A PHYSICAL WELL-BEING SERVICE FOR MENTAL HEALTH CLIENTS

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DEVELOPMENT

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A PHYSICAL WELL-BEING SERVICE FOR MENTAL HEALTH CLIENTS
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This article describes the development of a physical well-being service for clients with a mental health problem. It explores the strategy, training, staff support and challenges to implementation. A trial of the service in one area has resulted in improvements in clients' physical health.

The physical well-being support programme began as a pilot initiative in February 2003 through a partnership between Eli Lilly and Company, Inventive Solutions training services and eight mental health trusts across the UK. Some 966 patients enrolled and 80% completed the two-year pilot. This found good outcomes in clients' smoking and teetotal status, as well as positive improvements in the areas of regular exercise, poor diet and self-esteem.

DEVELOPING THE SERVICE IN KENT

In 2006 two mental health trusts within Kent merged to form the Kent and Medway NHS and Social Care Partnership Trust. The trust covers a population of approximately 1.6 million and has around 4,000 members of staff from all disciplines.

Within the former East Kent Partnership Trust, community mental health nurse Karen Healy took part in an 18-month secondment to Inventive Solutions as part of the pilot. Ms Healy delivered the well-being support service, offering physical health, medication management and lifestyle assessments to clients with severe mental illness in the trust’s Thanet area.

Clients were given a minimum of four one-to-one consultations and immediate access to physical activity groups set up in the local community.

The data confirmed our initial thoughts. Of the 184 clients enrolled:

- The majority (77%) had a BMI over 25 (overweight or obese);
- Nearly half (48%) had a BMI over 30 (obese);
- Some 71% were hypertensive.

Following blood screening the results showed:

- Some 18% had raised prolactin;
- One-fifth (20%) had raised blood glucose;
- Over half (54%) had raised cholesterol.

All clients were then followed up and abnormal results addressed. By the end of the secondment:

- Over a third (36%) had significantly increased their physical activity levels;
- Some 40% had reduced alcohol intake;
- Nearly a third (27%) had reduced the amount they smoked and 11% had stopped;
- Almost a quarter (23%) participated in healthy living groups;
- Non-attendance rates were only 12%.

Ms Healy reported that the clients had thoroughly enjoyed this holistic approach to their care and had participated fully in recommended changes to their lifestyles. They had felt more involved in their care and, consequently, took more responsibility for their mental and physical well-being.

Following a European conference held by Eli Lilly, the trust was given a substantial number of free training places for the implementation of the service, although it became apparent that the initiative was not just about training staff to deliver the service. There was a bigger issue of the change in practice for nurses. Regardless of their specialty, nurses have increasing amounts of work placed on them without dedicated time given to their tasks. If the implementation was to be successful, it could not be seen as another ‘add-on’.

Strategy

Before training started, there had to be agreement with the trust’s executive management team about its implementation. At the time, the trust did not have a policy on physical health although it was evident one would support the service. Agreement also had to be obtained from operational directors/managers to ensure that trained staff had one day a week of protected time to implement the service. This was agreed and the training programme started at the end of September 2006.

Training

The training consisted of a three-day programme, which was provided by Inventive Solutions and sponsored by Eli Lilly. It comprised:

- How to set up a physical well-being service locally;
- The process of carrying out physical health checks;
- The needs of service users and improve their chances of success, as well as help to retain staff through the development of a new role with high job satisfaction.

It is anticipated that the development of the service within the trust will meet the needs of service users and improve their chances of success, as well as help to retain staff through the development of a new role with high job satisfaction.

NICE (2002) guidelines on the treatment and management of schizophrenia. Other trusts may be considering how they can implement this NICE guidance – perhaps developing a physical well-being service may be the answer.

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BACKGROUND

The Department of Health’s (2004) white paper Choosing Health: Making Healthy Choices Easier recommended the physical health of people with a mental health problem be improved; this is important due to higher risk of premature death in people with severe mental illness.

The CNO’s review of mental health nursing (DH, 2006) supported the improvement of the physical health of these individuals. That mental health nurses should focus on clients’ wider needs is a key recommendation.

NICE (2002) guidelines on the management of schizophrenia made a range of recommendations to improve physical health, such as reviewing and monitoring medication with regard to side-effects, physical assessment and physical health checks.

Monitoring side-effects of treatment;
How to run a healthy living group;
How to set up and run a physical activity group;
How to offer appropriate lifestyle advice.

The trust decided initially to make the training four days with the inclusion of phlebotomy training, which would enable staff to deliver the service more or less immediately. Through Inventive Solutions, the programme has RCN accreditation.

The staff who received training worked in inpatient services, community/crisis resolution team settings or rehabilitation services. So far, 72 nurses or occupational therapists have been trained, with many more waiting to undertake the training.

THE SERVICE

The overall aim of the physical well-being service is to improve lifestyle and reduce physical ill-health in clients with severe mental illness. Once trained, all nurses and occupational therapists set up consultations with either the clients in their caseload or clients within their team who have been referred by their care coordinator. These consultations assess physical health needs and identify areas that patients would like to address and work towards improving. This is done through physical health observations such as blood pressure, weight, blood tests to check and monitor for diabetes, prolactin and cholesterol levels, and also the assessment of BMI. In addition, clients participate in healthy living groups and physical activity groups.

The physical well-being support service has three components:
A one-to-one consultation by a nurses or occupational therapist who carries out a complete health check and reviews lifestyle and side-effect management;
Referrals to other NHS agencies when health issues are identified that require specialist intervention;
Access to healthy living groups (for weight management advice, for example) and physical activity groups.

Staff support and steering group
To support the professionals trained for the physical well-being service, regular six-weekly link meetings were set up to discuss and share how their practice was developing. It was also an opportunity to problem solve. These meetings are led by the physical well-being clinical nurse specialist and the lead nurses for the trust.

As the service was developing across the organisation, a steering group was established. Its aims were to ensure that the service was sustained within the trust and to support staff in its implementation.

CHALLENGES TO IMPLEMENTATION

Although agreement for ringfenced time was given by the executive management team and operational directors, agreement with middle managers was not successful in all areas. This has left some staff frustrated at being unable to implement the service.

In addition, as part of the training, staff are taught how to input data into a web-based audit tool. Each site has its own web page to measure programme progress, epidemiological data, key data on physical health and lifestyle indicators, interventions and reports that support the achievement of targets. Unfortunately, some staff find it difficult to find the time or forget how to input, resulting in some data remaining paper-based and slowing down evaluation.

The service also had to overcome suspicion concerning the input of a pharmaceutical company. The training programme has never been product-related and Eli Lilly has been most supportive, providing the drive for its development within the trust.

Data collection
A web-based audit tool collects data on the service. This information is entered by either the nurse or the occupational therapist. To date, the service has picked up three new cases of type 2 diabetes. Some 34% of the clients enrolled have a BMI over 25 and 24% have a BMI over 30.

CONCLUSION

The physical well-being service has proved to be a valued role for nurses and occupational therapists. It has brought the nurses’ role back into focus. It is important to recognise that the essence of the service is about maximising opportunities for working with clients and enabling them to consider their choices around lifestyle.

Due to its success, the service has now been rolled out to other directorates in mental health, such as older adult services, learning disabilities and child and adolescent mental health services.

REFERENCES

