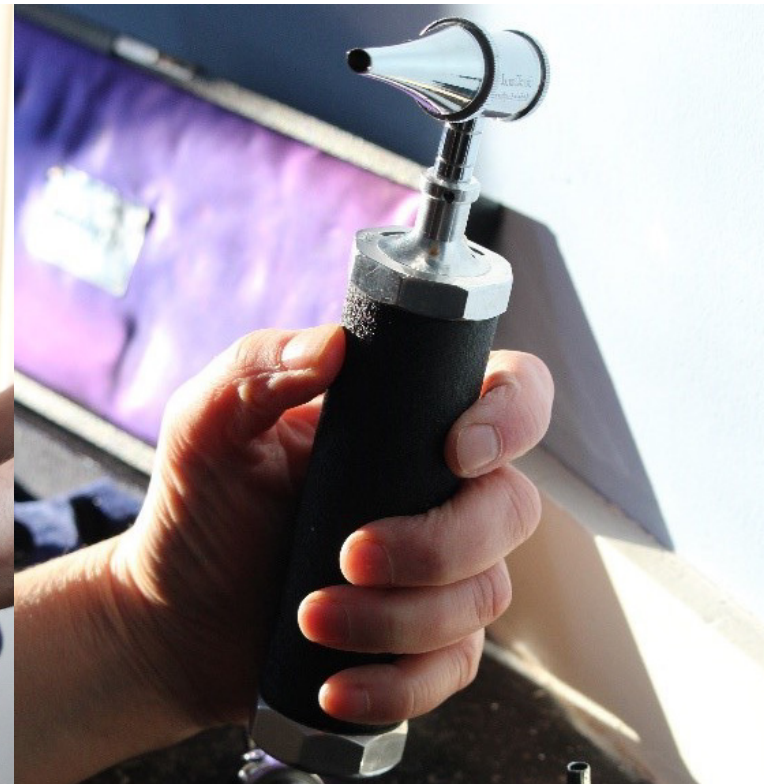


SOMATIC HEALTH CARE IN A PSYCHIATRIC SETTING



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Acknowledgements:	We want to thank stakeholders, experts, professionals and patients for sharing their knowledge, opinions and experiences through meetings and interviews. We very much appreciated the time and effort of patients in coming forward and sharing their stories; A warm thank you to all of you. We thank the patient organisations l'ASBL Psytoyens (Daniel Muller, François Vilain, Thomas Grégoire, Laëtitia Cunin, Véronique Sneessens, Joëlle Sprumont), Uylenspiegel (Ann Van Der Vloet), Ligue des usagers des services de santé (LUSS) (Sabine Corachan), and Steunpunt Geestelijke Gezondheid (Rik Van Nuffel) for their contributions and input. We thank the expert Dr Herwig Van Dijck, Sint-Maarten Hospital, the employees of ministerial offices and federal and regional



administrations for their responsiveness to our questions and in particular the team from Adhoc (Nathalie Terryn, Ine Alaerts, Delfien Verhelst, François Windy), l'Agence pour une Vie de Qualité, AVIQ (Anouck Billiet, Patrick Vanneste, Christophe Buret), the VIP² and VIKZ team (Ariane Ghekiere, Svin Deneckere), and PAQS (Quentin Schoonvaere). We would like to thank the Easytranslate team for transcription of the interviews (Willem Van Den Brekel). Thank you to Sophie Gerkens (KCE) for her advice on the organisation chapter.

Reported interests:

'All experts and stakeholders consulted within this report were selected because of their involvement in the topic of Somatic health care in a psychiatric setting . Therefore, by definition, each of them might have a certain degree of conflict of interest to the main topic of this report'

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Holder of intellectual property (patent, product developer, copyrights, trademarks, etc.): Martin Desseilles (Books and scientific publications)

Fees or other compensation for writing a publication or participating in its development: Martin Desseilles (Books and scientific publications)

Participation in scientific or experimental research as an initiator, principal investigator or researcher: Jan De Lepeleire (Project somatic clearance UPC - KUL), Martin Desseilles (With esketamine, rilatine), Charlotte Seaux (UPC-KUL), Kris Van den Broek (Several projects)

A grant, fees or funds for a member of staff or another form of compensation for the execution of research described above: Martin Desseilles (First spin off project F Peters), Kris Van den Broek (Professor in Public Mental Health)

Consultancy or employment for a company, an association or an organisation that may gain or lose financially due to the results of this report: Martin Desseilles (CPFA), Chantal Mathy (INAMI), Frans Vandendriessche (Janssen farma)

Payments to speak, training remuneration, subsidised travel or payment for participation at a conference: Martin Desseilles (Droit d'auteur), Lindsay VanBelle (Training), Kris Van den Broek (For Domus Medica)

Presidency or accountable function within an institution, association, department or other entity on which the results of this report could have an impact: Dien Cuypers (Coordinator somatic aspects for the PC Bethanië), Jan De Lepeleire (Coordinator Medical Centre UPC-KUL), Raf De Rycke (President of the organisation Broeders en Liefde), Martin Desseilles (President du BCNBP, directeur departement de Psychology Université Namur), Ariane Ghekiere (Data-analyst VIKZ), An Haekens (Medical director psychiatric hospital), Karen Smets (Netwerk EMERGO), Hilde Stoop (Medical doctor psychiatric hospital PC Bethanië / Multiversum), Kris Van den Broek (Director Vlaamse Vereniging voor Psychiatrie), Frans Vandendriessche (Chairman medical council UPC Duffel)



Layout:

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- **The external experts were consulted about sections of the report initially and a preliminary version of the scientific report. Their comments were discussed during a teleconference meeting and via mail. They did not co-author the scientific report and did not necessarily agree with its content.**
- **The stakeholders reviewed and discussed the final results during a teleconference meeting.**
- **A final version of the scientific report was submitted to the validators. The validation of the report results from a consensus between the validators. The validators did not co-author the scientific report and did not necessarily all three agree with its content.**
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Publication date:

23 March 2021

Domain:

Health Services Research (HSR)

MeSH:

Belgium, Psychiatric Somatic Therapies, Mental Disorders, Mental Health Services, Health Care

NLM Classification:

WM100

Language:

English

Format:

Adobe® PDF™ (A4)

Legal depot:

D/2021/10.273/4

ISSN:

2466-6459

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How to refer to this document?

Jespers V, Christiaens W, Kohn L, Savoye I, Mistiaen P. Somatic health care in a psychiatric setting. Health Services Research (HSR) Brussels: Belgian Health Care Knowledge Centre (KCE). 2021. KCE Reports 338. D/2021/10.273/4.

This document is available on the website of the Belgian Health Care Knowledge Centre.



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LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
AAEP	The American Association for Emergency Psychiatry
AGREE	Appraisal of Guidelines Research and Evaluation
AWMF	The Association of the Scientific Medical Societies in Germany
AVIQ	Agence pour une Vie de Qualité
BAP	British Association for Psychopharmacology
BMI	body mass index
CANMAT	Canadian Network for Mood and Anxiety Treatments
CBR	Consensus based recommendation
CI	Confidence interval
CVD	Cardiovascular Disease
DSM	The Diagnostic and Statistical Manual of Mental Disorders
EBM	Evidence based medicine
EASD	by the European Association for the Study of Diabetes
EBR	Evidence based recommendation
ECG	Electrocardiogram
ED	Emergency department
EPA	The European Psychiatric Association
ES	Effect size
ESC	The European Society of Cardiology
FFS	Fee for services
FRB	Financial Resources Budget (Budget des moyens financiers – Het Budget Financiële Middelen)
FPS - FOD - SPF	Federal Public Service – Federale overheidsdienst – Service public fédéral
GGPO	German Guideline Program in Oncology



GP	General practitioner
GRADE	Grading of Recommendations, Assessment, Development and Evaluations
HAS	Haute Autorité de Santé France
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HCPI	Healthcare professional interviewed
HIV	Human immunodeficiency virus infection
HR	Hazard ratio
ICD-10	International Classification of Diseases 10 th Revision
ISBD	International Society for Bipolar Disorders
M/SUD	Mental or substance use disorder
MetS	Metabolic Syndrome
MPD - MPG - RPM	minimal psychiatric data - minimale psychiatrische gegevens - résumé psychiatrique minimum
NICE	National Institute for Health and Care Excellence
NIHDI	National Institute for Health and Disability Insurance
OR	Odds ratio
PH - PZ - HS	Psychiatric hospitals - Psychiatrisch ziekenhuis - Hôpital de psychiatrie
PSGH - PAAZ - SPHG	Psychiatric service of a general hospital - Psychiatrische afdeling in een algemeen ziekenhuis - Service de psychiatrie d'un hôpital général
PNH - PVT - MSP	Psychiatric nursing homes - Psychiatrische verzorgingstehuizen - Maisons de soins psychiatriques
RR	Relative risk
SHI - IBW - IHP	Sheltered housing initiative - Initiatieven Beschut Wonen - Initiatives d'Habitations Protégées
SIGN	Scottish Intercollegiate Guidelines Network



SMI	Severe mental illness
STI	Sexually transmitted infection
T2DM	Type 2 diabetes mellitus
UK	United Kingdom
VIKZ	Het Vlaams Instituut voor Kwaliteit van Zorg
WBSBP	World Federation of Societies of Biological Psychiatry
WHO	World Health Organisation



■ SCIENTIFIC REPORT

1 GENERAL INTRODUCTION

1.1 Aim of the study

Patients with a severe mental illness (SMI) (see disclaimer in 1.2.1) have a reduced life expectancy of 13-30 years as compared to the general population and about 60% of this excess mortality is due to physical (co)morbidity; therefore, it is an important public health problem that should be addressed.¹⁻³ Cardiovascular disease and the metabolic syndrome, often as a result of the prescribed medication, are linked to 50% of this raised mortality.⁴ On top of this, common disorders e.g. diabetes mellitus, hypertension, obesity and disturbed lipid metabolism, and behavioural aspects e.g. alcohol, tobacco use, physical inactivity, sedentary behaviour, poor diet, poor sleep, are all risk factors for cardiovascular disease inflating the physical morbidity of a person with SMI.^{3, 5} Other physical illnesses frequently encountered in the person with SMI are epilepsy, liver disease, chronic bronchitis, and asthma.¹

To address prevention aspects of modifiable risk behaviours, the under detection of morbidity, and the excess mortality, it has been advocated that interventions are needed on different levels.^{6, 7} The Lancet psychiatry commission described in their recent paper that people with mental illness not only have an increased risk of physical disease, they also suffer from reduced access to adequate health care.³ The poor management of physical morbidity affects the personal, social, and economic cost of mental illness throughout their life. Interventions therefore are needed at the individual level, either the person with the disorder or the carer, at the healthcare provider level, at the health system level, and at the societal level.⁷ WHO advocates to increase efforts at all levels to improve the health and quality of life of persons with SMI.² Specifically, the aim is to reduce one-third of premature mortality by 2030 (target 3.4 of the Sustainable Development Goals Ensure healthy lives and promote well-being).⁸

The somatic health of the patient with SMI has correspondingly been a topic of debate and study by Belgian authors.⁹⁻¹¹ A Belgian consensus workshop in 2004 formulated recommendations for psychiatrists on interventions for the management of side effects of antipsychotic medication.¹² Tools for



improved monitoring of antipsychotic medication have since been proposed for use by nurses, psychiatrists, pharmacists and general practitioners in Belgium.¹³⁻²⁰ Some of the aspects of sub-optimal care or barriers described in the literature from Belgium are, for example, no consensus on a list of standard clinical tests when a patient with a mental illness is admitted to hospital,²¹⁻²⁴ a high number of admissions happens through casualties,²⁵ inpatient referrals for emergency care are not always appropriate,²⁶ stigma, and low empathy of the healthcare provider for the patient with SMI are commonly encountered,^{25, 27, 28} and limited information provision, involvement of the patient and respect for patient rights are reported by patients²⁹⁻³¹.

The primary aim of this project was to examine the status of somatic health care of the person with SMI and to understand why this care is sub-optimal. More specifically, the main questions posed are:

- What is the prevalence of somatic problems in persons with a severe mental illness?
- What are the barriers perceived and experienced by healthcare professionals when delivering somatic care for a person with SMI while admitted for care?
- What are the barriers perceived and experienced by a person with SMI when receiving somatic care while they were residing in a psychiatric setting?
- How is the somatic health care for persons with an SMI organised and financed in Belgium?
- Do guidelines exist on the somatic health care of persons with SMI and how are the barriers and facilitators/motivators for somatic health care addressed?

In a first instance, this project aimed to form hypotheses rather than provide specific interventions for the identified barriers. Although the aim of this report is to focus on somatic health care, the approach of the patients should be one of 'global health'. This report should be read with an integrated and holistic basic view in mind which we realise might be difficult as we focus on 'somatic health'.

1.2 Scope of the study

This study deals with the somatic health care of the adult patient with SMI in Belgium. It focuses on the somatic health care in the person with SMI admitted to a care facility in psychiatric hospitals (PH - Psychiatrisch ziekenhuis (PZ) - Hôpital de psychiatrie (HP)), psychiatric service of a general hospital (PSGH - Psychiatrische afdeling in een algemeen ziekenhuis (PAAZ) - Service de psychiatrie d'un hôpital général (SPHG)), psychiatric nursing homes (PNH - Psychiatrische verzorgingstehuizen (PVT) - Maisons de soins psychiatriques (MSP)), or when living at a sheltered housing initiative (SHI) - Initiatieven Beschut Wonen (IBW) - Initiatives d'Habitations Protégées (IHP)). The situation of the ambulant patient and care by the general practitioner is addressed only in relation to a stay at the identified care facilities, this means for example, follow-up after discharge, liaison with a general practitioner visiting a care setting. The care of children, and forensic centres is not included. Somatic health care includes prevention, screening, therapy and health promotion.

The final scope of the study was decided at the stakeholders meeting held the 7th of June 2019 at KCE; the stakeholders are listed in Appendix 1.1.

1.1 Methods

The methodology is described in detail in each chapter. In short, the most recent Minimal Psychiatric Data (MPD) were employed to study the prevalence of somatic disorders in Belgium. For the overview of the barriers and solutions, and the guidelines on somatic care of the patient with SMI, a literature review was performed. Next, a qualitative study was set up interviewing healthcare givers in the four settings on the barriers and motivators perceived when delivering care. Patient interviews were performed to elicit their views on the barriers of care. To understand the organisation and reimbursement of somatic care of the patient with SMI, a document analysis was performed and set up interviews. During the process of research, input and feedback from experts and stakeholders was gathered via mail and teleconference meetings. The following definitions were determined for this project.



1.2.1 Definition of severe mental illness

Disclaimer:

Throughout this report we use the term '**person or patient with a severe mental illness**'. This term is currently used in the scientific literature and accepted internationally. For a scientifically oriented audience, this term is commonly used and clear. From a patient perspective though, this term is regarded as incorrect. It describes the patient with a mental illness as 'severely ill' and has therefore a negative connotation. Therefore this term should preferably not be used outside of a scientific context. In the chapters on patient and health care views, the use of the definition 'the person with a mental illness' was preferred.

Throughout the literature several definitions have been used for severe or serious mental illness. Table 1 gives an overview of the variety of descriptions from international recognised bodies, Belgium, and neighbouring countries.

The definition for this report, in line with the KCE report 144, considers the three components: diagnosis, duration of illness, and disability. For the diagnosis a diagnosis of schizophrenia or related conditions, bipolar disorder, and moderate or severe depression was included. Instead of specifying the duration and disability in our definition of SMI, the focus is on the admission to one of the four care facilities (psychiatric hospital - psychiatric department general hospital, psychiatric nursing home, or an initiative for sheltered living). This admission status refers to the severity of illness or the degree of functional impairment along the spectrum of a certain diagnosis.

Table 1 – Definition of severe mental illness as applied in the literature and by recognised instances

Reference	Definition Severe/serious mental illness
The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness³	Included: schizophrenia, schizoaffective disorders, bipolar disorder, first episode psychosis, major depressive disorder. Excluded: 'Common mental disorders' e.g. mild to moderate depression, and anxiety disorders; 'Alcohol and substance disorders'; and 'other' e.g. personality disorders, behaviour disorders, pervasive developmental disorders.
WHO policy brief 'Helping people with severe mental disorders live longer and healthier lives'⁸	Included: schizophrenia and related conditions, bipolar disorder and moderate and severe depression. They cause significant disability and are usually long lasting.
World Psychiatric Association: Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care¹	Included: schizophrenia, schizoaffective disorder, bipolar disorder and major depressive disorder
Consensus on the definition of people with severe mental illness (SMI) in the Netherlands³²	An SMI is defined as a psychiatric disorder - that requires care/treatment (not in symptomatic remission) - and which is accompanied by severe limitations in social and/or community functioning (not in functional remission); - and where the impairment is a cause and consequence of a psychiatric disorder; - and is not of a temporary nature (structural or long-term, at least several years); - and in which coordinated care by professional care providers in care networks is indicated in order to realise the treatment plan.



National Institute of Mental Health United States https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154788	Defined as a mental, behavioural, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI.
The Diagnostic and Statistical Manual of Mental Disorders (DSM–IV)³³.	This is published by the American Psychiatric Association and defines and classifies mental disorders in order to improve diagnoses, treatment, and research. A “mental disorder” can be defined as follows: “a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioural or biological dysfunction in the individual. Neither deviant behaviour (e.g. political, religious or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above”. No definition of severe or serious is given by the DSM. The categories that are used are: schizophrenia, psychotic disorders, depression, bipolar personality syndromes, disorders youth, adjustment disorders, cognitive disorders, substance related syndromes, anxiety disorders, and personality disorders.
ICD-10 (International Classification of Diseases 10th Revision) https://icd.who.int/browse10/2010/en	The fifth chapter of the ICD-10, containing the WHO’s International Classification of Mental and Behavioural Disorders, defines mental disorders as: ‘the existence of a clinically recognizable set of symptoms or behaviour, associated in most cases with distress and with interference with personal functions’. No definition of severe or serious is given by the DSM.
Improving the physical health of adults with severe mental illness: essential actions – United Kingdom ³⁴	‘Severe mental illness’ is a frequently used phrase, but is imprecise in its nature. It is generally accepted to have three elements. • Diagnosis: a diagnosis of schizophrenia, bipolar disorder, or other psychotic disorder is usually implied. • Disability: the disorder causes significant disability. • Duration: the disorder has lasted for a significant duration, usually at least 2 years.
KCE report 144: Organization of mental health care for persons with severe and persistent mental illness. What is the evidence?³⁵	The definition of “severe and persistent” psychiatric patients most commonly includes 3 components (DDD): “<u>diagnosis</u>”, “<u>disability</u>” or severity of illness (or degree of functional impairment) along the spectrum of a certain diagnosis, and “<u>duration</u>” of illness. The “duration” of the disorder, is often limited to between 6 months and 2, 3 or even 5 years as cut-off in the definition of “severe and persistent psychiatric patient”. A difficulty remains that in some publications duration of illness is taken into account, and in other duration since the first contact with professional help. Importantly this reports mentions that care for a person with mental illness should be as for all other people with a medical or psychosocial problem: treatment and support of people with mental illness should as much as possible link up with the rest of health and welfare care so that treatment becomes the same for citizens.

DSM: Diagnostic and Statistical Manual of Mental Disorders



1.2.2 *Definition of somatic health care*

A broad definition for somatic health care was used to include aspects of prevention, early detection of illness, and treatment and management of somatic health. The word 'somatic health' refers to 'physical health' or health aspects that are outside of the mental diagnosis. 'Care' defines all activities and services that exist to organise optimal somatic health. This refers to the individual level, patient and carer, as well as the organisational and system level.

1.3 Report outline

The report starts in Chapter 2 with an overview of prevalence data on somatic disorders in the patient with SMI, discussing prevalence internationally and presenting the available data for Belgium.

As a background, a short overview is presented in Chapter 3 for the organisation of somatic health care where we make an effort to define who is responsible, who is doing what, the regulation/legislation, and the financing.

In Chapter 4 the topic of barriers and facilitators for protecting somatic health and treating somatic disorder in a person with SMI was explored and introduced. A summary of the qualitative literature is presented; for this the multilevel framework structured around individual-focused interventions, health system-focused interventions and community level and policy level interventions was applied.

For Chapter 5 and 6 the barriers and facilitators from the Belgian care givers and patients were identified. Results from interviews and group discussions and described health carers' experiences when delivering somatic care for the SMI patients in the four defined care settings are summarised. The views of patients on the care they experienced collected through interviews is presented.

The existing international guidelines on somatic problems for the patient with SMI was reviewed in Chapter 7 for their quality. The content of the guidelines by country and by content as identified in the guidelines is presented. The guidelines were appraised and a summary for a patient trajectory proposed.

Finally, the elements from the preceding chapters are summarised in Chapter 8.



2 PREVALENCE OF SOMATIC DISORDERS IN PERSONS WITH SEVERE MENTAL ILLNESS

2.1 Overview of the existing international literature

Key points

- An increased risk of somatic disorders has been observed internationally across the entire spectrum of mental illnesses.
- Prevalence estimates show that one out of three persons with SMI suffer with hypertension, metabolic syndrome, and obesity while diabetes is present in one out of ten. Osteoporosis (13%), asthma, and chronic obstructive lung disease (9%) but also the communicable diseases hepatitis B (16%) and hepatitis C (7%) are prevalent in persons with SMI.
- The co-occurrence of physical health conditions is common for patients admitted with a mental or substance use disorder and twice as high (84% vs. 42%) as compared to patients admitted with a principal physical health diagnosis.

2.1.1 Aim

Physical health disparities have been observed internationally for many decades across the entire spectrum of mental illnesses and are still a global public health problem. This chapter aims to outline the existing literature in this field.

2.1.2 Methodology

No systematic review has been performed for this report, as several reviews have been published recently. In particular, a recent systematic meta-review by the Lancet Psychiatry Commission on the physical health comorbidities associated with mental illness was based on almost 100 systematic reviews and meta-analyses.³ The authors systematically identified all systematic reviews and meta-analyses of chronic physical disorders in people with common mental disorders (depression and anxiety), SMI (schizophrenia and bipolar disorders), alcohol and substance use disorders, and various other mental health disorders, published between January 1st, 2000 and October 26th, 2018.

This chapter is entirely based on this systematic meta-review and presents those meta-analysis focussing on depression, schizophrenia, bipolar disorders and mixed SMI, which enter into the scope of this study. While originally studies mostly reported on premature mortality,^{36, 37} the amount of studies investigating physical health outcomes in persons with SMI has considerably increased over the past decades; the ones presented in this chapter include cardiovascular diseases and hypertension (N=8), metabolic syndrome, obesity and diabetes (N=8), cancer (N=3), other non-communicable diseases (N=8), and infectious diseases (N=2).

2.1.3 Cardiovascular diseases and hypertension

The prevalence of cardiovascular diseases (CVD) is increased in patients with a broad range of mental illnesses, including substance use disorders, various common mental disorders (such as depression and anxiety), and particularly in patients with SMI. In fact, cardiovascular diseases are among the most common causes of premature death in persons with SMI, who experience a high burden of conditions that increase the risk of cardiovascular diseases, such as obesity, hyperlipidaemia, hypertension, and diabetes mellitus (see section 1.1.1). Among severe mental illnesses, schizophrenia has been associated with the greatest degree of cardiovascular risk, partly due to the side effects of drugs for psychosis.³ Several reviews reported on cardiovascular diseases and hypertension in patients with SMI (Table 2).



Five of the meta-analyses reported on the risk of CVD in patients with SMI and showed increased risks for patients with depression,^{38, 39} schizophrenia,⁴⁰ bipolar disorder,⁴¹ and mixed SMI.⁴² In the most recent of the meta-analyses, persons with major depressive disorder, bipolar disorder and schizophrenia were all at increased risk of CVD, including coronary heart disease, cerebrovascular disease, congestive heart failure, and CVD-related death, with significant variations according to the type of studies (prevalence estimates from 3.6% in longitudinal studies to 9.9% in cross-sectional studies).⁴² Moreover, CVD incidence was increased with antipsychotic use ($p=0.008$), higher body mass index (BMI) ($p=0.008$) and higher baseline CVD prevalence ($p=0.03$) in patients.⁴²

For patients with depression, the risk of developing hypertension is around 40% higher than in the general population, according to a meta-analysis from 2012.⁴³ Next to this, in an American review, the prevalence estimates of hyperlipidaemia and hypertension in persons with SMI were 26.6% (range: 9.0%-61.0%) and 35.0% (range: 10.0-68.0%), respectively.⁴⁴ The higher risk of hypertension in persons with SMI was further confirmed in a recent meta-analysis.⁴⁵



Table 2 – Meta-analyses on cardiovascular diseases and related risk factors in persons with severe mental illness*

Review-Study	Population	Main results
Cardiovascular diseases (CVD)		
Fan et al, 2013⁴⁰	People with and without <u>schizophrenia</u> (422,698 CVD outcomes), n studies=13	RR=1.53 (95% CI, 1.27-1.86) for pooled CVD RR=1.20 (95% CI, 0.93-1.53) for coronary heart disease RR=1.71 (95% CI, 1.19-2.46) for stroke
Prieto et al, 2014⁴¹	People with (n=27,092) and without <u>bipolar disorder</u> , n studies=5	RR=1.09 (95% CI, 0.96-1.24) for myocardial infarction RR=1.74 (95% CI, 1.29-2.35) for stroke
Li et al, 2015³⁸	Patients with and without <u>depression</u> (N=399 791), n studies=36	RR=1.45 (95% CI, 1.31-1.61) for stroke
Correll et al, 2017⁴²	3,211,768 patients with <u>SMI</u> and 113,383,368 controls, n cross-sectional studies=38 and n longitudinal studies=65	Cross-sectional studies: Prevalence of pooled CVD=9.9% (95% CI, 7.4-13.3) OR=1.53 (95% CI, 1.27-1.83) for pooled CVD OR=1.51 (95% CI, 1.47-1.55) for coronary heart disease OR=1.42 (95% CI, 1.21-1.66) for cerebrovascular disease Longitudinal studies: Prevalence of pooled CVD=3.6% (95% CI, 2.7-5.3) HR=1.78 (95% CI, 1.60-1.98) for pooled CVD HR=1.54 (95% CI, 1.30-1.82) for coronary heart disease HR=1.64 (95% CI, 1.26-2.14) for cerebrovascular disease HR=2.10 (95% CI, 1.64-2.70) for congestive heart failure
Shi et al, 2017³⁹	Patients with and without <u>depression</u> (N=118 954), n studies=4, 8 and 5	RR=1.62 (95% CI, 1.37-1.92) for sudden cardiovascular death RR=1.47 (95% CI, 1.23-1.76) for ventricular tachycardia/ventricular fibrillation RR=1.43 (95% CI, 0.99-2.05) for atrial fibrillation
Hypertension		
Osborn et al, 2008⁴⁶	9612 patients with <u>SMI</u> and 3,449,677 controls, n studies=26	RR=1.11 (95% CI, 0.91-1.35)
Meng et al, 2012⁴³	Patients with <u>depression</u> and controls (N=22 367), n studies=9	RR=1.42 (95% CI, 1.09-1.86)
Ayerbe et al, 2018⁴⁵	Patients with bipolar disorder or schizophrenia	Bipolar disorder: RR=1.27 (95% CI, 1.15–1.40) Schizophrenia: RR=0.94 (95% CI, 0.75-1.14)

CVD: cardiovascular disease; HR: Hazard ratio; OR: Odds ratio; RR: Relative risk; SMI: Severe mental illness.

* Adapted from Firth J et al. *Lancet Psychiatry*. 2019.



2.1.4 Metabolic syndrome, obesity and diabetes

Obesity, hypertension, and diabetes mellitus are important risk factors for CVD, the most common cause of death in persons with SMI, and seem to be more common in persons with SMI (Table 3). These higher rates in this patient group appear to be driven by a lack of physical activity,⁴⁷ poor diet,⁴⁸ high rates of smoking,⁴⁹ and side effects of commonly prescribed antipsychotic medications that generate weight gain and altered glucose metabolism.⁵⁰

Three meta-analyses reported prevalence estimates of metabolic syndrome of 32.5%, 37.3% and 30.5% in persons with schizophrenia,⁵¹ bipolar disorder,⁵² and depression,⁵³ respectively. While only one meta-analysis reported on obesity;⁵⁴ a review of 16 studies in the United States reported a prevalence of obesity of 40.6% (range: 26.0%-55.0%) in persons with SMI.⁴⁴ The prevalence of obesity was higher in studies using clinical data (42% vs 36% for those using self-reported data) and in studies using outpatient study populations (46% vs 37% for inpatient and 38% for community study populations). Finally, four meta-analyses revealed higher risks of diabetes in persons with SMI, with prevalence estimates of 9.5%, 9.4% and 8.7% in patients with schizophrenia⁵⁵, bipolar disorder,⁵⁶ and depression,⁵⁷ respectively.

Table 3 – Meta-analyses on metabolic syndrome, obesity and diabetes in persons with severe mental illness

Review-Study	Population	Main results
Metabolic syndrome (MetS)		
Mitchell et al, 2013 ⁵¹	25 692 patients with <u>schizophrenia</u> (no reference group), n studies=77	Prevalence of MetS=32.5% (95 CI, 30.1-35.0)
Vancampfort et al, 2013 ⁵²	6983 patients with <u>bipolar disorder</u> and general population, n studies=37	Prevalence of MetS=37.3% (95% CI, 36.1-39.0) OR=1.98 (95% CI, 1.74-2.25)
Vancampfort et al, 2014 ⁵³	5531 patients with <u>depression</u> , n studies=5	Prevalence of MetS=30.5% (95% CI, 26.3-35.1) OR=1.54 (95% CI, 1.21-1.97)
Obesity		
Keck & McElroy, 2003 ⁵⁴	Patients with <u>bipolar disorder</u> and controls, n studies=4	Patients with bipolar disorder appear to be at greater risk than general population
Diabetes		
Osborn et al, 2008 ⁴⁶	9612 patients with <u>SMI</u> and 3,449,677 controls, n studies=26	RR=1.70 (95% CI, 1.21-2.37)
Stubbs et al, 2015 ⁵⁵	145,718 patients with <u>schizophrenia</u> and 4,343,407 controls, n studies=25	Prevalence of T2DM=9.5% (95% CI, 7.0-12.8) RR=1.82 (95% CI, 1.56-2.13)
Vancampfort et al, 2015 ⁵⁶	6595 patients with <u>bipolar disorder</u> and 783,049 controls, n studies=19	Prevalence of T2DM =9.4% (95% CI, 6.5-12.7) RR=1.98 (95% CI, 1.60–2.40)
Vancampfort et al, 2015b ⁵⁷	154 366 patients with depression and 2 098 063 controls, n studies=16	Prevalence of T2DM = 8.7% (95% CI, 7.3-10.2) RR=1.49 (95% CI, 1.29-1.72)

MetS: Metabolic Syndrome; OR: Odds ratio; RR: Relative risk; SMI: Severe mental illness; T2DM: Type 2 diabetes mellitus.

* Adapted from Firth J et al. *Lancet Psychiatry*. 2019.



2.1.5 Cancer

As persons with SMI experience more risky behaviours, such as poor diet and smoking, it has been hypothesised that they might also be at increased risk of cancer. However, the relationship between mental illnesses and cancer risk is uncertain (Table 4). Although one review found that depression is associated with a small increase in overall cancer risk,⁵⁸ other reviews described a decreased overall cancer risk in patients with schizophrenia or other central nervous system disorders.^{59, 60} However, the risk of cancer associated with mental illness might vary across gender and cancer types. For instance, while the incidence rate of colorectal cancer

decreased in male patients with schizophrenia, the incidence rate of lung cancer increased in female patients.⁵⁹ Also, whereas patients with common or severe mental illnesses have an increased risk of lung cancer, the risk of colorectal cancer appears to be similar to (or even lower than) that in the general population.^{58, 59}

Further research is required to understand these relationships, but a possible explanation is that people with mental illness have a reduced life expectancy, resulting in a reduced lifetime rate of cancer in this group. Multinational and larger sample studies are required to further research and support these associations. Moreover, confounding factors such as smoking and alcohol use should be considered in future studies.

Table 4 – Meta-analyses on cancer in persons with severe mental illness*

Study	Population	Main results
Catala-Lopez et al, 2014⁶⁰	Patients with <u>central nervous system disorders</u> (n= 577,013 participants) , n studies=16	ES=0.92 (95% CI, 0.87-0.98) for overall cancer
Jia et al, 2017⁵⁸	1 469 179 patients with <u>depression</u> and 89 716 cancer cases, n studies=25	RR=1.15 (95% CI, 1.09-1.22) for overall cancer RR=1.20 (95% CI, 1.01-1.43) for liver cancer RR=1.33 (95% CI, 1.04-1.72) for lung cancer No significant association with breast, prostate or colorectal cancer.
Li et al, 2018⁵⁹	480 356 patients with <u>schizophrenia</u> and 41 999 cancer cases, n studies=16	RR=0.90 (95% CI, 0.81-0.99) for overall cancer RR=0.82 (95% CI, 0.69-0.98) for colorectal cancer RR=0.55 (95% CI, 0.42-0.71) for prostate cancer RR=0.89 (95% CI, 0.81-0.98) for colorectal cancer in males RR=1.12 (95% CI, 1.01-1.25) for lung cancer in females

* Adapted from Firth J et al. *Lancet Psychiatry*. 2019. ES: Effect size; RR: Relative risk; SMI: Severe mental illness;



2.1.6 Other non-communicable diseases

While the risks of asthma⁶¹⁻⁶³, autoimmune disorders⁶⁴, and Parkinson's disease⁶⁵ are increased in persons with SMI, the risk of osteoporosis is also particularly high; a meta-analysis reported a prevalence rate of 13.2% (95% CI, 7.8-21.6) in patients with schizophrenia⁶⁶ and higher risks were observed for patients with depression as well⁶⁷ (Table 5).

Conversely, two previous meta-analyses reported lower risks of rheumatoid arthritis in patients with schizophrenia⁶⁸ or SMI⁶⁴. Finally, a higher prevalence of chronic obstructive pulmonary disease has been reported in people with SMI in the United Kingdom (UK)^{69, 70} and in the United States (prevalence of 8.9%; range: 2.0%-12.9%)⁴⁴ but there is no published meta-analysis to date.

Table 5 – Meta-analyses on other non-communicable diseases in persons with severe mental illness*

Study	Population	Main results
Wu et al, 2010 ⁶⁷	Patients with and without <u>depression</u> (N=33 428), n studies=4	RR=1.52 (95% CI, 1.26-1.85) for osteoporosis
Jiang et al, 2014 ⁶²	5510 patients with <u>depression</u> and 14 491 controls, n studies=3	RR=3.17 (95% CI, 2.82-3.56) for asthma
Stubbs et al, 2014 ⁶⁶	3038 patients with <u>schizophrenia</u> , n studies=19 and 8	Prevalence of osteoporosis =13.2% (95% CI, 7.8-21.6) OR=2.86 (95% CI, 1.27-6.42) for osteoporosis
Euesden et al, 2015 ⁶⁸	145 901 patients with <u>schizophrenia</u> and 4 485 088 controls, n studies=10	OR=0.48 (95% CI, 0.34-0.67) for rheumatoid arthritis
Gao et al, 2015 ⁶³	2334 patients with <u>depression</u> and 83 684 controls, n studies=6	OR=1.43 (95% CI, 1.28–1.61) for asthma
Wu et al, 2016 ⁶¹	5750 patients with <u>bipolar disorder</u> and 139 529 controls, n studies=6	ES=1.86 (95% CI, 1.40-2.47) for asthma
Cullen et al, 2018 ⁶⁴	Patients with <u>SMI</u> (population based and healthcare settings), n studies=10	OR=1.43 (95% CI, 1.04-1.95) for autoimmune disorders OR=0.65 (95% CI, 0.50-0.84) for rheumatoid arthritis
Wang et al 2018 ⁶⁵	Patients with and without <u>depression</u> (N=483 071), n studies=11	RR=2.20 (95% CI, 1.87-2.58) for Parkinson's disease

* Adapted from Firth J et al. *Lancet Psychiatry*. 2019. OR: Odds ratio; RR: Relative risk; ES: Effect size



2.1.7 Infectious diseases

Studies from a wide range of countries highlighted that persons with SMI are at increased risk of infectious diseases including human immunodeficiency virus infection (HIV) and hepatitis viruses, such as hepatitis B virus (HBV), hepatitis C virus (HCV), and other types of hepatitis viruses compared to the general population.

Reviews on infectious diseases in persons with SMI found that the average prevalence, across multiple countries, for HBV, HCV, and HIV was 15.6% (95% CI, 7.2-30.7), 7.2% (95% CI, 4.4-11.5), and 7.6% (95% CI, 4.8-11.8), respectively,⁷¹ and that the prevalence of syphilis was between 1.1 and 7.6% (no pooling of data).⁷² Moreover, although there was no significant association between gender and HIV or syphilis, there was a significantly increased risk of HBV and HCV infections in men compared to women.

While high-risk sexual behaviours and intravenous drug use could be the cause, there is currently a gap in the literature regarding the underlying factors explaining the increased rate of infectious diseases among people with mental illness and further research is needed so that more appropriate and targeted solutions can be developed.

2.1.8 Multi-morbidity

While most of the existing literature on somatic health in persons with mental illness has assessed the prevalence of specific health outcomes or disorders in isolation, the prevalence and specific effects of physical multi-morbidity (i.e. the presence of more than one physical health condition) in people with a mental illness are not completely understood.

Physical multi-morbidity has been reported in people with SMI,⁷³ common mental disorders (depression,⁷⁴ anxiety⁷⁵), and substance use disorders,⁷⁶ in some large-scale, multinational studies. In the United States, the Healthcare Cost and Utilization Project (HCUP) Statistical Brief presented data on the co-occurrence of physical health conditions and mental or substance use disorder (M/SUDs).⁶⁹ In 2014, 84.2% of all adult inpatient stays for an M/SUD had co-occurring physical health conditions, and this

percentage was higher among females (86.9% vs 82.0%) and older age groups (97.9% for patients aged 65+; 92.3% for 45-64; and 75.8% for ages 18-44). Moreover, the co-occurrence of physical health conditions and M/SUDs was more common among stays with an M/SUD principal diagnosis than among stays with a physical health principal diagnosis (84.2% vs. 42.4%, respectively). The most common co-occurring physical health conditions among adult inpatient stays with an M/SUD principal diagnosis were hypertension (30.6% of stays), fluid and electrolyte disorders (14.8%), oesophageal disorders (14.1%), disorders of lipid metabolism (13.7%), and diabetes without complications (11.4%).

While multi-morbidity greatly increases the personal and economic burden associated with chronic conditions, it reduces life expectancy compared with a single morbidity.⁷⁷ Urgent attention is required to address the onset and accumulation of physical multi-morbidity.

2.1.9 Risk factors

High rates of comorbid medical conditions in persons with SMI can be attributed to several factors. In addition to the health behaviours, such as smoking, alcohol consumption, low physical activity and diet, and the metabolic side effects of antipsychotic medications described above, persons with SMI are more likely to experience social risk factors, such as poverty, unemployment, homelessness, and disability, which are associated with increased risk of poor health outcomes.⁴⁴ The Lancet review summarised key factors that were identified as modifiable (Figure 1). The risk of being afflicted by a SMI is associated with the risk of being at high risk for some somatic chronic illnesses. Indeed, an abundant literature demonstrates that today mental disorders should be considered in a whole-body perspective and not only related to neurobiological or psychological aspects. Several studies have identified biological markers, e.g. microbiota and inflammatory markers, in patients with SMI.⁷⁸⁻⁸⁰ Currently no consensus exists on the use of biological markers for the early detection of somatic disorders.

**Figure 1 – Prevalence of behavioural risk factors across different mental health diagnosis***

	Alcohol	Tobacco use	Physical activity	Sedentary behaviour	Poor diet	Poor sleep
Major depression	SR: around 30% of patients have or have had alcohol use disorder ¹²⁴	SR: patients are more likely to smoke and be dependent on nicotine, are less likely to quit, and are more likely to relapse ¹²⁵	MA: around 60–70% of patients do not meet physical activity guidelines ^{126,127}	MA: patients are sedentary for 8–5 h per day ¹²⁷	ES: patients have significantly higher food intake and poorer diet quality than the general population ¹²⁸	ES: patients have significantly poorer continuity of sleep and reduced sleep depth compared with healthy controls ¹²⁹
Anxiety disorders	ES: 17–9% of patients have alcohol dependence or misuse ¹³⁰	MA: 41% increase in risk of regular smoking and 58% increase in risk of nicotine dependence ¹³¹	ES: individuals with panic disorders, social phobia, and agoraphobia report significantly less activity ¹³²	SR: inconsistent evidence for increased sedentary time in people with anxiety ¹³³	Insufficient evidence	MA: anxiety disorders ^{125,134} and obsessive-compulsive disorder ¹³⁵ are associated with reduced sleep quality
Bipolar disorder	MA: 1 in 3 patients have or have had alcohol use disorder ¹³⁶	MA: increased rates of current smoking (higher than in patients with major depression but lower than in patients with schizophrenia) ¹³⁷	MA: the majority of patients meet physical activity guidelines and are no different to the general population ^{135,136}	MA: patients are sedentary for more than 10 h per day ^{135,136}	MA: patients consume around 200 calories more than the general population per day ¹³⁸	MA: even between episodes, people with bipolar disorder have increased sleep-wake disturbance, similar to patients with insomnia ¹³⁹
Schizophrenia	MA: 1 in 5 patients have or have had alcohol use disorder ¹⁴⁰	MA: significantly higher rates of current smoking, heavy smoking, and nicotine dependence ¹⁴¹	MA: the majority of patients do not meet physical activity guidelines ^{138,136}	MA: patients are sedentary for around 11 h per day ¹⁴²	MA: patients consume around 400 calories more than the general population per day ¹³⁸	MA: patients have significantly reduced sleep time and quality of sleep ^{139,134}
First-episode psychosis	MA: 27% of patients have or have had alcohol use disorder or alcohol dependence ¹⁴³	MA: 58% of patients use tobacco, which is a significantly higher prevalence than in matched controls ¹⁴⁴	MA: patients are less active than individuals with long-term schizophrenia ¹⁴⁵	Insufficient evidence	Insufficient evidence	MA: patients have significantly reduced sleep time and quality of sleep ¹³⁴
Post-traumatic stress disorder	SR: increased prevalence of comorbid alcohol misuse (10–61%) compared with the general population ¹⁴⁶	MA: patients are 22% more likely to be current smokers than the general population ⁹⁸	MA: patients are 9% less likely to be physically active than the general population ⁹⁸	Insufficient evidence	MA: patients are 5% less likely to have a healthy diet than the general population ⁹⁸	MA: significantly poorer continuity of sleep and reduced sleep depth compared with healthy controls ¹²⁹

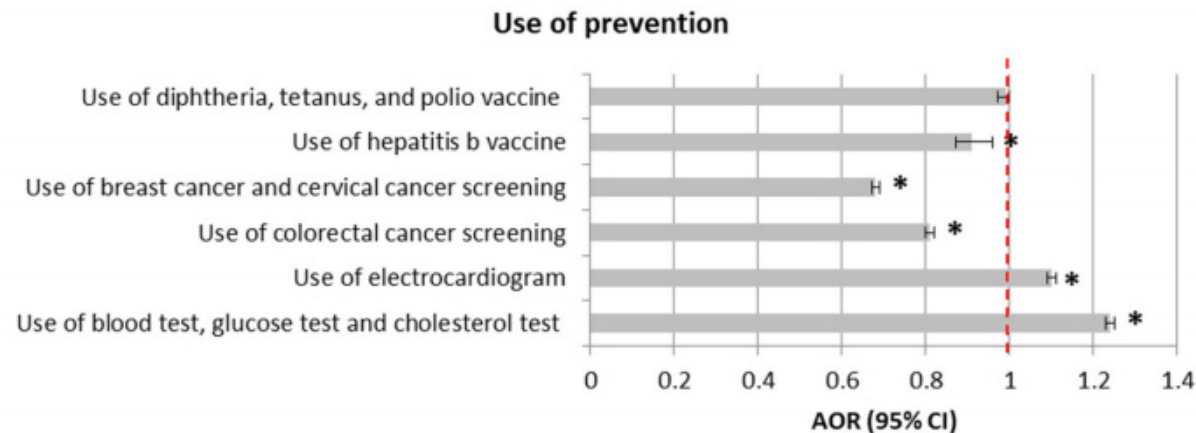
Results described as significant had $p < 0.05$. Comparisons are with the general population unless otherwise stated. SR—systematic review of case-control, clinical, or epidemiological research. MA—meta-analysis of multinational data. ES—large-scale epidemiological studies.

Table 2: Prevalence of behavioural risk factors across different mental health diagnoses

* From Firth J et al. *Lancet Psychiatry*. 2019.

