Feature

Physical health passports for patients with severe and enduring mental illness

For people diagnosed with severe and enduring mental illness (SMI), priority can understandably be placed on treatment of that SMI first and foremost, with other considerations such as the patient’s physical health status taking a back seat. But one UK Health Trust (Central and North West London NHS Foundation Trust [CNWL]) has decided to proactively help these patients to manage their physical health by providing easier to understand assessments and lifestyle advice, all held together with their medical history in a passport-style document.

Their team, including psychiatrist Ed Beveridge and psychologists Bill Tiplady and John Green, received a grant from the Health Foundation—an independent charity working to improve the quality of health care in the UK—to undertake a project aimed at improving the physical health of patients with severe and enduring mental illness. “We know that this group of our patients have significantly worse physical health, including higher risk of stroke and heart attack and shorter life expectancy,” explains Beveridge. “Like many other trusts in London and elsewhere, we know that physical health monitoring is an area we need to improve on—as shown in last year’s National Audit of Schizophrenia.”

Upon admission to the Danube Ward—a mental health ward at the St Charles Mental Health Centre in London, where the project pilot has been running—patients now receive a joint mental and physical health assessment, and the results are recorded in a document, “My Physical Health Explained”, which is a patient-held physical health record. This document gives patients a greater understanding of their current physical health state and future risks, an understanding of what they can do to make realistic beneficial lifestyle changes, and access to appropriate treatment and lifestyle support to suit their needs. Users of CNWL’s services who were members of the original project team had a key role in the initiation and design of the document. “This will be completed with, and explained to, all patients before they leave the ward,” says Beveridge. “This document explains the results from their physical health assessment, including body-mass index and waist measurements, cholesterol level, blood pressure, smoking status, and alcohol use. A traffic light system is used to explain what the results mean in terms of future risks of having a heart attack or stroke and developing diabetes.”

The project is in collaboration with the UK Government-funded National Institute of Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care Northwest London (CLAHRC NWL)—an organisation that helps health-care providers to put clinical research into practice. CLAHRC NWL uses the skills, knowledge, and expertise of researchers, health and social care professionals, managers, commissioners, and patients to do high-quality research to find new ways of improving health care and deliver improvements using an evidence-based approach. “Our aim is to solve the problems the NHS faces and deliver real improvements that matter to patients and the public,” explains Liz Evans, lead for mental and physical wellbeing at CLAHRC NWL, hosted at Chelsea and Westminster Hospital and Imperial College London. “Both CLAHRC NWL and CNWL work hard to ensure that mental health service users are involved in our work to improve services. Service users are a valuable asset and bring both experience and new innovative solutions to the problems we grapple with in the NHS.”

The passport project has seen 100% of patients admitted to the ward receiving a physical health assessment and more than 40% having a documented cardiovascular risk score. “The physical healthcare plan developed by the service users, is crucial in ensuring that patients understand what this risk means and what they can do to reduce their risk of having a cardiovascular event,” explains Evans. She adds that the work “recognises the interconnectedness of mental and physical wellbeing to improve overall patient health and patient experience in all our service improvement research and delivery activities.”

The passport element of the project was led by service user project team members including Sandra Jayacodi and Jenny Trite, who have been integral members of the project team from the outset. Jayacodi said, “The shock of hearing the statistics, about life expectancy for people with severe mental illness, made me aware that I need to take physical health seriously. The project has encouraged me to take steps towards improving my lifestyle through the knowledge I have gained.” Trite said, “I have worked on a lot of projects over the years, but this is the first time I have really felt like a part of the team—not just like a service user ‘stuck on’.”

This CNWL project was presented at the recent THINK physical event hosted by CLAHRC Greater Manchester, UK. “It has also now been adopted by a team at Metro North Hospital and Health Service, Brisbane Australia, who were evidently impressed hearing about it at a CLAHRC Northwest London event,” explains Beveridge. “We hope that by April 2016—the end of this phase of the
Robert Spitzer: the most influential psychiatrist of his time

Debate is ongoing about whether the flow of history is pushed forward by ineluctable forces or by the prominent people who represent them. I usually subscribe to the former opinion, but must admit the relevance of the latter in the one small piece of history that I got to watch from the ringside.

Bob Spitzer, who died at 83 years of age on Christmas Day 2015, shaped psychiatry far more than anyone else in the past half century. Rarely have so many owed so much to just one individual. Bob was a great force of nature, able to turn improbable ambitions into standard psychiatric practice. His impact was wide, deep, pervasive, and enduring, guiding the work of millions of mental health practitioners and improving the lives of hundreds of millions of patients all over the world. Had Bob never existed, psychiatry would have meandered gradually toward its present course but much more slowly and indirectly, cutting channels with very different depths and directions.

Bob entered world history before his 40th birthday, accomplishing a feat whose scope went far beyond psychiatry to influence religious, legal, societal, and popular attitudes and practices. Homosexuality had previously been vilified by religions as sin; by legal systems as crime; by society as deviation; by the average person as weakness; and by the diagnostic system in psychiatry as a mental disorder. Bob led a courageous and difficult struggle to recognise that different sexual preferences were normal variants of human potential, and rescuing it from the arbitrariness and lack of credibility of psychiatric illness.

The removal of “homosexuality” from DSM II in 1973 was engineered by Bob—the result of his single-minded and almost single-handed crusade to eliminate the psychiatric stigmatisation of difference. Without Bob, such liberation and validation would have taken additional decades. No one else in the specialty combined his package of passionate fairness, knowledge of science, stubborn determination, political acumen, debating skills, and pure delight in heated controversy. Bob was the irresistible force that was eventually able to remove the immovable object. This first step turned out to be a tipping point, leading to a cascade of more general destigmatisation. Once the error of mislabelling homosexuality as illness was accepted, why not reconsider the legitimacy of labelling it as crime or as sin? Bob opened the door that led 40 years later to Supreme Court decisions that legalised gay marriage and criminalised discrimination against homosexual people. Without Bob, homosexuality might still be viewed as a mental disorder and society might not be granting full marital status and child custody rights.

Bob’s other major accomplishment was to save psychiatry from a crisis of credibility. Two widely publicised studies in the early 1970s made it clear that psychiatrists could not agree on diagnosis and were keeping patients in hospital who didn’t need to be there. It looked like psychiatrists didn’t know what they were doing. Bob happened to be working on a criteria-based method for assessing and sorting psychiatric symptoms. The American Psychiatric Association turned to Bob and gave him power and discretion to accomplish a radical task. Could he adapt his method to achieve reliability—intended originally for use only in research settings—to the needs of everyday clinical practice? This would aim to achieve diagnostic agreement among clinicians, improve clinical communication, facilitate research and education, and provide more accurate statistics. However, the risk would be the creation of a cumbersome system that no one would use.

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Only a master psychometrician could create DSM III and only a master salesman could convince clinicians of the need to accept and use it. It had many limitations and caused its own set of problems, but DSM III had the great virtue of raising the scientific standards of psychiatry and rescuing it from the arbitrariness and lack of credibility of warring and unsupported opinions.

When Bob began work on DSM III in the mid-1970s, precious little scientific evidence was available to guide how the different disorders should be defined. So Bob created working groups on the various disorders and invited the experts to numerous meetings that all followed the same pattern. He would let us rant and rave in the mornings, blowing off steam promoting competing concepts. Bob would type at blazing speed and was like a magician who seemed to pull DSM III out of a hat—or rather, his computer.

A giant deli lunch would eventually arrive that made everyone drowsy and less argumentative. Bob would then present a beautifully worded criteria set that captured the best of the morning’s suggestions and pacified most disagreements. Thus, DSM III was born.