://www.energywise.govt.nz/funding-and-support/funding-for-insulation/
30. Jun L, Kamal AM, Newton LV, et al. The physical health of people with serious mental illness in Dunedin. Dunedin: Otago Medical School; 2000.
31. Hert MD, Correll CU, Bobes J, et al. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in healthcare. World Psychiatry. 2011;10(1):52-77. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3048500/
32. Wheeler A, McKenna D. Stereotypes do not always apply: Findings from a survey of the health behaviours of mental health consumers compared with the general population in New Zealand. N Z Med J. 2013:126(1385):35–46
33. Scott D, Happell B. The high prevalence of poor physical health and unhealthy lifestyle behaviours in individuals with severe mental illness. Issues Ment Health Nurs. 2011;32(9):589–97.
34. Marmot M. Fair society, healthy lives: strategic review of health inequalities in England post-2010. The Marmot Review; 2010. Available from: www.instituteofhealthequity.org/projects/fair-societyhealthy-lives-the-marmot-review
35. Vasudev K, Martindale BV. Physical healthcare of people with severe mental illness: everybody's business! Ment Health Fam Med. 2010;7(2):115–122. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2939459/
36. Hardy S. Physical health checks for people with severe mental illness: a primary care guide. Mental Health Partnerships; 2013. Available from: http://mentalhealthpartnerships.com/resource/physical-health-checks-for-people-with-smi/
37. RNZCGP. GP Pulse. Issue 50: February 2016. p 6. Available from: https://www.rnzcgp.org.nz/RNZCGP/Publications/GP_Pulse_magazine/RNZCGP/Publications/GP%20

Pulse%20magazine.aspx?hkey=76ac444c-3eca-407d-b974-5e7c2db085ad
38. Curtis J, Henry C, Watkins A, et al. Metabolic abnormalities in an early psychosis service: a retrospective, naturalistic cross-sectional study. Early Interv Psychiatry. 2011;5(2):108–114.
39. bpac^{NZ}. Prescribing atypical antipsychotics in general practice. Best Practice Journal. 2011; 40. Available from: http://www.bpac.org.nz/BPJ/2011/november/antipsychotics.aspx
40. RNZCGP. Policy Brief. Problematic polypharmacy and deprescribing. Issue 7. Wellington: Royal New Zealand College of General Practitioners, 2016. Available from: https://www.rnzcgp.org.nz/RNZCGP/Dashboard/Resources/Good_practice/RNZCGP/Dashboard/Resources/Good_practice.aspx?hkey=30ed3119-2e6c-4f13-a8a5-4f8b7f0e9788
41. Ministry of Health. Pharmacy Action Plan 2016–2020. Wellington: Ministry of Health; 2016. Available from: http://www.health.govt.nz/publication/pharmacy-action-plan-2016-2020
42. RANZCP. Position Statement 86 – Recovery and the psychiatrist. Royal Australian and New Zealand College of Psychiatrists; 2016. Available from: https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-86-Recovery-and-the-psychiatrist-March-2016.aspx
43. Slade M. The contribution of mental health services to recovery. Journal of Mental Health. 2009;18:367–71
44. Orygen. Australian clinical guidelines for early psychosis. 2nd ed. Orygen, the National Centre of Excellence in Youth Mental Health; 2016; p.57.
45. Jenkins J, Glass S. Catastrophic complications related to psychopharmacologic drug withdrawal. Psychiatric Annals. 2016;46(8):466–72.
46. Curtis J, Newall H, Samaras K. Positive cardiometabolic health: an early intervention framework for patients on psychotropic medication. NSW: Health Education Training Institute; 2011. Available from: www.heti.nsw.gov.au/cmalgorithm
47. Maulavizada M, Emmerton L, Hattingh HL. Can a pharmacy intervention improve the metabolic risks of mental health patients? Evaluation of a novel collaborative service. BMC Health Services Research. 2016;16(146).
48. Naylor N, Das P, Ross S, et al. Bringing together physical and mental health: a new frontier for integrated care. Kings Fund; 2016. Available from: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Bringing-together-Kings-Fund-March-2016_1.pdf
49. RANZCP. Mental health for the community; principles to underpin effective mental health service delivery to the community. Royal Australian and New Zealand College of Psychiatrists; 2012. Available from: https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/ps73-pdf.aspx
50. WHO. Integrating mental health services into primary health care (Infosheet). WHO; 2007. Available from: http://www.who.int/mental_health/policy/services/3_MHintoPHC_Infosheet.pdf
51. New Zealand Guidelines Group. Identification of common mental disorders and management of depression in primary care. An evidence-based best practice guideline. Wellington: New Zealand Guidelines Group; 2008. Available from: http://www.health.govt.nz/system/files/documents/publications/depression_guideline.pdf
52. Matthews, Rose (National Manager NZ, RANZCP). Personal communication. April 2016.

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Equally Well is a collective of organisations and individuals working together to improve physical health outcomes for people with experience of mental health and/or addiction issues. The Royal New Zealand College of General Practitioners has recognised the importance of this work and its relevance to general practice and endorsed the Equally Well consensus position paper (2014).[1]

- Find out more on the **Te Pou** website
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If you have any questions about this issue, or would like to express a view on this topic, please contact the College's policy team: policy@rnzcgp.org.nz

The Royal New Zealand College of General Practitioners is the professional body that provides training and ongoing professional development for general practitioners and rural hospital generalists, and sets standards for general practice.

PO Box 10440, The Terrace, Wellington 6134 | T +64 4 496 5999 | F +64 4 496 5997 | E rnzcgp@rnzcgp.org.nz | W www.rnzcgp.org.nz