Moreover, persons with SMI are overall less likely to receive prevention health services and high-quality medical care than persons without SMI.⁸¹ A large case-control study on 428.093 patients with a SMI (psychosis, schizophrenia and bipolar disorders) performed on the national data of France, observed a reduction for the use of prevention related health care (Figure 2).⁸² A significant difference was noted for hepatitis B vaccination,

cancer screening e.g. breast and cervical cancer (Adjusted OR: 0.68, 95%CI: 0.67–0.69) and colorectal cancer (Adjusted OR: 0.81, 95%CI: 0.80–0.82). Prevention measures recommended to target the adverse effects of antipsychotic drugs were significantly more frequent in the SMI population but was limited to those using antipsychotics.

**Figure 2 – Use of prevention health care in France for patients with SMI compared to patients without SMI***

*From Gandré et al. IJERPH. 2020.⁸² AOR: adjusted odds ratio; CI: confidence interval

2.1.10 Further considerations

Unfortunately, despite the increasing amount of research on this topic and the high evidence of an increased risk of somatic disorders (and the associated decrease of life expectancy) in persons with SMI, the number of years lost due to physical health conditions in this population might be still increasing.⁸³ More research in this field is thus necessary to improve our knowledge on the prevalence and specific effects of physical outcomes affecting persons with SMI.

Also, further research is needed to examine whether the psychological distress associated with mental illness is compounded by the additional burden of these chronic conditions. Among others, diabetes⁸⁴ as well as obesity⁸⁵ have been associated with distress in the general population, which can negatively affect the person's quality of life. Also, in addition to the personal burden, somatic disorders in persons with SMI result in an increased financial cost, the extent of which requires further research. Finally, following existing management strategies and recommendations is essential to improve physical health outcomes in patients with SMI.

2.2 Situation in Belgium

Key points*

- In 2018, there were 120 900 stays in psychiatric hospitals and psychiatric services of general hospitals, among which 18 978 had at least one somatic diagnosis reported, giving a prevalence of stays with at least one reported somatic disorder of 15.7%. The mean number of somatic disorders reported for the last treatment period of a stay was 1.7.
- Among all reported disorders, the five highest percentages were 6% for diabetes, 5.3% for liver disease, 5.0% for hypertension, 4.8% for epilepsy, and 4.3% for obesity. Although these percentages are low, the percentages reflect the disorders mostly prevalent in the international literature.



- **The minimal psychiatric data are not reliable for studying the prevalence of somatic disorders in the settings studied. The purpose of the database is on psychiatric diagnosis; the somatic diagnosis are limited to a number of three maximum which are related to the psychiatric disorder; the results should therefore be interpreted with caution as the data are incomplete.**

** based on data for psychiatric hospitals and psychiatric services in general hospitals only; other data were not available for analysis.*

2.2.1 Aim

As described in the literature review above (section 2.1), many studies reported on the prevalence of somatic disorders in persons with SMI. However, to date, no research on prevalence has been performed in Belgium and as a result it is unknown how prevalent somatic disorders are in Belgium compared to other countries published in the international research. In this chapter, the prevalence of somatic disorders reported in adult patients with a severe mental condition was studied, by using the minimal psychiatric data (MPD) (minimale psychiatrische gegevens (MPG), résumé psychiatrique minimum (RPM)). Specifically, the aim was to describe the prevalence of somatic disorders across the studied settings, gender, age, and the duration of stay in a facility.

2.2.2 Methodology

2.2.2.1 Data source

The collection of **MPD** is obligatory for the four studied settings (PH, PSGH, PNH and SHI). The anonymised data of all residents in the facilities is passed on to the federal public service (FPS) for health, food chain safety and environment. The data is collected at the beginning and at the end of residential treatment (a stay), as well as after each significant period in the treatment (e.g. when the resident moves to another treatment unit) or at least every 6 months.

2.2.2.2 Data selection

All stays in psychiatric hospitals and psychiatric services of general hospitals and somatic diagnosis of patients 18 years and above registered for the period 2008-2018 were included. The data for the psychiatric nursing homes and the sheltered housing initiatives were not available. Indeed, following the 6th state reform, PNH and SHI are no longer under federal jurisdiction. However, the FPS published a study in 2016 based on the MPD data from 2013 for all 4 settings. The methodology was similar to the one applied in this project^a. We will refer to this 'FPS 2013' study in the results section in order to provide results for the PNH and SHI settings.

2.2.2.3 Definitions

A 'stay' and a 'treatment period' in a psychiatric facility

A 'stay' in a psychiatric facility is defined as the period between the patient's admission and the patient's discharge. All stays (for patients ≥ 18 years old) for 2018 in psychiatric hospitals or psychiatric services of a general hospital were taken into account, irrespective of whether the stay started before or during 2018, and ended during 2018 or after.

^a Federal Public Service (FPS) Health, Food Chain Safety and Environment. MPG Publicaties Lichamelijke gezondheid van psychiatrische patiënten – RPM Publications Santé physique patients psychiatriques. Available from: <https://www.health.belgium.be/en/node/29532>



During a stay, a patient could have been subject to several intermediate discharges and readmissions. A new medical admission was noted only if the last discharge from the facility was considered by the doctor as a medical discharge; in other words, a new stay only started if the previous stay was closed. When the patient was readmitted (to the same living unit and under the same treatment service index as) within 30 calendar days of his intermediate discharge, the treatment period preceding the intermediate discharge continued^b. In case the patient was not readmitted administratively within 30 days of the intermediate discharge, it was automatically reported as a medical discharge, meaning the end of the stay. Several stays can thus be registered for the same patient in a year.

Next to this, a stay may have included one or more treatment period. A treatment period is the part of the stay which takes place in a living unit and under a service index, for a period not exceeding 6 months.^c This study focused, for each recording year, on the last available treatment period.

Psychiatric diagnoses groups

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), published by the American Psychiatric Association, defines and classifies mental disorders in order to improve diagnoses, treatment, and research. This codification system is different from the International Classification of Diseases (ICD) system. Although, a more recent version of the DSM-V is now in use internationally, this new classification is not adapted for the current MPD.

The main psychiatric diagnoses groups (severe and others) are based on the DSM-IV codes, and were grouped as shown in Table 6.

^b However, if the treatment period preceding the intermediate discharge reaches the maximum duration of 183 calendar days during this intermediate discharge, then this period is closed on the date of the intermediate discharge and a new treatment period is started on the date of the intermediate readmission.

Table 6 – DSM-IV psychiatric diagnostic groups*

Group		DSM-IV codes
Main severe psychiatric diagnostic groups		
Schizophrenia		295.10-295.30, 295.60, 295.90
Psychotic disorders		295.40, 295.70, 297.1, 297.3, 298.8-298.9, 293.81-293.82
Depression		300.4, 311, 296.20-296.26, 296.30-296.36
Bipolar syndromes	personality	296.00-296.06, 296.40-296.46, 296.50-296.56, 296.60-296.66, 296.7, 296.80, 296.89, 296.90, 301.13
Other main psychiatric diagnostic groups		
Disorders youth		317 t/m 319, 315.xx, 307.0, 307.9, 299.xx, 314.xx, 312.8, 312.9, 313.81, 307.3, 309.21, 313.23, 313.89, V619, V618, V6281, V7102, 307.52-307.59, 307.20-307.23, 307.6-307.7, 313.9, 7876
Adjustment disorders		309.0, 309.24, 309.28, 309.3-309.4, 309.9
Cognitive disorders		294.0, 294.8-294.9, 293.83, 293.9, 310.1, 780.9, 290.0-209.43, 294.1, 294.9, 293.0, 780.09
Substance syndromes	related	303.90, 305.00, 291.0-291.3, 291.5, 291.8-291.9, 303.00, 304.10, 305.40, 304.00, 304.20-304.60, 304.80-304.90, 305.10-305.30, 305.50-305.70, 305.90, 292.0, 292.11-292.12, 292.81-292.84, 292.89-292.9
Anxiety disorders		300.00-300.02, 300.21-300.29, 300.3, 308.3, 309.81, 293.89
Personality disorders		301.0, 301.20, 301.2, 301.50, 301.7, 301.81, 301.83, 301.4, 301.6, 301.82, 301.9

*the exact wording from the DSM-IV is used in the table

^c See the manual for recording the MPD, third Edition: https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_the_me_file/handleiding_mpg_derde_druk.pdf; https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_the_me_file/manuel_rpm_troisieme_edition.pdf



Somatic disorder

The reporting of somatic disorders for the data collection of the MDP are defined on the third axis of the DSM-IV. The reporting focuses on ongoing somatic disorders of importance for understanding the patient's health or his treatment and up to maximum three somatic disorders can be entered by the clinician, using ICD-9-CM codes. For this study, the detail of somatic pathologies was limited to the first three digits of the ICD-9-CM codes. We focussed on all somatic disorders reported in the last treatment period available for a stay. Therefore, 'stays' only reporting a diagnosis of "Mental disorders" or "V-codes"^d without a somatic diagnosis were not considered as stays with a "somatic" diagnosis and were thus excluded from the analyses.

2.2.2.4 Measures

The **prevalence of stays with a somatic disorder** among adults aged 18 years or above was calculated as the number of stays in a psychiatric facility with at least one reported somatic diagnosis divided by the total number of stays.

The evolution of this prevalence from 2008 to 2018 was assessed. The prevalence for the year 2018 was calculated across the following subgroups:

1. The psychiatric diagnostic groups: Schizophrenia, Psychotic disorders, Depression, Bipolar personality syndromes, Disorders youth, Adjustment disorders, Cognitive disorders, Substance related syndromes, Anxiety disorders, Personality disorders
2. The settings: psychiatric hospital and psychiatric service of a general hospital
3. Gender: female and male
4. Age categories : 18-44 y, 45-64 y, ≥65 y
5. Regions: Flanders, Brussels, Wallonia

6. Duration of the stay: 0-3 months, 3-6 months, ≥6 months. The calculation of the duration of stays only included the stays ending in 2018 as for non-ended stays, the duration of the stay was unknown.

The overall number of somatic disorders (maximum three per stay) covering all the stays was calculated and also studied by subgroups as defined above.

2.2.2.5 Analysis

The analyses were performed by the data and strategic analysis team of the FPS Public Health, using the SAS software, version 9.4.

2.2.3 Prevalence of stays with somatic disorder in PH and PSGH

In 2018, there were 120 900 stays in PH and PSGH, among which 18 978 had at least one somatic diagnosis reported, giving a prevalence of stays with at least one reported somatic disorder of **15.7%**. The total number of somatic disorders reported for all stays was 26 486 (13 334, 7 392 and 5760 as first, second, or third somatic disorder reported, respectively). Indeed, the mean number of somatic disorders reported for the last treatment period of a stay was 1.7. The analysis of the FPS 2013 study, including PH, PSGH as well as PNH and SHI, showed a prevalence of 22% or 25 104 somatic disorders for a total of 113 962 stays.

2.2.4 Prevalence of stays with somatic disorder across psychiatric diagnostic groups in PH and PSGH

The highest proportion of the total somatic disorders were reported during a stay related to substance use (28%) (Table 7). The psychiatric diagnoses categorised under the 'severe diagnosis group' represented 38% of the somatic disorders reported; this was 20% for depression and approximately 6% for schizophrenia, psychotic disorders, and bipolar personality syndromes each.

^d Defined as "Supplementary Classification Of Factors Influencing Health Status And Contact With Health Services"

**Table 7 – Somatic disorders across psychiatric diagnostic groups for PH and PSGH in 2018: distribution and prevalence of stays**

	All somatic disorders reported - N (%)	Number of stays with at least one somatic disorder - n	Total number of stays - N	Prevalence ^β of stays with at least one somatic disorder - %
Total	26 486 (100)	18 973*	120 900	15.7
Severe diagnosis				
Schizophrenia	1 553 (5.9)	1 090	5 091	21.4
Psychotic disorders	1 654 (6.2)	1 187	7 268	16.3
Depression	5 390 (20.3)	3 771	25 774	14.6
Bipolar personality syndromes	1 513 (5.7)	1 038	4 614	22.5
Other diagnosis				
Substance related disorders	7 475 (28.2)	5 300	29 501	18.0
Adjustment disorders	2 615 (9.8)	1 925	19 307	10.0
Cognitive disorders	1 702 (6.4)	1 239	9 086	13.6
Personality disorders	1 079 (4.1)	752	3 621	20.8
Anxiety disorders	929 (3.5)	693	2 776	25.0
Disorders youth	699 (2.6)	528	2 690	19.6
Other disorders	1 877 (7.1)	1 450	11 172	13.0

Data source: Federal public service; *for 5 of the 18 978 stays, the DSM-IV code was missing. ^β Prevalence of 'stay with at least one somatic disorder' = Number of 'stays with at least one somatic disorder' / Total number of stays.

Compared to the overall prevalence rate of 15.7%, the prevalence of a reported somatic disorder was higher for a person admitted for schizophrenia (21.4%), bipolar personality syndromes (22.5%), personality disorders (20.8%), anxiety disorders (25.0%), and disorders in youth (19.6%) (Table 7). On the contrary, stays for adjustment disorders (10.0%), other disorders (13.0%), cognitive disorders (13.6%), and depression (14.6%) showed lower rates than the global prevalence rate of 15.7%.

2.2.4.1 Prevalence of stays with somatic disorder across patient's characteristics

Among the 26 486 somatic diagnoses reported during a stay in 2018, 52% were reported in psychiatric hospitals, 52% concerned females, 69% were in persons aged 45 years and above, and 79% lasted less than 3 months (Table 8). In 2018, the prevalence of stays with at least one somatic reported disorder was 15.7% for both hospital settings (PH and PSGH), was higher



among females (16.1% vs 15.3% for males), was highest in the older patients (24.4% in ≥ 65 years old) and increased with the duration of the stay (from 15.5% for 0-3 months to 19.1% for stays longer than 6 months) (Table 8).

The FPS 2013 study reported 25 104 stays with at least one somatic reported diagnosis. Among these, 12 161 were in PH, 10 566 in PSGH, 1566 in PNH, and 811 in SHI. While stays with at least one somatic diagnosis were more frequent among men (13 047 vs 12 057 among women), the distribution across age groups was similar: 6 846 among 25-44 y, 11 655 among 45-64 y, and 4 907 among >64 y.

Table 8 – Somatic disorders across patient characteristics for PH and PSGH in 2018: distribution and prevalence of stays

	All somatic disorders reported - N (%)	Number of stays with at least one somatic diagnosis - n	Total number of stays - N	Prevalence of stays with at least one somatic disorder - %
Total	26 486 (100)	18 978	120 900	15.7
Setting				
Psychiatric hospital	13 790 (52.1)	10 239	65 230	15.7
Psychiatric service in general hospital	12 696 (47.9)	8 739	55 670	15.7
Gender				
Male	12 746 (48.1)	9 206	60 222	15.3
Female	13 740 (51.9)	9 767	60 678	16.1
Age group				
18-44 years	8 244 (31.1)	9 221	59 008	15.6
45-64 years	13 250 (50.0)	6 413	48 219	13.3
≥ 65 years	4 992 (18.9)	3 339	13 673	24.4
Duration of stay*				
0-3 months	20 952 (79.1)	15 019	86 675	15.5
3-6 months	2 118 (8.0)	1 506	8 074	18.7
≥ 6 months	1 522 (5.9)	1 088	5 682	19.1

Data source: Federal public service. * For this variable, only stays which ended in 2018 are included: the total number of stays with at least one somatic diagnosis is 17 613 and the total number of stays is 100 431.



2.2.4.2 *Reported somatic disorders across psychiatric diagnostic groups*

The ICD-9 codes of reported disorders are reported and ordered under the following 16 groups:

1. endocrine, nutritional and metabolic diseases and immunity disorders,
2. nervous system and sense organs,
3. diseases of the digestive system,
4. circulatory system,
5. diseases of the musculoskeletal system and connective tissue,
6. symptoms signs and ill-defined conditions,
7. diseases of the respiratory system,
8. injury and poisoning,
9. infectious and parasitic diseases,
10. neoplasms,
11. diseases of the genitourinary system,
12. diseases of skin and subcutaneous tissues,
13. congenital anomalies,
14. blood and blood forming organs,
15. complications of pregnancy, childbirth and puerperium,
16. conditions in the perinatal period.

Further, the categories “Mental Disorders” and “V-codes”^e, are used in the reporting for a secondary somatic diagnosis.

Table 9 lists all the reported somatic disorders by the ICD-9 categories (18 groups) and severe psychiatric groups. The detail of disorders is presented for disorders representing a minimum of 2% (for at least one psychiatric group) of the total number of reports. The table listing the reported somatic disorders by other psychiatric groups is reported in Appendix 2.

Among the 26 528 reported somatic disorders across all psychiatric groups, an approximate 50% or 13 967 are endocrine, nervous system, digestive system, or circulatory system related. The following most frequent disorders have an absolute number of above 1000 reports in 2018: diabetes (6.0% of the total number of reported disorders), liver disease (5.3%), hypertension (5.0%), epilepsy (4.8%), and obesity (4.3%). Higher percentages of these disorders are noted for the psychiatric diagnostic groups psychotic disorders, schizophrenia, and bipolar personality syndromes i.e. diabetes 8.8%, 9.7%, and 7.4% respectively, and obesity 6.5%, 10.4%, and 5.8% respectively. The highest percentages for epilepsy are recorded in the diagnostic group cognitive disorders (6.6%), disorders youth (12.6%), and other disorders (8.7%). The burden of liver disease is carried by the substance related disorders; 15.7% of the total number of recorded somatic disorders in this diagnostic group. Hypertension is reported in similar percentages for most diagnostic groups and is the highest in the bipolar disorder diagnostic group (7.1%).

Other disorders that were internationally recognised as prevalent (see section 2.1) were present in less than 2% and/or recorded under different headings. The metabolic syndrome is not recorded in the ICD-9, nevertheless ‘disorder of the lipid metabolism’ was reported 525 times (1.97% of all reported disorders). The highest percentages were seen in psychotic disorders (3.6%), schizophrenia (3.2%), and anxiety disorders (3.5%). Similarly, osteoporosis is not recorded in the ICD-9 but the items classified under ‘other disorders of bone and cartilage’ represented 0.5% of disorders. Asthma was reported 450 times or 1.7%, chronic bronchitis 534 times or 2%, viral hepatitis 322 times or 1.2% (with 199 reports in the substance disorder (2.7%), 39 reports in schizophrenia diagnostic group (2.5%)).

^e Defined as “Supplementary Classification Of Factors Influencing Health Status And Contact With Health Services”



Table 9 – Number of somatic disorders by ICD-9 category and severe psychiatric group for PH and PSGH in 2018

ICD-9 categories	Depression (N=5396)		Psychotic disorders (N=1657)		Schizophrenia (N=1553)		Bipolar personality syndromes (N=1516)	
	n	%	n	%	n	%	n	%
ENDOCRINE	1021	18.9	396	23.9	421	27.1	356	23.5
Diabetes	344	6.4	145	8.8	151	9.7	112	7.4
Obesity	226	4.2	107	6.5	162	10.4	88	5.8
Hypothyroidism	158	2.9	42	2.5	32	2.2	79	5.2
Lipoid metabolism	121	2.2	60	3.6	50	3.2	32	2.1
Malnutrition	9	0.2	.	.	.	.	.	.
NERVOUS SYSTEM	596	11.0	227	13.7	135	8.7	157	10.4
Epilepsy	163	3.0	89	5.4	42	2.7	38	2.5
Cerebral degenerations	21	0.4	10	0.6	<5	0.1	5	0.3
Neuropathy	19	0.4	<5	0.1	6	0.4	6	0.4
Parkinsons	54	1.0	26	1.6	10	0.6	25	1.7
Migraine	87	1.6	6	0.4	<5	0.1	12	0.8
Extrapyramidal	30	0.6	13	0.8	6	0.4	8	0.5
DIGESTIVE SYSTEM	482	8.9	170	10.3	156	10.0	154	10.2
Liver disease	77	1.4	16	1.0	14	0.9	25	1.7
Esophagus	120	2.2	50	3.0	43	2.8	31	2.0
Functional digestive	97	1.8	33	2.0	36	2.3	45	3.0
CIRCULATORY SYSTEM	578	10.7	162	9.8	156	10.0	174	11.5
Hypertension	335	6.2	79	4.8	67	4.3	107	7.1
Occlusion cerebral	8	0.2	<5	0.2	<5	0.3	<5	0.2
Cerebrovascular disease	17	0.3	<5	0.2	.	.	7	0.5
Cerebrovascular accident	10	0.2	<5	0.1	.	.	<5	0.1
Transient ischaemic attack	<5	0.1	<5	0.1	.	.	<5	0.2
MUSCULOSKELETAL SYSTEM	786	14.6	106	6.4	89	5.7	140	9.2
Disorders of back	170	3.2	25	1.5	12	0.8	27	1.8
Soft tissues	153	2.8	8	0.5	<5	0.2	10	0.7
Intervertebral disc	141	2.6	12	0.7	16	1.0	27	1.8
SYMPTOMS & ILL-DEFINED	396	7.3	83	5.0	85	5.5	74	4.9
General symptoms	164	3.0	15	0.9	12	0.8	27	1.8
Unknown causes	29	0.5	21	1.3	21	1.4	8	0.5



RESPIRATORY SYSTEM	271	5.0	98	5.9	107	6.9	119	7.8
Chronic bronchitis	80	1.5	38	2.3	44	2.8	44	2.9
Asthma	95	1.8	30	1.8	35	2.3	32	2.1
INJURY AND POISONING	159	2.9	47	2.8	48	3.1	47	3.1
Intracranial injury	<5	0.1	.	.	<5	0.2	<5	0.1
INFECTIOUS DISEASES	91	1.7	52	3.1	70	4.5	23	1.5
Viral hepatitis	21	0.4	24	1.5	39	2.5	8	0.5
NEOPLASMS^a	170	3.2	44	2.7	38	2.4	35	2.3
Neoplasm female breast	40	0.7	7	0.4	<5	0.3	17	1.1
GENITOURINARY SYSTEM^a	95	1.8	47	2.8	31	2.0	55	3.6
SKIN SUBCUTANEOUS^a	75	1.4	31	1.9	48	3.1	26	1.7
CONGENITAL ANOMALIES^a	60	1.1	17	1.0	10	0.6	12	0.8
BLOOD AND FORMING ORGANS^a	27	0.5	12	0.7	14	0.9	7	0.5
COMPLICATIONS OF PREGNANCY^a	20	0.4	10	0.6	5	0.3	22	1.5
PERINATAL PERIOD^a	<5	.	.	.	.	.	<5	.
MENTAL DISORDERS^u	258	4.8	100	6.0	94	6.1	43	2.8
V-CODE[*]	310	5.7	55	3.3	46	3.0	69	4.6

Data source: Federal public service; ^a individual items below 2% of total; ^u in this case the mental disorder was recorded as secondary diagnosis; ^{*}Supplementary Classification Of Factors Influencing Health Status And Contact With Health Services

2.2.4.3 Reported somatic disorders by patient characteristics

Only slight differences in percentages were noted for the most frequently reported disorders between the two settings PS and a PSGH (data available upon request to KCE). Hypertension, asthma and chronic bronchitis was equally distributed by gender, whereas obesity was slightly higher in females (4.8 vs 3.8%), and diabetes (5.4% vs 6.7%), epilepsy (3.9% vs 5.7%), viral hepatitis (0.6% vs 1.9%), and liver disease (3.9% vs 6.9%) was lower than in male patients. Diabetes was more commonly reported in older patients versus younger patients but obesity was mostly reported in the younger age group (6.5% 18-44y vs 3.9% 45-64y vs 1.8% 65+y. Epilepsy was highest in the younger age-group (7.2%), and liver disease in the 45-64y group (6.8%). As expected, hypertension percentages increased with age.

2.3 Discussion

In several European countries, population registries allow researchers and policy makers to estimate the prevalence and incidence of medical conditions among persons with SMI over time. For the Belgian data available for this study, although limited to two settings only, we tried to describe the most commonly reported disorders. It has to be stressed that the data collecting system is not intended to provide estimates of prevalence and results should therefore be interpreted as an indication of the most commonly reported somatic disorders only. This obviously is a shortcoming for this report.

Wide variability in prevalence estimates among people with SMI across studies for most medical conditions was present. This can be due to differences in measurement. Indeed, there is significant variation in measurement techniques across national studies, which have important implications for prevalence estimates. Self-report of medical conditions



through a national survey, as well as the use of administrative data, can lead to an underestimation of the true prevalence.⁸⁶ Supplementing self-reported medical history with physical examination and laboratory data provides more valid measurements for most conditions. Moreover, the characteristics (e.g. demographic factors, level of disability, and antipsychotic medication use) of different study populations of persons with SMI also contribute to the variation in prevalence estimates. These methodology and population differences have to be considered when comparing prevalence estimates of somatic disorders in persons with SMI from different countries and settings. These particularities impair the comparison of prevalence estimates from one country to another.

We set out to study how common somatic health problems are in the person with SMI in Belgium compared to internationally. We learned that across the entire spectrum of mental illnesses an increased risk for somatic disorders has been observed internationally. For each three persons with SMI, one person suffers with either hypertension, metabolic syndrome, or obesity. Further, on average one out of ten persons with an SMI has a diagnosis of diabetes, osteoporosis, asthma, chronic obstructive lung disease, or viral hepatitis. Often, a co-occurrence of physical health conditions for patients admitted with a mental or substance use disorder was noted (84%) and was twice as high as compared to patients admitted with a physical health principal diagnosis (42%).

In Belgium, the prevalence we retrieved from the MPD data does not reflect the real situation of somatic disorders in this population. We learned from experts that although the data collection is an obligation for all psychiatric disorders and is performed systematically, the somatic diagnosis are to be reported when 'relevant' for psychiatric disease only. Historically, the collection of somatic diagnosis was proposed by the universities for study purposes and was then adapted on a federal level and implemented. Experts explained that the MPD is required for funding and accreditation standards but not for all settings. Other problems with the MPD are the following: a limit of three somatic diagnosis only can be recorded, when the somatic pathology is present but not considered to be related to mental illness it is not encoded, somatic diagnoses are not given priority in the encoding of MPD by the settings; and the recording sequences do not facilitate the reconstruction of information for the same patient over time.

We learned that for only 16% of the psychiatric stays a somatic disorder was reported. The above may explain why the prevalence is much lower than what would be expected based on the international prevalence reported. It is likely that underreporting is therefore happening systematically.

The commonly reported disorders in Belgium, though, do reflect the same somatic diagnosis recognised as most prevalent disorders in the international literature. The diagnostic psychiatric groups with high burdens of hypertension, diabetes, and obesity were found in the schizophrenia, psychotic disorders, depression, and bipolar personality syndromes groups. This is similar as what is found internationally.



3 ORGANISATION OF SOMATIC HEALTH CARE FOR PERSONS WITH SEVERE MENTAL ILLNESS IN BELGIUM

Key points

- Current Belgian law defines that the focus of a PH and PSGH is on care. This is different from the focus of PNH and SHI where supervision of daily living activities and support to maintain functioning is the core; and less so psychiatric or somatic care. This focus is reflected in the characteristics of the staff composition at each of the settings.
- Historically, somatic health care at PH was provided by 'external' specialists or GPs as care was conceptually dichotomised between psychiatric and somatic health. With the somatic care needs of the complex patient with co-morbidity increasing, psychiatrists linked (often contracted by the PH) a set number of GPs or specialist to provide for regular care and follow-up and to attend team meetings. Unfortunately, the nomenclature and the related funding was not foreseen for this way of organisation. A coordination function for a medical physician similar to the coordinating physician at the nursing homes is lacking at the PH and PSGH.
- For hospital settings, the financing of care is directly linked to the B2 budget (90% is spent on the staff caring for the patients). For PH and PSGH, the sub-part B2 is allocated based on a number of historical variables such as the number of beds, the quotas of hospitalisation days and the occupancy rate. Unfortunately, these budgets which are based on historic staff numbers have not been re-evaluated in the past 50 years and the fixed day price therefore remains unchanged.
- Whenever examinations have to be set up off-site of the PH, the logistics and cost of transport and personnel time are a logistical and financial burden. The broader network and the

geographical location of the PH defines which medical tests are easily provided on admission. Globally, there is a lack of standard of care in the organisation of somatic health care for patients with SMI leading to a high variability of the quality of somatic health care provided.

- PNH and SHI fall under the jurisdiction of the regional governments since 2018. The regions are responsible for the organisation of health care for non-admitted and admitted persons to a 'care' institute/hospital except for the constitutional legislation, the NIHDl, and the residual health policy items such as medication, medical appliances, patient rights, the rules on practicing health professionals. In SHI there are several household and associated costs that are not covered by the health insurance, in addition to the honorarias, medication, transport etc.
- In residential settings, the psychiatric care of the patient is organised through the coordinating psychiatrist, who has limited time and skills to coordinate somatic follow-up for the patients. The somatic healthcare aspects are thus referred to local GPs, who have to deal with somatically complex patients. So, in practice, a better somatic medical coordination of the residential structures is clearly needed. In all settings, preventive aspects are often neglected and the psychiatrist and somatic healthcare problems may therefore be diagnosed at a late stage.



3.1 Aim and Methods

In this section we looked at the organisation of somatic health care for the person with SMI and aimed to answer the following questions:

- Who is responsible for somatic health care?
- Who is performing what type of somatic health care?
- What is the regulation or legislation affecting the organisation of somatic health care?
- How are financing aspects influencing somatic health care?

and this for the mental healthcare service settings:

- Psychiatric service of a general hospital
- Psychiatric hospital
- Psychiatric nursing home
- Sheltered housing initiative

The information and background to answer these questions were sought through interviews with stakeholders and on websites. Several organisations and legal bodies were contacted by mail. This resulted in 4 interviews, yielded between July and October 2019 by KCE experts (Appendix 1.2). Additional information was provided by the experts via mail and during the expert meeting on January 12th 2021 (Appendix 1.2). The general description of the four settings is further based on: the findings of previous KCE reports and the report 'Organisation and financing of mental healthcare in Belgium'; and websites from Governmental bodies and committees, insurance bodies, legislative publications, and websites and publications of care networks were screened to retrieve more recent information.^{87, 88}

This chapter is structured as follows. The first part gives an overall description of the four settings. Then, the next parts describe the legislation, the organisation and the financing of somatic health care, with a comparison between the four settings. Finally, the costs for the patient are described.

To provide context to the chapter we summarised the reforms that took place in recent years in Belgian mental health care.⁸⁹ First, psychiatric beds were reconverted to living accommodation outside the psychiatric hospitals offering appropriate care to patients with chronic mental health problems i.e. psychiatric nursing homes and sheltered housing initiatives. The second reform wave endorsed additional reconversions of hospital beds to psychiatric nursing homes and sheltered housing initiatives. Per thousand inhabitants 0.6 beds were planned for the psychiatric nursing home and 0.5 places for sheltered housing initiatives. This second wave initiated a voluntary reconversion of "classic psychiatric beds" to PNH and SHI beds, in order to promote and enhance specialisation, transmurality and to increase the capacity of chronic psychiatric care. Moreover, several semi-ambulatory structures were set up, such as day centres, day hospitalisation, and night hospitalisation.

Next, mental health care was tailored to networks providing patient centred and **integrated care**, directed to the patient at the personal living environment. In practice, psychiatric home care teams, activation projects to get back to work, initiatives to provide counselling and the discharge management in psychiatric hospitals were set up. Most of these projects were conducted in the so-called "therapeutic projects".

In 2010, the next step of the reorganisation of mental health in Belgium was initiated by launching the Article 107 projects. These Art. 107 projects replaced the concept of the "therapeutic projects" and aimed at further implementing a community based approach of mental health care. Beds in psychiatric hospitals were 'frozen' and the deliberated budget and resources were transferred to the created art 107 networks to realise several functions (promotion, prevention, early-detection...) and especially the further development and creation of mobile teams. With the Art. 107 projects, the government aimed to orient mental health care towards a progressive reduction of residential hospital care in favour of recovery and reintegration, and to provide/embed mental health care in the community.

Finally, the first of July 2014, following the 6th institutional state reform in Belgium, a broad range of responsibilities, including the responsibilities for PNH and SHI were transferred to the federated authorities. Psychiatric hospitals and in-hospital psychiatric departments in general hospitals were still subject to the specific hospital legislation, a federal responsibility.



Furthermore, the price agreements and conventions (collectively fixed tariffs within the NIHD between sickness/health funds and the representative organisations of health professionals) were also transferred from the federal level to the federated communities/regions.

3.2 Global description of the four settings

In Belgium, patients with a mental condition can be treated, supported, followed and housed in several settings. This study included four of them, which are described below.

3.2.1 Psychiatric services in general hospitals

Psychiatric services in general hospitals provide short-term hospitalisation for **assessment and treatment** of patients who suffer from acute and severe mental illness e.g. major depressive disorders, schizophrenia, psychotic episodes, and alcohol or drug addiction. During their hospitalisation, the patients benefit from multidisciplinary health care and input, including contacts with psychiatrists, psychologists, social assistants, occupational therapists, and (psychiatric) nurses. General hospitals reserve approximately 10% of their beds for psychiatric day care and/or night care. The perceived advantages of these services are the lower threshold for consultation at a 'general hospital' compared to a 'psychiatric hospital', sometimes described as destigmatising, the immediate accessibility of somatic care in the mental healthcare environment and vice-versa (trend towards liaison psychiatry), and the 'short stay' treatment vision which shifts the focus to early ambulatory care.⁸⁷

The different types of hospitalisation services are grouped according to whether they are more acute/chronic or more somatic/psychic in nature; "acute" beds (for short stays, i.e. stays that do not require long-term treatment), "chronic" beds (for longer-term hospitalisations or for patients requiring chronic treatment), and "psychiatric" beds, intended for health care (only during the day or at night) of patients with mental disorders (observation and neuropsychiatric treatment) for adults (index A, A1, A2, T

and T1) or for children (index K, K1 and K2).⁹⁰ In 2019, among the 52 565 accredited hospital beds in Belgium, there were 3995 psychiatric beds. De mean length of stay for a patient in this setting was 25 days for 2018.^f

3.2.2 Psychiatric hospitals

Psychiatric hospitals provide **assessment and treatment** for patients with an acute or severe mental illness. Besides full-time hospitalisation for all patients regardless of their age, a PH can also offer ambulatory treatment, day- and night care. In this case the patient is still considered as 'admitted' from a legal and financial perspective. Multidisciplinary teams (psychiatrist, psychologist, occupational therapist, (psychiatric) nurse, social worker ...) within one or more specialised service offer the most appropriate therapy to the problem the patient encounters. The adult patient is admitted under one of several options (cumulating is not allowed):

- Day and night hospitalisation for neuropsychiatric observation and treatment (index A): treatment of adult individuals (15 years and older) who require either emergency intervention in case of a crisis, or observation or active treatment, during the day (A1) or at night (A2).
- Day and night hospitalisation for neuropsychiatric treatment (index T): treatment of adults (15 years and older) focused on maximum social rehabilitation activities during the day (T1) or at night (T2).
- Intensive treatment of psychiatric patients, index IB: specialised services with beds for intensive treatment of psychiatric young (less than 18 years) and adult patients with a greatly disturbed behaviour.
- Psychogeriatric Service, index SP: specialised service for the treatment and rehabilitation of patients with psycho-geriatric disorders.
- Psychiatric foster care, index TFB: care for patients whose psychological and social balance can only be maintained if permanent care is provided.

^f Team data and strategic analysis, SPF



- Day and night care for geriatric patients, index Tg: day and night beds for geriatric patients requiring neuro-psychiatric treatment.⁸⁹

In September 2017, PH had 14 927 recognised beds (10 012 in Flanders, 4 085 in Wallonia and 830 beds in Brussels). The majority of beds were T-beds (42.7%) and A-beds (40.5%).⁸⁷ The mean length of stay for a patient in this setting was 100 days for 2018.⁹

3.2.3 Psychiatric nursing homes

Psychiatric nursing homes are collective living facilities for adult patients of all ages with a stable chronic mental disorder or mental disability.^h They appeared in 1990 (AR 10/07/1990) and were created to shorten the stay in psychiatric hospital and / or to avoid it. Patients housed in these structures no longer require acute treatment in the hospital. However, they are unable to live independently in the community or in other living communities (e.g. sheltered housing initiatives, nursing homes for older persons). The person needs permanent supervision. This supervision is provided by a multidisciplinary team (psychiatrist, nurses, physiotherapist, occupational therapists, educators, social workers, speech therapists, psychologists, etc.). The overall care is more supportive and medicalised compared to sheltered housing initiatives (see below) but less so when compared to a hospital setting. The autonomy and the rehabilitation of the patients are encouraged by various activities (speech therapy, occupational therapy, cooking, sewing, travel, shows, cultural visits, sports, creative workshops, therapeutic groups, etc.).

In May 2017, there were 1896 places in Flanders, 818 in Wallonia (including 30 in the German speaking community) and 229 in the Brussels region. The mean stay for patients in this setting was 3.5 years for Wallonia in 2018.ⁱ

The PNH admission procedure follows several admission criteria to ensure the continuity of recovery-oriented support both during the stay and afterwards, while respecting the freedom of choice of the resident. Each

resident should have a care plan that includes: a statement of care needs, the preferences of the resident, the objectives with prioritisation to be achieved through support, and this in the form of actions and care activities. PNH have a clear discharge policy for its residents. Whenever a resident is discharged, a letter is written and accompanied by a report describing the care and support the resident received during the stay.

3.2.4 Sheltered housing initiatives

Sheltered housing initiatives provide support for adults who do not need or no longer need continuous treatment in a hospital but who, for psychiatric reasons, need help in their living environment for the acquisition of social skills. The main aim is to support people with mental health problems to live as independently as possible.⁹¹ The patients are supported by a multidisciplinary team and each patient is assigned an accompanying person (or coach). These persons are not constantly present at the home of the care user. During the day, the residents have a daytime activity, some go to day activity centres, other follow treatment in a psychiatric hospital, receive training, go to work or do voluntary work. Similar as in PNH, an admission procedure is standard to ensure a support plan and care plan. Housing is sometimes provided but this is not obligatory. For example, residents can have the following types of living arrangements:

- Housing from the SHI:
 - Collective: 3 to 10 people share a home with both common and private spaces
 - Individual studio or flat
- Private housing:
 - Rented by the patient

^g Team data and strategic analysis, FPS

^h <https://www.health.belgium.be/en/health/taking-care-yourself/patient-related-themes/cross-border-health-care/healthcare-facility-3>

ⁱ AVIQ data 2018



- Owned by the patient

SHI are constituted as non-profit organisations and have to be dependent of a PH or a PSGH (hospital sector) and a mental healthcare centre (ambulatory sector-mental health services). According to the terms of the 26th June 1990 Act, it must be administered jointly, at least, by representatives of the hospital sector and the ambulatory sector. The mission of the SHI is to provide a program of psychosocial rehabilitation, administrative and financial guidance, in cooperation with the network, with a view to optimal social and residential autonomy. The team is multidisciplinary; psychologists, social workers, nurses, physiotherapists often compose the supervising staff. SHI provide the recovery-oriented support with accompanying persons (or coaches) not constantly being present at the home of the care user. The support aims are: maintaining skills, the acquisition of additional skills, foresee proper living environment, and this based on the care needs of the resident.

There is no standard model of SHI; each one works quite specific depending on the geographical environment and the presence of day hospitals nearby. There is always a partnership with a hospital and a mental health service in order to promote the links between the residential and the ambulatory sectors. Two third of SHI residents are referred by a psychiatric hospital and one third by front-line services (general practitioners, private psychiatrists, social services, family ...).

In May 2017, the number of recognised institutions in Flanders, Wallonia and Brussels amounted to 43 facilities (2 899 beds), 27 facilities (798 beds) and 18 facilities (560 beds), respectively. The mean stay for patients in this setting was 2 years for Wallonia in 2018.^j

3.2.5 Other services not included in the report

Internment

Internment or internee concept requires three main elements to be appropriately used: the person has committed a crime needing detention; the person presents mental health problems during the judgement impairing his ability to decide; and there is a risk of recurrence of crimes. The usual place for internment is in a social defence institute (Etablissement de Défense Sociale-EDS – Inrichting tot Bescherming van de Maatschappij - IBM), in a centre of forensic psychiatry (Forensisch Psychiatrisch centrum - centre de psychiatrie légale), or in secured psychiatric hospitals. However, a part of the interneers are detained in psychiatric annexes of prisons. In Belgium, only a few centres provide this type of residential psychiatric care. We have not discussed this setting in the report as it was excluded from the scope of the study.

Mobile teams

Mobile teams were introduced during the mental health reform from 2010 onwards. These teams often work in close collaboration with acute services and emergencies. The interventions are delivered to a patient after discharge at home or when temporarily at home, still under a hospitalised status, in order to prepare for full discharge. As a result, a different nomenclature code exists when they visit a medical doctor. Mobile teams are increasingly being used in mental health care. The team consists of a multidisciplinary team of specialists such as nurses, social workers, psychologists, paramedics and a psychiatrist but their interventions are often limited to the psychiatric illness.¹⁹ This may be explained by the profile of the team members in the mobile team representing low skills on somatic issues or due to time constraints. They visit the patient several times a week, or even several times a day if necessary. Treatment time is limited to about three weeks. After that, a more long-term solution will be sought. Team 2a focuses mainly on crisis intervention and stabilisation. Team 2b also focuses on rehabilitation and recovery. After a hospital admission, or after an intervention by the 2a team, the patient can be monitored by the 2b team.

^j AVIQ data 2018



The operation of the mobile teams is still relatively young in the Belgian mental health sector and may differ from region to region.

We have not discussed this setting in the report as it was excluded from the scope of the study. Nevertheless, the experts stressed that mobile teams are important for a holistic set up of care for the patient, addressing the integration of primary and secondary care.

3.3 Belgian legislation applicable to somatic health care for persons with SMI

The general Belgian hospital law applies to the psychiatric hospital settings.⁹² A recent national coordination document dated November 2018, describes the hospital legislation.⁹² An agreement between the NIHDI, psychiatric hospitals and services and the sickness funds (health insurance) was installed in 2018.⁹³ The norms for the overall care of a psychiatric patient 'admitted' to a hospital are set by federal law as 'to provide the most optimal **assessment and treatment**'. For a psychiatric resident living in a PNH, federal law states that **support** should maintain the level of functioning of the resident as high as possible whereas a client in a SHI should be **supported** to live with as much social and residential autonomy as possible. The different focus of assessment and treatment versus support defines who has the final responsibility for the somatic health care of the patient and influences how this health care is organised within the four settings.

In short, current Belgian law defines that the focus of a PH and PSGH is on care. This is different from the focus of PNH and SHI where supervision of daily living activities and support to maintain functioning is the core and less

so psychiatric or somatic care. These characteristics are reflected in the type of personnel and support that is offered.

PNH and SHI fall under the jurisdiction of the regional governments since 2018 (originally agreed in 2014).^k A description of the rules, expectations and quality for the care exists for Flanders^l. General information with a list of all the existing centres is available for Wallonia only^m. The B2 content / spending is defined by norms only on a federal level. No specifications of the number of staff with a specific education is required. A certain number of full time equivalents has to be employed on this budget. Next, the quality of the care is evaluated on a regional level e.g. a certain number of nursing care staff per patient number has to be present / 24hours. The standards have to be met before services are recognised and can qualify for government funding.ⁿ

The regions are responsible for the organisation of health care for non-admitted and admitted persons to a 'care' institute/hospital except for the constitutional laws ('organieke' legislation), the NIHDI, and the residual health policy items such as medication, medical appliances, patient rights, the rules on practicing health professionals. This is specified in the **Belgian constitution** in the following articles that relate to healthcare.⁹⁴

- Article 127: The regions organise by decree 'education' (except minimal requirements for awarding diploma)
- Article 128: Aspects related to 'persons' (persoonsgebonden aangelegenheden) are organised by decree by the regions individually

^k http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&table_name=loi&cn=1990071030 and http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&table_name=loi&cn=1990071038

^l Agentschap zorg en gezondheid: Psychiatrische verzorgingstehuizen. Available on: <https://www.zorg-en-gezondheid.be/psychiatrische-verzorgingstehuizen> and Overnamedecreet van 6 juli 2018 en

uitvoeringsbesluit met bijlagen. Available on: <https://www.zorg-en-gezondheid.be/overnamedecreet-van-6-juli-2018-en-uitvoeringsbesluit-met-bijlagen>

^m <http://sante.wallonie.be/?q=sante/soins-hospitaliers/dispositifs/etablissements-psychiatriques>

ⁿ <https://www.health.belgium.be/en/health/taking-care-yourself/patient-related-themes/cross-border-health-care/healthcare-facility-3>



Each setting can set its own criteria to answer to the federal norms and regional regulation of norms and requirements. The NIHDI conventions regulate the honoraria of psychiatrists and of some medical personnel.

Importantly, nomenclature codes for GPs are not accessible for hospitalised patients. The GP nomenclature codes are to be used for patients in PNH and SHI.

3.4 Organisation of somatic health care for persons with SMI

3.4.1 *In hospital settings*

Who is responsible for somatic health care?

The treating doctor at the hospital is responsible for all health care of the psychiatric patient including somatic health care.

In a PSGH setting, specialists for all disciplines are located in the same building and therefore a psychiatrist's referral for a consultation with a specialist should logistically not cause a problem.

In a PH, the access to a GP or specialists is less evident. Historically, patients in a PH were considered as 'ambulant' for all somatic health related consultations and acts. GPs are structurally not part of a PH. At some PH some this has been tried and set-up however (see described below). In general the patient has to be referred to the GP or to a general hospital for a consultation with a specialist. The logistics and cost of transport and personnel time, often needed to accompany the patient, are a burden. The somatic health care inclusive preventive aspects, are often not a priority for the patient and the psychiatrist and somatic healthcare problems may be diagnosed at a late stage. In some cases, as a result, an acute health problem may develop and the patient may end up at the emergency department. The emotional and financial costs of this happening can be high.

At some PH, the psychiatrists pro-actively involve GPs and specialists to take care of the somatic health of the patients on a regular basis. The setting up of a contract between the PH and the GPs allows better follow-up of the "somatic health" of the patient. The final responsibility stays with the psychiatrist who delegated the care to the GP. For example at one PH each admitted patient is assigned to a GP who is involved at the following levels:

- At admission, each patient will see a GP and perform routine medical tests (radiology chest, laboratory tests, electrocardiogram (ECG)...))
- Afterwards, the GP follows up the results and the continuity of care during his planned weekly visit schedule. The GP is responsible for the follow-up of the patient including starting treatment (e.g. diabetes), taking into account the side effects of drugs, planning and organising vaccines, screening activities (prostate cancer, cervical cancer...), and providing prevention advice and treatment according to the risk factors of the patient (alcohol, tobacco, age, obesity ...)
- An on call system of GPs of the geographical area includes the patients at the PH, meaning that the medical permanence includes a psychiatrist and a GP.

Similar to engaging GPs, specialists can be attracted to perform consultations at a regular frequency at the PH. Unfortunately, the remuneration for this is very limited.

What concerns the medical investigations e.g. tests, or treatments for a patient in a PH, they are mostly prescribed by the psychiatrist. The psychiatrists can prescribe following the nomenclature for somatic conditions for a 'hospital setting'. Restrictions exists e.g. a psychiatrist in a PH and PSGH is, firstly, never allowed to prescribe a treatment for speech therapy (which may be needed for patients when their speech or swallowing is affected e.g. by psychiatric medication), and secondly, only allowed to prescribe physiotherapy for the psychiatric condition.^o

^o <https://www.riziv.fgov.be/nl/professionals/verzorgingsinstellingen/ziekenhuizen/Paginas/omzendbrieven-psychiatrisch-ziekenhuis.aspx> see letter 2005/06



As a result, a consultation with a GP has to be organised to access the ambulant nomenclature prescriptions.

As a result of all the above aspects, the organisation of somatic health care decided on a local level results in variability of the quality of somatic health care. No defined standard of care exists.

Where are medical tests performed?

Generally, patients have to access a general hospital for their medical tests (radiology, ECG, bicycle ergometer ...) or to see a specialist (dentist, ophthalmologist...). In this situation, transportation cost are paid by the patients with the exception, for chemotherapy, radiation therapy and dialysis^P. Although for these exceptions a (variable) fee is reimbursed, the paperwork is time consuming. Some PH benefit from a medical technology centre which allows to perform all necessary tests on the premises at admission and while hospitalised. The costs to run these centres are nevertheless high and not always sustainable. On the other hand, agreements between hospitals making up networks e.g. CHwapi, EPICURA, permit to recover test results from previously performed medical tests. This type of network organisation allows for a better follow-up of the patients.

3.4.2 In residential settings^Q

Somatic health care responsibility

The PNH has one or more **coordinating and treating specialist in psychiatry or neuropsychiatry**, who is responsible for the medical and psychiatric treatment and coordination of admitted care users. The psychiatrist works at least six hours a week (for all patients) to fulfil these responsibilities. The precise number of hours depends on the number of care users and is fixed in the collaboration agreement between the PNH and the psychiatrist. The psychiatrist liaises with the team during team meetings taking place at regular intervals. The somatic health care aspects are referred to local GPs. The somatic profile of PNH patients is particularly heavy due to the presence of chronic and entrenched psychiatric disorders

and the older age of the patient. Although the patient can choose his GP, as in a general nursing home, the PNH needs a coordination of somatic care which the coordinating psychiatrist can't offer, and therefore one or more GPs are taking care of all patients.

The psychiatric care of the patient at a SHI is organised through a **coordinating specialist in psychiatry or neuropsychiatry** who has to be present at least three hours a week at the SHI. Similarly to PNH, the SHI have a multidisciplinary team under the direction of a coordinator. However, only one full-time equivalent staff member, including the coordinator, is foreseen for a group of eight residents. They include the following disciplines: health care and medicine, socio-educational work, psychology and educational sciences, social sciences, physiotherapy and functional rehabilitation. For the somatic care aspects, **each resident at an SHI should have a GP or has to be linked to a medical practice**. The SHI team will guide the resident to the correct somatic health care but care is not provided by the team. The social skills that can help the resident to improve their somatic health cover many aspects of life, including how to care better for somatic health; this can include organise personal follow-up consultations including transport and planning, scheduling of pill taking, health eating and exercise aspects etc. The somatic health care is under the responsibility of the GP but regular follow-up of chronic problems e.g. diabetes, bronchitis, smoking is often difficult and not happening. Often the repeat prescriptions are automatically provided by the pharmacist and organised by a nurse visiting the patient at the SHI. Prevention aspects of somatic health care are often neglected although residents are exposed to high risk factors such as smoking, poor eating habits, and low physical mobility.

The role of multidisciplinary teams

As mentioned in the Decree of 7th December 2018, the PNH have a **multidisciplinary team** under the direction of a coordinator with leadership and management skills. Apart from the coordinator, the staff capacity is set at a minimum of 13 full-time equivalents for 30 care users, of whom a

^P artikel 95 van het KB van 10-07-2008; coördinatie van de ziekenhuiswet

^Q http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&table_name=loi&cn=2018120730



maximum of five full-time equivalents are nursing assistants and a minimum of eight full-time equivalents have one of the following qualifications: nurse (preferably psychiatric nurse), social worker, clinical educational psychologist, occupational therapist, psychologist, physiotherapist or educator. This support team should guarantee a multidisciplinary approach for each patient with, among other things, psycho-educational and psychosocial interventions. Through the interviews it appeared that the teams of SHI are too small or have limited time to guarantee the necessary support for residents. Moreover, the infrequent presence of the psychiatrist hampers good communication within the team. This can mean that the follow-up of the resident's mental illness is less intense and psychiatrists mostly manage an eventual crisis.

3.5 Financing and cost of somatic health care of persons with SMI

3.5.1 In hospital settings

Global financing

The financing of general and psychiatric hospitals follow similar rules (as well as patient's contribution).

The aim of this section is therefore to describe the main characteristics of their financing, with a focus on PSGH and PH specificities.

For both general and psychiatric hospitals, a dual financing system has been established:

- A national hospital budget covering nursing and non-medical activities, called the Financial Resources Budget (FRB, *Budget des moyens financiers / Het Budget Financiële Middelen*).^r
- Fees and flat rates for medical activities: Medical and medico-technical acts (consultations, laboratories, medical imaging and technical

procedures) and paramedical activities (physiotherapy) are mainly paid via a fee-for-service system to the service provider. It should also be noted that to counter potential over-consumption, a mixed system (Fee-For services and flat-rate) has been introduced for medical imaging and clinical biology.

Together, these two remuneration systems account for almost 80% of a hospital's turnover. Hospitals receive additional funding from:

- Outpatient and inpatient sale of pharmaceuticals and assimilated products.
- Lump sums for specific ambulatory activities, such as day care, dialysis and rehabilitation;
- Extra-billings charged to patients for single rooms;
- Non-hospital activities, such as commercial operations, cafeteria, newspaper shop;
- Private legacy or corporate grants.

The Financial Resources Budget (FRB), for nursing and non-medical activities

The FRB is a national close-ended budget fixed annually to cover nursing and non-medical activities and is allocated to individual hospitals according to a large set of criteria and parameters. The FRB setting and allocation rules to individual hospitals are described in the royal decree of 25 April 2002.⁹⁵ The PH have a separate budget within the global FRB (in 2018, the global FRB was 7.801.594.869€, of which 1.248.255.179€ (16%) was for PH).^s

The FRB is composed of 3 parts: (A) capital and investment costs, (B) operational costs, and (C) some corrections (positive or negative) for past financial years. Each part is further divided into sub-parts.

^r <https://www.healthybelgium.be/en/key-data-in-healthcare/general-hospitals/financing-of-general-hospitals/financial-resources-budget>

^s https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/tabel_nl_2018.pdf



The part A of the FRB covers capital and investments costs in infrastructure, building, furniture and heavy medical equipment. Since the 6th State reform, most of this budget has been transferred to Federated entities (except the costs of short-term credits, i.e. the sub-part A2).

Operational costs are covered by the part B of the FRB. The two main sub-parts are the sub-part B1, covering common operational costs (administration, maintenance, laundry, etc.) and the sub-part B2 covering clinical operational costs (nursing and care personnel and medical equipment), mainly allocated to hospitals based on the number of 'justified' beds, depending on the 'justified activities' in each service. The services concerned by the calculation of the so-called 'justified' activities (which focus on the pathology-weighted length of stay) are medical, surgery, geriatrics, maternity and paediatrics services.

The concept of justified activities nevertheless does not apply to PH or PSGH. For PH and PSGH, the sub-part B2 is allocated based on a number of historical variables such as the number of recognised beds, the quotas of hospitalisation days and the occupancy rate.⁸⁸ Since the calculation is mainly based on the indexation of historical amounts (that are judged as no more appropriate by experts interviewed in this report), the annual changes in the FRB for a psychiatric hospital is mainly explained by the application of the index. The remainder part of the change is mainly explained by catch-up amounts (positive or negative) and other adjustments such as the financing of pilot projects and other specific financings (sub-part B4), end-of-career measures and social agreements. Indeed, it should be noted that in the sub-part B4, specific financing concerned psychiatric projects, i.e. psychiatric consultation platforms, registration of minimum psychiatric data in psychiatric care homes, additional staff in neuropsychiatry, improvement of the quality of care in psychiatric hospitals, and psychiatric pilot studies on behavioural disorders.

Since 2002, the payment of the FRB to individual hospitals consists of:

- a fixed part (theoretically 80% of the sub-parts B1 and B2 and 100% of all other parts), paid on the basis of monthly advances called 'provisional twelfths';

- a variable part (theoretically for 20% of the sub-parts B1 and B2) paid according to the number of admissions, i.e. which is a hospital- specific fixed payment per admission (theoretically 10%), and the number of nursing days, i.e. which is a hospital- specific fixed payment per day (theoretically 10%).

Medical and medico-technical activities: Fee-For services (FFS) and mixed systems (flat rate and FFS)

Medical and medico-technical acts and paramedical activities are mainly paid via a Fee-For-Service system to the service provider. All reimbursed acts are described in the nationally established fee schedule, called the nomenclature (*nomenclature/nomenclatuur*), which specifies the official fees, cost-sharing mechanisms (i.e. the share reimbursed by the sickness funds and the patient contribution), and reimbursement conditions. For hospitalised patients, extra-billings (*ereloon*supplementen / supplement d'honoraire) can also be asked on top of these national fees if the patient asks for a single room (with some exceptions).

The possible remunerations systems for physicians working in hospitals are various (e.g. salary, contractual regulated percentage on the FFS or on the pool of FFS) but whatever the remuneration system, a central collection of all fees for medical, medico-technical, and paramedical acts is compulsory for all hospitalised patients and a share of these fees is ceded to the hospital ('system of retrocession') to pay for (part of) the costs directly or indirectly linked to the provision of medical activities (for hospital space, equipment, personnel). The amount and mechanisms of health care providers paying for these costs differ between hospitals and specialities. On a macro level, it has been estimated that approximately 42% of physician fees is transferred to the hospital; but large differences exist between hospitals and between medical disciplines.⁹⁶ Given this retrocession system, a distinction must therefore be made between the 'gross' fees (as invoiced to the sickness funds and patients) and the 'net' fees, i.e. the part of the fees that ultimately goes to the healthcare provider.

Not all medical and medico-technical acts are reimbursed on a FFS basis. To counter potential over-consumption, a mixed system (FFS and flat-rate) has for example been introduced for medical imaging and clinical biology.



A surveillance fee per diem has also been introduced for hospitalised patients. This surveillance fee covers visits by all doctors involved in this surveillance and varies according to the type of bed index and the length of stay (decreasing with the number of days; see example in Appendix 3.1). The payment of surveillance fees excludes any possibility of reimbursing fees for consultations, visits or advices provided for in Chapter II of the national fee schedule, whether they take place outside or inside the hospital. A specific fee is nevertheless for example foreseen for GPs who visit patients in a psychiatric hospital (if requested by the hospital physician specialised in psychiatry) (nomenclature codes 109045, 109060 and 109082) but such a reimbursement is limited to 2 per month and 12 per year.

The nomenclature clearly describes what can be invoiced and which fees can be combined or not. It can for example be noted that if some technical acts (described in the article 20, § 1er, f and fter of the nomenclature) are performed by another physicians (and invoiced at 100%), the surveillance fee is only reimbursed at 50%.

Somatic healthcare costs

According to experts interviewed during this report, somatic care in psychiatric hospitals are not enough covered by the national fee schedule (*nomenclature/nomenclatuur*). The cumulating rules are very strict and the reimbursement of somatic care are usually limited to some technical acts and advices. According to experts, only one specialist consultation a month for a certain set of specialties and paid at only 50% of the usual reimbursement rate is allowed.

It should also be noted that the need for somatic care are increasing with time (their chronic problems usually increase with time), while the surveillance fee that must cover most physicians visits is decreasing. The gap in the financing of somatic care is therefore also increasing with time, which is especially a problem in psychiatric hospitals, where the stays are usually long.

Another difficulties for psychiatric hospitals highlighted by experts is the difficulties to attract medical specialists and GPs for somatic care because these visits would be financially less attractive than in other settings. Additionally, the nomenclature for example only allows for 2 GPs visits per month and 12 per years, which is considered by experts as not enough

considering the needs of these patients. They highlighted it was not realistic for GPs to deal with complex cases when they can only attend on an infrequent basis.

The fact that coordination of care (including the coordination of somatic care) is expected to be covered by the surveillance fee was also criticised. These problems were yet more pronounced during the COVID-19 pandemic.

Furthermore, other activities have to be set up e.g. prevention and screening (especially for long-term stays).

According to experts, only 20-50% of the acts needed for their patients can be invoiced and hospitals are using creative ways to pay for them, such as via the system of retrocessions, increasing tensions between psychiatrists, GPs and other medical specialists. For example, in one interviewed PH, 17% of the pool was devoted to 75% of the medical interventions which were all related to somatic health care.

3.5.2 In residential settings

Global financing

The successive state reform operations and the resultant change in responsibilities regarding health care have significantly influenced mental health policy in Belgium, increased the complexity of the system and directly influenced the financing of healthcare. While the federal level remains responsible for the financing of general and psychiatric hospitals, the most recent 6th institutional state reform transferred responsibilities related to PNH and SHI from federal to federated entities. During a transition period (from July 1st, 2014 to December 31st, 2018), the NIHDI continued to execute these regulations but in the name and on behalf of the federated entities. The old NIHDI regulation for PNH and SHI were therefore applied until the end of December 2018. The following federated entities are presently responsible for the funding and organisation of PNH and SHI:



- For the Flemish Community: 'Agentschap zorg en gezondheid' (<https://www.zorg-en-gezondheid.be>);
- For the French Community (Fédération Wallonie-Bruxelles): 'Agence wallonne de la santé, de la protection sociale, du handicap et des familles' (AVIQ, <https://www.aviq.be>);
- For the Brussels-Capital Region: Iriscare (<http://www.iriscare.brussels/fr/iriscare-fr>);
- For the German-speaking Community: Ostbelgien (<http://www.ostbelgienlive.be>).

For example, the resident pays 41.38€ per day (price since Q4 2013) for the stay in a PNH bed (regional government regulation). These costs are reduced by a state intervention depending on the category of the patient (Appendix 3.2).⁹⁷ The federated authorities can also provide funds for infrastructure. Each resident of a PNH has a minimum monthly amount of 192.43€ as pocket money exclusively for personal purposes.

In SHI, support by staff members is funded by the healthcare insurance. A shortage of qualified personnel at PNH and SHI was described in the interviews. This may be due to a shortage of graduates, differing salary scales across the settings for the same level of expertise e.g. master in nursing or psychiatric nurse, and the workload that is experienced to be heavier.

What is included or excluded for somatic healthcare costs?

Similar as for the psychiatric hospitals, the coordinating psychiatrist has to organise somatic health care but has limited time and skills. Similarly, the healthcare team designed for psychiatric follow-up has to deal with a somatically complex patient. So, in practice, the GPs of the patients are summoned in. The somatic health care therefore is mostly provided by one or more external GPs, prescriptions are following the nomenclature of the GP, and the costs incurred are for the patient. Experts explained that for

long-term follow-up of patients a structurally organised somatic medical coordination of the PNH is clearly needed.

Examples for the healthcare cost in PNH from the regions

The healthcare costs, for those in order with their health insurance, are covered by the regional Agency for Care and Health. This contribution covers, among other things:

- The supervision and care provided by all supervisors working at the PNH (supervisors of the living groups, social services, responsible day care, psychologist, team coordinator, etc.).
- The medical care provided by the coordinating psychiatrist and the attending psychiatrist.
- Physiotherapy and speech therapy services provided by care providers authorised to do so, with the exception of physiotherapy services not forming part of the psychiatric treatment and which are prescribed by an attending physician, other than the coordinating and attending psychiatrist.
- Accommodation and living expenses

The housing and living costs are at the patient's expense. The Agency for Care and Health determines the amount of these living and accommodation costs (per day of admission), which is adjusted on a regular basis. These costs include the following: infrastructure, food, maintenance, energy, reception, bed and bath linen and their maintenance and administration. In order to guarantee affordability for the residents, the Agency for Care and Health bears an additional part of these living and accommodation costs, taking into account the individual profile and the available information on the insurance status and income. For the payment the PNH usually draws up a monthly invoice. Costs that are not included are: the purchase, maintenance and repair of clothing and personal laundry, shoes, **glasses and prostheses**, a **fixed daily fee for medication**, the costs of insurances,

^t http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=nl&la=N&table_name=wet&cn=2018120730



transport, any reimbursement of the administrator, **consultations with the GP**, hairdresser, **pedicure** and other personal expenses, such as smoking accessories, extra food products of own preference outside the PNH's offer, participation in activities outside the PNH/vacation, etc.

The fixed daily fee for medication at € 1.2 per day provides for medication for which reimbursement is provided by the health insurance. The NIHDI pays a lump sum to cover healthcare services (staff salary according to the established norms for the minimum personnel availability) and the help required to provide support for the activities of the daily living. To keep the transport costs e.g. visits to the hospital or GP low, the cheapest means of transport are used; often a free service is available to and from the local hospital. Finally, a collective insurance against physical accidents may be organised e.g. 0.02€ per day.

According to the law, PNH must be independent from the hospital. In practice, PNH are often attached geographically to a hospital to reduce costs. As such, the somatic health care is financed partially by a hospital, although patients are most of the time considered as outpatient. For example, psychiatric physiotherapy is included in the day price while consulting a physiotherapist for a somatic complaint is considered an external prescription. The GP has to be consulted for this.

Example for costs in SHI from the regions

The accompaniment is financed by the health insurance of the patient through the federated entities. The resident does not have to pay a personal contribution, so this guidance is free of charge. In Flanders, each resident has a personal coach providing the accompaniment. In the Brussels and Wallonia region, a multidisciplinary team, in collaboration with a psychiatrist, provides permanent or occasional counselling, depending on the situation. This specialised team provides support in various aspects of everyday life, including administrative and domestic matters. Residents in group housing pay a subsistence allowance to the sheltered housing initiative. This allowance is variable and may include costs for energy consumption, as well as digital television and internet. Joint purchases may be made for communal meals and maintenance of the house. The occupant contributes to the household for this purpose. In individual sheltered housing, the occupant is responsible for his own household and the associated costs.

To be able to finance the living costs, residents should have a fixed income. SHI residents only receive 70€ a week to cover these expenses, which is very low. The financial barriers for residents to live healthily can be high as a result.

It is common for residents to have to adhere to rules such as, taking care of the responsibility for self-care and the use of medication, to choose a GP and psychiatrist who is responsible for the medical-psychiatric follow-up. **Somatic health care is not part of the SHI support** offered and the medical care aspects that are not part of the SHI support are medication, fees for general practitioner or psychiatrist, services provided by home nursing or home care services, etc. All the costs have to be paid for separately by the resident to the care provider. Participation in leisure activities, food, and sports activities etc. are always at the expense of the resident.



3.6 Summary of characteristics of the four settings

The following table summarises some of the characteristics that are related to the organisation of somatic health care for the patient with SMI.

Table 10 – Organisation of somatic health care for persons with a SMI: Summary*

	Psychiatric service general hospital	Psychiatric hospital	Psychiatric nursing home	Sheltered housing initiative
General description				
Objective	Short term assessment and treatment by the multidisciplinary team (psychiatrists, psychologists, psychiatric nurses, etc.)	Assessment and treatment by the multidisciplinary team (psychiatrists, psychologists, psychiatric nurses, etc.)	Supervision by multidisciplinary team for persons with a stable chronic mental disorder or mental disability	Support for adults who do not need or no longer need continuous treatment in a hospital but who, for psychiatric reasons, need help in their living environment
Somatic care				
Somatic care provided?	Multidisciplinary health care, including contacts with specialists, social assistants, occupational therapists	High variability between hospitals	Overall care less medicalised	None
Person taking care of somatic care?	Specialists at the hospital	2 main situations: ➤ Patients' GP, other GP or specialist from general hospital (requires logistics, transportation, guiding staff...) ➤ Salaried GP or specialists (who visit patients on a regular basis) but with prescribing limitations due to nomenclature	The coordinating psychiatrist of the PNH (who is responsible for the medical and psychiatric care) but care is delegated to GP of the patient or a limited number of GPs for reasons of coordination	The GP of the patient (the patient can be guided by the SHI team to the correct somatic health care but care is not provided by the team)
Somatic examination and tests at admission?	Variable list of tests	Variable list of tests	Sometimes done	No
Who prescribes tests and treatments during the stay?	Psychiatrist or specialist	Mostly the psychiatrist but sometimes a consultation with a GP is required	➤ The coordinating psychiatrist of the PNH ➤ The GP of the patient	➤ The coordinating psychiatrist of the SHI ➤ The GP of the patient
Where are these medical tests performed?	At the hospital	Often performed in a general hospital, sometimes at the PH	Ambulant care (hospital or GP)	Ambulant care (hospital or GP)



Prevention regarding somatic diseases?	when a medical centre is available on site			
	Not a priority	Not a priority but high variability between centres	No	No
How are the stays of patients financed?	➤ Medical and medico-technical activities (including somatic care): on a fee-for service basis or via flat rates. Reimbursed activities are described in the nomenclature but not all acts are covered (see section 3.5 for details) ➤ Nursing activities and non-medical activities (including infrastructure, food, maintenance, energy, ...): BFR	➤ Medical and medico-technical activities (including somatic care): on a fee-for service basis or via flat rates. ➤ Nursing activities and non-medical activities (including infrastructure, food, maintenance, energy, ...): BFR	➤ Financed partially by a hospital when geographically attached ➤ Patients considered as outpatient	➤ Patients considered as outpatient. ➤ The personnel is financed by the federated entities.

* This summary is very finite and should be read together with the text of the report.



4 LITERATURE ON BARRIERS AND FACILITATORS OF SOMATIC HEALTH CARE

Key points

The barriers and facilitators and common interventions promoting and sustaining physical health that were identified in the international and Belgian literature were:

- Individual level barriers
 - international: The patient experienced the quality of care compromised by practical problems e.g. lack of transport, difficulties making and managing appointments, long waiting times, and interpersonal difficulties with healthcare providers e.g. disrespectful and non-caring behaviour. Service providers, mental health nurses and physicians stated a feeling of ambivalence when taking up physical health care. They experienced limited training, lack of confidence and felt uncertain and apprehensive leading to identifying physical complaints as mental symptoms.
 - Belgium: In addition to the international identified barriers, healthcare providers described that at the time of admission, a lack of consensus on a list of standard clinical tests, a high number of admissions through casualties and this with a high frequency of inappropriate inpatient referrals were encountered. The patients reported stigma and low empathy of the healthcare provider and limited information provision as a problem. Further, patient involvement and respect for patient rights was considered sub-optimal.

- Individual level facilitators:
 - The early detection of side effects of antipsychotic medication is advised by applying existing Belgian and international (detailed) guidance. Clinicians who prescribe antipsychotics to patients should have a duty of care to ensure that the patients are given access to evidence-based lifestyle interventions from the start of treatment. The patient should be counselled on the metabolic risk of the underlying disease and the risks associated with the planned drug treatment. A comprehensive lifestyle screening assessment has to be performed to assess a range of behavioural risk factors (eg, exercise, diet, substance use, and sleep) at once, and thus identify key drivers of poor physical health. More training of healthcare staff is required for patients with chronic conditions and to increase the awareness of multi-morbidity. Tools to detect and follow-up physical health have proven helpful: a Dutch mental health nurse monitoring tool exists and the Australian computerised Positive Cardiometabolic Health Algorithm was developed.
- Health system and organisational barriers
 - International: Care coordination and integration of physical and mental health is internationally regarded as very important and could lead to improved care overall and reverse
 - underuse of evidence-based medical services (for example, individuals with schizophrenia and diabetes received diabetes care that is significantly sub-optimal compared with patients without schizophrenia concerning guideline-concordant testing for HbA1c, lipid testing and eye exams);
 - overuse of some types of services (such as increased rates of intensive-care-unit admissions, ambulatory care, and emergency department visits);



- **high risk of medical errors.**
- Access to care is often blocked due to financial costs, organisational and logistical issues (making appointments, transport), limited on-site equipment, negative workforce beliefs and workload.
- Belgium: In addition to the international barriers above, in Belgium, a high number of admissions happens through casualties, and it is stated that this could be avoided by better coordination between primary and secondary care. At discharge from hospital, provision of patient medication information is performed rather ad hoc than on a systematic base. The Brussels health institutions state that especially for their most complex patients in psychiatric hospital beds, psychiatric nursing homes and initiatives sheltered living a health system with leadership, sufficient financing, and human resources is needed.
- **Health system and organisational facilitators**
 - Examples from Belgium and international literature on how to organise care better are
 - Shared budget for liaison psychiatry services
 - Recruitment of additional support team members that are trained in the other discipline
 - Training of team and professionals on somatic care and practical aspects, screening and prevention
 - Referral pathways for targeted interventions across primary and secondary care to manage cardiovascular risk factors which are commonly encountered when antipsychotic medication is prescribed
 - Integration of qualified exercise professionals into mental health services could ensure mental health staff's knowledge on how to give clear advice on exercise

- Improved information technology to support professionals: computer prompts on medication with pharmacy support, electronic tools like EBM PracticeNet and shared electronic patient health records to be developed and used
- Involve the patient and the informal carer an important partners in care
- Set up a care trajectory (personalised, integrated, multidisciplinary care) with interdisciplinary meetings (protected time) and before discharge organise a meeting including the pharmacist and the GP
- **Community barriers**
 - International and for Belgium: Factors leading to adverse physical health and mental illness are strongly intertwined and persons with mental illness are more likely to live in poverty and suffer from cardiometabolic diseases. Social support and access to information is often limited which is amplified by a lack of social skills resulting in difficulties communicating health needs. Stigma in society and negative perceptions of persons with SMI are recognised barriers in the community. Investment in quality of care is low and secondary and tertiary prevention is underused.
- **Community facilitators**
 - The patient and family should take their responsibility and be actively involved and participate in the care process; develop a strategy and local policy to guaranty patient safety and quality.
 - Social prescribing of local voluntary and community sector activities in the UK led to: a range of well-being outcomes, including improved mental and physical health, feeling less lonely and socially isolated, becoming more independent.



- **Stigma reduction campaigns directed to communities with SMI and the general public; To improve the patients' right to information by increasing the knowledge of the Belgium law describing the patients' rights (August 22nd, 2002). The law describes the commitments of Health Care Providers and the rights for patients.**
- **Public health programmes: Policy-level ban on smoking on mental health wards and hospital premises; Primary prevention strategies need to be adapted for people with mental illness.**
- **Improvement of socially deprived areas e.g. local green spaces with walking routes.**

4.1 Methods

To identify the literature we performed a pragmatic literature review. The identified reviews were analysed and summarised in excel for research objectives, aims and hypothesis, type of review, search strategy, somatic and psychiatric health focus, design, tools used, and for information on barriers and motivators on an individual focused level, a health-system and organisational level, and a community and policy level. Summary tables were created for the different levels. In a second search we identified primary articles, theses, and documents including Belgian data on the topic. The content and information was analysed and summarised similar to the reviews.

4.2 Literature review

4.2.1 Search strategy

We performed a pragmatic literature review in preparation for the work in the next chapter: the qualitative interviews of healthcare providers and patients on barriers and motivators in the somatic care of persons with a SMI. The aim was to identify the major topics of importance in the international literature. In this end, we performed an explorative review of literature with

the focus on earlier review studies. Systematic, integrative or narrative reviews were searched describing 'barriers and motivators' for protecting 'physical health' in people with a severe mental health illness. The Belgian literature was identified through stakeholders of the project, websites of universities, and searching of references from identified articles.

4.2.2 Selection of references

Twenty-six reviews were identified (Appendix 4) of which 15 were systematic and the remaining 11 were narrative reviews. The most recent systematic reviews collected data up to the middle of 2018.^{3, 98, 99} Several reviews were commissioned by international organisations; one review was executed in preparation for a WHO consultation meeting on mental health in 2015 describing a multilevel framework,⁷ another was developed for an educational model for the World Psychiatric Association,¹⁰⁰ one paper was a preparation for the United Kingdom British Association of Psychiatrist consensus meeting in 2015 (based on UK guidelines only),¹⁰¹ and the National Institute of Mental Health authored a paper for a meeting on improving health and longevity of SMI¹⁰². Finally, an extensive recent review was set up by the Lancet commission for psychiatry.³ The comprehensive review by Firth et al summarises the most recent status in the field with the challenges, actions for improvement and solutions, and lists future research priorities.³

The multilevel framework, defined by a forum in collaboration with WHO, was used as the backbone to build this result section.⁷ Barriers identified from the other reviews were added to the framework blocks and more in depth or recent papers on a specific topic were added as a reference.



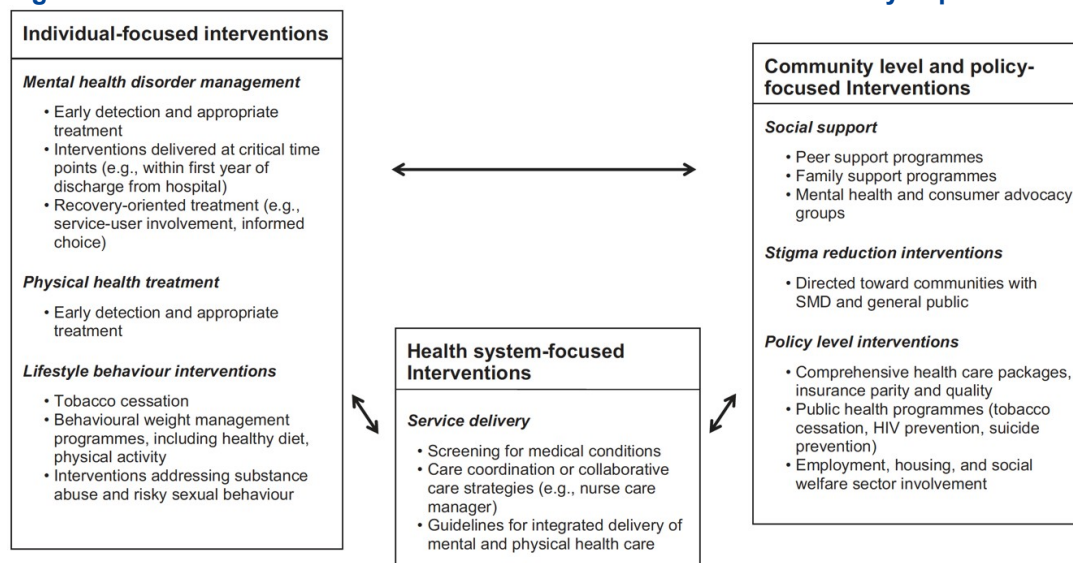
4.3 Result of reviews

The countries that were strongly present throughout the retrieved reviews were Australia, Canada, the United Kingdom and the United States of America. Research topics included 'health risk behaviour interventions, examples, screening, health promotion, smoking cessation', 'health care monitoring', 'barriers access to care', 'role, knowledge and attitudes of nurses', 'attitudes of practitioners', 'collaborative care models', 'addressing major medical conditions', 'interventions by peers', 'interventions to reduce mortality', 'interventions to increase uptake of cancer screening', 'health care advice', 'metabolic screening', 'multilevel interventions', and 'pharmacological interventions'.

The barriers and motivators for protecting somatic health in people with mental health illness are multifactorial due to the range of somatic health problems and the mental health diagnoses. As a result, the reviewed literature discusses a vast number of considerations and viewpoints. Therefore, rather than attempting to discuss all possible combinations of physical and mental comorbidities individually, we aimed to describe common interventions promoting and sustaining physical health, together with the identified barriers and motivators in the literature on: a) an individual (patient or health professional) focused level; b) a health-system and healthcare organisation level; c) a community and policy level. Secondly, we present a summary of the literature on the actions and initiatives for health policy and clinical services addressing these issues.

4.3.1 A multilevel intervention framework

A multilevel intervention framework to reduce excess mortality was described by the World Psychiatric Association in collaboration with WHO.⁷ Figure 3 describes the backbone of interventions that are necessary for assuring good health and improving morbidity and eventually reducing excess mortality in persons with severe mental disorders.⁷ Barriers to good physical health and risk factors for excess morbidity have been described in the identified systematic, integrative and narrative reviews of quantitative and qualitative literature. We will list them for each level.

**Figure 3 – Multilevel model of interventions to reduce excess mortality in persons with severe mental disorders**

Source: World Psychiatric Association in collaboration with WHO ⁷

4.3.2 Individual level barriers

The risk for excess mortality in persons with SMI as described in the international literature can be related to individual factors and strategies that target mental health condition, physical health and lifestyle behaviours (Table 11). Although the individual-focused interventions below are described separately, they will be affected by the functioning of the health care system as a whole. Further, individual-level risk factors will be related to the severity of the mental illness (e.g. symptoms, hospitalisation, impulsivity, physiological and emotional dysregulation) and will influence the interaction of the person with the health care system (e.g. cognitive deficits, social skills deficits, low motivation or mistrust).⁷

The patient experiences the quality of care compromised by practical problems e.g. lack of transport, difficulties making and managing appointments in primary and secondary care, long waiting times, and interpersonal difficulties with health-care providers e.g. disrespectful and non-caring behaviour. Service providers, mental health nurses and physicians state a feeling of ambivalence when taking up physical healthcare. They experience limited training, lack confidence and feel uncertain and apprehensive. These aspects can lead to diagnostic overshadowing (identifying physical complaints as mental symptoms).

Similar aspects of sub-optimal care or barriers have been described in the literature from Belgium as compared to the international reviews.



Several studies highlight the lack of consensus on a list of standard clinical tests when a patient with a mental illness is admitted to hospital.²¹⁻²⁴ When admitted to the emergency department it is noted that: a high number of admissions happen through casualties,^{25, 103} the inpatient referrals for emergency care are not always appropriate,²⁶ and 'diagnostic overshadowing' is common.²⁴

Stigma and low empathy of the healthcare provider for the patient with SMI are commonly encountered.^{25, 27, 28} The information provision, the involvement of the patient and respect for patient rights as reported by patients is sub-optimal.²⁹⁻³¹ Several studies focus on the role of the mental health nurse and general practitioner for the outpatient with SMI and lifestyle behaviour interventions have hardly been studied in Belgium.

Table 11 gives an overview of the individual-level interventions that are described through the reviews and for Belgium. The left column describes the interventions or actions that should be in place to deliver somatic health for the SMI patient. The middle column cites the 'barriers'; meaning factors or determinants of risk for a somatic illness not been detected or for somatic care not been offered from the international literature. The right column lists the factors from the Belgian literature. These 'barriers' can be patient-related or provider-related. The literature reviewed varies in providing very general to very specific 'barriers' depending on the topic that was reviewed or discussed in the specific references. Data from international reviews by Belgian authors is presented in the international reviews column.^{3, 100, 104, 105}

Table 11 – Individual level interventions and barriers identified in international reviews and Belgian literature

Interventions	Barriers international	Barriers Belgium
Mental health disorder management		
1. Early detection and appropriate management	Medication for severe psychiatric illness has important side effects causing somatic illnesses; good medication management is difficult: • Antipsychotic medication is incorrectly prescribed e.g. high dosage.⁷ • Side effects of medication are not managed e.g. obesity, Type 2 diabetes, hyperprolactinemia, xerostomia, constipation.¹⁰⁰ • Side effects of antipsychotic medication are not followed up.¹⁰⁵ • In routine clinical practice, metabolic monitoring is concerning low in people prescribed antipsychotic medication. Although guidelines can increase monitoring, most patients still do not receive adequate testing.¹⁰⁵	Medication for severe psychiatric illness has important side effects causing somatic illnesses; good medication management is difficult: • Most healthcare professionals found it difficult to discuss side effects with their patients, especially when these were severe side effects, e.g. weight gain.¹⁷ • Patients with SMI maintained on antipsychotic medication cannot be reliably screened for diabetes using clinical variables (BMI, waist/hip ratio and height) alone. For complete diagnosis a specific biochemical protocol is still necessary.²⁰ • Side effects of antipsychotic medication are not sufficiently followed up by the general practitioner.¹³ • In routine clinical practice, metabolic monitoring is concerning low in people prescribed antipsychotic medication. Although guidelines can increase monitoring, most patients still do not receive adequate testing.¹⁶
2. Interventions delivered at critical time points	Poor quality service provision. ⁷	No information



Interventions	Barriers international	Barriers Belgium
3. Recovery-oriented treatment	The severity of mental symptoms leads to the patient not keeping appointments.¹⁰⁶ The patient is less compliant with medication due to illness-related factors.¹⁰⁰	The severity of mental symptoms leads to the patient not keeping appointments.¹⁰⁷ The patient is less compliant with medication due to illness-related factors.¹⁰⁷
Physical health treatment		
1. Early detection	The patient does not identify the problem: - Low motivation of the patient to seek advice and treatment.^{7, 100} - Patients with SMI on antipsychotic medication have reduced pain sensitivity.¹⁰⁰ - Preoccupation with mental illness, disregard of physical health concerns and symptoms e.g. cognitive impairment, social isolation.^{100, 106, 108}. A supportive environment may identify and help to address the problem together with the patient. - The patient is unaware or does not understand secondary preventive strategies, such as screening for colorectal, cervical and prostate cancer.^{3, 109, 110} The patient does not access care: - Preoccupation with mental illness, disregard of physical health concerns and symptoms e.g. cognitive impairment, social isolation and suspicion and mistrust.^{100, 106, 108} - Negative beliefs and attitudes of the workforce and stigmatisation.^{7, 98, 100, 111} - Patient experiences staff as disrespectful or neglectful and will not attend for care when in need.¹⁰⁶ Health care services do not recognise the problem: - Physical complaints are regarded as psychosomatic symptoms.¹⁰⁰ - The patient often presents a complex case with multiple problems. Patients with SMI commonly have multiple health risk factors and lifestyle factors e.g., substance abuse, poor diet, smoking, lack of exercise and unsafe sexual practices.^{3, 100} - Negative beliefs and attitudes of the workforce and stigmatisation.^{7, 98, 100, 111} Examples: Some authors suggest that the poorer health outcomes could be related to providers' negative beliefs and attitudes towards persons with SMI, including beliefs about the causes of illnesses, ability of persons with SMI to maintain an active and healthy lifestyle or other beliefs about functioning. Mental health and primary care providers'	The patient does not identify the problem: - Low motivation of the patient to seek advice and treatment.^{14, 107} - Preoccupation with mental illness, disregard of physical health concerns and symptoms e.g. cognitive impairment, social isolation.¹⁰⁷ The patient does not access care: - Negative beliefs and attitudes of the workforce and stigmatisation with as result lower investigations of symptoms.²⁸ Health care services do not recognise the problem: - Physical complaints are regarded as psychosomatic symptoms e.g. medical clearance is carried out less consistently at emergency departments.²⁴ - The patient often presents a complex case with multiple problems. Patients with SMI commonly have multiple health risk factors and lifestyle factors e.g. substance abuse, poor diet, smoking, lack of exercise and unsafe sexual practices.¹⁴ - Negative beliefs and attitudes of the workforce and stigmatisation could lead to social exclusion and low quality care.²⁸ - A consensus is missing (psychiatry setting in Flanders) on which examinations should be performed as standard and when additional physical examinations are necessary and useful when an adult patient is admitted to a psychiatric ward in order to arrive at a diagnosis and appropriate treatment.^{22, 23}



Interventions	Barriers international	Barriers Belgium
	attitudes towards patients with SMI appear related to treatment intentions, including their likelihood of referring patients to a specialist or refilling their prescription. There is evidence of variation in the quality of care depending on the provider, insurer and type of health care system. - Secondary preventive strategies, such as screening for colorectal, cervical and prostate cancer, are often underused in people with mental illness.^{3, 109, 110} Studies that examined the reasons for non-uptake of cancer screening in people with SMI identified similar reasons for individuals with and without mental illness. Reasons for non-uptake included low income, increasing age, lack of transport, embarrassment, lack of reminders and lack of familiar care providers.¹¹⁰ - A reluctance of staff to make a referral and repeat the testing requests by consumer.¹⁰⁶	
2. Arrival and access to health care centres	The patient does not know how to appropriately access health care: - Patient accesses emergency care and not primary care services due to late presenting or inappropriate use.¹⁰⁶ Emergency care is disturbing for a psychiatric patient and is more costly. The patient postpones problems and accesses emergency care when primary care is closed. The patient has difficulties with the 'somatic care centres': - The patient experiences fear and anxiety of medical procedures, has difficulties communicating symptoms and lacks confidence and assertiveness.^{106, 112} - The waiting environment, waiting times, the rushed session are viewed as barriers by the patient.^{106, 112} The 'somatic' physician is not comfortable dealing with psychiatric patients: - The physician perceives the assessments as intrusive to the patient, lacks the knowledge and skills and is reluctant to make referrals or repeat testing.¹⁰⁶	The 'somatic' physician is not comfortable dealing with psychiatric patients: - The physician lacks the knowledge and skills.¹¹³ - Nursing staff at emergency settings have negative experiences with the 'amount of time' a psychiatric patient needs and this especially in case of patients with alcoholism, aggressive behaviour, drug use and unkempt impression.²⁵
3. Initial treatment	The patient will not follow health care advice given¹⁰⁰: - Difficulty comprehending health care advice due to psychiatric symptoms, - Low educational attainment due to mental illness, - Reduced social networks due to mental illness, - Lack of employment and family support, poverty, poor housing.	The patient will not follow health care advice given: - Difficulty comprehending health care advice due to psychiatric symptoms,¹⁶ - Low educational attainment due to mental illness,¹⁶ - Reduced social networks due to mental illness,¹⁰⁷ - Lack of employment and family support, poverty, poor housing.¹⁶



Interventions	Barriers international	Barriers Belgium
3. Ongoing care	Patients have a low tendency to come for follow-up: - The patient does not follow health care advice given due to reasons mentioned under 2) above. Patients with SMI have fewer medical visits, with the most severely ill patients making the fewest visits and are less compliant with treatment.¹⁰⁰ - Patient autonomy and decision making is not respected.³⁰ The clinician's knowledge of physical health is insufficient: - The psychiatrist tends to focus on mental rather than physical health with infrequent baseline and subsequent physical examination of the patient.¹⁰⁰ - A reluctance of staff to make a referral and repeat testing requests by consumer.¹⁰⁶ - Lack of assessment, monitoring and continuity of care of the physical health status of people with SMI.¹⁰⁰ - Guidelines are perceived as a threat to autonomy and not well known or not clinically accepted by psychiatrist.¹⁰⁰ Unequipped or underfunded teams to deal with somatic follow-up: - The physician and his team are unequipped or underfunded to handle behavioural and emotional problems of patients with SMI. While the complexity and time intensity of coordinating both medical and psychiatric medications makes it even more difficult.¹⁰⁰ - Nurses are inexperienced and embarrassed to ask patients about sexual side effects of antipsychotic medications.⁹⁸	Patients have a low tendency to come for follow-up: - The patient does not follow health care advice given due to reasons mentioned under 2) above. Patients with SMI have fewer medical visits, with the most severely ill patients making the fewest visits and are less compliant with treatment.¹⁰⁷ - Patient satisfaction points for improvement, i.e. in the areas of information provision, patient participation and patient rights; strong points i.e. information on destination after discharge, participation on end of treatment and respect for privacy.²⁹ The clinician's knowledge of physical health is insufficient: - The psychiatrist tends to focus on mental rather than physical health with infrequent baseline and subsequent physical examination of patient.¹⁶ - Lack of assessment, monitoring and continuity of care of the physical health status of people with SMI.¹⁶ - Guidelines are not used by general practitioners.^{107, 113} The clinician experiences 'fatalism': - An important barrier is a patient group which is hardly motivated for the correct use of medications and lifestyle changes.^{14, 113} Psychiatrist experience their task as complex compared to other disciplines: - Literature and evidence is limited; patients' presentations are complex and individual; the diagnostic possibilities and the relation with the patient make it more difficult.^{113, 114}
Lifestyle behaviour interventions		
Tobacco cessation	The clinician faces complex cases: - All psychiatric diagnoses are associated with a wide spectrum of lifestyle risk factors.³ - Difficulty comprehending health care advice and/or carrying out required changes in lifestyle due to psychiatric symptoms and adverse consequences related to mental illness (e.g., low educational attainment, reduced social networks, lack of employment and family support, poverty, poor housing).¹⁰⁰	The clinician faces complex cases: - All psychiatric diagnoses are associated with a wide spectrum of lifestyle risk factors.¹⁶ - Difficulty comprehending health care advice and/or carrying out required changes in lifestyle due to psychiatric symptoms and adverse consequences related to mental illness e.g., reduced social networks.¹⁰⁷
Behavioural weight management programmes, including healthy diet, physical activity	Knowledge and beliefs of clinicians/care providers are lacking or incorrect:	



Interventions	Barriers international	Barriers Belgium
Sedentary behaviour and physical activity Sleep improvement actions Substance abuse interventions Sexual health interventions	• Erroneous beliefs by psychiatrist e.g. SMI patients are not able to adopt healthy lifestyles, weight gain is mainly an adverse effect of medications, or lower cardiac risk medications are less effective.¹⁰⁰ • Mental health nurses liberal views about smoking restrictions, more worrying attitudes about the benefits and utility of cigarette use as a therapeutic tool, and less confidence in the ability of mental health patients to quit smoking. This was particularly concerning in the study context which was about attitudes to physical healthcare with younger, first-episode psychosis patients.⁹⁸ • Staff working in mental health services expressed they did not have the confidence to adequately address smoking cessation for people living with mental illness.¹¹⁵ Lack of approaches and interventions specific for SMI: • People living with mental illness would like support and encouragement support to help them achieve successful smoking cessation and prefer mental health services support rather than mainstream smoking cessation services.¹¹⁵ • General population smoking cessation approaches have not worked for the persons with SMI; they are more nicotine-dependent and less likely to seek out and receive appropriate interventions tailored to their needs. 3	



4.3.3 Individual level actions and solutions

The international literature on the identification of barriers and motivators for lifestyle risk factors in mental illness suggests that simultaneously considering multiple lifestyle factors in the patient is more appropriate than focusing on individual factors. Literature considering multifactorial approaches, however, is still scarce. An important aspect pointed out by Firth et al. is that no suitable tools are available for clinicians to comprehensively assess lifestyle factors as part of standard care.³ Clinical guidelines are increasingly recommending that assessments of diet, physical activity, and health risk behaviours are done alongside assessments of biological parameters e.g. blood pressure, glucose, lipids, to assess current somatic health and future risk. Importantly, it was also shown that the sole use of biological markers e.g. high blood pressure, and an abnormal lipid profile, meant that interventions were prescribed too late in the process to protect metabolic health or pre-empt obesity.^{3, 116}

A Belgian consensus workshop in 2004 formulated recommendations for psychiatrists on interventions for the management of side effects of antipsychotic medication.¹² Tools for improved monitoring of antipsychotic

medication have since been proposed for use by nurses, psychiatrists, pharmacists and general practitioners in Belgium.¹³⁻²⁰ These tools partially address the need as framed by Frith et al, to develop instruments to comprehensively assess lifestyle factors as part of standard care.³ The national third multi-annual quality and patient safety programme (2018-2022) stipulates for hospitals to organise themselves so that patient safety and quality are optimally guaranteed for the following aspects: the information transfer of somatic care and of medication care, to involve the patient and his/her family in pharmacological care, according to their needs and abilities, and develop a strategy and policy on drug care to ensure optimal patient safety and quality.¹¹⁷

Table 12 gives an overview of the individual level interventions that are described through the reviews with the middle column listing the actions and/or solutions that have been described in the international literature. The right column describes the Belgian actions. Some of the solutions provided hereunder also concern the settings and services (section 4.3.5) when the implementation is organised on an institutional level e.g. screening strategies, tests, tools.

Table 12 – Individual level actions and solutions identified in international reviews and Belgian literature

Interventions	Proposed actions / solutions international	Proposed actions / solutions Belgium
Mental health disorder management		
1. Early detection and appropriate management	Side-effects of psychotropic medications should closely be monitored. Scientific knowledge of SSRIs and second-generation antipsychotics when accumulating over time is poor, particularly during the transition from childhood or adolescence into adulthood.³ More training of healthcare staff is required for people with chronic conditions.³ Given the high likelihood of physical health deterioration, while taking antipsychotics, clinicians who prescribe them to patients have a duty of care to ensure that the patients are given access to evidence-based lifestyle interventions from the start of treatment.³	Metabolic complications of psychotropic medications should closely be monitored.¹² Recommendations for practising psychiatrists when initiating and maintaining therapy with antipsychotics from the Belgian consensus workshop are available.¹² Health care services at emergency departments should perform a full anamnesis and set of clinical (vital parameters included) and laboratory tests (when anamnesis or clinical is abnormal) to assess that the patient is stable. This is called 'medical clearance'.²⁴



Interventions	Proposed actions / solutions international	Proposed actions / solutions Belgium
2. Interventions delivered at critical time points	Implement a physical health culture for mental health services. Regular screening is needed for physical disorders and associated risk factors among patients with mental illness, with evidence-based health promotion initiatives for staff and service users.³ Clinical guidelines for metabolic screening upon initiation or continuation of second-generation antipsychotics recommend that blood pressure, body-mass index, blood glucose, and lipid profile should be checked at least every 6 months.^{3, 5, 101}	General practitioners should perform regular screening for physical disorders, side effects of medication and associated risk factors among patients with mental illness. A set of parameters is proposed for follow-up of antipsychotic medication.¹³ Mental health nurses are well placed to screen and follow-up metabolic side effects upon initiation and continuation of second-generation antipsychotics. A scheme of tests is proposed.¹⁵ The use of an National Health Service adapted guideline is feasible.¹⁴ Patients on antipsychotics should undergo regular laboratory blood testing of blood sugar, blood lipids, as well as body weight and blood pressure.¹² Weight and waist circumference weekly in hospital and monthly ambulatory; fasting blood glucose monthly when underlying risk; after 6 and 12 weeks and then 3-monthly; fasting lipids every 3 months for a year then yearly; blood pressure every 3 months.¹² All patients with SMI taking antipsychotic medications should be tested for diabetes:²⁰ - at initiation of the drug test Glycated haemoglobin (HBA1c): - If negative (<5.7%), the test should be repeated again in 6 months. - If positive, immediately obtain fasting glucose and a two-hour oral glucose tolerance test at conventional cuts-offs. - Every 6 months test HBA1c
3. Recovery-oriented treatment	Lifestyle interventions should be made available even to those with intact metabolic health. Intervening with medication should not wait until visible weight gain or metabolic dysfunction happens.³	No information
Physical health treatment		
1. Early detection	Self-management and screening strategies for physical health risk factors are urgently needed.³ Early testing is needed because behavioural risk factors precede, rather than accompany, the onset of psychotic disorders, and metabolic disturbance might be present from mental illness onset.³	All patients with SMI taking antipsychotic medications should be tested for diabetes:²⁰ - at initiation of the drug test Glycated haemoglobin (HBA1c): - If negative (<5.7%), the test should be repeated again in 6 months.



Interventions	Proposed actions / solutions international	Proposed actions / solutions Belgium
	Screening for multiple lifestyle factors, rather than single factors or biological markers alone, will be the most efficient method for improving health outcomes for people with mental illness.³ Multi-morbidity awareness, and education of health professionals is needed.³ Two monitoring tools for mental health nurses to identify physical health needs are the Wellness Support Programme (WSP)¹¹⁸ and the HIP (health improvement profile)¹¹⁹, a physical health assessment tool favoured by mental health nurses in the UK. It enables nurses to plan care based on the level of risks identified.¹²⁰ The WSP is mostly used to screen for CVD risk factors and the impact of antipsychotic medications as a contributor to CVD.^{120, 121}	○ If positive, immediately obtain fasting glucose and a two-hour oral glucose tolerance test at conventional cuts-offs. ● Every 6 months test HBA1c
2. Arrival and access to health care centres	A tool for a comprehensive lifestyle screening assessment is urgently needed; this to be used across different diagnoses, settings, and services, to assess a range of behavioural risk factors (eg, exercise, diet, substance use, and sleep) at once, and thus identify key drivers of poor physical health on a case-by-case basis.³ Avoid diagnostic overshadowing: The risk of physical symptoms being wrongly attributed to mental health disorders should be acknowledged, and the stigma that presents barriers to health care for people with mental illness must be addressed.³ More training of healthcare staff and wider access to screening and treatment (including cardioprotective medications, bariatric surgery, cancer screening) are required for people with chronic conditions.³	At arrival of a patient a good somatic examination and laboratory investigation has to be set up: a proposition is provided.²¹
3. Initial treatment	Implement a physical health culture for mental health services. Regular screening is needed for physical disorders and associated risk factors among patients with mental illness, with evidence-based health promotion initiatives for staff and service users.³ Referral to evidence-based lifestyle interventions.³	The psychiatric nurse can play an important role to assess the patient's baseline risk factors, perform a clinical examination (weight, BMI, abdominal circumference, blood pressure), perform a fasting glucose and lipids, and advice the patient on risk for diabetes, ketoacidosis, and healthy living.¹⁵



Interventions	Proposed actions / solutions international	Proposed actions / solutions Belgium
		The patient should be counselled on the metabolic risk of the underlying disease and the risks associated with the planned drug treatment. Patient information includes the risk of diabetes, weight gain, and dyslipidemia, and measures to prevent these conditions (lifestyle changes, diet). Since diabetic ketoacidosis (polyuria and polydipsia, weight loss, nausea and vomiting, dehydration) cannot be foreseen, patient education on this condition is mandatory. Specifically, the patient, family members and caregivers must be educated about the warning signs of the acute decompensation of diabetes, as it is life-threatening, albeit infrequent.¹²
3. Ongoing care	Avoid diagnostic overshadowing The risk of physical symptoms being wrongly attributed to mental health disorders should be acknowledged, and the stigma that presents barriers to health care for people with mental illness must be addressed.^{3, 112} The potential of digital technologies for checking health status and monitoring an individual's risk, and facilitating the delivery of lifestyle interventions need to be explored.³ Monitoring tools for preventing cardiovascular events in individuals suffering from first-episode psychosis: a computerized version of the Australian Positive Cardiometabolic Health Algorithm.¹²² Continuity-of-care trajectory at hospital discharge for both mental and non-mental illnesses.³	Electronic tools like Evidence based medicine (EBM) PracticeNet and shared electronic patient health records have to be developed and used.¹⁴ Better information technology to support professionals is needed.¹³ A higher degree of patient involvement is associated with higher satisfaction and empowerment scores and satisfaction and empowerment are positively associated.³¹ Built on 10 factors to increase patient autonomy and decision making: understanding information, applying information to one's own situation, gaining insight into one's own situation, considering choices, estimating consequences for oneself as well as for others, motivating choice in a tangible and understandable way, being free from coercive influences from within as well as from outside, and motivating choice on the basis of one's own values.³⁰
Lifestyle behaviour interventions		
Tobacco cessation	Clinicians who prescribe antipsychotics to patients should have a duty of care to ensure that the patients are given access to evidence-based lifestyle interventions from the start of treatment. ³	Patients should be counselled about measuring and charting their own weight and waist circumference. ¹² Concerning diet and exercise, patients should (a) decrease the fat and energy content of their diet and increase fibre intake, (b) eat more fruits and vegetables, (c) eat complex rather than simple carbohydrates, (d) avoid sugary drinks, and (e) exercise for at least 10-15 min per day, ideally 30 min per day. ¹²
Behavioral weight management programmes, including healthy diet, physical activity	A tool for a comprehensive lifestyle screening assessment is urgently needed; this to be used across different diagnoses, settings, and services, to assess a range of behavioural risk factors (eg, exercise, diet, substance use, and sleep) at once, and thus identify key drivers of poor physical health on a case-by-case basis. ³	Diabetes lifestyle information should be provided to patients and family from treatment initiation, to protect metabolic health. ¹²
Sedentary behavior and physical activity		Smoking cessation has to be offered to all patients started on antipsychotic treatment. ¹²
Sleep improvement actions		
Substance abuse interventions		
Sexual health interventions		



Interventions	Proposed actions / solutions international	Proposed actions / solutions Belgium
	Patients should receive more 'actionable' health information to make changes to protect their health e.g. digital and wearable technologies.^{3, 123} Multidisciplinary referral pathways should be available through both primary and secondary care.³ Access is needed to specialised physical activity, smoking cessation, dietetics health services, depending on the individual's specific behavioural profile and health goals.³ Innovative smoking cessation interventions and the service delivery of these interventions for people living with mental illness are needed.¹¹⁵ Diabetes lifestyle interventions should be implemented from treatment initiation, to protect metabolic health.³ Improved referral pathways to specialised services for managing comorbid substance use disorders are needed.³ Pharmacological interventions (bupropion and varenicline) are effective interventions for smoking cessation for people with SMI.^{3, 124} To develop local smoking cessation interventions with service users.^{3, 125, 126} Training on smoking cessation is now freely available online for healthcare professionals (Public Health England).³ Fitness goals designed by fitness professionals: focus on improving fitness rather than weight is more motivating and achievable.^{3, 127, 128} Use the Lifestyle intervention guidelines adapted from the Diabetes Prevention Program with measurable and specific goals.¹²⁹	



4.3.4 Health system and organisational barriers

As already pointed out above, it is important to emphasise that multiple levels contribute towards excess mortality in persons with SMI. Service delivery components will vary across different settings depending upon the number of specialists versus primary care providers, the different distribution of health risk factors, the presence or absence of universal health care, and the availability of health technologies and medications.⁷

A summary of the reviewed literature is presented in Table 13. One of the items that stands out is that care coordination and integration of physical and mental health is internationally regarded as very important and could lead to improved care overall. Indeed, Bullock et al. explain that there are three types of care problems: • underuse of evidence-based medical services (for example, individuals with schizophrenia and diabetes received diabetes care that is significantly sub-optimal compared with patients without schizophrenia concerning guideline-concordant testing for HbA1c, lipid testing and eye exams); • overuse of some types of services (such as increased rates of intensive-care-unit admissions, ambulatory care, and emergency department visits); • high risk of medical errors.¹³⁰

The case-control study in France (Figure 4) is an example of use of services with slightly more frequent use of primary care in the SMI population, while on the contrary the average number of contacts with a specialist physician was far lower.⁸² Differences were particularly strong for gynaecological and ophthalmological care. Regarding admissions to non-psychiatric hospital departments, differences were more marked for avoidable hospitalisations (Adjusted OR: 2.00, 95% CI: 1.94–2.08).⁸²

A summary of the Belgian literature is presented in the right column. One document from Brussels describes the bottle necks they experience to arrive to optimal care coordination and integration of physical and mental health.¹³¹ In general, a high number of admissions happens through casualties,²⁵ and this could be avoided by better coordination between primary and secondary care.^{25, 107, 113, 132}

Table 13 – Health system and organisational barriers identified in international reviews and Belgian literature

Interventions	Barriers international	Barriers Belgium
Health system-focused interventions		
A health system with leadership, sufficient financing, and human resources is needed.	Insufficient funding, leadership and human resources.^{3, 7, 133} Mental health nurses' responses indicated a gap between their perceived responsibilities for physical healthcare and their practice: they reported very low levels of endorsement of related skills training need.⁹⁸ Poor system of communication between care providers.⁷ The stigma of mental illness and health care system division.¹⁰⁶ A systematic reluctance of staff to make a referral and repeat testing requests by consumer.¹⁰⁶ Physical training interventions delivered by non-specialised practitioners.¹³⁴	Insufficient funding, leadership and human resources.¹³¹ • Lack of financial resources - particularly in Brussels. • The supply of psychiatric hospital beds in Brussels, with only 8.4% of the country's beds, is already smaller compared to that of the other regions. • Imbalance in the financing of remuneration and working conditions between the various health care sectors (public/private, hospital/mental health care/elderly). An employee in the different health care sectors should be financed in an equal way.



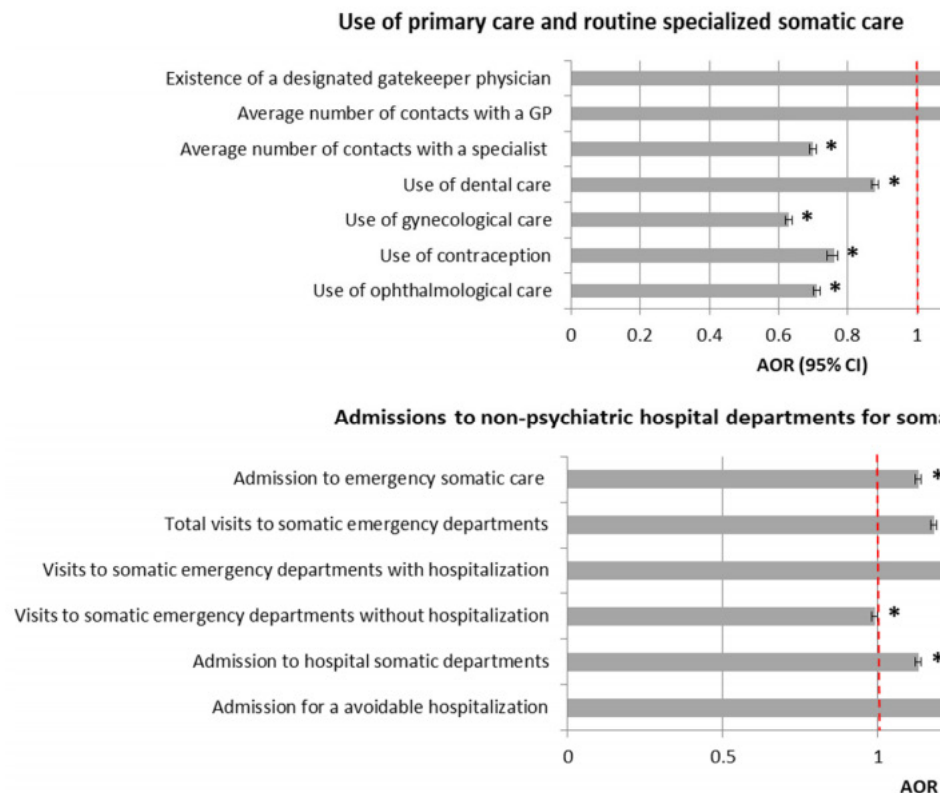
Interventions	Barriers international	Barriers Belgium
		• Lack of better manned structures to care for the most complex patients, both in the hospital and in the psychiatric care home (PNH), the mobile intervention cell, the accommodation centre or the day-care centre. • Lack of beds in psychiatric care homes and sheltered living initiatives in Brussels. Only one third of the planned PNH beds have been opened. Waiting lists are long for patients who want to be admitted to a PNH or an SHI. • The funding of staff in the psychosocial rehabilitation contracts for adults and of the psychiatrist in the PVNH also needs to be updated to cover real costs. • Nursing homes are not in a position to provide the dual care: psychiatric disorders and increasing degree of dependence 'only' related to their age. In reality, these persons need a specific structure that provides them with a professional framework, provided by staff specifically trained for this purpose. Poor communication between general practitioners and psychiatrists.¹¹³ Long waiting lists in mental health care experienced by general practitioners.¹¹³ The stigma of mental illness and health care system division.²⁷
The quality and availability has to be assured.	Availability of care from the patient's site is blocked: • Access is not always assured due to limited insurance.^{3, 135} • The patient finds it difficult to contact services and make appointments.¹⁰⁶ • The patient lives too distant to services and transport is unavailable.¹⁰⁶ • Financial cost too high for the patient.¹⁰⁶ The provider barriers to quality - available care are: • Limited access to equipment locally (on-site of the psychiatric hospital versus local general hospital) or	Availability of care from the patient's site is blocked: • Patient satisfaction of care needs improvement for: i.e. in the areas of information provision, patient participation and patient rights.²⁹ • Availability, accessibility, affordability, timeliness of care and access to information for all presuppose in many cases neighbourhood-based care.¹³⁷ The provider barriers to quality - available care are: • People with SMI have more emergency department visits that could be avoided would the regular primary and secondary follow-up care be assured.^{25, 132}



Interventions	Barriers international	Barriers Belgium
	unavailable screening equipment e.g. radiology, MRI, mammography.^{7, 108} • People with SMI have more emergency department visits that could be avoided would the regular primary and secondary follow-up care be assured.¹³⁶ • Negative beliefs, attitudes and workload issues will affect the quality of care negatively for the SMI patient.^{98, 108}	Negative beliefs, attitudes and workload issues will affect the quality of care negatively for the SMI patient.²⁸
Service delivery		
Screening and treatment for medical conditions	Individual factors, physician's beliefs, diagnostic overshadowing results to patients being less likely to receive cardiac catheterisations and coronary artery bypass grafting, and medication for cardiovascular disease.³ Resistance to change and high staff turn-over are negative factors for good follow-up.¹⁰⁸ Difficult relationship building between consumer and staff due to changing facilities and changing staff.¹⁰⁶	Current nursing care within Flemish 2b-teams does not meet the desired situation according to the medical care providers involved. The current care is mainly limited to psychosocial interventions, where the desired situation is also based on somatic and pharmacological care.¹⁹
Care coordination or collaborative care strategies	Verticalisation (programmes for specific health programmes) and fragmentation of health services.⁷ A lack of coordination and communication of findings between primary care & mental health care.^{106, 111, 133}	A lack of coordination and communication of findings between primary care and mental health care.¹⁰⁷ Provision of patient medication information at discharge from hospital is performed rather ad hoc than on a systematic base.¹⁷
Guidelines for integrated delivery of mental and physical health care	Limited knowledge of mental health nurses.^{98, 111, 138} Responsibility on physical health care is unclear.^{98, 106}	No information
Integrated care structurally organised	A lack of integration when care is required across service settings is partially responsible for the poorer physical health outcomes.^{3, 7, 133} Although practice development and integrated care models are needed, it is unlikely to be sustained without public and political support.¹⁰⁶ Individuals with mental illness are often left behind from population gains in public health.^{3, 7, 133} The physical and mental health care is not sufficiently available especially integrated care models for efficient management of physical and mental multi-morbidity are absent.	GIBBIS (Gezondheidsinstellingen Brussel - Bruxelles Institutions de Santé) describe in their document 'More value as part of care' the complexity of the regulations as an important bottle neck to arrive to optimal care coordination and integration of physical and mental health.¹³¹



Figure 4 – Use of primary and specialised health care in France for patients with SMI compared to patients without SMI*



*From Gandré 202082; AOR: adjusted odds ratio; CI: confidence interval

4.3.5 Health system and organisational actions

Several examples are given on how to organise care better: • additional support team members that are trained in the other discipline can be recruited • referral pathways for targeted interventions across primary and secondary care are important to manage cardiovascular risk factors which are commonly encountered when antipsychotic medication is prescribed.

It was noted by Firth et al. that the integration of qualified exercise professionals into mental health services could ensure mental health staff's knowledge on how to give clear advice on exercise.³ The qualification of exercise professionals also mattered greatly to the physical and psychological benefits and adherence outcomes as compared with interventions delivered by non-specialised practitioners.^{3, 134} As was identified in the international reviews, similarly for Belgium, several examples are given on how to organise care better.


Table 14 – Health system and organisational actions identified in international reviews and Belgian literature

Interventions	Proposed actions / solutions international	Proposed actions / solutions Belgium
Health system-focused interventions		
A health system with leadership, sufficient financing, and human resources is needed.	Lifestyle interventions should be implemented trans-diagnostically from treatment initiation, to protect metabolic health; potential benefits for improving mental health outcomes should also be examined.³ Shared budget for liaison psychiatry services from mental health and non-mental health services.³ Strengthening of the six building blocks of the health systems – service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (stewardship) – would improve outcomes for persons with SMI.⁷ Better benefits and adherence outcomes of physical training by specialised practitioners.¹³⁴ Empower staff and service users.¹³³	To provide the dual care for elderly psychiatric patient: these persons need a specific structure that provides them with a professional framework, provided by staff specifically trained for this purpose.¹³¹ The role of the patient, since socialisation and de-institutionalisation of mental health care is taking place, is more and more as an active participant and experiential expert. More care in society means that the informal carer also becomes an important partner in care.²⁷
The quality and availability has to be assured.	Appropriate boost-trainings and team meetings will improve knowledge and motivation.¹⁰⁸ Dietary interventions in people with mental illness are more effective if they are delivered by specialist clinicians, such as dietitians, and at an early stage of treatment.¹³⁹	No information
Service delivery		
Screening and treatment for medical conditions	Improved use of medical investigations and treatments: More training of healthcare staff and wider access to screening and treatment (including cardioprotective medications, bariatric surgery, cancer screening) are required for people with chronic conditions.³ Computer prompts and the presence of a pharmacist can improve service delivery.¹⁰⁸ Better information technology to support professionals is needed.¹³³	Computer prompts and the presence of a pharmacist can improve service delivery.¹³ Electronic tools like EBM PracticeNet and shared electronic patient health records have to be developed and used.¹⁴ Better information technology to support professionals is needed.¹³ At intake of a patient a good somatic examination and laboratory investigation has to be set up: a proposition is provided.²¹ Nursing care within Flemish 2b teams could increase somatic care for the patient with SMI in the following ways.¹⁹



		1. Up-to-date view of clients' medication regimen 2. Taking general parameters (blood pressure, pulse, temperature) at regular intervals 3. Systematic screening for metabolic syndrome if client uses antipsychotics 4. Regular sober blood sampling in clients to determine lipids and glucose 5. Annual measurement of blood pressure 6. If indicated, take an electrocardiogram at home 7. Determining client's subjective experiences with medication
Care coordination or collaborative care strategies	Continuity-of-care programmes at hospital discharge for both mental and non-mental illnesses.^{3, 133} Protected hours for interdisciplinary meetings to supervise case management.³ Tele psychiatry and telemedicine for case supervision.³ Sharing of medical records between clinical professionals from mental health and non-mental health services.^{3, 133} Cardiometabolic care and subsequent dietary intervention are best implemented within a multidisciplinary framework.¹⁴⁰	Psychiatrists who prescribe antipsychotics are often best placed to coordinate the risk assessment and the approach, especially if concrete agreements are made about shared care between general and specialist health services.¹⁸ Referral pathways need to be in place for metabolic side effects follow-up e.g. when glucose measurements are disturbed, a GP or specialist should be consulted.¹² Before the discharge of patients: organise interdisciplinary meetings including the pharmacist with timely announcement of discharge date.¹⁷ A care trajectory for the psychiatric patient may help the general practitioner with the planning of care for the psychiatric patient including information on side effects of medication.¹¹³ System integration to strengthen continuity of care:¹⁴¹ • exchange of information across the range of service types (i.e. social, medical, and psychological) and facilitating referrals between them, • identification and use of alternatives to hospitals whenever possible and become a vehicle for optimal discharge after hospitalisation, • improve social integration of patients by helping them to access care while remaining in the community, maintain social activity, and find resources to assist with access to the (competitive) labour market,



		independent housing, social interaction, and participation in society, • improve patients' global, subjective quality of life. Sharing of medical records between clinical professionals from mental health and non-mental health services.¹⁴¹ Computer led care path to be used by any carer that gives flags whenever parameters are exceeded (blood tests etc) and produces referral letters. The communication between care providers has to be improved aiming at a personalised, integrated, multidisciplinary care.¹⁴ At intake of a patient: Importance of a (electronic) medical record in the psychiatric hospital that is dynamically and multidisciplinary updated and based on the anamnestic and clinical evaluations of the patient. Preferably a somatic doctor is responsible for the somatic examination but who is knowledgeable in psychiatry.²¹
Guidelines for integrated delivery of mental and physical health care	Development of national guidelines that consider multi-morbidity, regardless of the direct relationship with mental health outcomes. ³	No information
Integrated care structurally organised	Service models that have been described are: shared protocols; joint funding and commissioning; co-location of services; multidisciplinary teams; liaison services; navigators; and reduction of stigma. The models need more research e.g. the replicability and generalisability.^{3, 7, 133} <u>Innovations in integrating physical and mental health care have been tested in interventions settings and have proven beneficial.</u>³	No information

4.3.6 Community and policy level barriers

Factors leading to adverse physical health and mental illness are strongly intertwined with people with mental illness more likely to live in poverty and to suffer from cardiometabolic diseases. For this project, we consider all factors that lead to poor somatic health or poor chronic physical health in the SMI population.

It is on this scale that national and local conditions will affect the relationship between mental health and somatic health. Social, economic and political factors should, therefore, be taken into account and can be relevant barriers (Table 15).


Table 15 – Community and policy level barriers identified in international reviews and Belgian literature

Interventions	Barriers international	Barriers Belgium
Social support		
Peers, family, mental health and advocacy groups interventions	Difficulty comprehending health care advice and/or carrying out required changes in lifestyle due to psychiatric symptoms and adverse consequences related to mental illness (e.g., low educational attainment, reduced social networks, lack of employment and family support, poverty, poor housing).¹⁰⁰ The patient has limited family, social and community resources.⁷ Lack of guidance and informational support and support outside health care.¹⁰⁶	No information
Community and public interventions		
Stigma reduction campaigns directed to communities with SMI and general public	Stigma in society and negative perceptions of persons with SMI. ⁷	Stigma in society and negative perceptions of persons with SMI. ²⁷
Policy level interventions		
Comprehensive care packages, insurance parity and quality	Low financial protection and coverage in health packages.⁷ Low investment in the quality of care.⁷ Tertiary preventive measures for people with mental illness are underused, despite their potential to improve health and reduce premature mortality.³	Low investment in the quality of care. ¹³¹
Public health programmes: tobacco cessation, suicide prevention	Absence of relevant policies and guidelines.⁷ Limited health information systems.⁷ NHS smoking ban has broader benefits by supporting a culture of physical health and wellbeing within mental health services.^{3, 142} Public health strategies that are effective in the general population are not always as effective for those with mental illness.³ Secondary preventive strategies, such as screening and preventive treatments, are often underused in people with mental illness.³	No information



Employment, housing, and social welfare sector involvement	Difficulty comprehending health care advice and/or carrying out required changes in lifestyle due to psychiatric symptoms and adverse consequences related to mental illness (e.g., low educational attainment, reduced social networks, lack of employment and family support, poverty, poor housing).^{100, 106} High level of unemployment, homelessness, low health literacy, infections and malnourishment and impoverished or unsafe neighbourhoods.^{7, 106} Migrant status or cultural diversity.¹⁰⁰ Lack of social skills resulting in difficulties communicating health needs.¹⁰⁰	The risk of suffering from chronic diseases is linked to social status: for example, the prevalence of diabetes is significantly higher among people on low incomes. Inequalities in access to care are also illustrated in the document on poverty from Brussels. Almost half of the Brussels residents with financial difficulties had to postpone care for this reason. In terms of preventive care, taking cervical cancer screening as an example, coverage is significantly higher for high-income women than among those on low incomes.¹⁴³
Integrated care models	A holistic manner approach is necessary for the effective management of multi-morbidity: so that common risk factors and the interaction between physical and mental health disorders are addressed in an integrated way.^{3, 144} Public and political support are needed for the development of integrated care models. An investment in integrated care is urgent needed.¹⁰⁶	No information

4.3.7 Community and policy level actions

International focus addressing health inequities have been published by for example WHO, Public health England, and the World Psychiatric Association.^{2, 7, 8, 100} An important factor of debate is 'who is responsible' to take up actions. Governments, health commissioners, and care providers all have an important role and respective responsibilities for improving the physical health for people with mental illness will need to be established. Table 16 describes the items of importance from the reviewed literature. Of note are the social prescribing interventions which have been set up in the United Kingdom.¹⁴⁵ voluntary and community sector interventions are supported financially and provide tailor-made support to persons with long-term conditions. They have shown benefits for persons with mental health problems.


Table 16 – Community and policy level interventions actions identified in international reviews and Belgian literature

Interventions	Proposed actions / solutions international	Proposed actions / solutions Belgium
Social support		
Peers, family, mental health and advocacy groups interventions	Cooking groups that allow for dietary restrictions or religious requirements.³ Translation of documentation to local languages.³ Social prescribing of local voluntary and community sector activities led to: a range of well-being outcomes, including improved mental and physical health, feeling less lonely and socially isolated, becoming more independent.¹⁴⁵	The patient and family should take their responsibility and be actively involved and participate in care process.¹¹⁷
Community and public interventions		
Stigma reduction campaigns directed to communities with SMI and general public	Examining how broader societal factors affect the interaction between physical and mental health conditions within a given region can provide insight into these comorbidities and their risk factors; in turn, this can inform the development and implementation of preventive strategies and interventions for chronic health conditions within a given socioeconomic setting.³	To improve the patients' right to information by increasing the knowledge of the Belgium law describing the patients' rights (August 22nd, 2002). The law describes the commitments of Health Care Providers and the rights for patients.¹⁷ Destigmatisation of persons with mental health needs is one focus point for Flanders.¹³⁷ The promotion of general policies for a more inclusive society: without social welfare, there can be no mental welfare.¹⁴⁶
Policy level interventions		
Comprehensive care packages, insurance parity and quality	Evidence-based integrated care should be provided from the onset of mental illness; changes are needed at the primary, secondary, and tertiary levels of care to reduce the prevalence and impact of physical health conditions in people with mental illness.³ Engaging and responsive, integrated care services are required with flexibility from individual clinicians and service planners. As a minimum level of integration, health providers should communicate with each other frequently to ensure the safety and effectiveness of treatment.³	It is important that Belgium further reduces the number of hospitalisations and increase the number of community-based services while clinicians need to be aware of their patients' vocational needs and make work of a positive collaborative engagement.¹⁴⁷ The actions proposed concerning somatic care are as follows: optimal information transfer between the carer and patient, actively involve the patient and family and stimulate participation, and develop a strategy and local policy to guaranty patient safety and quality.¹¹⁷ The Flemish preliminary draft decree on mental health aims first and foremost at valuing, protecting and strengthening the mental health of all citizens, not only those with mental



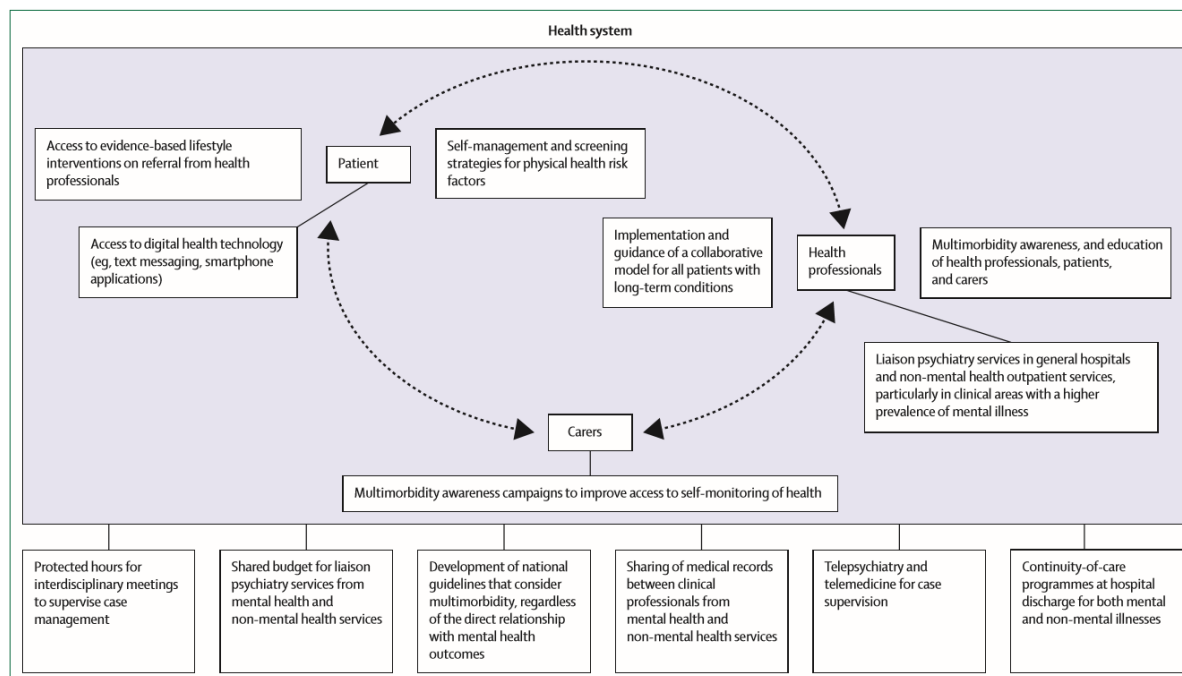
Interventions		Proposed actions / solutions international	Proposed actions / solutions Belgium
			health needs. Destigmatisation of persons with mental health needs is one focus point for Flanders.¹³⁷ A press release by 1400 GPs of the Brussels region describes the following points of attention:¹⁴⁶ • An articulation of appropriate somatic care in a comprehensive approach to the health of psychiatric patients through their contacts with the hospital. • Continuous evaluation of efforts and measures aimed at promoting and implementing the general practitioner (single or in a medical centre, etc.) or in a specific care centre) in his central position as care coordinator. • Increased accessibility of outpatient mental health resources, whether they are second-line (e.g. psychiatrist in mental health services) or first-line (e.g. mobile psychosocial support), or support to low-threshold psychosocial structures (now saturated and unable to offer a permanence). • An integrated approach, whenever necessary, to social and economic support and psychological support.
Public programmes: tobacco cessation, prevention	health suicide	Policy-level ban on smoking on mental health wards and hospital premises and the dissemination of smoking cessation interventions throughout community care was installed in the National Health Services.^{3, 142} Authorisation of e-cigarettes on-premises.^{3, 148} mHealth technology and other digital technologies provide many novel methods for promoting physical health and delivering interventions at home.³ Primary prevention strategies need to be adapted for people with mental illness.³	No information
Employment, housing, and welfare involvement	social sector	Improvement of socially deprived areas e.g. local green spaces with walking routes.³ To provide a suitable environment for effective medical and lifestyle interventions.³	Reforms relating to the right to social assistance and social security taken at the federal level may have important impacts at the local (Brussels) level affecting people with low social protection e.g. chronic illness. This should be taken into account when defining actions as part of the reforms. ¹⁴³
Integrated models	care	Collaborative care approaches, described in the review by Firth et al, all use structured management plans, scheduled patient follow-ups, and extensive interprofessional communication. ^{3, 149} The figure from Firth et al describing the model	No information



Interventions	Proposed actions / solutions international	Proposed actions / solutions Belgium
	of collaborative care aspects is presented below (see Figure 5). Examples of evidence from trials is listed below, but studies with chronic SMI patients are lacking. Examples of studies of integrated care interventions are the following but are so far mostly linked to primary care: The COINCIDE trial tested a psychological intervention (behavioural activation, healthy lifestyle, exercise, and diet) for people with depression and comorbid diabetes or cardiovascular disease. Health benefits, depression and patient satisfaction were sustained at 24-month follow-up, and the intervention was found to be cost-effective.^{150, 151} The RAINBOW trial supported collaborative care models for improving both physical and mental health outcomes in people with common mental disorders and cardiometabolic comorbidities.¹⁵² The PRIMROSE study¹⁵³ showed that integrated care did have a 12-month mean cost difference of –£824 (95% CI –568 to 1079) compared with usual care, and was found to be cost-effective because of fewer hospital readmissions over a 12-month period.¹⁵³	



Figure 5 – Potential components of a collaborative care model for improving health management in people with physical and mental comorbidities.



Source: figure 3 from Firth et al³



5 THE SOMATIC CARE OF PERSONS WITH SMI: QUALITATIVE RESEARCH ON THE HEALTHCARE PROFESSIONALS' PERSPECTIVES

Key messages

- The divide between somatic and psychiatric health care was evaluated as outdated by the healthcare professionals interviewed (HCPI). Integrated care would enable better continuity and quality of care at a lower cost, as double work could be reduced and collaboration difficulties prevented.
- The collaboration and information flows between psychiatric healthcare professionals and non-psychiatric healthcare professionals were troublesome.
 - Collaboration with non-psychiatric healthcare professionals (even within general hospitals) was evaluated as difficult by the interviewed healthcare professionals. They mentioned stigma and prejudice, lack of feeling or sensitivity for psychiatric patients, and difficult communication and data transfer as explanations for this observation.
 - In psychiatric wards of general hospitals the management of somatic health problems was cumbersome and time-consuming. Patients were kept waiting because the staff had to find out which physician to contact; and the specialists had to find time to come over to the psychiatric ward.
 - A patients' transfer to a somatic ward whenever the care became too complicated to manage at a psychiatric ward was not self-evident. While the psychiatric staff felt they lacked skills or equipment to provide good care, the staff at the somatic ward was assumed to fear not being able to manage the psychiatric disorder.
- Interviewed GPs and psychiatrists said they had to advocate equal care for their patients at colleague somatic physicians.
- Interviewees stated that psychiatric patients were often too rapidly discharged from the emergency ward, assuming that, because the patient resided in a hospital, a psychiatric hospital or a sheltered housing initiative, there was skilled nursing staff available to take care of the patient.
- If after discharge from a somatic ward, patients returned to the psychiatric ward or setting, practical problems such as unavailability of equipment, infrastructure not being adapted (e.g. for wheelchairs or hospital beds) or patient safety not being guaranteed were encountered.
- GPs, psychiatrists and nurses of psychiatric settings found it cumbersome to find the patient information they needed, especially when patients had no regular GP. Often they had questions about the medication schedule or were they not able to trace the reasons for medication prescriptions. Healthcare professions were thus obliged to re-start medication from zero.
- Psychiatric healthcare professionals lack somatic health knowledge and skills.
 - Psychiatrists specialise in mental health early on in their training program, thus somatic health is less addressed. Already during the internship, technical acts are preferably performed by trainees from somatic specialities. The somatic part of their training tends to degrade to passive knowledge. During the further career course, somatic care skills are no longer practised, nor kept up to date.



- Nurses mentioned that they had lost their somatic skills like wound care, injections or blood sampling. Because they were less experienced with this kind of tasks, they felt unsure and uncomfortable performing them. The lack of exercise and knowhow of somatic nursing skills hampered the management of somatic care.
- Somatic healthcare professionals (e.g. GPs, specialists, dentists) lacked knowledge and skills about psychiatry.
 - Staff of psychiatric settings reported it was not self-evident to find dentists, GPs or specialists able and willing to see residential psychiatric patients. Medical shopping or the lack of a regular GP complicated the management of somatic health care.
 - Healthcare professionals at emergency services seemed not to be trained to provide adequate care to a psychiatric patient: accounts were reported about patients not being taken seriously and somatic symptoms being attributed to the psychiatric disease. A written referral letter facilitated emergency care.
- GPs played a pivotal role in the care for somatic health problems in persons with a mental illness. For example, they helped to interpret health data (e.g. blood sample). In addition, GPs facilitated communication between primary and secondary care. A clear division of tasks between GPs and psychiatrists facilitated collaboration.
- Time shortages occur due to insufficient and inadequate staffing.
 - Psychiatric nurses were well placed to accompany patients to consultations or examinations outside the psychiatric ward; however, this was very time consuming and not always possible because of understaffing of the wards.
 - Insufficient staffing reoccured relative to various subjects: care coordination, listening to patients, keeping electronic

medical files up to date, prevention and health promotion initiatives etc.

- Interviewed healthcare professionals addressed some shortcomings of the hospital pharmacy: medication schedules were adapted to the availabilities in the formulary and too much time passed between medication prescription and its administration. Even for symptomatic drugs (e.g. painkillers) a procedure of approvals needed to be followed, disabling the staff to quickly relieve the patients' discomfort.
- The current financing was perceived as not facilitating the collaboration between somatic and psychiatric healthcare professionals, nor continuity of care between primary and secondary (hospital) care. Hospitals had to use their own resources to offer qualitative somatic care to their inpatients (e.g. financing of an in house GP).

5.1 Method

5.1.1 Design

In order to collect data on the barriers to appropriate somatic care for patients with severe mental illness, we conducted face-to-face semi-structured interviews with several healthcare practitioners in several residential settings.

In semi-structured interviews a set of predetermined open-ended questions is used to guide the interview, but additional questions may emerge from the conversation. In this research project we were interested in individuals' personal perspective on how somatic health problems were treated in a psychiatric setting. Individual face-to-face interviews allow to build trust and get in-depth and detailed information. This technique is therefore very suited to share personal and sometimes confidential information.

We combined individual face-to-face interviews with group interviews. Physicians were interviewed individually, but the members of the multidisciplinary team were interviewed in groups.



5.1.2 Sampling

We identified for each region (Flanders, Brussels, Wallonia):

- 1 Sheltered Housing Initiative (SHI) / Initiative d'Habitation Protégée (IHP) (/ Initiatief Beschut Wonen (IBW)
- 1 psychiatric ward of a general hospital (PSGH)
- 1 psychiatric hospital (PH)
- 1 psychiatric nursing home (PNH) / Maison de Soins psychiatriques (MSP) / Psychiatrisch Verzorgingstehuis (PVT)

We searched for a balance in the participation of private and public settings, academic or not and French and Dutch language.

5.1.3 Recruitment

Settings were identified through an address list of mental healthcare settings.

In January 2020, we contacted the settings (direction staff) by phone and if they showed interest in the study we invited them formally by e-mail. The Flemish-speaking settings were directly invited by e-mail from February onwards.

Each setting in the sample was visited. During the site visits we interviewed:

- a psychiatrist in an individual face-to-face interview
- a somatic practitioner: GP or specialist (if there was no GP entitled to the setting) in an individual face-to-face interview
- the multidisciplinary team (psychiatric nurses, psychogologists, educators) in a group interview

5.1.4 Data collection

Based on the literature and exploratory informal meetings with healthcare practitioners, we developed two semi-structured interview guides, one for the physicians and one for the multidisciplinary team. For the teams we used 'case examples - patient scenarios' to facilitate the discussion. The guides are available in the appendices (Appendix 5).

The core topics of the interview guides were the following:

- What is the place of somatic care in the management of patients: from intake to discharge?
- How is the quality of the management of somatic chronic care perceived?
- What are barriers or challenges in somatic care for chronic and acute health problems, as well as prevention of health problems?
- What are examples of good practices?
- Do you have suggestions to improve somatic health care?
- The collaboration between healthcare professionals

For the groups with the multidisciplinary teams, case examples were constructed describing somatic health problems frequently occurring in the population of psychiatric patients (e.g. weight gain, diabetes) or common acute or chronic problems (a fall, a cough, chronic bronchitis). Several case scenarios were developed and discussed with a representative of the patient organisation 'Steunpunt Geestelijke Gezondheid' before finalisation. On the basis of the examples, the different participants were questioned how the somatic health scenario was addressed and managed in their setting.

Interviews were originally planned in February, March and April 2020. Unfortunately, due to the COVID-19 crisis, we had to postpone or cancel a number of interviews to June and July 2020. Three (out of 18) individual interviews (1 with a French-speaking GP and 2 with Flemish GPs) were performed remotely by means of an online conference call application (Zoom).



5.1.5 Analysis

Transcripts have been coded in Nvivo© by two KCE researchers (WC and LK), the Dutch interviews by the same native Dutch researcher, the French interviews by the same native French researcher. An inductive thematic analysis was performed by both researchers. Each researcher made her own list of primary nodes, i.e. without clustering. In a second step, both Dutch and French nodes were compared and clustered together, resulting in a hierarchical node tree. Findings were described based on these clusters of nodes.

We added quotes (in the mother-tongue of the participant) in the text to illustrate our findings.

5.2 Findings

We were not able to recruit as many participants as intended. Consequently, we did not reach data sufficiency. This means that our final findings may not be generalisable to all psychiatric settings and are in fact hypotheses that necessitate further research in order to come to firm conclusions.

The discussion of the results of the healthcare professionals are integrated with the results of the patient interviews in chapter 6 (see section 6.3).

5.2.1 Description of the participants

In total we met about 50 healthcare professionals from 10 different settings. The sample is described in more detail in Table 17. Every setting was located in a different province and we searched for a balance between public and private settings. We did not mention this information to insure the anonymity of the participants.



Table 17 – Description of the participants

	Flanders				Brussels				Wallonia			
Type of setting	Psychiatric ward	Psychiatric hospital	Psychiatric nursing home.	Sheltered Housing Initiative	Psychiatric ward	Psychiatric hospital	Psychiatric nursing home.	Sheltered Housing Initiative	Psychiatric ward	Psychiatric hospital	Psychiatric nursing home.	Sheltered Housing Initiative
Language	Dutch	Dutch	/	Dutch	French	French	Dutch	French	French	French	French	/
Psychiatrist	1	1	-	1	2	1 + 2**	1	1	1	1	-	-
Somatic physician	1 emergency doctor	1 GP	-	1GP	1 GP	1 GP +1* GP	1 GP	/	1 GP	1 specialist	1 GP	-
Paramedical team	Team of nurses and psychologist	Team of nurses	/	Team of nurses and educators	/	Team of nurses and social workers	Team of nurses and educators	Multidisciplinary team	Team of nurses, psychologist, physiotherapist, educator	Multidisciplinary team	Multidisciplinary team	/

* Via videoconference - ** Psychiatrists in training



5.2.2 How is somatic care managed in daily practice?

Daily practice differed between the different types of settings under study. At one extreme, psychiatric wards in general hospitals handled crisis situations and aimed foremost to stabilise the patient. Patients stayed only a few days, or maximum up to two or three months. At the other extreme, in sheltered housing initiatives and psychiatric nursing homes patients resided for several years, even lifelong.

5.2.2.1 Role of the different actors in psychiatric settings relative to somatic health care

Psychiatrists

Psychiatrists were in charge of inpatients or residents during their stay. Because the intake was related to mental health problems, priority was obviously given to mental health. Somatic health problems related to the psychiatric problem may have been present but were not the primary reason for the hospitalisation.

In theory, psychiatrists, as treating physicians were the contact person for any health problem. Psychiatrists were responsible for the health condition of their patients, including somatic health checks at admission (e.g. clinical examination, blood sample). The psychiatrist was the final prescriber and took final decisions and referred the patient to the GP or a specialist if this was necessary.

In sheltered housing initiatives residents had their own entitled psychiatrist. The medical director (being a psychiatrist in the sheltered housing initiatives we have visited) was responsible for assessing candidate residents; this included, among others, whether the physical/somatic health status allowed the candidate to live in a sheltered housing initiative. Because one of the aims of the sheltered housing was to guide the resident to more autonomy, residents had to manage their own healthcare, i.e. visiting their GP, psychiatrist or any other specialist.

In all settings, psychiatrists were on call outside office hours, for both somatic and psychiatric problems, except in sheltered housing initiatives. Psychiatrists in training took over this role in absence of the psychiatrist.

Because psychiatrists did not practice somatic medicine often, some of them felt uncomfortable with somatic care and tended to refer the patient to a general practitioner or specialist for somatic problems.

« S'il s'agit d'une simple hypothyroïdie ou... un simple manque de vitamines, je crois que nous, on est capables de gérer ça. Mais un patient en hypertension grave, par exemple, voilà. En urgence, on sait mettre un petit AMLOR, mais le traitement de fond pour la suite, ça, ça reste quand même de l'ordre d'un interniste ou du [médecin généraliste]. Je crois que là, on doit quand même reconnaître aussi qu'on est spécialistes en psychiatrie. Mais donc, on doit au moins, je crois pour nous, au moins repérer le problème, être capable d'en gérer une partie, et les autres, on doit savoir – en fait, on doit connaître nos limites, et savoir à quel moment on fait appel à un collègue. »
(Psychiatrist-PSGH)

Interviewed psychiatrists explained that they specialised in mental health already early on in their training program, thus somatic health was less addressed and subsidiary to mental health. Already during their internship, technical acts were preferably given to candidates of somatic specialities. During the further course of their career, they did not maintain their somatic care skills and the somatic part of their training tended to degrade to rather passive knowledge. It was mentioned that psychiatrists in Belgium are not used to do physical examinations.

« ...Un psychiatre, lui, sait peut-être, mais de toute façon, souvent les psychiatres ne désirent pas s'occuper de ce qui n'est pas de la psychiatrie pure et dure, même au tout début de leur assistanat. Quand on a des assistants en première année de psychiatrie, je pense que très vite, ils disent « Non, non, s'il y a un potassium anormal, moi je ne m'occupe pas de ça », même si trois mois avant, quand il était stagiaire, il s'en occupait très bien. » GP-PSGH

“En als ze dan nog lichamelijke comorbiditeiten hebben, dan moeten we eigenlijk een beetje kijken welke collega's dat we daarvoor in consult roepen. (...) Onze psychiaters zijn daar toch wel wat minder mee vertrouwd geworden door de tijd” (Psychiatrist-PSGH)



The GP

In psychiatric settings we encountered several ways of how the GPs was taking care of the somatic health of the residents in general:

- The entitled GP was theoretically allowed to visit the patient during the stay. Nevertheless, this was rather scarcely reported by the respondents.
- The “in-house” GP was employed by the hospital in order to manage somatic care for the residents. The GP was part-time or full-time attached to the psychiatric ward; had a private practice or not outside the hospital; saw the patients at the ward or at the practice; was on call during the night or the weekends in psychiatric settings (PH, PNH); and as such took care of the patients during their stay.
- Some settings had collaboration contracts with GPs. They came on a daily or weekly basis. In psychiatric settings, they were sometimes on call at night and in the weekends. In this case they combined their private practice with working in the psychiatric hospital.

GP-psychiatrist communication and coordination aspect on somatic care were the following:

- Psychiatrists referred patients with somatic health ‘complaints’ to a GP without first assessing the patient if a referral was really needed.

« Voilà, c’est sûr que le corps va exprimer énormément de choses aussi, donc... voilà, c’est vrai que si je vois chaque patient qui a une crampe au ventre... euh, ça devient très compliqué. Ou alors, il faudrait une force de travail supplémentaire, mais je maintiens que... que le psychiatre et médecin avant tout est quand même aussi capable de pouvoir discuter de douleurs abdominales, de voir s’il y a un degré d’urgence, une gravité, ou est-ce qu’il y a un degré d’autre chose. » (GP-PSGH)

- GPs helped to clarify, structure or interpret health examinations (e.g. results blood sample) received by psychiatrists.

« Les prises de sang ont été revues, parce qu’elles étaient hyper dures à déchiffrer. Il y avait plein de trucs demandés, le psychiatre était

complètement perdu et en fait, on a re-réfléchi : (...) demander peut-être quelque chose de plus raisonnable, de plus facile aussi à lire pour le praticien psychiatrique, et qui du coup, comme c’est plus lisible et plus interprétable, c’est plus facilement pris en charge. » (GP-PSGH)

- It was clearly highlighted by respondents that not all physicians had a ‘psychiatric sensibility’, but if present, it facilitated working with psychiatric patients.
- In one of the general hospitals we visited during our interview round, the GP was the liaison between the psychiatric ward and specialists within the same setting. The GP facilitated the communication between primary and secondary care and took care of physical examinations.

« En général dans les hôpitaux et les services psychiatriques des hôpitaux généraux, c’est en général un somaticien qui fait l’examen somatique. Il faut dire qu’un examen somatique de qualité, ça ne s’improvise pas. Donc il faut faire une palpation, une auscultation cardiaque correcte, enfin bon. Ça ne s’improvise pas, et si vous le ne faites pas régulièrement, vous ne savez pas le faire. » (Psychiatrist-PH)

Regular staff meetings were key moments to discuss the condition of each patient including somatic needs. Unfortunately, because of organisational issues, the participation of external GPs was not foreseen. External GPs had not enough time to participate.

Although the psychiatrist was responsible while the patient was admitted, the responsibility for care that was started previous to admission was not always clear and differed from one place to another. According to respondents, this deserved to be discussed to improve collaboration: who prescribes for what purpose, who encodes the information in the medical file etc.

« Si les patients n’ont pas de généraliste et qu’ils ont besoin de leur Glucophage ou leur puff, est-ce que je dois dire comme psychiatre « Oh ce n’est pas mon problème, je ne suis pas somaticien » ou est-ce que je les prescris ? Avec le risque que, en effet, je continue à prescrire un puff qui n’est peut-être pas au top. Mais je me dis que c’est mieux que rien. Et oui, je propose à nos patients de faire une épreuve de fonction respiratoire, et oui, je leur propose d’aller voir le diabétologue ou le



généraliste pour adapter son Glucophage mais je me dis que s'il ne le fait pas, je ne vais pas non plus me dire « Non je ne m'en occupe pas ». (Psychiatrist- PSGH)

A GP working in collaboration with a psychiatric hospital reported that work was always in direct collaboration with the nurses of the ward; during consultations the nurse accompanied the GP. This facilitated information transfer and the follow-up (demand of tests, appointments) by nurses.

The specialist

Some general hospitals opted to refer the residents to a specialist of their setting for somatic health problems. In the psychiatric ward of a general hospital the head of department and the nursing staff explicitly formulated the need for a specialist affiliated to the psychiatric ward to take care of the somatic health care. It was however clear that they did not believe this kind of function would be created because this type of physician is extinct: in a fee for service system function with few technical acts at the one hand and a lot of case study work and coordination on the other hand is not well paid.

Specialists are nowadays so specialised in one field of medicine that they are no longer able to care for 'general problems'. Finally, a kind of 'psychiatric sensibility' is also recommended, which makes it even more difficult to find the right person.

In some hospitals the hospital specialist was on call for somatic problems during the day. At night and in the weekends emergency services were used.

The nurse

In psychiatric hospitals or in psychiatric wards, nurses were 'psychiatric nurses'. It meant that they were primarily in charge of and trained for mental health issues. The interviewed nurses also organised, coordinated and followed the appointments of their patients with healthcare professionals outside the psychiatric ward or hospital. Regarding the management of somatic care, they mentioned that they had lost their somatic skills like wound care, injections or blood sampling. Because they were not or less experienced with these tasks, thus felt unsure and uncomfortable performing

them. This lack of exercise and knowhow of somatic nursing skills hampered the management of somatic care.

« Il y en a certains qui me disent « Voilà, écoute, viens parce qu'il faut suturer », et je sais que oui, je dois venir parce qu'il faut suturer. Il y en a, je ne sais pas peut-être que... La plupart du temps je ne dois pas suturer. Parce qu'ils ne savent plus faire la différence entre quelque chose qui est saturable ou pas. Donc oui, même ça c'est... Après, il y a toujours des « Peut-être qu'il faudra » et que là effectivement c'est peut-être... Et voilà. Mais, il y en a ils m'appellent et je ne suis pas sûre que je vais devoir suturer. Ça dépend de l'infirmier que j'ai au bout du téléphone, et ça aussi avec le temps on apprend qui est au bout du téléphone et dire « Si lui m'appelle c'est que je dois y aller » (GP-PNH).

Nurses were in close contact with the patients and had to maintain 'peace' on the ward. They listened to the residents, managed their behaviour and/or moods. They were the principal point of contact for residents' somatic complaints. Because they were used to handle mental illness in general and had knowledge of the residents (at least in case of long stays), in the majority of the cases, they were able to translate the nonverbal expression of troubles or the images expressed by the patient when they were suffering from a physical health problem (e.g. a snake is eating my stomach) to somatic complaints (e.g. stomach ache). Nurses said were good 'translators' between the patient and the non-psychiatric world, i.e. the nurses and physicians trained in somatic care. Residents also trusted the nurses. Therefore, nurses accompanying patients to consultations or examinations external to the psychiatric ward or setting facilitated the work of specialists or other healthcare professionals outside psychiatry. Also preparing the consultation in advance works well.

Nevertheless; this was not everywhere foreseen in their job description and wards were understaffed making it very difficult for nurses to leave the ward to accompany patients. Also nurses mentioned it was very time consuming to accompany patients to a consultation or examination because they had to spend time sitting in waiting rooms of specialists.

Specifically in psychiatric wards of general hospitals where the staff lacked a GP or specialist, nurses reported a knowledge-gap regarding somatic



health issues. In these setting, nurses had to compensate and take on much more tasks then they were trained for.

“Ik denk dat dat als de verpleging zich alleen maar zou bezighouden met hun taak als verpleging, dan loopt het helemaal mis. Want het is de taak van de verpleging die het altijd maar meer en meer op zich neemt, die op den duur gaan die de dokter gaan overnemen, maar toch heel veel zaken doet, die eigenlijk niet voor ons bestemd zijn.” (Team-PSGH)

« Ook rond medicatie en dergelijke ook. Maar ge moet alles maar opvolgen, ja. Aanpassing van medicatie, dat eigenlijk ons taak niet is. Dat eigenlijk de dokter moet zien, als die de patiënt en het dossier gezien heeft. Moet dat opnieuw bevragen van ‘hé, zou ge die medicaties niet aanpassen?’ of dit of dat. Kijk, vroeger moest het allemaal niet hé. Kijk, ik had een dokter vroeger die elke dag aanwezig was en die de medicatie bekeek. Ik heb mij vroeger nooit moeten moeien met medicatie. Het is niet goed dat de verpleging moet zeggen aan een arts ‘zout ge die medicatie eens bekijken?’ dat mag niet, vind ik persoonlijk hé. Maar dat is iets dat zal overal zo zijn. In alle ziekenhuizen, op alle afdelingen denk ik, dat de verpleging meer en meer taken op zich neemt, die eigenlijk misschien niet bestemd zijn voor hen. »((Team- PSGH)

The other staff

Depending on the setting, other additional professionals were working with psychiatric residents: physiotherapists, psychologists, socio-therapists, social workers, artistic animators, etc. Everybody received patients' complaints. They discussed the patients/residents during staff meetings.

5.2.2.2 Key moments in the journey of the resident.

In general, the interviewed healthcare professionals saw a positive evolution in the past five years regarding the consideration for somatic health problems of psychiatric patients.

« Ik denk de weg die we hebben afgelegd rond lichamelijk welzijn, daar ben ik wel fier op. Omdat dat de afgelopen 5-6 jaar.... Hebben we eens

een poging gedaan om er iets mee te doen. Dat is dan wat verwaterd, of wat personeelsswissels die dat wat benadeeld hebben. En nu zijn we toch al twee jaar echt binnen lichamelijk welzijn met verschillende projecten bezig en dat gaat traag, maar er zijn zo wel een paar... En dan denk ik aan de wondzorg, wondzorg referenten, diabetes begint op poten te staan, we nemen onze start met dat metabool syndroom. We denken in de toekomst na over hoe gaan we het met mondzorg doen?” (Team-PNH)

The place of somatic health in pre-admission procedures in a sheltered housing initiatives

Pre-admission referred to the decision whether or not to allow a patient to reside in a sheltered housing initiative. The assessment procedure included a minimal evaluation of somatic antecedents to exclude patients with severe somatic pathologies in need of specialised care or equipment. In the pre-admission procedure the somatic history of the candidate was taken into account based on the information provided by the patient and not by consultation of the patients' medical file. The main purpose of the limited somatic assessment was to estimate whether the accommodation was sufficient. By consequence a candidate can be refused if the sheltered housing initiative is not sufficiently equipped.

In addition, residents of sheltered housing initiatives were free to choose a GP external to the organisation, also if they had a collaboration agreement with one specific GP or GP practice. In one of the sheltered housing initiative having a regular GP was a condition for admission.

Overall, it seemed that somatic health is not a priority in the pre-admission procedure of sheltered housing initiatives.

Attention paid to somatic health in admission procedures

Several scenarios were reported regarding the place of somatic aspects at the moment of admission in a psychiatric setting. Different **actors** were involved depending on the type of setting or depending on the way the patient was admitted (via emergency services or a planned hospitalisation)



- Admission via emergency service, i.e. for the patients placed in 'observation', who received a physical examination by a specialist.
- Admission by GP or psychiatrist's referral: the somatic aspects were investigated during an admission interview that was carried out by the psychiatrist, the psychiatrist in training, the specialist, the GP, or, partly by nurses.
- In sheltered housing initiatives, the psychiatrist briefly questioned the resident on somatic problems.

The search for information on somatic antecedents (e.g. in medical files) was not systematically but

- In SHI: the medical report from the psychiatrist included somatic aspects
- In PNH: residents were generally coming from a hospital. If the GP of the PNH had access to the medical file of the hospital, this file was checked for medical and surgical history and which screenings or tests had been done.
- Electronic medical files were not accessible for all physicians. Accessibility depended of the software. In addition, not all physicians consulted the medical file when available.

For patients with a somatic chronic disease, it was mostly not easy to gather information on what had already been done. The staff spent a lot of time searching for information.

"Maar wat we wel merken is dat als mensen extern binnenkomen bij ons, dat wij heel weinig info krijgen. Soms is dat een papier, een blaadje, twee blaadjes. Of dat mensen een hele reeks somatische medicatie krijgen maar ge eigenlijk niet weet waarom is dat opgestart? Hoe lang loopt dat nu nog? Is dat nog nodig eigenlijk allemaal? Dus dat is eigenlijk tot grote frustratie soms wel van ons, ge moet dan inderdaad beginnen zoeken, beginnen opbellen, verslagen gaan vragen links en rechts... Er is nooit... Iedereen spreekt altijd maar van netwerken en netwerken. Maar de info wordt nooit doorgegeven. Soms hebt ge echt 't gevoel van 'ik moet beginnen vanaf 0' wat dan eigenlijk niet kan." (Team-PH)

Contact with the entitled GP, if any, was performed according to the needs (e.g. the current medication schedule). In some settings the GP (employed by the setting) tried to see all newly arrived patients with a history of somatic health problems, but this was not always possible because of the high workload.

"Ik zie niet altijd meteen de nieuwe bewoners. Dat hangt ook een beetje af van de problematiek. Als dat jonge mensen zijn die geen problemen hebben, dan zie ik die soms pas enkele maanden nadien. Maar als dat mensen zijn die echt wel wat meer antecedenten hebben, dan zie ik die de eerste keer, dan legt X [de hoofdverpleegkundige] mij een beetje uit wat dat't dossier is." (GP-PH)

In sheltered housing initiatives the medical director demanded the agreement of the resident to contact other healthcare professionals for more information on the medical history or the medication schedule of the resident. Sometimes this agreement was a condition to be accepted in the sheltered housing initiative.

GPs, psychiatrists and nurses of psychiatric settings found it cumbersome to find the information they needed, especially if the patient had no regular GP. Often they had questions about the medication schedule of the patient or were not able to trace the reasons for each drug on the schedule. The healthcare professions told us they often had to start from zero.

"Ook heel veel van onze bewoners veranderen heel vaak van arts en je weet niet of die huisarts die op het papier staat nog de juiste is. En dan begint echt wel... het zoeken, he. Ja. En sprokkelen..." (Team- PH)

The **content of the first somatic consultation after admission** in a psychiatric ward/hospital/sheltered housing initiative varied:

- Information about somatic health was searched through questioning the patient, e.g. his medication schedule
- GPs in general hospitals did not always have sufficient time to have an individual interview with every new patient. The interview was systematic for polytoxicomaniac people because they always had somatic problems that needed investigation but for the other psychiatric inpatients, this happened only on demand of the psychiatrist. It also



depended on the psychiatric state of the patient (confused or not). Sometimes if there was no GP but a specialist, there was special attention to one specific disease, depending of the specialist main topic (e.g. diabetes).

- In psychiatric hospitals, usually every patient was seen within 48h after intake by the GP for a full examination: BMI, physical auscultation, etc.
- In general hospitals, nurses had a standard assessment procedure with weight, blood pressure, and pulse to be taken 48 to 72 hours after admission.

Information could also be completed by family members.

« Donc il y a quand même un minimum de recueil de données anamnestiques. Celles que les patients sont capables de donner, celles que la famille complète, parce que la famille amène des vêtements par exemple deux heures après l'admission et dit « Je ne sais pas si elle vous a dit mais elle doit prendre des médicaments pour le cholestérol, pour la thyroïde » - « Ah bon elle ne nous l'a pas dit merci ». Donc on intègre ces données. » (Psychiatrist –PH)

The **examinations and tests** realised at intake also varied. In general hospitals or psychiatric hospitals, a blood test seemed to be a standard procedure. The content of the blood test was defined by the psychiatrist, sometimes in collaboration with the GP. The aim was e.g. to detect secondary effects of pharmaceutical treatments, but was also an opportunity to screen for tuberculosis, sexually transmitted infections, hepatitis, serology, or pregnancy. Other test/exams, such as ECG, EEG, urine test were done in some settings, but this varied widely.

Regarding the **pharmaceutical treatment** of the patient, the psychiatrist did the follow-up of existing psychopharmaca, the GP took care of somatic treatments if necessary.

During the stay

Routine somatic care

For every patient, in general or psychiatric hospitals, **parameters** were taken by the nurses. Results of blood tests were interpreted and followed up by the GP, psychiatrist or nurse in charge. The GP managed prescriptions and interpreted the results of examinations.

Part of routine care involved the follow-up of the side effects of the psychiatric pharmaceutical treatment. Several standardised **therapeutic protocols existed to monitor the side effects of medicines**, e.g. for Clozapine, Depakine, Leponex. Their use depended on the setting and the physician.

« (...) les protocoles en salle sont déjà bien dans le sens où le psychiatre, malgré tout, à nouveau dans son rôle de médecin, il sait que s'il prescrit de la Dépakine, il faut doser la dépakinémie ; s'il prescrit du lithium, c'est pareil. Il y a une pesée systématique une fois par semaine de tous les patients hospitalisés. Donc oui, si, ça c'est sûr qu'il y a un suivi. Si on prescrit un médicament qui allonge l'espace Q-T sur un électrocardiogramme, on va prescrire un électrocardiogramme. » (GP-PSGH)

“Hoe op te volgen en hoe zoiets aan te pakken. Dat is wel opgesteld volgens de richtlijnen. Die procedure bestaat wel. Maar of die altijd overal evengoed gevolgd werd, dat weet ik niet. Dat is denk ik al iets minder dan wat op papier staat. Er is ook een procedure rond het gebruik van medicatie die monitoring vergen. Daar zijn ook procedures voor, dus dat staat wel allemaal op papier en is wel uitgewerkt volgens de richtlijnen. Maar of dat.... Ik heb daar ook niet zo'n zicht op omdat dat ook niet mijn verantwoordelijk alleen is he. Dat is op de afdeling dat daar voorschriften gemaakt worden en dat is eigenlijk aan de psychiater om daarmee te begeleiden. Maar ik zeg het, we proberen daar meer en meer aandacht op te vestigen om dat wel te volgen.” (GP-PNH)



The minimal follow-up of side effects of psychopharmaca was regular blood sampling and weighing. When there was no specific protocol, it was considered as the basic management of the somatic care of the patient. The aim was to detect metabolic troubles, diabetes, dyslipidaemia, problems with the renal or thyroid function. Who was responsible for it depended on the setting: if a GP was connected to the setting, this was part of the follow-up but this was not the case in all settings. If there was a collaboration with a specialist, it seemed that the follow-up was mostly done by the psychiatrist.

Moreover, the stay in a (general) hospital was sometimes taken as an opportunity to do a **general check-up**, especially for patients who had no contact with a doctor for a long time, to relaunch a treatment or do examinations which had been postponed. Some of the interviewed GPs (connected to a psychiatric hospital) tried to see patients systematically e.g. every year or every six months, depending on their health condition.

« J'ai l'exemple de quelqu'un qui avait une anomalie quand même assez importante au niveau de l'œsophage, qui devait être contrôlée, ça datait d'il y a 2 ou 3 ans, ça n'avait pas été fait. On a profité de son hospit' pour prévoir les examens. On pallie un peu effectivement au rôle d'un médecin traitant extérieur. » (GP-PH)

“Wij hebben nu redelijk wat mensen die in chroniciteit nog verblijven he. Die echt een langdurig verblijf hebben hier. En voor die mensen is er wel een systeem op poten gezet dat die minstens één keer per jaar naar de huisarts worden gestuurd en dat daar dan telkens, even toch globaal zo, een keer wordt bekeken: is de medicatie nog op punt? Is er een bloedname gebeurt? Is er gekeken naar andere risicofactoren? Alles waar chronische problemen, dat dat dan nog eens wordt overlopen. Dat die... En zo... preventieve onderzoeken gelijk mammografie, dat dat ook gebeurt bij mensen die lang verblijven. Maar dat is bij een minimum verblijfsduur van 12 maanden he.” (GP-PNH)

“De hoofdverpleegster zet daar de patiënten op een lijst voor mij, die moeten gezien worden die dag. Zo een aantal zaken die acuter zijn en voor de rest probeer ik, min or meer in de mate van het mogelijke, volgens een vast stramien de mensen te zien, afhankelijk van hun pathologie. Dus ofwel zie ik ze één keer om de zes maanden, als dat mensen zijn die nog jong zijn en eigenlijk voor de rest geen raadpleging

nodig hebben. En dan heb ik mensen die ik eigenlijk wel wat vaker moet zien, maar ja, over het algemeen wordt dat vooral geleid door de psychiatrisch verpleegkundige daar, die zelf ook wat bijhoudt wanneer wie bloedafname moest hebben enzovoort. Eigenlijk op zich is dat zo wel een beetje een vast roulement daarin, afhankelijk van de problematiek van de patiënt.” (GP-PH)

By consequence severe somatic problems (e.g. hepatitis or cancer) were discovered during routine check-ups.

The contact with the GP was also the opportunity for the GP to **evaluate the usefulness or appropriateness of the somatic medication**. In general, what was done depended on the length of stay in the ward/hospital.

“(...) De behandelende arts moet eigenlijk wel het overzicht... En zo op dat jaarlijks consult probeer ik dat ook altijd eens te overlopen van zijn daar sommatiemedicaties die misschien niet meer nodig zijn of die misschien niet veel zin meer hebben op dit moment. Dat probeer ik dan ook altijd wel te bekijken. Maar de psychofarma, wat ik zeg, daar blijf ik vanaf.” (GP-PNH)

In case of comorbidities, e.g. for diabetic patients for example, the GP proposed another treatment in function of the psychiatric problem, even if it was theoretically not the most optimal one.

“On est amenés parfois à déprescrire. Le patient évidemment a une prise en charge qui est plus globale, avec des suivis aussi donc psychiatriques et psychothérapeutiques. (...) entre équilibrer un diabète, l'un dans l'autre, ce n'est pas difficile. Ce qui est difficile, c'est de se dire (...) bien sûr, ce patient diabétique était mieux équilibré avec l'insuline qu'avec mes médicaments oraux à sa sortie. Mais à partir du moment où le patient me dit : Moi je ne prendrai pas mon insuline », j'essaye de ne pas me limiter au fait que mes valeurs de glycémie sont bonnes à l'hôpital en sachant pertinemment qu'en fait, à la maison, ça sera la dégringolade. Donc je suis d'accord qu'on est dans quelque chose de moins obsessionnel et, on va dire... de moins optimisé, mais malgré tout en fait non, de plus optimisé parce que ça colle plus au patient. On reste dans ce contexte, je pense qu'on oublie trop vite que l'Evidence-b, c'est quand même un triple cercle entre ce que dit la



littérature, d'accord, l'expérience du clinicien et le désir du patient.” (GP-PSGH)

The **Electronic Medical File (EMF)** was mentioned as a useful tool to insure an appropriate follow-up.

“Ik heb een somatisch dossier binnen het psychiatrisch elektronisch dossier, waar ik dan mijn bevindingen noteer. Waar ik dan ook wel een overzichtje maak van de patiënt zijn voorgeschiedenis enzo. En waar ik dan ook probeer een planning op te maken van naar opvolging toe. Er staat in wat er op dat moment moet gebeuren van medicatie en therapie, maar als er iets van chronische factoren zijn dan probeer ik daar ook wel een vervolg aan te maken.” (Psychiatrist - PH)

For example, in a PNH we visited, the GP tried to see residents regularly and created an EMF for each patient in addition to the medical file to be able to access every result and the patients' history from the GPs laptop during the consultations.

Although we did not encounter this everywhere, GPs and psychiatrists tended to consult each other, e.g. to schedule the necessary tests.

Nevertheless, it was reported that the GP did not have sufficient time to keep the EMF up to date and the psychiatrist was not financed to keep the somatic part of the EMF up to date.

Acute health problems during the day

In case of an acute problem during the day, patients reported this to a member of the staff, mostly an educator or nurse. If not urgent, the information was shared during a staff meeting.

Unless a GP consultation was already foreseen, nurses called the GP, or put a note in the patient file or in a notebook to ask for a consultation.

Nurses and psychiatrists filtered the patients' requests before calling the GP. The nursing staff tried to objectivise what was expressed by taking the parameters and referred to a GP only if necessary. It appeared during the conversations that, in general, everybody was cautious with somatic complaints and preferred to check rather than to wait.

Even if there was no complaint by the patient, if a professional saw something like an injury or a bruise, or if the patient seemed not to behave as usually, the staff actively searched for an explanation.

« - Ça peut être des aides-soignants, des éducateurs qui détectent quelque chose, donc d'office ils en réfèrent aux infirmiers qui eux prennent... les prises de paramètres, voir un peu, dégrossir la situation, voir un peu ce qu'il se passe comme plainte et puis alors après c'est l'infirmier qui en parle au généraliste. Mais ça peut être une constatation à la base d'un membre du personnel soignant.

- Oui parce qu'il n'y a pas toujours une plainte de la personne concernée, c'est des observations, un décodage, on voit que la personne est moins bien mais elle n'exprime rien. Alors soit elle n'a pas la capacité d'exprimer, ou bien elle ne souhaite pas parce qu'il y en a certains qui se taisent et qui camouflent tout parce qu'ils ont peur d'aller à l'hôpital par exemple. (...) Peur de payer parce que certains gèrent eux-mêmes et qu'ils connaissent leur budget.” (Team-PNH)

The nursing staff and GP estimated the urgency and seriousness of the complaint and acted accordingly. The evaluations and impressions of the nursing staff were an important source of information to the GP.

« A ce moment-là le principe de précaution veut que je vienne et que je constate par moi-même, et après j'essaye de leur dire « Écoute oui, ok il tousse. Mais il tousse, mais il fume quatre paquets par jour donc à un moment je veux bien qu'il tousse mais je ne sais rien faire de plus ». Donc elle essaye d'expliquer c'est quoi la bronchite chronique, c'est quoi le diabète, quelle prise en charge, à quoi il faut être attentif, ou alors « Quand est-ce qu'il faut me rappeler ? », « Bah, rappelle-moi si tu vois qu'il chauffe au-dessus de 38 ou... À ce moment-là tu me rappelle », mais ce n'est pas toujours évident. » (GP-PNH)

« Et donc moi je suis très attentive à ce que les infirmières peuvent me dire, même s'il n'y a rien au niveau physique. Et je dis « Écoute non, moi je ne trouve rien », « Ouais, mais elle n'est pas comme d'habitude ». Enfin, voilà, je pense qu'il faut être plus attentif ici, en psychiatrie, à ce que les infirmières ramènent, parce qu'elles ont plus l'habitude avec leurs patients, y compris les patients qui sont vraiment dans une bulle... » (GP-PNH)



If a problem seemed to be really acute, the ambulance was called or the patient was sent to the emergencies. In general hospitals sending the patient to the emergencies because it seemed to be too difficult for the psychiatric staff to manage the problem was weighed against the risk of destabilising the patient.

« Parfois on me dit « Mais est-ce qu'on n'enverrait pas aux urgences? ». J'essaye quand même si possible de ne pas envoyer parce que ça redéstabilise le patient s'il est envoyé aux urgences et qu'il est hospitalisé une semaine et puis qu'il revient. Il faut toujours trouver le bon équilibre entre le meilleur soin pour le patient à ce moment-là et les capacités de l'équipe à pouvoir répondre. Il y a beaucoup de gens avec des problèmes de BPCO quand ils commencent à être dans des moments d'exacerbation ; ce n'est pas toujours simple à gérer pour les infirmières. » (GP-PH)

For life-threatening problems, like suicide attempts an ambulance was called immediately.

The availability of internal procedures to know how to react was perceived as useful by the teams, e.g. in case of falls.

« (...) Des procédures il y en a et ça nous aide beaucoup. Il y a une farde qu'on a dans le service ici, c'est un bon rappel pour tout le monde aussi. Mais c'est vrai que quand il y a un incident qui se passe comme ça dans le service, on parle du somatique mais il peut y avoir des fugues aussi pour des patients qui veulent se mettre en danger et des choses comme ça. Ça nous aide quand même à pouvoir réagir et agir le mieux possible, sachant que ce sont des procédures qui sont partagées avec le reste de la clinique, et donc... » (Team-PSGH)

The presence of a doctor on call on site was perceived as an advantage. This was obviously the case in general hospitals but not necessarily for psychiatric hospitals.

The communication between professionals was really important to guarantee a good management of the somatic issues, especially in case of problems. Clear communication strategies or procedures for information transmission between healthcare professionals were not always available. Interviewees reported that there was always a risk of losing information.

« Parfois, les informations sont complètement perdues. Ou par exemple, le médecin généraliste va avoir fait... Je pense à une patiente ici qui faisait beaucoup de fièvre, après j'étais de garde, j'ai vu qu'elle avait été vue par les médecins généralistes deux heures avant, et où la note se résumait à « hyperthermie, suspicion d'infection urinaire » et c'est tout. Du coup, on ne sait pas combien de température, qu'est-ce qui a été fait à l'examen physique, qu'est-ce qui a été exclu, pas exclu. Est-ce qu'il y a des consignes à suivre si la température... Donc c'est vrai que moi, ça m'aiderait beaucoup s'il y avait plus d'informations dans ce sens aussi. Après, je suppose que c'est aussi parce qu'ils n'ont pas beaucoup de temps et qu'ils doivent courir d'un service à l'autre qui fait que ça se résume à... » (Psychiatrist in training-PH)

Acute health problems during the night or weekend

In case of acute health problems during the night or weekend, the staff contacted the psychiatrist or GP on duty. In some settings the psychiatrist decided whether or not to refer to the GP or emergency services, in other settings the GP was contacted directly. During the weekend, if the GP (working in or in collaboration with the psychiatric setting) was unavailable, the psychiatrist managed the somatic health problem.

In a sheltered housing initiative the situation was different because residents functioned autonomously. The residents contacted their GP or accessed an emergency service. Also, neighbours took care of each other and called for help.

Health promotion

Although health promotion was not a priority in psychiatric settings and perceived as impossible in crisis wards, several initiatives were mentioned by the respondents:

- Promotion of 'good health' by nominating one day or one week per year dedicated to good health.
- Workshops on health related themes

«Ja, hier is zo'n werkgroep opgericht en dat noemt Lichamelijk Welzijn en daarin probeert men toch zo buiten... Ook naast medische.... Van



die gezondheid bevorderende zaken te doen rond rookstop is er bijvoorbeeld.... Ge hebt hier Vlats dat zijn (...) therapieën die over verschillende afdelingen kunnen mensen naar die sessies gaan en zo is er bijvoorbeeld iets gestart rond rookstopbegeleiding. Dus wie wil kan daar naartoe. Ook rond metabool syndroom, kennen jullie wel he? Van dat dat zo gebonden aan de medicatie hier vaak dat er iets van uitlegssessie... van infosessies plus ook rond voeding en beweging dan kan gewerkt worden als de patiënt dat wilt, kunnen we die daar wel naar verwijzen. Dat zijn zo bijvoorbeeld de initiatieven die daaruit ontstaan zijn. Ik heb daar bijvoorbeeld in voorgesteld van bij opname een systematische bevraging te doen naar rookstop, naar risicofactoren, naar voorgeschiedenis. (...).” (GP-PNH)

- Because smoking had a huge prevalence in the psychiatric population and smoking was also very common between staff, initiatives were undertaken to reduce the smoking behaviour:
 - A ‘smoke free hospital’ with progressive closing of the smoking rooms and suppression of the vending machines.
 - Proposal to give up smoking with prescription of nicotinic substitute. In some places the nicotinic substitutes were even charged to the hospital and not to the patient.
- Dental health:
 - Proposal to visit the dentist
 - Toothbrush education
- Proposal/ reminder to participate in screenings (cervical cancer, breast cancer or colon cancer)
- Vaccination
- Contraception
- Encouragement to do some **physical activities**:
 - Day care centre when the behaviour of the resident allowed to be with ambulatory non-psychiatric patients
 - Access to a garden

- Sport equipment (e.g. tennis table)
- Proposal of activities (e.g. a daily walk, start to run)

The latter is also related to the management of side effects of the psychotropic medication inducing an increase in weight. Encouraging physical activities is very challenging due to: limited space available for sport activities, patient characteristics, and financial shortcomings to finance additional staff, infrastructure or sports equipment.

« La chose que j'essaye de faire, par exemple, par rapport à ça, mais c'est basique hein, mais pourtant une petite chose très importante, c'est insister pour convaincre le patient qui est ici à fréquenter un centre de jour où on peut faire du sport, par exemple. Donc essayer de mettre dans la vie des patients la piscine. J'essaye de prescrire la piscine, J'essaye de prescrire du tennis, du volley, le volley c'est facile parce qu'au centre de jour on joue au volley souvent. Donc j'essaye vraiment de faire des prescriptions pour soigner l'obésité. (...) C'est quelque chose que doucement moi je commence, et après le sociothérapeute voit que j'insiste sur la piscine et sur la prescription de la piscine et donc durant les entretiens que chaque sociothérapeute fait avec les patients, il essaye aussi de parler un peu plus de la piscine, des problèmes d'obésité, de l'importance de bouger, et tout ça. » (Psychiatrist-SHI)

According to the interviewed healthcare professionals, psychiatric patients experienced strong barriers to use sport infrastructure used by the general public, such as sport clubs, or even the sport facilities of the general hospital: they felt watched or stigmatised.

“We merken dat onze bewoners... Dat is algemeen in psychiatrie ook... Moeilijk hebben om aan te sluiten bij gewone sportclubs of wandelclubs. Om een of andere reden voelen mensen zich daar niet welkom of voelen ze zich daar buiten gekeken of denken niet goed daar te kunnen functioneren in die groepen, waardoor de drempel hoog is.” (Psychiatrist- SHI)

A domain that was reported to be difficult to manage, also related to the side effects of the medication, was **nutrition**. The setting was not always able to supply dietetic food. For example, in some places residents had to choose between different sodas to drink with their meals, because mineral water



was not available. In open settings residents were allowed to go outside, thus they were also free to buy all kinds of snacks in shops nearby. Visitors also brought unhealthy food. The availability of unhealthy food made it difficult for the staff to maintain a healthy alimentation for the residents.

« Et puis l'accès est facile quand même ici, on a des distributeurs de canettes, où il a des sodas sucrés. Ici il y a une cafétéria boutique. On avait même envisagé à un certain moment, on avait eu un groupe de travail là-dessus sur le fait de l'offre qu'on propose dans cette cafétéria. On avait décidé de limiter les grands contenants d'un litre et demi de coca, pour éviter... Parce qu'il y a des personnes qui boivent tout d'un coup en disant « Bah on va plutôt fractionner ». Exemple hein. Et proposer autre chose que tous les snacks sucrés qu'on peut avoir. Là maintenant ça n'a pas vraiment tenu, parce qu'il y a une demande importante des personnes qui disent « Oui mais moi ça me revient moins cher de partager avec les autres une bouteille de coca, on s'arrange et ça me revient moins cher comme ça », donc on remet. » (Team-PNH)

Prevention and health promotion were even more difficult when the length of stay was short, as was the case in general or psychiatric hospitals. Nevertheless, it remained a window of opportunity to promote health behaviour once patients were stabilised.

Psychiatrists and GPs also had a role to play in health promotion and prevention. At some places the GP saw each resident at least once a year to make sure vaccination and screenings were done. They also paid attention to a healthy lifestyle by means of sensibilisation and information provision. However, GPs lacked time for prevention and health promotion.

The discharge

Sometimes the correct somatic diagnosis was delayed due to waiting lists for further examinations like an MRI (magnetic resonance image). The result of the examination influenced the appropriate type of residence for the patient. The delay was often substantive and postponing the discharge. The healthcare workers were frustrated that there existed no priority rule for inpatients.

“Comment ça se fait que les patients doivent attendre 10-15 jours pendant qu'ils sont hospitalisés ? Ça devrait quelque part pouvoir aller plus vite, parce que les séjours se prolongent à cause des soins somatiques, qui prennent – si moi, j'ai besoin d'une RMN pour, par exemple, voir si quelqu'un a un Alzheimer, ou un Huntington ou quelque chose, je dois attendre deux mois mon RMN. Mais pendant deux mois, il est en service aiguë, notre patient ne bouge pas. On ne s'est pas avancés parce qu'on ne sait pas le placer. C'est clair qu'il faut le placer, mais l'orientation du placement va être en fonction du diagnostic, et moi je dois attendre deux mois mon RMN. C'est extrêmement frustrant que dans un hôpital aigu, on est sujets à des listes d'attente. » (Psychiatrist –PSGH)

It was reported that, because of the lack of beds, some patients were discharged when their psychiatric disorder was stable or under control, while a longer stay enabled a more efficient care for somatic health problems.

At discharge, a discharge report was prepared. This report was mainly 'psychiatric', containing minimal information on somatic health care, nor including results of examinations. It also contained alerts about medication and the necessary follow-up or appointments with other health practitioners. Appointments were scheduled before discharge. Continuity of care was facilitated when the setting was embedded in a hospital network (e.g. from hospital to PNH).

If the patient consented, the report was sent to the entitled psychiatrist and GP. If the patient had no ambulatory psychiatrist or a regular GP, an effort was made to find one. Sometimes, this was only the case when patients asked for an ambulatory psychiatrist or a regular GP. However, it was reported that it was really difficult to find a GP ready to accept new patients (e.g. practitioners lists are full), and especially psychiatric patients.

Ideally a somatic consultation was done at discharge and integrated in the discharge report. This was reported as not feasible because of the workload and because it was not financed.

For patients who were not in a regular situation (e.g. refugees), it was reported that the social worker of the psychiatric ward of a general hospital prepared the documents to ask for Emergency Medical Help (AMU) and



gave all the needed information to the patient who had to take care of the request him/herself.

In the PNH and SHI, a somatic discharge report was not available whenever somatic health problems were followed by a GP or specialists outside the organisation, which was mostly the case.

In order to provide continuity of treatment, patients received a minimum amount of medication to take home (e.g. for minimum 2 days).

In case of transfer to palliative care, the GP of the psychiatric setting contacted the entitled GP e.g. to explain how the patient expressed pain.

« (...) il y en a parfois qui sont transférés en soins palliatif, mais qui sont des personnes qui sont mutiques, ou qui crient. Donc il faut expliquer que oui, ils crient mais ils crient tout le temps, mais qu'ils ne crient pas comme d'habitude. Donc s'il crie mais qu'il y a la larme qui coule c'est parce qu'il a mal. C'est des petites choses auxquelles on est... Enfin moi je suis habituée avec les patients parce que je les connais maintenant depuis plusieurs années. Et donc, il y en a que je vois, et où je sais que ça ne va pas. » (GP-PNH)

5.2.2.3 The Management of medication prescriptions

Psychiatric settings have a 'hospital' pharmacy system. Thus the prescribed medicines have to be provided by the hospital pharmacy, hence have to be foreseen in the 'formulary' of the pharmacy. This led to several problems.

For **patients with chronic somatic disease**, like diabetics for example, healthcare professionals had to provide the type of medication available in the formulary; this was not necessarily the type or brand that was prescribed or which the patient was accustomed to.

GPs asked the pharmacy to add a medicine to the formulary but the request was not always granted. The option was that the pharmacy switched to a similar product available in the formulary, sometimes causing compatibility problems. When the patient was discharged, again the continuation of the medication was difficult with either going back to the initial treatment; this way impairing the stability of the somatic condition.

« L'autre truc qui est vraiment embêtant pour les maladies chroniques, c'est la pharmacie et le switch des médicaments. C'est-à-dire qu'on est obligés de donner ceux qu'on a au formulaire, et donc je pense que là, on fait du mal, parce que les patients ne ressortent pas obligatoirement avec le traitement d'entrée et on vient foutre le bordel dans une organisation un peu stable. Donc ça, c'est un souci, je trouve. » (Psychiatrist –PSGH)

When a **new medicine was prescribed** by a GP or a specialist, it took a couple of days to get the prescribed medicine to the patient, because the prescription needed to be approved by the psychiatrist in charge and by the hospital pharmacy.

“-Daar zit een hele vertragende... Dus bijvoorbeeld iemand krijgt van de specialist een voorschrift voor bepaalde specifieke medicatie of antibiotica. Dan zit er iets heel vertragend op onze apotheek op dat dat soms een paar dagen...”

- Ja, soms echt wel ja, dus de specialist geeft een papieren voorschrift mee, dat moet dan eerst door ons, want dat kan zijn dat op dat moment als die terugkomt de dokter niet aanwezig is, wij geven dan als verpleegkundigen dat voorschrift in het systeem. Dan moeten wij door onze psychiater dat voorschrift goedkeuren, want...

- Afhankelijk van de dag, want anders moet hem langs de dokter gaan.

- Ja, inderdaad, want als de psychiater al aanwezig is, de onze, dan moet ge nog maar zien dat ge hem kunt bereiken om dat voorschrift te kunnen valideren. Dan moet de apotheek het voorschrift nog valideren en dan moet het nog schoon zijn dat ze die na service niet moeten bestellen dus... (...)

- Ja, dus dan passeert er soms twee dagen eer dat hij zijn medicatie krijgt. Terwijl dat ze aan de overkant van de straat in het dorp gaan, dan zit daar de [apotheek] en dan hebben ze het een uur later. En wij doen daar dan twee dagen over. » (Team - PNH)

Finally, the access to oral contraception was problematic: patients had to buy it themselves at the local pharmacy.



Using the treatment delivered by the hospital pharmacy or by a local pharmacy had a cost impact for the patient. During hospitalisation, patients paid a fixed fee for medication, whatever their medication schedule was. At the local pharmacy, however, they had to pay it out-of-pocket.

« Par exemple, pour qu'une jeune schizophrène hospitalisée à l'hôpital général où j'étais chef puisse continuer de prendre sa contraception tous les soirs, je devais faire une ordonnance sur papier libre et lui dire parfois en cachette « Va à une pharmacie chercher ta pilule parce qu'ici ça n'ira pas ». (Psychiatrist –PH)

« Dus, voor dingen dat zo bij de apotheek extern gehaald worden, betaald de patiënt zelf, dus van de eigen centen. Terwijl dat dingen dat binnen het formularium vallen, medicamenten die binnen het formularium vallen hier binnen de apotheek, die zijn binnen een bepaald forfait dat eigenlijk gerekend word in de [dag prijs]. Dus ge hebt sommige zaken dat buiten 't formularium vallen, maar waar de patiënten normaalgezien ook van de op de hoogte gesteld van 'kijk, ge kunt dat medicament, we kunnen dat hier bestellen voor u, maar dat gaat een meerprijs geven op uw factuur.' »

- En 't zijn die medicamenten dat als toch buiten het forfait valt, dan zeggen we vaak 'het valt toch buiten de forfait, ge moet het toch zelf betalen. Kies dan voor de snelheid en ga naar de apotheek in 't dorp, want het komt sowieso uit uw eigen portemonnee. Bij medicamenten die binnen de forfait vallen doen we dat niet, want vind we dat te schandalig hé. Dan doen we 't wel via de correcte weg. Omdat het anders niet correct is... » (Team- PNH)

Healthcare professionals tried to find solutions to overcome the delay or the unavailability of certain medicines through the hospital's pharmacy:

- Some teams reported not to be allowed to give any medication without the approval of the physician in charge. For quick relief of symptoms (e.g. fever or pain), the staff sometimes advised the resident to buy the medicine themselves outside the setting instead of awaiting the internal procedure.

« Soms zeggen we het ook tegen mensen. "Hoest jij? Ga naar de [apotheek] een hoestsiroop halen" zou ik zo zeggen, want dat is veel sneller." (Team-PNH)

- Another solution was to ask visitors to bring the personal medication to avoid the waiting time.

« La famille doit apporter les boîtes de médicaments pour qu'il n'y ait pas de rupture de continuité alors qu'on est quand même dans des hôpitaux très spécialisés, très achalandés. » (Psychiatrist –PH)

« Il faut pouvoir joindre la famille, en disant « Est-ce que vous pouvez aller récupérer la boîte de (...) l'anti parkinsonien je ne sais plus de quel nom, « Et l'amener vous-même à la clinique, et on va mettre l'étiquette de madame dessus et on lui donnera ». Maintenant, ce n'est peut-être pas un mauvais système, tant que ça fonctionne. » (Psychiatrist –PH)

- Staff also bought medication for the patients at the local pharmacy.

« Moi je refuse qu'on aille acheter à la pharmacie du coin, parce qu'à un moment, devoir toujours palier comme ça...(...) C'est une stratégie qui a fonctionné avant que j'arrive, mais voilà moi je trouve que c'est à l'hôpital de fournir le traitement médicamenteux pour les patients, et que ce n'est pas au personnel soignant d'aller... De nouveau, c'est un personnel qui quitte la salle, c'est des soins en salle qui sont moins... Enfin voilà, moins de présence en salle, plus d'insécurité, (...) Enfin voilà, la présence en salle ça permet aussi aux patients d'être contenu, d'éviter monter, de... d'avoir des réponses à leurs questions, à leur anxiété. Et ça c'est le travail du personnel soignant, c'est à dire la gestion de l'ambiance au quotidien pour éviter que la salle ne monte. Et quand il y a moins de personnel, forcément la salle est plus compliquée à gérer. (Team-PH)

In the worst case scenario, if medication was unavailable in the hospital pharmacy and there was no way to circumvent this, either the patient did not receive the treatment, or the patient switched to a similar drug which was available.



« Et dans le cas où il n'y a pas de relais à l'extérieur ?

Interviewé : La patiente ne prend pas son traitement. (...) Donc dès que vous avez un médicament très cher qui saute du forfait, il vaut mieux ne plus le donner quoi. » (Psychiatrist –PH)

Talking to the hospital staff, we also heard that having access to a GP to discuss the medication schedule facilitated its management. We also heard examples of smooth collaboration between the GP and the hospital pharmacy.

« Imaginons qu'on a un médecin généraliste dans le service, effectivement ce genre de chose sera vachement plus facile à gérer. Et de nouveau, c'est la même chose, c'est se dire « Moi je suis infirmière psychiatrique ». Oui je suis dans le débat, mais connaître un nouveau antidépresseur qui ne va pas avec untel ou autre, je n'en sais rien. Un psychiatre, c'est peut-être un peu la même chose, il ne connaît pas tout en finesse. » (Team -PSGH)

5.2.3 Specific issues of the somatic care for psychiatric patients

Healthcare professionals highlighted that psychiatric patients suffered from more somatic health problems and had less access to high quality somatic health care in comparison to the general public, despite the specific needs. We firstly described the factors related to psychiatric patient characteristics and secondly factors related to the non-psychiatric world.

5.2.3.1 Specificities linked to patient characteristics

Psychiatric patients presented characteristics influencing their somatic needs and the way to respond to these needs.

Somatic status

Psychopharmaceutical drugs, lifestyle and health behaviours (e.g. lack of hygiene, addictions) resulted in common somatic problems such as cardiovascular disorders, obesity, diabetes, hypertension, chronic bronchitis, dermatological and dental problems.

« La dermato aussi parce qu'ils sont obèses, ils ont des dermatites, ils ont des peaux qui parlent avec des abcès, des... Je fais beaucoup plus

de dermato ici qu'ailleurs. Mais donc il y a des trucs vraiment spécifiques à l'état psychiatrique ou à la représentation perturbée de leur santé à tous les problèmes endocriniens, métaboliques, oui sûrement. » (GP-PH)

In addition, psychiatric illness can lead to the incapacity to continue employment or reorient in the labour market. Economic uncertainty and unemployment is often the result. A precarious socio-economic status is linked to the social gradient in health care, hence associated with the risk of comorbidities and difficult, distressing situations. Finally they also run the risk of becoming the victim of violent behaviour or abuse. « Les pathologies psychiatriques elles-mêmes induisent des comorbidités comme je vous ai dit... et leur pauvreté, la pauvreté, purement et simplement, la précarisation des patients psychiatriques est un autre facteur, qui est évidemment d'un point de vue épidémiologique, un poids important, puisqu'ils n'ont pas non plus les moyens de se soigner. Ils doivent faire un choix, les médicaments, ils mettent tout ça ensemble, toutes les prescriptions qu'on leur a faites, même s'ils sont de bonne volonté ils doivent faire un choix. » (Psy HP)

« La santé d'un patient psychiatrique, ce n'est pas la vôtre. C'est beaucoup plus amoché par la vie. » (GP-PSGH)

« C'est parfois des gens qui arrivent complètement décompensés, avec des situations comme on imagine plus que ça peut arriver en Belgique. Et donc, il faut tout reprendre dès le départ parce qu'ils sont dans des états somatiques catastrophiques et donc... Parfois ça prend vraiment beaucoup de temps, avec des patients qui sont parfois incapable de dire qu'on est en 2020, en quelle saison on est, où ils habitent, quel est leur médecin traitant. Et donc ça peut vite prendre une heure de faire une entrée correctement à l'observation. Ça plus la défense sociale, avant c'était Korsakoff, donc c'était encore autre chose, c'était des patients plus chroniques. Maintenant ça tend à changer dans cette unité-là, et donc c'est aussi très prenant parce que c'est des patients qui étaient en prison pour la plupart avant. Et donc en prison, il n'y a rien comme suivi, c'est catastrophique. Que ce soit la dentisterie ou les soins somatiques en général, tout ce qui est prévention on oublie, puisqu'ils sont complètement sortis du système. Donc il faut aussi tout reprendre et donc... » (GP-PNH)



« Soit ils sont ramenés en mille morceaux par aide d'interventions policières musclées, soit ici ils se frappent dans les murs de détresse, ils se battent aussi entre eux. Il y a beaucoup de traumatologie. Beaucoup, beaucoup, beaucoup. Ils sautent les murs pour filer de l'hôpital. Donc la traumato est fort représentée. » (GP-PH)

Finally, clinical somatic local guidance were perceived as not adapted to the specificities of psychiatric patients. Some guidelines were too general and therefore not applicable to very specific cases and contexts. Guidelines were not adapted in function of the specificities of the setting (e.g. psychiatric nursing home versus psychiatric ward of a general hospital).

“- Algemene richtlijnen in de psychiatrie werkt maar half. Want ge kunt een algemene richtlijn en dan hebt ge die casus, die patiënt, die geschiedenis, die problematiek en dan vervalt de helft van uw richtlijn.

- Ge moogt nog een duidelijke procedure hebben, toch gaat ge nog een verschil hebben op een opnameafdeling, op een persoonlijkheidsafdeling, op een psychoseafdeling, het is nog een heel verhaal. Isoleert maar eens iemand op een psychoseafdeling, of isoleert maar... Ik bedoel, dat is een heel ander verhaal. En dan hebt gij wel u procedure, maar zo dat persoonlijke werk in de psychiatrie, dat kan niet genoeg benadrukt worden vind ik.” (Team-PNH)

Expression of complaints and bodily awareness

The way psychiatric patients expressed their difficulties complicated somatic health care. Depending on the mental illness, patient expressed a heightened bodily sensitivity, a low threshold for pain and discomfort and by consequence expressed pain or discomfort rapidly, or even in an exaggerated way. By contrast, patients experienced difficulties in identifying pain and discomfort, because of a disconnection from the body.

“En dan hebt ge nog het verschil denk ik in toestandbeeld of in ziektebeeld, op X zitten heel veel chronische persoonlijkheidsstoornissen, die zullen sneller met hun klachten komen, dan, denk ik, dan een echte psychoot die niet weet wat boven of onder is en met heel veel andere dingen bezig is buiten wat dat hij voelt in zijn lijf. Die hebben vaak geen contact of minder goed contact

met hun lijf. Dus eer dat ge daar door hebt er is iets verkeerd, er is iets aan de hand.... En dan moet ge er nog mee naar de juiste consultaties geraken.” (Team-PNH)

Difficulties to express complaints and to accept that a consultation or examination was necessary had several consequences in terms of somatic health care provision:

- It led to longer medical consultations or consultations that had to be done in several times.

« Déjà nous, dire comment on a mal, la douleur, où, comment, à quel moment, etc., ce n'est pas évident. Alors un patient psychiatrique c'est encore plus compliqué parce que leurs représentations corporelles sont quand même fort altérées. Et donc, je pense que c'est un examen de médecine générale, bien sûr, et on a vraiment besoin du regard du somaticien. Mais qui doit vraiment avoir une écoute, et une temporalité autre, ce n'est pas un examen qui se fait en un quart d'heure. Et parfois, c'est un examen qui doit pouvoir se faire en plusieurs fois. » (Team-PH)

- Listening to the patient took time but was a prerequisite to understand and identify the problem. Unfortunately, healthcare professionals are often running out of time.
- Patients had an unclear overview of their medical history. They partially remembered medical antecedents or which treatments they were taking or had been prescribed in the past.

« (...) il y avait eu un oubli de médicament, un anticoagulant, ce qui est très important, qui n'avait pas été retranscrit. (...). La patiente ne l'avait pas dit. Après, elle en a parlé au personnel quelques jours après. (...) ce que je voulais dire, c'est que ça peut être un facteur de risque par rapport à la moins bonne gestion de problèmes somatiques. » (GP-PH)

- Patients had difficulties to find a healthcare professional (e.g. GP) who was able, willing and ready to take care of the patient. This led to medical shopping or absence of a regular GP, which also complicated the management of somatic care, because other healthcare professionals (such as psychiatrists or the nursing staff of a psychiatric



hospital) had no point of contact in case they needed additional information.

« Quand ils ont un problème, ils alternent entre les différents services d'urgence, et du coup c'est très difficile pour nous aussi de rassembler les informations d'où ils viennent. » (Psychiatrist in training-PH)

Compliance

Because of the psychiatric disorder, compliance was even more problematic in psychiatric patients than for non-psychiatric patients. When a treatment was initiated, it was difficult to keep psychiatric patients compliant. This led to a deterioration of somatic problems.

« (...) en salle fermée, souvent, arrive avec une histoire médicale qui est très pauvre, qui est très décousue. Il y a parfois une maladie qui est connue... par exemple, un patient qui est obèse et diabétique : il arrive, il est complètement décompensé bah... parce que son observance ambulatoire a peut-être été mauvaise dans le cas de sa décompensation psychiatrique, par-parfois il y a un médecin traitant, parfois il n'y en a pas, parfois il y a une errance un petit peu entre médecins spécialistes où le patient s'est retrouvé hospitalisé un jour et puis il est ressorti avec un traitement qu'il a pris ou pas pris. » (GP-PSGH)

« Les somaticiens sont souvent découragés d'avance, en disant : « Il ne va pas nous écouter, pourquoi est-ce qu'on doit encore une fois venir ? », ou « Le patient ne va pas suivre son traitement. Pourquoi est-ce qu'on doit instaurer un traitement ? Parce qu'il va quand même tout rater à la sortie. ». Ce n'est pas une raison pour ne pas offrir des soins de qualité, donc c'est souvent une grande frustration. » (Psychiatrist – PSGH)

When a psychiatric patient with a chronic somatic pathology was hospitalised, the health status was controlled and followed, which was not always the case outside hospitalisation. Their health condition during hospitalisation did not reflect their condition outside the hospital. This was sometimes misleading for healthcare professionals, especially if they extrapolated the health status during hospitalisation to what would happen

after discharge. Not anticipating life outside the hospital may have led to difficulties in the management of chronic diseases (e.g. stabilising sugar values in case of diabetes). In order to prevent deterioration after discharge, a “discharge session for the patient” was considered helpful:

« Je ne change certainement jamais les hypocholestérolémiants, je n'en instaure jamais, ce n'est pas mon métier. On a un souci avec la gestion d'hypertension, parce qu'en fait soit il y a un sevrage pour une série de patients qui viennent ici pour un problème d'alcool et on a de l'hypertension, soit parce qu'ils sont ici un peu plus calmes avec un régime de vie meilleur, ils sont hypotendus parce que dehors, ils avaient un type de comportement qui faisait qu'on devait taper plus fort avec les médicaments. » (Psychiatrist –PSGH)

« (...) On a l'intention de faire une session de sortie pour revoir un peu si le patient a bien compris les tenants et aboutissants de l'aspect somatique de sa santé, et quelle est la suite qu'il va donner s'il a un médecin... Ça, on ne sait pas encore le faire maintenant, mais on a déjà discuté de ça avec le docteur X pour améliorer. (GP-PSGH)

In addition, paradoxically patients who were less surrounded by healthcare professionals (e.g. in sheltered housing initiatives and when living independently), were monitored even less because of the setting's structure. Therefore, they needed more monitoring and follow-up in primary care (e.g. by a GP) than patients who were admitted to a psychiatric ward or hospital. However, in reality the opposite was true: they were less seen by a GP.

« Eigenlijk al de mensen die zo Clozapine nemen, die worden opgevolgd, dat wordt gemonitord. Het is iets anders dan als er mensen zo echt in een eerder soort beschut wonen of zo, hé. Die minder echt structureel opgevolgd worden, daar is dat ander, hé. Want hier worden ze eigenlijk heel regelmatig gemonitord en kan er weinig mislopen bij wijze van spreken, want het wordt opgevolgd. Ja, wat natuurlijk anders is als er zo een minder strak kader is, hé. Dus daar valt er nog meer, vind ik, verantwoordelijkheid bij ons [explanation added by researcher: ons = de huisartsen]. Want... En ja, dat is dan weer paradoxaal, worden wij ook vaak minder bezocht ook. Terwijl dat, ja, dat we 't bij die mensen waar dat er minder kader is een nauwere opvolging door ons dan zou moeten zijn.» (GP-PH)



Refusal of treatment

Because of their illness, patients did not easily accept to be examined or had their parameters taken. This made them nervous, anxious, or aggressive. The refusal of care also induced ethical issues for the healthcare professionals (see 5.2.6)

Need for accompaniment

Psychiatric patients often needed to be accompanied for health service use external to the setting (e.g. specialists, dentist, emergency services). The need was explained by the fact that the patient was not calm enough to go alone, was an inpatient or risked to run away from the setting if the wait was too long. Also the accompanying person, mostly a member of the hospital staff, needed to clarify the complaints. The hospital staff took the role of translator between the patient and the other healthcare professionals. However, accompanying patients weighed heavily on the workload of the care teams, because it is very time consuming. Solutions were found with trainees or logistic helpers, at least in general hospitals.

« C'est une grosse contrainte logistique, ça nous prend beaucoup de temps. Organiser, trouver un moyen de transport adapté. Un membre du personnel, soit un moyen de transport soit c'est lui qui doit conduire et il faut qu'il ait un permis de conduite, faut qu'il y ait une voiture disponible, sinon il faut faire appel à une ambulance. Puis l'ambulance arrive la veille. Puis l'examen est parfois annulé ou déplacé à une heure après. » (Team –PH)

5.2.3.2 Difficulties in the collaboration with non-psychiatric healthcare professionals

The management of somatic health care for psychiatric patients involved self-evidently somatic healthcare professionals who were not engaged in a psychiatric setting. The collaboration with non-psychiatric healthcare professionals was evaluated as difficult throughout our interview round. Interviewees mentioned several explanations for this observation: stigma and prejudice towards psychiatric patients, timeliness in psychiatry, and difficult communication and data transfer.

Stigma and prejudice towards psychiatric patients

The professionals we interviewed reported that stigma was still a heavy burden weighing on psychiatry: psychiatrists were not considered 'real' physicians, psychiatric nurses not real nurses, and psychiatric patients' somatic health problems were not taken seriously. Patients were judged by means of stereotypes such as non-hygienic, not taking care of themselves, difficult to understand, not compliant, skipping appointments, etc. The staff of psychiatric settings reported it was not self-evident to find dentists, GPs or specialists willing to treat residential psychiatric patients.

« Ce sont des patients qui... comme je dis, ils ne sont pas sexy, ce sont des patients qui sont mal vus, qui ne sont pas toujours les mieux soignés, pas les plus propres sur eux, pas les plus patients dans une salle d'attente, ou parfois très bizarres. Ils parlent tout seuls, ils... viennent avec, je ne sais pas, des sacs bizarres, habillés de manière un peu bizarre, leurs cheveux en l'air. Voilà, ce n'est pas des patients – allez, on voit souvent de loin que ce sont des patients psychiatriques, et donc ils ne sont parfois pas très bien vus, ou ils ne viennent pas à l'heure, ils viennent soit deux heures plus tard, soit cinq heures trop tard, ou ils viennent un autre jour. Euh... voilà, il y a quand même – on voit quand même qu'il y a des cabinets de généralistes qui concentrent les patients psychiatriques, surtout les patients psychotiques, et d'autres qui... qui vraiment les limitent. » (Psychiatrist-PSGH)

Even more, it was difficult to make a specialist come to the psychiatric ward of a general hospital to see a patient, because the ward was separated from the rest of the hospital, because they did not feel comfortable with psychiatric patients, or because of time constraints. The same accounts for the help from volunteers.

« Un des problèmes d'avoir une unité de psychiatrie qui a été délocalisée, c'est que ça demande plus de déplacements, c'est plus compliqué. On va plus facilement voir un patient qui est au quatrième étage, que sortir de l'hôpital pour aller voir un patient. » (Internist-PSGH)

Prejudices towards psychiatric patients was explained by a lack of 'feeling' and a lack of training. Interviewed healthcare professionals stated that because these skills were lacking, psychiatric patients were treated



differently compared to non-psychiatric patients and had less chances to receive the care they needed.

“Het algemene aanvoelen van hoe dat patiënten binnen somatische diensten worden behandeld. (...) Ja, ofwel hebt ge daar als arts voeling mee, ofwel niet. Ofwel hebt ge daar al wel een opleiding rond gehad, ofwel niet. En ja, als dat allemaal nee nee nee is, dan gebeurt dat niet goed. (...) Het gaat wel over de opleiding ook, hé. Dat gaat over hoe kunt ge ook mensen met een psychiatrische problematiek zien als een patiënt zoals een ander. En ja, dat blijft een, ja ik zegt het al, dat zien alsof dat... ja, aliens zijn. Mensen die anders voelen misschien? Weet ik veel hoe zij dat zien? Ze zien eigenlijk vooral dan de diagnose en niet de mens. Die wordt toch altijd zo wat ingeschat alsof ze minder intelligent zouden zijn, of minder, ja, niet gevoelig of anders gevoelig of weet ik veel. Maar die perceptie is anders. Ja, de kansen voor die mensen zijn daardoor ook wel echt minder.” (GP-PH)

“Ik heb de indruk dat er soms discriminatief met hen wordt opgegaan. Dat is te zeggen, men gaat sneller denken “oh, het is een psychiatrisch patiënt, het zal misschien niet zo erg zijn”. Of men gaat ook de behandelingen niet ...,” ja, maar die nog zo bestralen, dat is toch zo moeilijk...” als iemand 12 keer moet bestraald worden, dan moet die 12 keer bestraald worden en het is aan ons hier om te zien dat we nog voldoende kunnen motiveren en eventueel de moeilijkheden die dat teweeg brengt, die moeten proberen te helpen. Het is niet aan een prof om te zeggen “we gaan die niet behandelen, want dat is een schizofrene patiënt”. Dat is een gevoelig thema.” (Psychiatrist-PH)

This stigmatisation led to the postponement of somatic care for a psychiatric patient or priority to other patients. In extremis, specialists did not initiate treatment assuming that, because of the illness, the patient would not adhere to it anyway.

« Moi je travaillais en hôpital général, et en hôpital général j'avais le même problème. Donc je me disais qu'à la limite, ça allait être plus facile de pouvoir avoir des avis de médecine chirurgicale, médecine interne oculiste, ophtalmologue ou tout. Et non, pas du tout. Le patient psychiatrique passait tout le temps en dernière position. » (PG-PH)

« Si vous avez une hépatite C et allez voir le médecin, est-ce qu'il va vous demander « Est-ce que vous serez institutionnalisée pendant trois mois, parce que je ne suis pas sûr que vous allez suivre votre traitement ? Sinon je ne commence pas ». Pourquoi est-ce que je dois prouver que mon patient sera trois mois à l'institution ? Pour prouver, pour confirmer qu'il prendra son traitement pendant trois mois. Vous pouvez l'arrêter autant que mon patient peut l'arrêter. Rien ne dit que vous allez être plus compliant que mon patient. Donc c'est un préjugé. Et si je ne dis pas « Non, ne vous inquiétez pas, on va institutionnaliser le patient, comme ça vous êtes sûre et certaine qu'il terminera ses trois mois chez nous », on n'aura même pas commencé le traitement. Pourquoi ? Ce n'est pas juste. » (Psychiatrist-PSGH)

The stigmatisation of and prejudices about psychiatric patients have repercussions for the management of patients at the emergency department or in case of a conventional hospitalisation. Moreover the stigma on psychiatric patients spills over to healthcare professionals working with psychiatric patients and the entire psychiatric ward or hospital (associative stigma^u).¹⁵⁴

« Et je pense que ce n'est pas une mauvaise volonté, c'est vraiment une non représentation de la réalité en psychiatrie. C'est un service qui est très stigmatisé, comme le patient en fait. On souffre des mêmes stigmatisations que les patients ». (Team-PH)

Nevertheless, we also heard positive accounts contradicting the associative stigma, with mental health professionals feeling heard and appreciated within the setting they worked.

^u “Stigma that persons experience not because of their own (attributed) characteristics but because they are associated with persons who belong to a stigmatized category in society” (p. 18)



« On a notre place dans l'hôpital. Moi je ne dois pas me battre pour que notre service existe. L'hôpital investit sur nous-autres. Mais c'est vrai que l'on a un pool global aussi. Donc les médecins sont tous payés au même prix. Ton patient, c'est mon patient. Ça rejoint aussi la culture. Et au niveau des urgences, qui est quand même un lieu de tri central. On a notre place. On ne se moque pas de nous. Je n'ai pas l'impression que... On est différents, mais on n'est pas dans une différence hiérarchique, on est dans une différence autre. Je n'ai pas ce vécu d'une différence hiérarchique. C'est un bel hôpital. (rire) » (psychiatrist-PSGH)

Differences between somatic medicine and psychiatry

Somatic medicine and psychiatry are characterised by different approaches, such as the first to be more linear, the latter to be more iterative, resulting in a different notion of time.

- Pace of time in psychiatry differs from the one in somatic care. Patients need more time. This may impact the quality of somatic treatments.
 - to accept that a consultation with a healthcare professional is necessary,
 - to 'enter into the 'consultation': when a physician has 15 minutes for a consultation and the patient needs 15 minutes to start the consultation, it becomes difficult,
 - to accept a treatment
- When a treatment was accepted, compliance of psychiatric patients had to be actively monitored. Often they had to be persuaded again and again of its importance. This implies a kind of iterative approach, which conflicts with the rather linear approach in somatic medicine, where healthcare professionals are used to reach the desired patient behaviour or health outcomes more directly.

« De toute façon, à quoi ça sert... Je suis déjà venu trois fois pour ce patient diabétique. Il continue à faire des hyperglycémies. Non, je ne viens plus parce que de toute façon, il ne m'écouterà jamais ». Il est en hyperglycémie, j'ai besoin d'un traitement, j'ai besoin d'une prise en

charge. Même s'il n'écouterà pas. On retente à chaque fois. Comme nous en psychiatrie, on retente à chaque fois. C'est ça. Donc, oui, il y a une... une logique dans la temporalité qui est différente. Vous, c'est du long terme de l'itératif, vous devez chaque fois remettre le traitement sur le tapis, essayer de le réenclencher, etc. (...): Eux sont dans un traitement à résultats, et si ça ne marche pas, tant pis. » (Psychiatrist-PSGH)

- When somatic care has to be managed in a psychiatric setting, it fits less easily into the organisation of the service. For example physicians did not have a daily round at the ward, or the equipment was not adapted or available.

« Et je trouve aussi qu'on est moins bien armés parce que notre organisation n'est pas celle d'une unité classique, et donc on n'organise pas des tours avec un chariot qui permet de prendre des paramètres à des heures fixes, qui nous permettrait effectivement d'avoir un suivi. On n'a à priori effectivement pas de médicaments en intraveineux et des choses comme ça, mais on est une organisation où on est beaucoup plus autonomes et souples je pense dans la façon dont on décide d'aller rencontrer des patients. Dès qu'il y a de plus gros soins somatiques qui demanderaient, je pense, des prises en charge à des heures plus fixes, là on est effectivement moins bien armés. » (Team-PSGH)

Collaboration psychiatric ward with specialists and other general hospital wards

Collaboration between psychiatric wards and somatic specialists and general hospital wards occurred in several situations. Below we described some typical situations we encountered during the interviews and the difficulties they brought about.

Somatic specialists asked to see a patient at the psychiatric ward of a general hospital

Whenever psychiatrists detected physical comorbidities for which they needed the expertise of a somatic specialist, the latter was called to visit the psychiatric ward of the hospital. One would have expected that in a general hospital, it would be easy to access any specialisation present from another



departments and to refer to the right specialist to provide tailored care. However, this was not necessarily the case. Psychiatric nurses experienced it as being cumbersome and time consuming to find out who to contact for a specific somatic problem, and to convince specialists to come over to the psychiatric ward. They reported that patients had to wait a long time before a specialist arrived, sometimes even several days. For acute health problems they brought the patient to the emergency department.

“De somatische specialisten op de afdeling krijgen, is niet altijd gemakkelijk. Daar gaat wel wat tijd overheen. De vraag is ook altijd een beetje “Wie doet dan wat?”. Ge hebt een hoofdbehandelaar, in dit geval de psychiater, neemt de somatische specialist dat somatische stuk dan helemaal over? Of verwacht die dat wij daar zelf nog een aantal dingen doen, zoals medicatie aanpassen, voorschrijven, onderzoeken aanvragen, onderzoeken bekijken... Daar zit wel wat variatie op de mate waarin mensen echt meekijken naar dat somatische stuk en dat echt in handen nemen, of ja, een advies geven en dat dan terug bij ons leggen. “

“Patiënt heeft klachten en dan moet de psychiater gecontacteerd worden. Wie er dan voor aangewezen die dat dan moet onderzoeken? Daar begint het al mee, dat is al heel omslachtig. Dan, ja, dan moet er een specialist daarover aangesproken worden. Gebeld worden, die moeten dan langskomen. Maar daar gaat allemaal tijd over vind ik, niet kort genoeg op de bal gespeeld. En we hebben toch al een paar keer ervaren, als dat heel acuut is, dat dat zeker geen evidente is. Op een gegeven moment is er wel de afspraak gemaakt, omdat we zo een paar casussen achter elkaar hadden, dat we dan in acute situaties wel onmiddellijk terug naar spoed kunnen gaan en dat het daar dan somatisch moet uitgeklaard worden. Maar ze zien ons ook niet zo graag komen hé... Dus ja, dat vind ik zelf vooral het pijnpunt zo van wat is er nu juist met het somatisch stuk aan de hand? Wie moet dat uitklaren? En ja, dat is in een ziekenhuis zo, iedere specialist heeft zijn domein en wat als dat zoiets overlappend is? Voor wie... Tot wie behoort dat dan? En dan: Wie gaat er dan mee aan de slag? En wie volgt het ook verder op? En... Het komt toch vaak erop neer dat ge zelf heel achter mensen bellen, achteraan lopen, ook qua opvolging nog eens moet kijken of er wel controleafspraken gepland zijn. En ja, dat vind ik persoonlijk dan

zelf dat 't toch wel hier in 't ziekenhuis beter zou kunnen. En misschien heeft dat ook te maken dat er niemand somatisch verbonden is aan onze dienst hé.” (Team-PSGH)

Also when psychiatric nurses asked colleague nurses from another ward for help because they were alone on the ward or because they needed to do something they were not familiar with, they experienced difficulties in finding someone who was willing to come over to the ward.

« Soms wordt dat eens gevraagd en dan komt er weleens iemand. Maar... Maar soms willen ze gewoon niet komen. Als ik alleen sta op TEPSI en ik moet een infuus prikken en dat lukt mij niet, dan kan ik mensen bellen. En dan, hé, als het een goede persoon is, een goede verpleger, die zegt “ik kom.” En een ander die zegt “nee, dat is mijn taak niet, dat ga ik niet doen, daar heb ik geen tijd voor...” Ja, weet je, en dan denk ik “Godverdomme toch hé. Weet ge, die doen dat dan 100 keer op een dag, jij doet het... nooit gedaan... Dus het is afhankelijk van wie ge juist aan de telefoon krijgt. De goodwill van de mens. » (Team-PSGH)

Once a somatic specialist examined a patient on the psychiatric ward, either the somatic care was taken on by the specialist or instructions were given to the psychiatrist on how to continue care in terms of treatment or examinations.

Psychiatric patients admitted to the hospital for a somatic problem

The inverse was also occurring, i.e. psychiatrists or nursing staff of psychiatric wards being asked to see patients with a psychiatric illness in a general hospital ward. Psychiatrists decided either to leave the patient at the somatic ward and providing psychiatric advice or to transfer the patient to the psychiatric ward. In case of behavioural problems, the treating specialist sometimes insisted on a transferal, or if this was not possible to have a member of the psychiatric staff stay with the patient at the somatic ward. We understood from interviews with the staff of psychiatric wards that the liaison function was underused and should be further developed. In most instances patients arrived from the somatic ward to the psychiatric ward even when they needed somatic care that the staff of the psychiatric ward felt uncomfortable about as they lacked training or equipment. A liaison person



could have anticipated and communicated some of those issues before the transfer happened. The distinction between somatic and psychiatric care was perceived as somewhat artificial in these situations. The nursing staff formulated the need for a more holistic approach.

“Dat is die populatie die opgenomen wordt voor ons, het stuk van de liaison psychiatrische patiënten, die komen op een andere afdeling en daar wordt een consult gevraagd aan psychiatrie, dat is dan de omgekeerde beweging, daar worden ook onze assistenten voor ingezet, die krijgen dan ook supervisie van de stafleden, en daar gaan we eigenlijk een consult doen van “wat is de toestand? Wat denken we dat er aan de hand is? Wat zou er moeten gebeuren?” En dat kan betekenen dat iemand overgenomen wordt, maar dat kan ook betekenen dat we een ambulant traject voorstellen voor na het verblijf in het ziekenhuis.” (Psychiatrist–PSGH)

“Ook als ze dan van ‘t intern ziekenhuis komen, dan lijkt het ook zo van ‘ok, ze zijn nu hier’ en van intern laten ze het volledig los. En dan is ‘t ook weer opnieuw van ‘tire ton plan’, maar dan moet weer alles uitgezocht worden van ‘ok, wie volgen die op die dienst? Wie volgt die op die dienst?” (Team – PH)

« Ja, het is hier afgesplitst, hé. Ieder heeft zo zijn stuk, dat is hier zeer afgesplitst en eigenlijk moet ge het geheel van die patiënt samen blijven bekijken, maar dat vind ik wel een gemis.” (Team – PH)

« Après, moi ma question c'est « Qui s'adapte ? ». En fait, j'ai l'impression qu'on est toujours dans une logique où c'est le support psychiatrique qui doit s'adapter. Le support somatique est très difficile à s'adapter. On nous a dit, par exemple, « On est d'accord de... » enfin voilà ça je l'ai eu au téléphone « ...de l'hospitaliser, mais je veux un soignant chez vous 24 heures sur 24 pour la soutenir ». Ce à quoi j'ai répondu « Mais madame, je ne peux pas libérer une personne de mon équipe 24h/24 », « Oui mais vous comprenez, on est un hôpital nous », « Bah, nous aussi », enfin voilà. Et je pense que ce n'est pas une mauvaise volonté, c'est vraiment une non représentation de la réalité en psychiatrie. C'est un service qui est très stigmatisé, comme le patient en fait. On souffre des mêmes stigmatisations que les patients. (Team-PH)

Psychiatric patients transferred to another general hospital ward

Sometimes a patient had to be transferred for a short time to a somatic ward when the care became too complicated to manage at the psychiatric ward. From the interviews it seemed that these transfers were not self-evident. While the psychiatric staff felt they lacked skills or equipment to provide good care, the staff at the somatic ward appeared very reluctant to take on the patient and psychiatric staff assumed the fear of not being able to manage the psychiatric disorder was an important factor in refusing the patient.

“C'est difficile d'arriver à un moment à justifier que les soins somatiques sont trop importants pour nous et qu'on doit les transférer, là où de notre côté on risque de nous dire « Non, c'est un truc somatique mais ce n'est pas si énorme que ça ». Par rapport à eux, forcément, il y a vite un décalage de « Qu'est-ce que c'est pour nous la difficulté d'un soin somatique ». Et puis il y a aussi l'idée eux de nous dire « En même temps, les soins psychiques sont pour nous difficiles à gérer ». Dans cette petite guerre entre guillemets, de se dire « Qu'est-ce qui à un moment prend le pas et quelle sera l'équipe la plus en difficulté ? ». » (Team-PSGH)

Staff at psychiatric ward asking for assistance from another ward

If an additional pair of hands was needed punctually at the psychiatric ward, because of staff shortage or because the staff had to perform an action they were not used to and they felt unsure about, they asked other wards for assistance. However, the interviewed staff indicated that sometimes it was difficult to find someone willing to come over to help them out. In addition, they could not rely on the hospital pool of reserve personnel as staff was not trained in psychiatry. By consequence, they could only fall back on members of their own team, who had to sacrifice free days.

“Soms wordt dat eens gevraagd en dan komt er wel eens iemand. Maar soms willen ze gewoon niet komen. Als ik alleen sta op [naam afdeling] en ik moet een infuus prikken en dat lukt mij niet, dan kan ik mensen bellen. En dan als het een goede persoon is, een goede verpleger, die zegt ‘ik kom’. En een ander die zegt “nee, dat is mijn taak niet, dat ga ik n iet doen, daar heb ik geen tijd voor.” Ja, weet je, en dan denk ik “Godverdomme toch, hé.” Weet ge, die doen dat dan 100 keer op een



dag, jij doet het nooit. Dus het is afhankelijk van wie ge juist aan de telefoon krijgt. De goodwill van de mens. (...) En ook nog wel van dienst tot dienst. De ene dienst is wat sneller (...), maar de andere dienst, ja, dat is nooit tijd of ja, dat is onze patiënt niet.” (Team-PSGH)

“Nu, wij kunnen ook nooit beroep doen op iemand van het ziekenhuis, hé. Er is een interim boek, als er ergens iemand op een afdeling uitvalt, kan die hoofdverpleegkundige beroep doen op het interim boek. Maar er zijn hier in het ziekenhuis praktisch geen, tot zeer weinig psychiatrische verpleegkundigen. Dus wij kunnen nooit zeggen van “oh zeg, we hebben nu een extra kracht nodig die de rest van de week bij ons moet komen bijspringen want we hebben een paar moeilijke casussen”. (...) Ook bij ziektes, hé. (...) Wij moeten dat uit onze eigen equipe halen. Met gevolg dat hier mensen... ja... hun vrije dagen afpakt, die hier inzet en dan weer ergens moet proberen terug te geven als dat lukt.” (Team-PSGH)

Collaboration with emergency services

From the interviews we learned that at one hospital the collaboration between the psychiatric ward, or psychiatric hospitals, and emergency services was formalised by means of service level agreements. The core of the agreement was that all patients were screened for somatic health problems when they entered the emergency service. Once a patient was declared somatically ‘healthy’, he was referred to a psychiatrist, who consulted the patient at the emergency service, or the patient was transferred directly to the psychiatric ward.

“De afspraak is heel simpel: wij screenen ze somatisch, als ze somatisch goed zijn, dan gaan ze naar de psychiatrische afdeling.” (Emergency physician-emergency service PSGH)

The staff of psychiatric wards we interviewed contradicted this and stated that patients were referred to the psychiatric ward to swiftly, without a decent screening for somatic problems.

“Er zijn dagen bij of avonden bij, als het echt te druk is op speed, dan wordt maar doorgesast en dan komen die bij ons en dan zijn ze eigenlijk niet somatisch gescreend geweest. (...) Dus dat lijkt zo soms ook wel

wat van ‘ok, verward’ of al op de psychiatrie geweest. Somatiek aan de kant en zo snel mogelijk naar psychiatrie. Zo dat gevoel komt er wel heel vaak bij kijken. (Team-PSGH)

Interviewees presumed that the staff at emergency services did not feel comfortable when caring for a psychiatric patient, because they lacked training to cope with the particularities of psychiatric patients. In the interviews, accounts were reported about patients not been taken seriously, attributing complaints erroneously to the psychiatric disease. In addition, the ways psychiatric patients expressed pain or discomfort were often not understood. A written referral note specifying the difficulties would help, but was not a sufficient condition.

“Ik merk dat ze ook op spoeddiensten of noem maar op, vanaf ‘t moment dat mensen zeggen ‘ik heb een psychische kwetsbaarheid’ of ‘ik ben opgenomen’ dat mensen met hun lichamelijke gezondheid niet meer 100% serieus genomen worden.” (Team-SHI)

The staff at emergency services was not aware of the specific somatic problems that were typical for psychiatric patients. For example, some examinations, like an ECG, were not performed due to the young age of the patient, while the addictive behaviour completely justified it.

« Et si vous voulez convaincre un médecin urgentiste d'un hôpital général – et ça c'était mon pain quotidien –, si vous voulez convaincre un urgentiste d'un hôpital général de bien vouloir faire un électrocardiogramme chez un jeune cocaïnomane de 30 ans, et qu'il vous dit « Mais il n'a pas l'âge de faire un infarctus » et qu'on lui a déjà trouvé deux séquelles d'infarctus, là ça rejoint votre sujet. (...) Parce que, comme le patient est schizophrène ou bipolaire, c'est pour la psychiatrie et donc... Et un ECG, enfin, chez un patient de 30 ans qui a des problèmes de psychiatrie, ça n'a pas de sens. Mais on sait qu'avec la cocaïne on peut faire infarctus à 25 ans. Enfin nous on le sait, les médecins urgentistes sont sensés le savoir, mais ne le font pas. » (Psychiatrist –PSGH)

Interviewees also stated that psychiatric patients were often too rapidly discharged from the emergency ward, assuming that, because the patient resided in a hospital setting, a residential setting or a sheltered housing



initiative, there was skilled nursing staff available to care; often time pressure was an issue.

“Wij hebben nu toevallig een patiënt (...) die komt van 't algemeen ziekenhuis en ik denk dat 't algemeen ziekenhuis soms redeneert 'wij transfereren die naar een psychiatrisch ziekenhuis' dus we kunnen die wat sneller terug transfereren.” (Team-PNH)

In addition, rules at the setting prevented a correct management of a somatic problem: in some settings no hospitalised patient was allowed to be treated at the emergency department. They were allowed to receive a diagnosis but no treatment. A patient with a broken leg on a Friday evening had to wait 24 to 48 hours for a cast. However, this was not specific for psychiatric patients.

« Même pour des fractures, ça arrive qu'un patient avec une fracture doit attendre 24-48h d'être plâtré. La semaine passée, j'avais un patient avec une luxation d'épaule, la radio est faite aux urgences, les urgences ne peuvent pas s'occuper des patients hospitalisés – c'est la règle de l'hôpital, de l'institut – et donc mon patient est renvoyé ici le vendredi soir avec une luxation de l'épaule et je dois faire appel à l'USI. Et l'USI, le lendemain, vient le chercher pour remettre son épaule à sa place. En quoi c'est logique que mon patient, avec sa luxation d'épaule, revient des urgences, le diagnostic est fait, mais il m'est quand même renvoyé... (...) Parce qu'il est hospitalisé, et les urgences ne peuvent pas s'occuper des patients hospitalisés. Pendant que l'épaule est luxée ! Mais ce sont des problèmes institutionnels. » (Psychiatrist-PSGH)

If the situation required a hospitalisation, from the interviews it appeared that the chance for a psychiatric patient to be hospitalised was smaller than for a non-psychiatric patient with the same indication.

« Si un psychiatrique doit être hospitalisé en médecine interne ou chirurgie ou service général, il a beaucoup moins de chances qu'un patient non psychiatrique de l'être pour la même indication. Quand je dis « beaucoup moins de chance » je suis très gentil. (...) Donc il y a un critère de pondération négative, pour décider d'une hospitalisation, quand vous êtes patient psychiatrique. Alors peut-être aussi que ce critère intervient quand vous êtes handicapé mental, ou personne à la

rue sans carte de mutuelle. Pour les patients psychiatriques, alors si vous avez les trois... aucune chance » (Psychiatrist-PH)

« Je pense à une autre patiente aussi s'était immolé le front et en gros, la question se posait de savoir si oui ou non elle devait avoir une greffe de la peau, ce qui finalement n'a pas été nécessaire, mais on entendait très bien qu'ils ne voulaient pas faire de greffe de peau. Pas parce qu'elle n'en avait pas forcément besoin, mais parce qu'ils ne se voyaient pas après reprendre une patiente psychiatrique au sein du service. » (Team-PH)

Collaboration with medical imaging service

Efforts to brief healthcare professionals about a patient referred to emergency services, but also medical imaging services were often in vain. GPs or psychiatrists preferred to refer the patient to a specific physician with whom they had good experiences. However, it was very difficult to influence who would actually see the patient.

« Meestal stuur ik een elektronische verwijfsbrief. (...) Het gebeurt dat ik toch bel, als ik echt denk van.... Ik moet echt wel de persoon te pakken krijgen en het nog eens goed uitleggen. Maar dan nog gebeurt het dan dat dan toch iemand anders de persoon ziet en dus... pffft... het is gelijk op radiologie is dat hetzelfde [als op spoed]. Ik probeer dan een afspraak te maken met echt één specifieke radioloog om te kunnen ervoor zorgen dat die patiënt gerustgesteld wordt, dat daar toch een beetje aandacht voor is, voor ook de psychologische kant. Maar dat is eigenlijk bijna niet te doen. Het is echt, 't gaat altijd iemand zijn die op dat moment werkt en ze kunnen dat niet op voorhand weten. Dat is radiologie. (GP-PH)

Lack of equipment

Sometimes after a somatic hospitalisation a psychiatric patient needed specific equipment e.g. perfusion and this was difficult to manage in a psychiatric setting. This was due to the unavailability of the equipment (infusion stand, bell), or due to the infrastructure of the ward (e.g. steps) that prevented the patient from moving around the ward, or because of other patient safety issues.



« Il faut vous rendre compte, aujourd'hui le service est étrangement calme, mais un pied à perfusion avec quelqu'un qui marche, le pied à perfusion quelqu'un va l'empoigner et ça va devenir un projectile. La perfusion, c'est un cathéter qui entre directement, un accès veineux direct, donc une autre va lui shooter de la cocaïne dedans. C'est très dangereux. » (Psychiatrist-PH)

5.2.4 Integrated care

Many patients face both somatic and psychiatric health problems (see chapter 2). Their health care needs demand a flexible health care organization in accordance with a holistic approach. The divide between somatic and psychiatric health care was evaluated as outdated by the HCPI. Integrated care would enable better continuity and quality of care at a lower cost, as double work could be reduced and collaboration difficulties prevented.

“Er zijn heel veel mensen met somatische problemen die ook psychische problemen hebben en andersom. En die combinaties die kunnen heel verschillende vormen aannemen en de mate van ernst kan heel erg verzinnen en... Vraagt in die zin een heel flexibele organisatie. Maar, voor sommige doelgroepen, heb je eigenlijk toch wel heel specifieke settings nodig, die echt een meerwaarde kunnen bieden. En ja, uiteindelijk, kom ik helemaal terug naar het begin van... Die opsplitsing, die is gewoon niet logisch. Die is... In de manier waarop we de gezondheidszorg organiseren. En er zijn ook hele interessante studies die hierop wijzen, bijvoorbeeld die aantonen dat ge ook door die verschillende organisatie en door die verschillende financiering, dat ge eigenlijk heel veel geld verliest en dat ge ook heel veel geld zou kunnen winnen, door te zorgen dat die zorg veel meer geïntegreerd georganiseerd wordt. Er is heel veel materiaal voor hé. Dat is aangetoond. En toch doet men dat niet. Toch smijt men eigenlijk de euro's door ramen en deuren eruit, doordat niet geïntegreerd te organiseren. Ook heel veel dingen die dubbel gebeuren. Wachtdiensten die dubbel gebeuren. Overal aparte

personeelsdiensten, juridische dienst... Alles. Ge zou perfect in grotere conglomeraten die integratie van uw zorg klinisch kunnen ondersteunen, door ook organisatorisch anders te gaan werken.” (Psychiatrist – PSGH)

5.2.5 Financial issues

5.2.5.1 Financing of the GP

Several types of financing for GPs caring for psychiatric inpatients were mentioned during our interview round.

In a general hospital, the GP we met was employed for a set number of hours by the hospital. He combined these activities with his freelance solo practice.

In psychiatric hospitals two systems were reported; either the GP worked employed by the hospital a set number of hours (sessions) or he attended his own patients or patients from another GP as part of his usual GP practice.

In the first scenario this was described as follows:

- Payment of the GP by half day per service with the mission of the follow-up of somatic care. This did not work well as the definition of the mission was rather large and subject to own interpretation.
- Independent GP attending the PH on certain days able to see a maximum of on average 3 patients as calculated by the nomenclature. Again, this scenario did not work as the GP often saw 10 to 15 patients per half a day. The duration of a consultation was long, varying from 5 minutes to 30 minutes.

« Je suis un indépendant, payé au forfait, l'équivalent de trois patients par jour si je les voyais dans une maison de repos. J'en vois 10 à 15. Donc forcément, je ne fais pas tout très bien. (rire) Donc c'est un forfait qui est prévu dans le financement de [l'hôpital psychiatrique] est remboursé de mes prestations, parce que le psychiatre demande une consultation somaticienne dans le cas de l'hospitalisation et un



remboursement. (...) dans une maison de repos, je gagnerais trois à quatre fois plus. » (GP – PH)

“Er is niets voorzien voor ons werk hé. Dat komt volledig uit de pool van wat de psychiaters verdienen. Dus ja, ik denk dat daar toch wel een belangrijke factor in zit wat ook begrijpelijk is he. Zij zijn ook artsen, ze kunnen dat voor een deel opvangen.” (GP – PNH)

The financing of the GP was insufficient to ensure somatic management of every inpatient. Therefore some hospitals asked the entitled GP to confirm attendance and follow-up of their patient at the start of hospitalisation. If they declined, often living at a distance, the hospital would bill fee-for-services for one visit per month for each patient after a request from the psychiatrist.

The current financing was perceived as not adapted to provide continuous somatic care and a fruitful collaboration between primary and secondary or hospital care. Hospitals had to use their own resources to offer qualitative somatic care to their inpatients. The main somatic activities were financed by the medical pool and covered only a part of the needs. Psychiatrists had to refer patients to the GP and selected therefore only the patients with clear somatic needs.

Interviewees explained that the NIHDI assumes that psychiatrists are able to take care of the somatic health of their patients. The way GPs are financed reflects the fear by NIHDI to pay twice for somatic health care for psychiatric patients.

In reality, not all psychiatrists felt confident to take on care of chronic patients, such as diabetes. They needed somatic expertise but the medical fees in residential settings did not foresee separate somatic and psychiatric care.

« Afin de pouvoir financer ces médecins somaticiens, nous avons, pour être en règle avec les règles de l'INAMI, nous envoyons une lettre systématiquement au médecin généraliste attiré du patient, en lui demandant s'il désire suivre son patient durant son hospitalisation. La grande majorité, pour ne pas dire la totalité des médecins généralistes disent que ça ne leur est pas possible. Hein, les visites en milieu psychiatrique sont peu financées, limitées à un certain nombre de visites, qui sont inadaptées au caractère aigu de nos hospitalisations.

C'était possible il fut un temps, où les patients passaient parfois une bonne partie de leur vie à l'hôpital psychiatrique, c'est plus le cas maintenant. Et donc, les gens viennent et sont pris en charge immédiatement d'un point de vue somatique par le médecin somaticien, sauf si le généraliste émet un intérêt à pouvoir y participer, alors il vient aux visites. Mais s'il accepte, il accepte de prendre en charge non seulement les visites financées par l'INAMI, mais les visites qui ne le sont pas, hein, puisqu'il y a un quota, un certain nombre de visites en hôpital psychiatrique qui doivent être à la demande du psychiatre. (GP-PH)

At the PNH, the GP interviewed said that he is paid by fee for service (NIHDI code per visit). This way of financing somatic care risked to limit the engagement of each GP.

It was suggested to pay a fixed sum for somatic care for each inpatient and at the same time authorise a visit by the entitled GP, e.g. twice a year. This system would also ensure the freedom of the patient to choose a GP.

Regarding the workload of the GP, the GP mentioned that the financing did not allow to:

- Participate in staff meetings
- Coordinate care
- Manage an appropriate patient medical file

5.2.5.2 Financing of nursing staff

Nursing staffing norms were said to be insufficient to manage somatic care for psychiatric patients. As mentioned before, the pace of work was different in psychiatry: staff needed time to listen, to make the patient comfortable to express a complaint, and decode the complaint (e.g. is pain real or a result of the psychiatric illness). If there was a somatic problem, they did not have sufficient time to manage it (e.g. wound care).

« Quand il y a des situations qui nécessitent plus d'implications somatiques dans le service, c'est certain que ça mobilise beaucoup l'équipe, et donc ça peut parfois mettre en difficulté le temps qu'on peut



octroyer ou que mes collègues infirmiers aussi peuvent octroyer aux patients. » (Team-PSGH)

Nurses reported also an inconsistency in the remuneration according to the setting: Psychiatric nurses in hospital seemed to benefit from a bonus for their specialisation in psychiatry which was not the case in PNH.

5.2.5.3 Transport costs

When a psychiatric resident needed to consult outside the setting, transport and accompaniment had to be organised. If there was no internal transport service available or the capacity was limited, other external solutions had to be sought e.g. out-of-office hours i.e. after 4 pm.

There were huge differences in prices of transport between the day hospital service and other external services.

Transport was an important cost for the setting and for the patient. If the transport was necessary because of the situation, costs were imputed to the setting. Otherwise, the patient paid (for example, a patient treated by a physiotherapist not working at the hospital).

With the closure of small on-site entities (e.g. polyclinics), patients had to travel further and the transport costs increased in consequence.

Healthcare professionals sometimes decided to transport the patient with their own means to a consultation, knowing they were not insured.

5.2.5.4 Affordability of somatic care for the patient

As a consequence of their psychiatric problem, psychiatric patients often lived in precarious situations (e.g. homeless, unemployed, illegality). Causality was also inversed: psychiatric problems were the result of a precarious situation.

In addition, there were economic differences between 'long-term patients' compared to new patients. Indeed, before the deinstitutionalisation trend, patients used to live in a hospital for years. The cost for the hospitalisation was very low and they had the opportunity to save money. When they arrived at a PNH they had sufficient funds to pay for their health care. This is no

longer the case and 'younger patients' now, were generally in a poorer economic situation.

« Il ne faut pas oublier qu'avant, beaucoup de patients restaient en hôpital, vraiment. Certains sont restés quasi 20 ans, 30 ans à l'hôpital, et donc mettaient presque 1000 euros de côté. Parce que bon, il gagne 1400, il dépense 80 centimes par jour, voilà et donc... Et encore ici des patients qui ont 100 000 euros sur leur compte. (...) Donc avant ils restaient en psychiatrie hospitalisés longtemps et en fait ça coûte beaucoup moins cher, une hospit' par rapport à un service résidentiel. Je pense qu'il y a aussi tous ceux qui sont maintenant avec des équipes mobiles qui sont arrivés, qui vont maintenir un logement à domicile avec des allers-retours hôpital. (...) et ça on verra plus tard, ils ont maintenu un domicile à l'extérieur donc ils continuent à payer leur loyer etc. Plus ils payent l'hôpital, ils s'endettent, et donc j'imagine qu'on va avoir des gens qui vont avoir du mal à finalement rentrer en MSP financièrement. » (Team-PNH)

Several issues concerning health insurance were mentioned by the interviewed healthcare professionals:

- Psychiatric patients were not aware, due to their precarious situation and the difficulties resulting from the mental status, of the available reimbursements that are part of the complementary insurance health package which is included in their health insurance membership. As a result they were missing out on for example dieticians or non-conventional practices (e.g. acupuncture, homeopathy).
- While patients were hospitalised, it was not possible to access or start up a file for emergency medical aid for immigrants (<https://medimmigrant.be/>) so the patients would benefit from health care once discharged. Patients had to initiate the public social assistance service (CPAS/OCMW) themselves once discharged. This way, obviously, no continuity of care for the patient was assured.

« C'est malheureusement un peu contradictoire de dire « Je veux une aide médicale urgente pour que le patient voit tous les mois son psychiatre ou son généraliste ». Parce que, une aide médicale urgente, c'est censé être une aide médicale urgente pour une appendicite, pour



un... pour une pneumonie. Mais, en même temps, si on ne fait pas ces soins-là, le patient va à nouveau se dégrader, va de nouveau devenir plus malade sur le plan psychiatrique ou somatique, et finalement, va prendre encore plus sur la sécurité sociale que cette... cette prise en charge ambulatoire. Donc on demande des AMU, mais ce n'est pas toujours évident. C'est, je crois aussi, pas évident qu'on ne puisse pas demander un AMU avant que le patient soit sorti, parce que ça veut dire qu'on doit vraiment compter sur le patient d'aller avec sa feuille d'AMU au CPAS ; qui doit encore tomber sur une assistante sociale un peu sympa, qui l'écoute dans sa demande. (...) Qui prenne le temps, ou à la limite qui prend le téléphone pour nous appeler, parce que nous on a signé pour demander « Tiens, pourquoi vous demandez un AMU ? », « Parce que le patient n'arrive pas à m'expliquer ». Donc je suis sûre et certaine qu'une bonne partie de nos prises en charge qu'on a organisées tombent à l'eau à cause de cela. Donc, c'est un peu idiot si on sait que le patient sort dans une semaine, qu'on ne puisse pas faire les démarches avant qu'il sorte. » (Psychiatrist - PH)

- Psychiatric patients who needed exclusive somatic health care were sometimes hospitalised in a psychiatric setting. Patients were not always aware that their private hospitalisation insurances did not cover psychiatric care.
- Practitioners wondered if psychiatric patients hospitalised in a psychiatric ward are well covered by their private insurance.

And, as already mentioned, patients had to pay transport costs for somatic care, which were sometimes very expensive.

« C'est quand même quelque chose que je trouve de plus en plus compliqué avec des personnes qui ont des comptes de plus en plus vides avec des frais de transports qui sont tout-à-fait énormes. J'avais calculé pour quelqu'un qui devait faire un soin somatique à l'extérieur, si on prenait un tel type de transport on en avait pour 1000 euros de transport pour ses 18 séances à l'extérieur, ce n'était juste pas possible. Alors qu'on est déjà dans une situation très précaire, et donc c'est aussi la débrouille des équipes pour arriver à trouver des transports à des prix raisonnables compte tenu des situations sociales, qui sont de plus en plus catastrophiques. » (Team-PNH)

5.2.6 Ethical issues related to somatic care

Three major topics emerged from our analysis relative to the ethical dimensions of the somatic care: the implications of the psychiatric treatment on the somatic health of the patient; privacy issues; and last, the attitude of the healthcare professionals facing patients who refused care.

5.2.6.1 The side effects of psychiatric pharmacological treatment

Psychiatric patients often received a large amount of medicines. Psychopharmaceutical treatments are well known for their side effects, in particular an increased risk of overweight and diabetes. Healthcare professionals questioned the balancing between these increased health risks and the benefits of the treatment of the psychiatric illness. In addition, too little attention was paid to informing patients about the potential side effects. Respondents recognised the difficulty to address such issues because medicines were prescribed in an acute phase of the psychiatric illness, when a dialogue with the patient was difficult or impossible.

«- Moi je crois qu'on doit au moins informer le patient et lui dire « Écoutez, si vous voulez le Zyprexa, vous pouvez l'avoir mais dans cinq ans vous aurez des problèmes de diabète, un problème de glycémie, et donc peut-être un problème au cœur ».

- Et l'information ne se fait pas de manière systématique ?

- Non, non. Non pourquoi : parce que ce sont des médicaments qui sont prescrits en phase aiguë, et dans la phase aiguë, c'est difficile de parler avec un patient qui est convaincu je ne sais pas moi, qu'il habite sur Mars. Donc c'est compliqué. Moi je pense que quand même, on doit informer, malgré le fait que le patient soit en phase aiguë, mais surtout, surtout on doit être avant tout médecin hein avant d'être psychiatre. Donc on doit faire attention aux effets aussi. Les prises de sang, l'électrocardiogramme. Je ne dis pas qu'on doit le faire nous-même, mais quand même suggérer au patient de le faire. » (psychiatrist-pSGH)



5.2.6.2 Medical confidentiality between professionals

On a few occasions healthcare professionals referred to the hurdle of medical confidentiality. They found it difficult to know what patient information to share with whom.

« Une différence très forte quand même entre la psychiatrie et la médecine générale, et qui rend parfois les relations compliquées, c'est qu'une des conditions à l'exercice de la médecine, c'est le secret, la confidentialité. C'est une condition de l'exercice de la médecine. La psychiatrie, c'est la gestion du secret. Donc le généraliste a besoin d'intime, mais nous on gère l'intime. Donc par définition, les gens ne peuvent pas rester tout le temps avec nous. Et il y a une partie de l'information qu'on doit partager et qu'on ne doit pas partager. Mais le cœur de notre métier, c'est le secret. Alors que pour le médecin, je le répète, la condition d'exercer c'est le secret. Ce n'est pas la même chose. Et donc ça, c'est déjà... Comment est-ce qu'on met ces deux concepts ensemble ? C'est vrai qu'on s'occupe moyennement bien de la santé physique, en disant « Gérez ça avec un autre ». (...) Donc des fois il y a des médecins qui nous mettent dans des pièges en nous disant « Je t'appelle mais tu ne peux rien dire, c'est untel qui... ». On ne sait plus travailler. En tout cas, ça c'est ma difficulté. La difficulté du médecin traitant avec moi, » (Psychiatrist-PSGH)

“ 'T is soms ook een voorbeeld als spoed belt. Dat vind ik altijd verschrikkelijk. En die mensen die bellen dan van spoed en die vragen dan heel veel en ondertussen zit ge aan 't denken 'wat mag ik hier zeggen, wat mag ik hier zeggen?' want ge mag niet teveel zeggen. ” (Team-SHI)

5.2.6.3 Informed consent and refusal of care

Psychiatrists as well as other members of the staff reported they felt sometimes uncomfortable about convincing patients to take actions for their somatic health: unless it was vital, such as for cancer or HIV, it was difficult to 'force' patients to take on treatment. Sometimes, hospitalisation was perceived as a window of opportunity, also because often diagnoses were made, to convince patients to accept treatment which they would otherwise refuse.

« Parfois on ne sait pas par où commencer, parce qu'il y a de tels problèmes qu'on découvre lors des séjours – et je ne parle pas d'un simple diabète, ou quelque chose comme ça. On découvre régulièrement des hépatites, des hépatites C, des HIV, des cancers – des choses qui ne sont pas « rien » et que voilà, qu'il faut prendre en charge dans un cadre où on sait que je ne peux pas obliger les soins somatiques, sauf si c'est vital. Et donc... voilà, on est tout le temps un peu sur cette... sur cette corde entre « jusqu'où est-ce qu'on oblige ». On oblige de manière un peu passive, on ne laisse pas trop le choix au patient, en sachant que c'est pour son bien et en espérant que plus tard, il verra le sens de son traitement. » (Psychiatrist-PSGH)

« Un patient qui – on a régulièrement, notamment en HIV, des patients qui connaissent leur diagnostic et qui très clairement disent « Je ne veux pas le prendre, mon traitement ». Je peux les obliger des soins psychiatriques, je ne peux pas obliger un soin somatique, sauf si ça devient vital. Un patient qui arrive ici avec une infection gangréneuse, qui refuse les antibiotiques, désolée, je lui donne les antibiotiques parce que je sais que c'est temporaire et que ça amène à la guérison. Pour l'HIV, comme c'est un traitement chronique, c'est beaucoup plus difficile d'obliger un patient et, en plus, je ne peux pas l'enfermer à vie pour prendre son traitement HIV. » (Psychiatrist-PSGH)

“Maar soms is er iets van 'ja, we moeten ook respecteren wat zij zelf willen.' En daar staan de artikels lijnrecht tegenover he. Sommige zorgverleners gaan heel veel mee in wat de patiënt wilt, anderen zijn wat strenger of wat directiever en soms moeilijk wel om een evenwicht te vinden hé. Ge wilt niet verwaarlozen zijn. Maar hoever moeten we dat overnemen zo he? Maar daar zijn soms wel echt extreme voorbeelden van he.

- Kan u zo'n voorbeeld geven?

- Ja... Mensen die behandeling weigeren voor kanker ofzo he totdat dat echt... Ja en dan wordt er soms wat afwachtend mee in te gaan om die toch niet te forceren, maar ja, dat stopt niet he. Dat evolueert dan. Dat wordt soms dan echt dramatische toestanden hoor.” (GP-PNH)



The issue was also raised in sheltered housing initiatives and discussed within the team.

« Jusqu'où va notre devoir de prendre soin ? Comment faire avec le refus ou la négligence, ou le je-m'en-foutisme par rapport à sa santé ? Donc ça, c'est une question éthique et avec laquelle on est toujours en difficulté, entre « Jusqu'où est-ce que le patient, on le laisse libre de se rapprocher de la mort un peu vite, au fur et à mesure des pratiques ? ». Mais c'est une question qui nous touche tous personnellement. Et là, on est dans une position quand même d'équipe de soins, donc ça nous interpelle d'autant plus. En contact, d'ailleurs, avec le médecin. » (Team-SHI)

5.2.7 Ideas for improvement of somatic care for psychiatric patients

Interviewed healthcare professionals mentioned ideas about how somatic care for psychiatric patients can be improved. Below we listed the ideas which were not integrated in the previous sections.

- Somatic care for psychiatric patients can be improved by means of structural improvements outside the healthcare system, e.g. housing, economic vulnerability, employment.

« Donc je pense que la gestion des soins physiques ne viendra peut-être pas de la santé, mais de la (...) réduction de la précarité, rendue élevée par la maladie. Donc, quand on est malade, on est pauvre. Quand on est malade mental, qu'on fume et qu'on est pauvre, on achète son tabac et donc pas son insuline. Et il y a le coût des soins à ce moment-là qui joue certainement un rôle important. Quand on est à la rue, effectivement, on ne s'occupe pas d'une engelure. On a eu une bande, je ne sais pas d'où ils venaient, des dentistes qui sont venus voir nos patients en service de santé mentale. Les soins dentaires, c'est la 14^è priorité. (...) Et c'est à cause du coût, ou plutôt à cause de la croyance du coût. Mais aller chez son dentiste tous les ans qui fait que les soins sont gratuits parce qu'il faut être installé. Les gens qui sont SDF ou à moitié SDF, précaires, dans des logements sociaux, ils se bagarrent avec le voisin, on ne sait jamais ce qu'il va se passer, ils n'ont pas... donc le dentiste... Ils y pensent quand il y a un abcès ; quand il

y a un abcès, antibiotique, et puis hop on tombe sur un jeune qui arrache, et pas de dentier. (...) C'est que ce ne soit pas une affaire du résidentiel, mais une affaire du lieu de vie. Ce n'est pas une affaire de résidentiel. C'est là où le patient vit. Or, le résidentiel n'est pas là où il vit, mais là où il passe. Donc c'est probablement pluridisciplinaire, et infirmiers psychiatriques dans la rue. Enfin, pas dans la rue mais dans la toile. » (Psychiatrist -PSGH)

- Improvement of the medical training: knowledge of the guidelines was said to be important but had to be adapted to the patient.

« Je crois, très personnellement et très honnêtement que je ne suis pas fan de l'examen d'entrée, je ne le cache pas. Parce que je ne crois pas que ce soit les gens avec le plus grand côté humain qui passent l'examen, c'est ceux qui traitent les dossiers, et qui sont très bien en chiffres. (...) Ils ne jugent pas de la valeur humaine et la capacité d'être empathique avec les gens, au contraire. Je crois qu'on rate énormément de bons médecins. Je ne dis pas... Voilà, s'il faut absolument les limiter, il faut les limiter d'une autre manière mais pas par un examen qui mesure la connaissance théorique des sciences. Et je parle très personnellement, je n'aurais jamais réussi l'examen d'entrée. Et je ne m'estime pas un mauvais psychiatre, et même pas un mauvais médecin. (...) Mais je crois... Et je vois ça aussi dans les étudiants, j'ai des gens hyper intelligents, mais même parmi les jeunes psychiatres, c'est les guidelines, les chiffres, les études. Non, prends le temps, examine ton patient. Et examiner, c'est : va lui parler, fais connaissance. Ton patient n'est pas une guideline. Oui, il faut connaître une guideline, mais il faut adapter la guideline au patient et pas le patient à la guideline. Et donc, je crois qu'on forme des étudiants brillants, mais pas les meilleurs médecins. » (psychiatrist-GWHG)

- Set up an internship of sufficient length in a psychiatric setting for all nurses, GPs and medical specialists during their training to make them aware of the challenges and complexity of psychiatric care and the interaction with somatic care.

« (...) on nous oblige tous à faire un stage dermato. Le dermato ne nous fait pas peur, et si ça ne nous intéresse pas, voilà, on assume. Pendant que les patients psychiatriques, vous en trouvez partout : à la maternité,



en chirurgie, en médecine, en gériatrie. Le seul endroit où on ne les trouve pas, c'est en anapath. Des fois ils sont là, mais ils ne disent plus rien. Mais, je veux dire, des patients délirants, mégalos, dépressifs, on va les trouver partout. Pourquoi est-ce que ce stage n'est pas plus obligatoire ? Obligatoire de manière un peu consistante, et pas deux semaines d'observation. » (Psychiatrist-PSGH)

“Maar dat kunnen ze eigenlijk ook oplossen. Ge hebt nu vierdejaars studenten, iedereen, als die het vierde jaar uit is, kan alles. Zowel psychiatrisch als spoed als noem maar op. In principe kunnen ze zeggen van ‘t ziekenhuis van “kijk hier, gij hebt ‘t vierde jaar gedaan, gij gaat hier als psychiatrische nu op spoed werken. Of ge gaat u meer bezighouden met de psychiatrische patiënten.” Dat moet kunnen. Ik vind dat ge als directie moet zeggen van “kijk, wij hebben nu de mogelijkheid voor de vierdejaars studenten. Als die uitkomen zijn dat ook psychiatrisch verpleegkundigen.” En ge moet ze daarin verplichten. Ge moet zeggen “Ok, ge gaat op spoed werken. Maar als er een psychiatrisch patiënt is, is dat voor u. Gaat gij dien doen.” (Team-PSGH)

- A recognition or label for ‘psychiatric friendly’ healthcare professionals would be useful.

« Il y a une équipe volante dans la clinique et parfois on demande de l'aide pour des soins plus somatiques. Et c'est vrai que – je ne vais pas citer de nom – une personne était dans l'équipe volante et on sait qu'il y a une fibre comme ça, santé mentale et psychiatrie, qui apprécie être là. Nous on est encore plus contents quand c'est elle qui vient parce qu'elle est contente d'être là aussi et que les choses se passent bien. Et c'est vrai que ce soit médecin, infirmier, aide-soignant, ce qu'on veut, je dirais même technicien de surface, je pense que quand on arrive dans une setting psychiatrique, il faut qu'il y ait quelque chose de l'ordre de la fibre, une sensibilité par rapport à ça. Et pour ça, il n'y a pas de procédure » (Team-PSGH)

« Moi je pense que maintenant, on doit traiter la psychiatrie au niveau des étudiants, donc peut-être favoriser des stages, dans des situations extrahospitalières, donc montrer qu'il existe tout un réseau extrahospitalier, où il y a la psychiatrie liée au relationnel. Où le

psychiatre n'est pas là pour donner des médicaments mais il est là pour parler, pour discuter, pour rigoler aussi. Ce n'est pas seulement le psychiatre autoritaire ; moi j'aime bien m'amuser aussi avec mes patients, j'aime bien rigoler parfois, ce n'est pas seulement prescrire des médicaments.(...) Peut-être nous on travaille dans des institutions extrahospitalières, essayer d'avoir le plus possible des stagiaires, médecins en formation, pour vraiment montrer, montrer vraiment qu'on peut soigner les patients psychotiques aussi avec des outils qui ne sont pas des médicaments » (Psychiatrist-SHI)

- It is important to have regular updates of the competences and skills of the staff.

« Et en plus ça les infirmières je ne sais pas comment ça se passe au niveau de leur remise à niveau, si elles sont obligées de se remettre à niveau. Mais tout ce qui est sujet somatique, avec des pathologies comme le diabète, où il y a beaucoup de nouveaux médicaments qui sortent, des capteurs de glycémie, tout ça, elles ne sont pas toujours au courant donc... C'est aussi difficile parce que moi je tiens au courant avec les guidelines avec tout ça, avec l'accréditation et puis à côté de ça j'ai parfois des équipes qui n'ont plus fait de mise à jour depuis plusieurs années, donc euh... Complicé. » (GP-PNH)

- Direct contact between healthcare professionals (e.g. by phone) facilitates somatic care

« Moi j'ai travaillé à l'hôpital général, le gros problème c'est comment les urgentistes parlent aux spécialistes d'étages, comment ils leur présentent les cas qui doivent être hospitalisés, et c'est là que le chaînon est plus difficile. Donc moi qui ai cette expérience-là de 13 ans, j'encourage ici l'équipe à travailler directement avec les spécialistes d'étages. Par le biais des consultations, ou en négociant de très courtes hospit' à partir d'ici directement, les salles d'urgences sont tellement, je ne sais pas... Envahies, débordées, fatiguées.” (Psychiatrist-PH)

- Revise staffing norms, especially nurses in order to have staff available to prepare the consultations, accompany patients to appointments, prepare discharge.



« On n'arrive pas à assurer un suivi correct malgré tout dans l'accompagnement de l'extérieur, et c'est frustrant en tant que soignant de se dire « Cette personne, si on avait été là, on aurait pu expliquer, on aurait pu faire ci, mais on n'a pas pu le faire parce qu'on n'était pas en nombre ». » (Team-PNH)

- Mobile dentists who come to the setting, this way making dental care more accessible for psychiatric patients.

« *Dentalmobilis(...)* C'est un cabinet dentaire qui se déplace sur le lieu de résidence des patients, pour les patients pour qui c'est difficile de se rendre au cabinet dentaire... Alors ils font préférentiellement les personnes âgées, ou les gens qui ont des troubles d'Alzheimer et qui sont en setting, qui ne savent plus aller chez le dentiste moyennant des encadrements, enfin c'est très compliqué. Donc ils viennent avec le cabinet dentaire et je donne ça à [l'infirmier chef] en lui disant peut-être que pour certaines patientes ici... Parce que j'ai des patientes qui ne sortent pas, soit parce que leur comportement ne le permet pas, mais même quand on leur donne l'autorisation de sortie elles disent « Moi je ne sors pas, parce que c'est plein de nazis dans la rue et je ne vais pas mettre le pied là », et donc voilà donc... Peut-être que si le soin vient ici plutôt qu'elles ne sortent, ça pourrait fonctionner. » (Psychiatrist - PH)

6 THE SOMATIC CARE OF PERSONS WITH SMI: QUALITATIVE RESEARCH ON THE PATIENTS' PERSPECTIVES

Key messages

- Patients felt not being listened to or not being taken seriously when experiencing somatic health problems. The perceived lack of due consideration of somatic health problems in a psychiatric setting resulted in delayed health care, distress and additional healthcare costs for patients.
- Patients reported not being (sufficiently) informed about admission procedures including examinations such as blood sample, EEG, weighing; about who to contact in case of a somatic health problem during hospitalisation; about which somatic health information was available to the setting; about whether their GP had been contacted; about changes in drug treatment or side-effects of psychopharmaca before starting a treatment.
- A shortage of basic somatic healthcare information was reported. This concerned the information flow between healthcare professionals (e.g. access to previous admission medical files, information sharing with GPs at the time of admission or discharge), but also between healthcare professionals and patients (e.g. timing of follow-up visits, psychiatric or somatic diagnoses, the prescribed treatment including changes in medication schedule and possible side-effects, and who to contact in case of a somatic health problem).
- The attention paid to somatic health in persons with serious psychiatric problems varied by the (type of) setting, the healthcare professional, and the physical complaint or disorder.



- According to the patients the reason for the hospitalisation had an impact on the access to somatic health care. Patients felt not being treated equally: e.g. patients with an addiction or initial somatic health problem were given priority to consult a GP.
- Several issues were raised regarding ‘somatic’ medication: patients no longer had access to the medicines they usually used to relieve somatic symptoms or discomfort. Their pre-admission medication scheme was often reviewed at admission in function of availability in the setting’s pharmacy. Changes in the medication schedule led to new difficulties, unanticipated side effects, anxiety and stress.
- A lack of resources, skills and competences was recognised to affect the quality of somatic health care, including staff’s high workload, and a lack of medical equipment and infrastructure.
- The continuity of somatic health care was sub-optimal for access to medication and access to specialists and examinations. Moreover, the follow-up of somatic aspects after discharge was not organised during hospitalisation.
- Health promotion and lifestyle interventions focused mainly on physical activities or flu vaccination. Although patients were made aware of healthy eating, access to healthy food was not always available or encouraged. Neither were interventions for smoking cessation.

6.1 Method

6.1.1 Design

In order to collect data to understand how somatic care is experienced by patients with a mental illness (in Belgium) and how this can be improved, we planned to conduct face-to-face focus groups with several users who had experience with staying in a residential setting.

Focus groups are a suitable way to interview persons with a severe mental illness. They are used to discuss personal issues in groups (e.g. for therapy or in self-help groups). To patients it may also feel more comfortable than if they were interviewed face-to-face.

6.1.2 Recruitment and sampling

Because of the exploratory nature of this part of the project, we planned to have six groups: two for patients from Flanders, two for patients from Brussels and two with patients from Wallonia. Classically one focus group counts 6 to 8 participants. So we intended to meet a maximum of 48 participants.

We foresaw the recruitment of persons with severe mental illness (lasting for at least 2 years), aged 18 years or older, Dutch or French speaking, who had stayed in a psychiatric setting (at a psychiatric hospital, psychiatric ward of a general hospital, psychiatric nursing home or a sheltered housing initiative at least once in the past 5 years).

We recruited participants with the collaboration of patient organisations: Psytoyens, UilenSpiegel and Steunpunt Geestelijke Gezondheid. Their members were invited by letter, email, social media, newsletters or when attending a meeting. Eventual candidates were asked to express their interest to participate in a focus group about their experience with the prevention, treatment and/or follow-up of their somatic health problems during residential psychiatric care. For this communication KCE provided a text which was adapted after discussion with and input of the patient organisations (see Appendix 5.1). Participants were not asked about their diagnosis. We assumed that the persons who agreed to participate, suffered from a severe mental illness and met the inclusion criteria.



Candidatures were gathered by the patient organisations. They ensured that the inclusion criteria were met and a list was transmitted to KCE researchers. Allocation to a group was set up according to region (Flanders, Brussel or Wallonia).

Next, the KCE researchers contacted the participant directly by e-mail, sending the information about the project and the informed consent form. The patients were invited to read the information and inform KCE researchers of their decision to participate or not.

6.1.3 Data collection

Semi-structured interview guides were developed by KCE researchers (see Appendix 5.3) in collaboration with the patient associations mentioned above. They were initially written in French and subsequently translated to Dutch. Four focus groups were to be conducted in French and two in Dutch.

The interview guide was piloted by KCE with a representative of Psytoyens. Examples of concrete situations were planned to be read to the participants in order to structure the discussion if needed. All interviews were moderated in the respondents' native language by KCE researchers.

Because of the COVID-19 crisis, focus groups had to be carried out online by means of Zoom with a limit of 5 participants per session. For each focus group one KCE moderator was foreseen accompanied by one observer (a representative of patient organisation^v) and one note taker (KCE researcher).

^v For Flanders, the patient representative withdrew because of work overload, hence no patient representative was present during the interviews. However, the patient representative took contact with all Flemish participants after the interview, in order to be sure they coped well with the interview.

6.1.4 Data treatment and analysis

The interviews were audio recorded. After the interview, a transcript was made by an external firm. Next, the transcripts were analysed by KCE researchers with NVIVO software. With this software the collected information was coded and codes were clustered in thematic groups to facilitate the analysis of the data.

6.1.5 Ethical committee approval

The study was submitted and approved by the hospital-faculty ethical comity of the Erasme Hospital (Université Libre de Bruxelles) under the referral CCB : / B406202042676.

An Informed consent form (see Appendix 5.2), (reviewed by Psytoyens to ensure the readability) was signed before the start of the interview: the moderator read through the information sheet of the informed consent, gave explanations, and answered participants' questions. The moderator also asked permission to audio record and transcribe the interview.

6.2 Findings

6.2.1 Description of the participants

Because of the lock down in March 2020, we first decided to postpone the data collection to September-October 2020. However, even then the recruitment took place in sub-optimal conditions and we had to do the focus group interviews online.

These conditions clearly hampered the recruitment of participants. For Flanders, eight candidates registered, but at the start of the online focus group interview, only two participants signed up, one for each focus group. The focus groups thus became individual interviews. The registered



candidates were contacted by mail and asked whether they were willing to do an individual interview instead of a focus group interview. Two replied positively and told us they felt more comfortable in a one-to-one online setting. Hence a total of four Flemish patients was reached. For Brussels, additional to the difficult conditions to recruit, difficulties in the regional coordination among the patient organisations hampered a good recruitment and finally one participant agreed to participate in an individual interview. For Wallonia, we met 5 patients for an online focus group.

6.2.2 Limitations

Before the presentation of the findings, we want to list the limitations of this study.

Because of the COVID-19 crisis, we were obliged to 'meet' the participants online. This way of data gathering may result in an additional selection bias: participants had to feel comfortable with the use of information technology and the 'distant' communication imposed by the video conference. It is probable that we met patients with a higher socioeconomic status than would have been the case if we had been able to recruit people for a 'in person' face-to-face interview. From the researchers' point of view, it is more difficult to create an atmosphere of trust and empathy in an online interview.

Another limitation is that the patients were recruited through patients' associations. These associations might represent a specific type of patients, being involved in and aware of 'self-care'.

Moreover, we were not able to recruit as many participants as intended. Consequently, we were not able to reach data sufficiency. This means that our final findings are not generalisable to all psychiatric settings and are in fact hypotheses that necessitate further research in order to come to firm conclusions.

In addition, as a general observation we would like to emphasise the large variation we found in patients' accounts. Apart from individual differences, also organisational settings largely diverged. However, due to the small number of participants we could not do setting specific analyses. In other words we could not differentiate between psychiatric wards of general hospitals, psychiatric hospitals, psychiatric nursing homes and sheltered

housing initiatives. We were forced to draw up general observations, without specifying the setting. In addition, during the interviews as well as in this chapter most attention was paid to what went wrong, leaving positive accounts largely unaddressed. However this does not mean positive experiences are non-existent.

Finally, we would like to mention that part of the data related to somatic health care in ambulatory psychiatry and general practice. We did not include this data in this report as the projects' scope was on residential settings.

6.2.3 Consideration for somatic health care in psychiatric care settings

In general, patients evaluated the attention paid to their somatic health problems during hospitalisation for psychiatric illness very differently: while some patients reported that little attention was paid to their physical health, others seemed to be satisfied. More specifically the latter perceived their hospitalisation as a window of opportunity and appreciated the possibilities to consult physicians and be treated for a somatic health problem during their hospitalisation.

« J'ai été hospitalisée à l'hôpital X donc c'est un hôpital général avec un pavillon psychiatrique. J'ai vu des médecins au début pour statuer sur mon état physique, même si j'étais là pour un problème mental. Ils ont vu que je faisais de la tachycardie donc ils m'ont donné un médicament contre la tachycardie. »

For this section we first present the differences in health care by setting and healthcare professional as perceived by the interviewed patients. Next, we structured the findings in function of three moments in a care trajectory: at admission, during the hospital stay and after discharge.



6.2.3.1 Differences in health care by setting and healthcare professional

From patients' accounts we understood that the attention for somatic health varies largely between type of setting (SPHG, PH, PNH, SHI), between settings of the same type, and between healthcare professionals. They claimed luck had to be on your side to receive good health care by a capable doctor or team.

“In principe mag er dat niet toe doen maar ik denk wel dat het verschillend kan zijn van instelling tot instelling ook, hoe dat er mee omgegaan wordt, en dan de dokters zelf. Het is zo dat je nog altijd heel veel geluk moet hebben van bij waar en bij wie dat je terecht komt.”

“Ja. Ja. En dat was in [Naam gemeente], en ik kan mij voorstellen dat dat niet overal zo is, hé want ja dat is, ik heb natuurlijk in meerdere klinieken gezeten, je merkt een enorm verschil tussen de zorg die er geboden wordt, (...) en ook de persoonlijke aanpak die verschilt.”

“Non, juste que j'ai fait la remarque à mon compagnon que j'étais tombée dans un hôpital 5 étoiles on va dire. On était au courant des effets secondaires des médicaments, on était, enfin voilà on était chouchoutés, enfin voilà, on avait beaucoup d'écoute en tout cas de mon côté. Mais voilà, en même temps, j'ai envie de soutenir tout le monde et de les encourager à continuer quand même malgré les hauts et les bas quoi comme on dit.”

« C'est vraiment mieux d'être dans un hôpital comme, oui, par exemple l'unité psychiatrie à [X] donc dans un hôpital général, je pense que c'est mieux parce qu'il y a quand même plus de moyens et plus de facilité de faire appel, je pense, pour eux aux équipes, à un médecin, que ce soit en urgence ou bien un médecin d'une spécificité particulière puisque les unités sont là. Tandis que en hôpital psychiatrique comme [Y] (...), alors là, je pense que là il y a un gros problème justement pour la question physique, où il faudrait tout repenser.

In the same way participants pointed to the reasons for the differences between hospitals assuming that the bigger the size of the hospital or ward, the more important was the lack of (human) resources.

« Mais il faut voir la taille de l'hôpital. A [hôpital psychiatrique X], il faut savoir que c'est déjà presque 2 000 patients dans plusieurs ailes mais déjà 2 000 patients, le manque du personnel et tout donc pour avoir quelque chose, plus c'est grand, c'est comme un l'hôpital normal, plus c'est grand, moins il y a de services parce que moins il y a de personnel et moins y a d'argent. Les plus petites structures pourraient fonctionner mieux parce que elles ont, elles pourraient avoir un petit peu plus d'argent. Mais plus c'est grand, plus c'est difficile d'avoir quelque chose. »

« je merkt een enorm verschil tussen de zorg die er geboden wordt, tussen het pakket dat daar geboden wordt, de therapieën, het ene dat is fantastisch dat in [stad naam 1] dat is [instelling X] daar kan ik alleen maar over zeggen dat dat fantastisch was. Daar ben ik een jaar geweest, en daar heb ik eigenlijk, en dat was mijn eerste opname en daar ben ik eigenlijk het meest van, ja daar heb ik het meest fantastisch geleerd eigenlijk. Dat was hé, zo uitgebreid en goed georganiseerd, ja dat was echt echt heel goed. En toen ben ik verhuisd naar [instelling Y], dat is bij [stad naam 2], dat is heel ergens anders, en ik ben hier in [stad naam 3] geweest, en in [stad naam 4], en in [stad naam 2] zelf, en in, hoe heet die andere nu [naam instellingen groep], nou ja maakt misschien ook niet zoveel uit, maar daar verschilt het enorm en ook de persoonlijke aanpak die verschilt.

For example, the access to and the availability of a GP also depended on the setting. Most of the time the GP was accessible on demand and the patient was given an appointment or was listed on a consultation list. However, in other places the psychiatrist was solicited whenever the patient worried about somatic health.

“En meestal werkt het zo dat als je je zorgen maakt om je medicatie, psychiaters die zijn dagelijks op de afdeling en daar kan je eigenlijk wel altijd een afspraak mee krijgen. “



6.2.3.2 The characteristic of the presenting somatic problem defining access to health care

Participants attributed the differences in the management of somatic health problems not only to the type of setting, but also to the type of somatic health problem.

When patients anticipated somatic health care at admission, e.g. for known diabetic patients, care was managed smoothly. However, care for unanticipated somatic health needs was problematic.

« Tout ce qui est soins planifiés, que ce soit par le médecin psychiatre ou par le médecin traitant et qui est dans le dossier du patient et qui est planifié, qu'on sait très bien que, je sais pas, on doit lui faire la piqûre d'insuline avant de prendre ses médicaments, ça il y a pas de souci. C'est à partir du moment où on demande un nouveau soin que là ça pose problème. Le médecin vient peut-être que entre 8h30 et 9h00 et je pose la question à 9h10 donc je suis bon pour attendre deux jours. Voilà, c'est tout ça, c'est que c'est à partir du moment, le truc qui tourne il tourne, mais à partir du moment où on met en grain de sable dedans, tout s'arrête. »

We learned about patients who were hospitalised for a somatic health problem but were transferred to the psychiatric ward because they had a psychiatric history. It seemed that the psychiatric staff was more attentive for setting up care and listened more carefully to these patients' somatic health needs as compared to the regular psychiatric patient's somatic needs.

« Et ces gens-là, forcément comme ils étaient à la base hospitalisés pour un problème physique qu'on envoie en psychiatrie, étaient plus pris en considération de leur douleur physique parce que ce qui les avait envoyé là à la base, c'était justement un problème physique. Il y avait une dame qui avait été hospitalisée suite à un incendie et donc elle avait perdu tous ses cheveux, elle avait perdu voilà une partie de sa main ce qui a fait que à un moment donné, une fois que les brûlures ont été soignées, ils l'ont transférée en psychiatrie. Elle était plus, voilà, il y avait des médecins qui venaient voir parce qu'elle avait encore un bandage au niveau de sa main, comment ça allait, la cicatrisation et

tout ça. Il y avait un autre monsieur qui était là parce qu'il était tombé, lui en fait il était soudeur sur les lignes à haute tension et il est tombé d'une ligne à haute tension et on l'a amputé des deux jambes. Et donc suite à son amputation, il s'est retrouvé en psychiatrie, lui aussi était plus pris en considération dans sa douleur physique que ceux qui étaient là pour un délire ou même pour une tentative de suicide. Parce que ma collègue de chambre, c'était une personne qui était là pour une tentative de suicide. Mais on n'avait pas de suivi de médecin à part le psychiatre, je veux dire on ne voyait pas le médecin traitant quoi. »

From patients' accounts it seemed that priority was given to patients with an addiction or another mental health issue with physical impact when GPs work was overloaded. For other residents with only somatic symptoms (e.g. cough, pain, and temperature) it seemed to be more difficult to get an appointment.

« C'est que le médecin généraliste, il y en deux pour tous les pavillons et il y a beaucoup de pavillons à [hôpital psychiatrique X]. Et nous on le voyait une fois la semaine. Il venait une fois la semaine. Alors il y avait les listes qui étaient faites, et alors vous voyez où on était dans la liste. Par contre, le psychologue on pouvait le voir et la psychiatre, et le psychiatre on pouvait le voir toutes les semaines si on voulait, il y avait pas de problème. Mais pour le médecin généraliste, avec tout ce qu'il avait, il était débordé, il ne venait qu'une fois la semaine au pavillon et c'est, comme je dis, c'était d'abord des listes. Et c'était surtout pour l'alcool et pour les drogues. Donc ceux qui n'avaient pas de problèmes avec l'alcool ou avec les drogues, ils passaient toujours en fin de liste. »



6.2.3.3 Consideration for somatic health care from admission up to discharge

Focus on somatic health care at the admission stage

In some settings, standard procedures, such as blood sample, EEG, ECG, weighing, were performed at admission but patients were not informed about why these examinations were done, nor what was investigated, and what the psychiatrist or the team already knew about the somatic health of the patient.

“Zo die standaardonderzoeken, een bloedafname, een ECG, een EKG, dat wordt meestal wel gedaan maar ook niet meer in elke setting. Meestal op de PAAZ-afdelingen, daar wordt dat meestal wel gedaan maar dat is ook het enigste dat ze vragen en dat is gewoon omdat in hun procedure staat.”

At admission, patients reported not being informed about who to contact in case of a somatic health problem. Neither did they know about what information on their somatic health was available to the setting and the healthcare professionals working there. They did not know whether their GP had been contacted or informed.

“Interviewer: Wel de vraag was of dat je uitleg gekregen had wie dat je kon aanspreken bij een lichamelijke klacht?”

Respondent: Ah ja, nee buiten ja zo van als er iets is, je weet de verpleegpost zijn.”

« C'est au fur et à mesure, quand l'équipe alors vient et qu'on discute qu'on peut dire quels sont, ce qui nous a amené là, quels sont les problèmes qu'on a physiques, quand on en a. Il y a des personnes qui ont des maladies mentales et qui n'ont pas de symptômes physiques. Mais moi c'est justement la partie la plus forte, donc sinon on ne sait pas justement ce qui est discuté, ce qui est retransmis, ni comment les gens le comprennent, parce que des fois, ça aussi c'est compliqué. Quand on explique les choses, ce n'est pas automatiquement compris comme ça et donc voilà. »

“J'étais pas suivie, enfin je sais pas s'il y a un lien, s'il contacte le médecin généraliste, je ne sais pas comment ça se passe donc. »

Attention for somatic health care while hospitalised

During a stay, physical parameters e.g. blood pressure were measured and this sometimes several times a day. At the occurrence of a somatic health problem the response of the nursing staff differed from one place to another. While in some places nurses acted independently and referred directly to the GP, in other places nurses were obliged to contact the psychiatrist first, who subsequently took care of the resident's complaint during consultation.

“Toen dacht ik dat er iets niet goed was met mijn pols, en toen heeft de psychiater die bekeken en die heeft toen meteen een briefje geschreven voor röntgenfoto's in het ziekenhuis.”

Thus, the way of working differed from one place to another and a referral to the adequate healthcare professional seemed not to be self-evident nor systematic.

« Et puis bon, j'ai jamais eu de médecin traitant dans cet hôpital. Je veux dire, j'ai eu une rage de dents, alors les infirmiers voilà, étaient quand même gentils parce que je leur avais dit "voilà, j'ai mal aux dents", ils m'ont quand même donné du paracétamol pour calmer la douleur mais jamais ils m'ont dit "on va vous prendre un rendez-vous chez le dentiste, on va voir ce qu'il se passe". »

“Doordat die hoest al zolang was blijven aanslepen en daar maar geen onderzoek naar gebeurde, allez ja na bijna twee maanden hoesten, heb ik er op aangedrongen dat er uiteindelijk eens iemand naar mijn longen zou luisteren op zijn minst “

An explanation raised by the participants was that the main focus for admission was mental health care and not physical health, as a result staff lacked competences in the domain of physical health.

« Non, mais voilà, le personnel infirmier est très bien mais comme ils disent, ils sont là pour la maladie mentale, dépression n'importe quoi, mais ce qui est physique, c'est pas leur domaine



Side effects of drug therapy

The side effects of the therapy were well followed during the stay, with the exception of the monitoring and management of weight gain, which was sometimes mentioned as being totally absent.

« J'ai vu plusieurs personnes qui avaient des troubles d'ordre, justement de symptômes d'ordre à un mauvais traitement et ça je crois que c'est très très bien géré. Ça, je pense qu'ils font même appel à des, quand il y a des cas comme ça, notamment la jeune femme qui était en sevrage morphinique, elle avait pas mal de symptômes et tout ça et là, dès qu'elle avait des trucs, ils faisaient un appel à un médecin, je pense même des urgences »

Access to the GP

Easy access to the GP was not always obtainable leaving patients with a feeling of helplessness when they were sick.

« Si on veut voir un médecin, parce que par exemple on est malade, imaginons, y a beaucoup de courants d'air dans un hôpital, j'attrape une bronchite ou une trachéite, là c'est vraiment beaucoup plus compliqué pour demander à voir un médecin. Alors je comprends évidemment, vu l'organisation dans l'hôpital où les médecins sont souvent occupés, ils ne peuvent pas comme ça, je comprends très bien. Mais d'un autre côté, c'est des choses à prendre en compte justement quand on est, si on vit là pendant trois mois, fatalement c'est des choses qui arrivent. »

« Moi, ils m'ont dit qu'ils me faisaient une piqûre. Ça en fait c'était contre la grippe et je l'ai attrapée. Ah oui, et j'ai été vraiment malade là. Là, quand j'ai été malade, on m'a laissée toute seule dans mon lit. »

Follow-up after discharge

Follow-up of somatic health problems after discharge was not necessarily organised by the staff but was encouraged. They did not make the necessary appointments with the GP, the specialist or other healthcare practitioners but they reminded the patient of making them.

« L'aspect physique, de toute manière, je pense que comme j'ai mon généraliste, je pense qu'ils se disent que j'irai là automatiquement. Donc, sinon c'était plutôt un suivi social que j'ai eu, donc pas physique. »

« Dat wordt volgens mij serieus opgevolgd, daar wordt in groep dan over gesproken, en vaak wordt dan ja, in de groepen waarin ik heb gezeten, toch wel ook besproken dat je daar aandacht voor moet hebben, dat je naar de huisarts moet gaan, dus bewustwording ook creëren ook bij de hele groep van zelfzorg, ja zelfzorg zou dat genoemd worden dan, denk ik dan. »

« Ik had op het laatste de kinesist nog, maar dat was eigenlijk niet meer nodig en dus heb ik dat niet verder gezet want ik was al veel beter... maar dan vragen ze wel van "zullen we samen met u een andere kinesist zoeken want deze is verbonden aan het ziekenhuis en dat mag niet meer, maar we willen wel samen met u een andere zoeken." Zo een dingen doen ze dan wel, als er iets lopende is dan zorgen ze wel... »

6.2.4 Issues related to somatic health care in psychiatric care settings

Participants reported several problems related to somatic health care: a lack of patient information or information transfer between the healthcare practitioners, a lack of being taken seriously or listened to, issues related to the timely access to care, a lack of human resources and material, issues.

6.2.4.1 Lack of information transfer towards patients

From our interview round it seemed that patients lacked information about the organisation of somatic health care during their stay in a psychiatric setting at several moments in their care trajectory, i.e. at admission, during their stay and at discharge.

During their stay, participants found it difficult to get information, e.g. on whether and when they could see a physician for a somatic health problem, or on which drugs they were administered.



« Donc si on veut voir par exemple un gastro-entérologue parce que justement quand on est très malade, là ça devient compliqué, là vraiment. Déjà pour être entendu, pour être écouté, pour avoir ne fût-ce qu'une réponse claire. "Oui, vous pourrez voir quelqu'un", imaginons "dans trois jours". Je préfère qu'on me réponde ça qu'on me laisse comme ça pendant des heures, des jours sans savoir si on va voir réellement quelqu'un et en attendant on subit les désagréments. »

Even so, patients reported not being informed when the treatment was adapted. They found out because they experienced bodily changes or side effects which they had not experienced before.

« Mais on nous donne même pas les noms des médicaments en fait, voilà. C'est, on prend des médicaments sans savoir ce qu'on prend. »

« Non, c'est-à-dire que mes cachets sont restés dans le pilulier mais ils ne m'ont pas dit qu'on changeait tout le traitement. C'est moi qui me suis rendu compte à force de les prendre qu'il y avait quelque chose qui n'allait pas, qu'ils me faisaient des effets autres que ceux que j'avais avant. Et j'ai pu ensuite en discuter avec le médecin, il m'a dit "je suis médecin, je fais ce que je peux". Le psychiatre m'a dit "moi, les médicaments que je vous ai prescrits, votre médecin traitant l'aura". Mais je dis "mais moi, je peux quand même être au courant", "il vaut mieux pas". »

« Je suis arrivé avec mon journalier mais en fait la semaine, ils me l'ont gardé et ils m'ont changé tout sans même le dire, je ne savais même pas ce que je prenais. »

Patients found it problematic not being informed about side effects before starting the treatment. When this information lacked, this may have had serious consequences for patients (e.g. misunderstandings, anxiousness, non-adherence).

« On nous explique pas en fait les effets secondaires des médicaments. Donc il peut nous arriver n'importe quoi, on ne sait pas. Moi, je pensais que j'étais enceinte. À un moment donné j'ai commencé à avoir des pertes de lait au niveau de mes seins, donc ça concordait réellement avec le fait que je pensais être enceinte, mes règles étaient en retard. Et c'est seulement à ma sortie de l'hôpital, quand j'ai été voir ma

gynécologue, qu'elle m'a expliqué que c'était un effet secondaire dû au médicament que je prenais en psychiatrie en fait. »

« Chose que je ne savais pas et moi en fait, j'étais dans mon délire, je pensais qu'on voulait pas me faire sortir de l'hôpital parce que j'étais trop maigre. Et donc je mangeais mais je mangeais encore plus parce que j'avais le Remergon et ça a été des prises de tête avec mon petit copain par la suite parce que comme on ne m'avait pas expliqué. Il me disait "mais tu manges comme un ogre, tu manges plus que moi" et ça a été vraiment des grosses disputes où j'avais peur de me servir à manger parce que je savais qu'il regardait ce que je mangeais et tout ça. Et il me disait "je suis un homme et je mange moins que toi, c'est pas normal". Je veux dire, on m'aurait expliqué les effets secondaires de médicaments, j'aurais pu lui dire "oui mais c'est à cause des médicaments, tu sais, ça me donne faim, j'ai tout le temps faim". Mais ça n'a pas été le cas donc, voilà. Ça m'a créé beaucoup de problèmes. »

Not informing patients on the timing of follow-up by a physician, their diagnosis and the treatment prescribed inclusive possible side effects, may have had consequences for their health, wellbeing and treatment. For example, patients may have refused to comply with any treatment.

« Et je veux dire, jamais aucun infirmier ou les psychiatres ou les psychologues ne m'ont dit "vous êtes en hôpital psychiatrique, vous avez un problème psychologique et c'est pour ça que vous êtes hospitalisée". On n'a jamais voulu m'expliquer, j'ai même arrêté de prendre les médicaments parce que je refusais de les prendre vu que on ne m'expliquait pas ce que j'avais. »

6.2.4.2 A lack of due consideration by healthcare professionals

Patients felt that their somatic health problems were not taken seriously during their stay in the psychiatric setting. This was a major theme during our interview round and occurred in a multitude of forms. On expressing somatic symptoms healthcare staff, for example, did not listen, attributed the symptoms to the psychiatric illness, did not believe the patient, ridiculed the patient, or problems were minimised or denied. In addition, patients mentioned some healthcare professionals were patronising.

**Table 18 – Quotes illustrating several ways of not being taken seriously**

Theme	Quote
Not listening to the patient	<i>« Donc si on veut voir par exemple un gastro-entérologue parce que justement quand on est très malade, là ça devient compliqué, là vraiment. Déjà pour être entendu, pour être écouté, pour avoir ne fût-ce qu'une réponse claire. »</i>
Attributing problems to stress or the psychiatric illness	<i>"Ik sukkel al jaren met mijn nek maar de nek is een stressgebied. Als je dat in een opname zegt van "ik heb daar heel veel pijn, ik wil dat er iets aan gedaan wordt", dan zeggen ze van "je moet uw stress minderen, dat is gewoon van de stress", en er wordt niks mee gedaan. Ik heb dat jaren zo te horen gekregen, ook van mijn huisarts trouwens, die zei van "dat is gewoon van de stress, dat gaat wel minderen als je minder stress hebt."</i>
Not believing the patient	<i>"Ja, je hoort dat op de afdeling van uw medebewoners wel heel vaak van "ik heb iets maar de dokter gelooft mij niet." Je hoort dat zo immens vaak. Of, je gaat naar een ziekenhuis en als ze dan in uw dossier zien dat je bent opgenomen geweest, dan wordt er ineens niet meer au serieus geluisterd. Ik heb daar al wel verhalen van gehoord die niet fraai zijn om te horen en die mij echt kwaad maken."</i>
Denying what the patient says	<i>"Die verpleging als ik dan zei: "ik krijg daar maagpijn van", dan was het van: "ja dat kan niet", en ik zeg: "ja die trillingen", allez ik had precies, ik was precies iemand met Parkinson, ik bedoel dat is echt, ik heb al gemorst met mijn eten en al, en dan was het van: "ja ja je zult wel een beetje onder de indruk zijn van hé, als er hier wat veel volk is of zo, allez ja dat zal daar van zijn."</i>
Patronising	<i>"Ik was 35 kg bijgekomen en dus heb ik gevraagd aan de psychiater: "Kan het van de medicatie zijn?" Haar antwoord was "Elk pondje gaat via het mondje". Het metabool syndroom werd gewoon ontkend, terwijl andere psychiaters dat wel gewoon zegden".</i>

It was challenging for a psychiatric patient to convince a healthcare professional that symptoms were not related to stress or psychiatric illness. Access to physical examinations (e.g. laboratory blood sample, clinical examinations such as lung auscultation or radiology) or to be referred to a specialist was a quest. Often patients were referred from one healthcare professional to the next, resulting in a long chain of referrals without addressing the physical complaint and attributing the complaint to the psychiatric illness or distress.

"Et donc, les médecins ne me prenaient pas au sérieux, j'ai dû attendre 3 ans avant qu'on découvre ce que j'avais réellement. Parce que en plus à côté de ça, quand ça s'est déclaré j'ai fait une très très grave, normalement on attrape ça dans les pays exotiques mais je me suis jamais payée de sortie à l'étranger et j'avais une très grave, genre colite infectieuse donc ça n'a pas aidé. Mais les médecins pensais que j'étais anorexique donc la seule chose quand j'allais voir un médecin, c'était "vous êtes anorexique, vous devez manger". Sauf que je mangeais 8 fois par jour mais je perdais tout quoi. Donc du coup, avec le milieu médical c'était pas évident. Et ça a amené petit à petit à vouloir ne plus vivre, et donc j'ai fait des tentatives de suicide, voilà. Tout est lié."

"Ik heb nu eigenlijk, ik denk dat ik er toch 10 jaar mee heb rondgelopen en nu, bij mijn laatste opname, was er een psychiater die wel eens luisterde naar het somatische en niet alleen naar het psychische en die mij doorstuurde naar het [Naam ziekenhuis]. Maar daar zeiden ze dan weer "het komt van de stress", ja... Maar die psychiater was daar niet tevreden mee en hij heeft mij dan naar een ander ziekenhuis gestuurd en naar een andere specialist en die heeft wel geluisterd naar die psychiater en die heeft wel onderzoeken gedaan en toen bleek dat er iets is met mijn wervels."

"Ik zat dan ook met enorm oedeem aan mijn voeten en ik was daar ook mee naar de huisarts geweest, en die had mij dan afgewimpeld zo van haha, het gaat volgende week nog erger worden, want het wordt in de 30°, zo van het is van de warmte, en doordat die hoest al zolang was blijven aanslepen en daar maar geen onderzoek naar gebeurde, allez ja na bijna twee maanden hoesten, heb ik er op aangedrongen dat er uiteindelijk eens iemand naar mijn longen zou luisteren op zijn minst, hé. Ik vond dat het minste."



“Ja, sowieso dat niet “au serieus genomen worden”, dat is het grootste probleem, denk ik. Maar ook zo dat doorverwijzen en doorverwijzen, want de psychiater stuurt u dan naar de huisarts, de huisarts stuurt u naar de specialist en op één of ander moment word je dan niet au serieus genomen en dan begint het helemaal terug opnieuw.... terug naar de psychiater, terug.... dat is zoiets wat ik ook wel een probleem vind.”

“Ik stoer mij aan het niet au-serieus genomen worden: neem een warm badje en een paracetamol. Probeer te ontspannen, dan gaat het wel over.”

Lack of responsiveness to psychiatric patients' health problems entailed several consequences. Not only serious health problems may have remained unnoticed for a long time and may have been discovered too late, but patients may have suffered in pain and discomfort, and felt anxious by the lack of reassurance. In addition, one of the respondents drew our attention to the fact that this chain of referrals increased healthcare costs for the patient (and the community). In the end, patients turned to the emergency department to find answers or reassurance for their problem.

“En soms ook wel kostelijk want je betaalt wel elke keer die specialist voor een opinie en dan moet je weer naar een andere specialist die je dan ook weer moet betalen. Soms wordt dat ook wel heel kostelijk en daar wordt ook niet altijd rekening mee gehouden.”

“Ook herhaaldelijk gezegd dat ik die diagnose van allergische astmatische bronchitis al twee keer had gehad, daar werd gewoon dan ook niet naar geluisterd of gedaan, allez ja. En ja. Dan met mijn voet was ik heel bezorgd want mijn linkervoet was op een gegeven moment dubbel zo dik als mijn rechtervoet, en dat ik schrik had dat ik een trombose had ofzo ook al omdat ik zo lang had stilgezeten, en maar dan werd dat ook afgedaan, en dan was ik ook eigenlijk niet gerustgesteld waardoor dat ik dan op de spoed ben gegaan”

Finally, patients state that they often felt not strong enough to challenge the physicians' judgement or diagnosis.

“Maar op sommige momenten, vooral als je in opname bent, ben je niet sterk genoeg om in discussie te gaan. En dan laat je dat voor wat het

is. Dan ga je bijvoorbeeld heel kwaad terug naar de afdeling en ik leg dat daar uit. Omdat ik weet dat die mensen naar me luisteren. Ik heb dat ook gedaan. Ik heb tegen de psychiater uitgelegd. En die heeft mij naar iemand anders gestuurd. Op die manier. Maar als je in opname bent, ben je gewoon niet sterk genoeg om in discussie te gaan met een specialist.”

6.2.4.3 Waiting times for access to care

Participants complained about the time they had to wait for a request to be granted e.g. demand for pain relief or a GP consultation. Nevertheless, waiting times varied between settings.

« Moi je demandais aux infirmières qui me disaient quand, le médecin était là tous les matins de 7h30 à 8h30 pour tous les patients qui en avaient besoin donc ça allait vite les consultations. Mais le lendemain, on était pris en charge. »

Participants also said they had to repeat their requests in order to be heard.

« Als je het gevoel hebt dat je verzuipt, dat er en je geeft dat aan en dan krijg je het antwoord, we zullen je morgen inboeken bij de psychiater, en dat je daar nog zelf drie keer achter moet gaan vragen, dat is heel frustrerend. En ook dat dan in die context van wat ik net zei, je moet zelf dingen vragen want ze komen het niet zelf aanbieden, maar als je dan die stap zet om het te vragen dan duurt het nog een eeuwigheid voordat er naar geluisterd wordt. »

« Doordat die hoest al zolang was blijven aanslepen en daar maar geen onderzoek naar gebeurde, allez ja na bijna twee maanden hoesten, heb ik er op aangedrongen dat er uiteindelijk eens iemand naar mijn longen zou luisteren op zijn minst, hé. Ik vond dat het minste. En dan ja, hebben ze mij naar de Coronadienst gestuurd en die inderdaad mijn longen beluisterd, en die heeft toen wel opgemerkt als je breekt heb je reflux, en dat is wt er uiteindelijk ook is uitgekomen. »

“Er is voor alles heel veel tijd nodig: een afspraak met een specialist, moet je verschillende keren opnieuw vragen.”



Waiting times resulted in frustration because patients felt that they were not being listened to while their discomfort was not being solved.

It seemed that the waiting time partly resulted from a 'temporisation' by the staff to assess the degree of seriousness or urgency before reacting.

« Il fallait attendre, ou bien alors il fallait vraiment avoir une grosse crise. Il y en a un qui a fait une grosse crise appendicite, il était vraiment mal, là ils ont téléphoné et l'ambulance est venue et puis il s'est expliqué par après. Mais comme on a vu que c'était une crise d'appendicite, l'infirmier il n'a pas eu de problème. »

Another reason for temporisation was due to staff not been granted independent decision making about somatic care; the psychiatrist had to be consulted to subsequently refer or decide on treatment.

“In [stad naam] had de afdeling, heel het ziekenhuis eigenlijk, een aparte huisarts die aan het ziekenhuis verbonden was en de psychiater luistert dan maar die geeft dan een doorverwijzing naar de huisarts. Maar je kon ook niet bij die huisarts terecht zonder doorverwijzing van de psychiater. »

The timing of the somatic complaint resulted in an increased waiting time for patients. For example if a somatic health problem occurred on a Friday night when no GP was on duty, the resident had to wait until after the weekend.

« Ik vind dat een beetje omslachtig omdat je dan... als dat echt iets dringend is dan bellen ze de psychiater en die geeft telefonisch... dan zegt die van “ze mag naar de huisarts.” Maar als dat niet echt iets dringend is, dan moet je eerst bij de psychiater komen, dan moet je wachten tot die consultatie heeft en die schrijft dan een verwijzing en dan moet je terug een afspraak maken met die huisarts, ja, dat is heel omslachtig. »

« On peut pas voir de médecin tout de suite, ils doivent demander l'accord donc on peut pas avoir un médecin, on ne sait pas quand, on reste tout le temps à attendre, on ne sait pas même, leur propre équipe d'infirmiers ou médicale, on ne sait pas quand on va les voir. Et ça je trouve que en hospitalisation, c'est très stressant, surtout quand le côté

physique au quotidien est très anxiogène, (...) quand on a beaucoup de symptômes physiques. »

« Oui parce qu'ils disent que ce n'est pas dans leurs attributions. Des soins de plaies ou quelque chose comme ça ou bien des diabétiques, ça c'est dans leurs attributions, ils vont pour faire les soins [...]. Mais tout, s'il y a une chute ou quoi, c'est pas leurs attributions, il faut passer par le médecin ou par le psychiatre, celui qui est responsable de l'unité. »

6.2.4.4 Information flow between healthcare professionals

Patients reported that communication between healthcare professionals was slow within the setting and difficult between intramuros and extramuros healthcare professionals. Sharing of discharge reports or the medical files was experienced as problematic.

“Ce que j'ai remarqué en fait, c'est qu'il y a peu de communication entre le psychiatrique et les médecins traitants. Mon médecin traitant, quand je suis sortie de l'hôpital psychiatrique, a forcément envoyé un mail pour avoir mon rapport de mon hospitalisation. Il a fallu des mois pour qu'il le reçoive donc voilà. »

« Le dossier, comme je vous ai dit, moi j'ai demandé pour avoir mon dossier parce qu'ils ne voulaient pas le transmettre non plus à mon médecin traitant. Ce qui s'est fait à l'hôpital psychiatrique reste à l'hôpital psychiatrique. Je dis : "mon médecin traitant a le droit puisque c'est quand même lui qui me suit depuis et il a le truc global". Et non, ça, ils ne voulaient pas. Même le psychiatre, elle m'a écrit pour avoir le rapport psychiatrique. Ça fait un an que je suis sorti, plus d'un an que je suis sorti, je l'ai toujours pas. »

“Ah ja hoe dat dat bij die huisarts verliep? Ja, alleen had die dan zo gezegd dat zij nog niet in de computer kon nog niet, omdat ze nog geen toegang had tot de dossiers maar dan bleek achteraf dat ze daar ook geen toegang tot zou krijgen omdat ze ook gewoon plaatsvervangend was en dat ze daarom de dingen ook op papier moest schrijven. Dus die had geen toegang tot mijn medisch dossier eigenlijk.”



6.2.4.5 Lack of resources and competences

Staff availability

Increased waiting times were perceived as the result of a lack of staff availability and heavy workload. This remark was not restricted to somatic health problems, and appeared generalisable to other more practical requests.

« Si par exemple on veut avoir, un mal de tête, on veut avoir un antidouleur, on n'est pas, enfin on n'est pas traités sur le plan physique de suite parce que ils sont en réunion, parce qu'ils sont occupés avec d'autres personnes, parce qu'il faut attendre. »

“Ik heb drie keer achter een handdoek gevraagd en ja waarschijnlijk waren ze, hadden ze dan andere dingen aan hun hoofd en is dat, waren ze dat vergeten, en ik heb dus geen handdoek gekregen en dan is dat door mijn psychose ding van ja, ... ik krijg geen handdoek, dat ze daar mee, dat ze wouden aantonen dat ik mezelf niet goed kon verzorgen en mij daardoor voor de rest van mijn leven opsluiten, dat was allemaal in mijn hoofd, dat speelde en daardoor kreeg ik dan geen handdoek, en heb ik dat dan ook niet meer nog eens gevraagd, maar dat is nu eens niet iets medisch maar ja. »

« Als ik in de psychiatrie zit, dan ben ik bijna de hele tijd boos. Boos op de begeleiding dat ze het niet goed doen, dat ze mensen in de steek laten, dat gevoel heb ik wel altijd heel erg, dat ze niet, dat er niet genoeg aandacht is, dat je zoveel aan je lot wordt overgelaten, maar dat vind ik meer psychisch dan lichamelijk. »

Participants complained about the staff's lack of proactivity. They said if they did not ask anything, nothing happened.

“Il faut pas espérer que les infirmiers psychiatriques vont être attentifs à ça, il faut que la demande vienne d'elle ou alors d'autres patients qui insistent "voyez, elle ne marche pas bien, il faut faire quelque chose". Mais d'eux-mêmes, les infirmiers ne viennent pas.”

“Nadat ik in het ziekenhuis was, heb ik dat dan ook gezegd van die chronische hoest, maar pas wel na twee weken. En voor die twee

weken is er mij ook niets gevraagd, ik had een spijscheur in mijn kuit omdat ik heel veel gestapt heb tijdens mijn crisis, ik ben een week lang op den dool geweest, ik heb toen heel veel rondgestapt, en ik had een spijscheur, en maar voor mij, in mijn hoofd, ja ik had, ik voelde die pijn in mijn kuit, maar door mijn psychose eigenlijk was dat bij mij, dacht ik dat ze een chip in mijn kuit hadden ingepland, en daardoor heb ik daar zelf niets over gezegd maar ik mankte wel. En achteraf bleek dat ze dat ook hadden opgemerkt, de verpleging, toen ik dan bij de dokter dat gezegd had van ja ik heb pijn in mijn kuit en hij heeft mij dan doorgestuurd naar de huisdokter van de instelling en dan bleek dat dat een spijscheur was waarschijnlijk. Maar ja, men heeft daar dus niets van gezegd tegen mij van oh jij mankt, heb jij pijn ofzo? Dat is niet gebeurd, dus achteraf zeiden ze dan wel als ze dan hoorde, dat ik dan zei van ja, ik heb waarschijnlijk een spijscheur, ah ja we hadden u al wel zien manken, maar ...”

Nevertheless, participants also realised that it was not easy for the staff to manage so many patients.

« (...) le fait de prendre en charge physiquement la personne est beaucoup plus difficile tout de suite, est beaucoup plus, ils doivent vraiment s'organiser. Déjà, le fait que par exemple, ils nous prennent nos médicaments, je pense qu'il y a tellement de gens des fois qui prennent des médicaments que, je prends des antiallergiques et des choses comme ça, que ils savent pas évidemment tout gérer pour peut-être une trentaine de personnes en hospitalisation. »

Lack of somatic competences

In terms of competences, participants were critical for the healthcare professionals taking care of them: they experienced that in psychiatry healthcare professionals' somatic health care skills and knowledge was not up to date.

« Je moest er zelf de psychiater over aanspreken, maar is niet hetzelfde als een huisarts. Sommige dingen van huisartsgeneeskunde weten ze niet meer.”



Participants noted that the main focus in psychiatric care settings is obviously on mental health care, not on physical health, which was reflected by the competences of the staff.

« Non, mais voilà, le personnel infirmier est très bien mais comme ils disent, ils sont là pour la maladie mentale, dépression n'importe quoi, mais ce qui est physique, c'est pas leur domaine. »

Lack of material and inadequate infrastructure

In psychiatric wards the equipment to handle specific somatic health problems, such as reduced mobility (e.g. crutches or wheelchairs) was often absent.

« Moi, quand je me suis fait la déchirure au mollet, j'ai dû téléphoner à ma femme pour qu'elle m'amène des béquilles parce qu'il y avait pas moyen d'avoir des béquilles. Au pavillon où on était, ils n'en ont pas et ils n'ont pas téléphoné à la pharmacie pour en avoir, rien du tout. Et c'est ma femme qui a dû m'amener les béquilles. Bon, c'est un bête exemple mais voilà. Vous vous blessez, vous avez besoin de béquilles ou bien de vous mettre dans une chaise roulante, ils n'ont même pas une chaise roulante non plus. Je trouve quand même ça un petit peu aberrant en sachant que c'est déjà des endroits où on est déjà faible au départ. Et par moment avec les cachets qu'on nous donne, on n'est pas toujours très lucides. Je trouve quand même que c'est le B a-ba d'avoir au minimum le matériel. »

« Il y en avait un qui était en chaise roulante, il devait se débrouiller pour aller se laver. Et je trouve ça un petit peu malheureux à notre époque que il y ait des handicapés physiques et mentaux et qu'il n'y a rien de facilité pour eux. Nous, pour sortir de notre pavillon, c'était des marches. Le gars, quand il voulait sortir avec la chaise, on était à quatre à le porter pour ne pas le lâcher pour qu'il puisse sortir ou bien aller fumer sa cigarette. »

6.2.4.6 Continuity of somatic health care

Participants mentioned several examples of lacking continuity of care, but these were mostly out of scope for this study because it concerned treatment of the psychiatric illness (e.g. admission to a general hospital in attendance of a place in a psychiatric hospital) or because it was about ambulatory care (e.g. switching between GPs). Three themes on continuity of somatic health care appeared in the data: access to medicines, continuity in the medication schedule, and access to specialists and examinations.

Access to medicines

Participants seriously questioned the access to medicines during their stay. As well as for their existing pre-admission medication scheme, as for new somatic problems, i.e. symptomatic needs.

As already mentioned by the healthcare practitioners, the pharmacy of the psychiatric setting did not always have access to the medications prescribed prior to the admission of the resident (see 5.2.3.2). This issue was also raised by residents. Patients with special medication requirement e.g. liquid medicines had no access to the same type of medication while hospitalised.

“Tous mes médicaments sont des médicaments liquides parce que j'ai un trouble de la déglutition donc je ne sais pas avaler les médicaments solides, c'est aussi quelque chose de très difficile en hospitalisation parce que tous les médicaments qui sont prévus sont bien souvent solides, donc c'est très dur d'en avoir en liquides. »

At admission, personal medicines were confiscated by the medical staff, inclusive dietary supplements e.g. magnesium. This was experienced as stressful and disrespectful for the residents who were used to manage their medication at home.

« Je suis très très souvent malade, je prends souvent des antidouleurs et des choses comme ça, et quand on rentre en hospitalisation, on n'a plus droit à avoir aucun médicament sur soi, tout est pris. (...)

Donc par exemple, comme je souffre de prédiabète, j'ai des graves chutes de ma glycémie. En hospitalisation, on ne peut pas avoir son



piqueur et donc si jamais on se sent mal, on n'a personne donc on doit vivre la crise comme ça et c'est stressant, on a peur. »

« Ik hoorde van een jonge gast die er was, die nam voedingssupplementen en zelfs dat nemen ze dus af en dat krijg je niet terug voordat de dokter daar zijn goedkeuring over geeft, dus dat. Zelfs geen medicaties, maar gewoon voedingssupplementen of vitamines, ik hoorde ook van iemand die magnesium nam, en die kreeg dan een andere, die kreeg dan wel een magnesiumsupplement maar dat was dan een andere vorm en een andere ding, dan ze gewend was om te nemen, maar dat van haar mocht ze dan niet nemen. »

Residents lost their independence and had to rely on the medical staff and internal procedures of the setting. Generally, patients had to wait for the doctor's permission for the nurse to administer a drug for pain relief, even if this was their usual treatment before admission.

« Moi j'avais du Dafalgan et j'avais du [nom de médicament] pour mon problème de dos. Et comme ils me l'avaient confisqué, j'avais vraiment mal au dos mais c'était le changement de temps et je lui dis "voilà, j'ai mal au dos mais c'est le changement, est-ce que je pourrais avoir un Dafalgan ?", "ah ben non, on n'a pas l'autorisation". Je dis "dans les cachets que vous avez eus, vous voyez bien que de temps en temps", je n'ai jamais pu l'avoir. J'ai attendu une semaine et demi pour avoir une autorisation du médecin mais c'était trop tard, la douleur était passée, le temps avait changé, la douleur était passée. »

« Si par exemple on veut avoir, un mal de tête, on veut avoir un antidouleur, on n'est pas, enfin on n'est pas traités sur le plan physique de suite parce que ils sont en réunion, parce qu'ils sont occupés avec d'autres personnes, parce qu'il faut attendre. Donc le côté physique est vraiment mis, en hospitalisation, de côté. »

In order to relieve the pain, residents developed strategies to have access to these medications, e.g. they asked family members or other visitors to purchase and smuggle medication inside. Patients hid the pills or creams or asked help from other residents.

« Si on a besoin de médicaments qu'on peut prendre à la demande comme des antidouleurs, ou je prends par exemple des antispasmodiques pour les intestins, ce sont des antispasmodiques qui fondent sous la langue, que je commande en France particulièrement, si je les donne à l'équipe médicale, je sais que je les aurai pas quand j'aurai des crampes, que j'aurai des douleurs. Donc en fait, j'ai dû carrément demander à ce que des proches m'apportent les médicaments et que je les cache dans mes affaires. »

« Je m'étais coincé totalement l'épaule sans rien faire de particulier, ça m'arrive souvent. Et donc normalement je mets de la crème, je prends des antidouleurs et tout ce qui s'ensuit. Et là j'avais pas le droit aux antidouleurs, j'avais même pas de médecin donc c'est en fait une autre jeune femme avec qui j'avais lié un peu amitié et contact, on va dire, comme on le fait souvent en hospitalisation, on se soutient, qui m'a donné sa propre crème antalgique. Comme elle souffre aussi de fibromyalgie et que elle en fait elle prenait de la morphine carrément et qu'elle était là pour désintoxication à la morphine puisqu'on devient souvent accro - moi j'ai demandé de la morphine mais j'y ai pas droit à cause de mes troubles intestinaux justement, les médecins veulent pas, enfin mon psychiatre ne veut pas - c'est elle qui m'a donné sa crème et qui m'a bien aidée parce que sinon je restais comme ça avec le cou et l'épaule totalement bloqués, à ne plus savoir rien faire. »



Continuity of the somatic prescriptions during hospitalisation and after discharge

As was already mentioned, the continuity of pre-hospitalisation somatic treatment is not assured because medication schedules are adapted in function of hospital pharmacy registers.

Another example mentioned by one of the participants was that a specific diet prescribed in order to perform a planned colonoscopy was not respected. The participant attributed this to a lack of communication between the nursing and the kitchen staff.

At discharge, patients received prescriptions to continue their treatment at home, however, transparency about the medication schedule was sometimes lacking.

« Interviewer: Ok. Donc ils ont changé tous vos médicaments quand vous êtes rentré. Et donc vous, quand vous êtes sorti, vous avez dû refaire le point avec votre médecin. »

Respondent : Avec le même médecin traitant parce que ça ne correspondait pas. Et comme ils ne m'ont pas laissé mon semainier, je ne sais même pas ce que je prenais. Donc quand j'ai eu la première sortie, j'ai téléphoné, j'ai dit à ma femme "téléphone au médecin", logiquement il ne reçoit pas le samedi mais exceptionnellement j'appelle le samedi matin et je lui ai dit "voilà, il y a ça, il y a ça, il y a ça, il y a ça" et c'est lui qui a téléphoné pour avoir les cachets qu'on m'avait remis parce que moi je ne savais pas ce qu'on me remettait. À part le cachet pour la tension qui était resté le même, tous les autres, ils les avaient bazarclés. »

Access to specialists and examinations

From the participants' accounts it seemed that psychiatrists did not often perform physical examinations. Rather, the psychiatrist referred patients with somatic health problems to a GP or a specialist. Subsequently, patients had access to somatic physicians or examinations, only after a prescription by their psychiatrist.

« het is zo je kon twee keer in de week de dokter zien, dus de psychiater dan en het was bij hem dat je ook met je fysieke klachten dan terecht moest, zodanig dat hij je kon doorverwijzen. »

In our interview round, respondents complained about the accessibility, and more specifically the delays to get examinations or specialist consultations during their stay.

« L'entorse elle est venue parce que j'avais, j'étais dans un groupe de marcheurs et comme il a commencé à dracher, on a couru pour aller se mettre à l'abri et voilà, je me suis fait une entorse. Mais j'ai attendu trois semaines parce que, trois semaines pour avoir une prescription et un rendez-vous à l'hôpital pour faire une radio et une échographie. Mais les médecins, là, ils sont là pour soigner la maladie, ils bourrent de cachets et puis c'est tout. À la limite, j'étais mieux suivi quand je suis rentré chez moi et que j'ai retrouvé mon médecin traitant qu'à [hôpital psychiatrique X], quoi. »

6.2.4.7 Health promotion and lifestyle interventions

The health promotion initiatives that were reported during the interviews mainly related to physical activities, education about and availability of healthy food and smoking behaviour. However, as one participant stated - being healthy is a 'contradictio in terminis' when talking about psychiatry- (see quote below). More specifically, patients reported that the majority of the patients smoked, drank a large amount of coffee, ate a lot of sweets, and the hospital food was not very appetising nor healthy.

“Gezond is wel een beetje in contradictie met de psychiatrie, als ik het eerlijk zeg. Ik denk dat 90% rookt, en op tijdens opname is dat ongeveer het enige wat mensen doen, de hele dag roken dat is ongelooflijk, hoeveel dat er gerookt wordt. En de hele dag koffie drinken, dat is echt ook ongelooflijk hoeveel koffie er wordt gedronken, dat is ook overal hetzelfde. En verder is het vaak ziekenhuiseten en dat typeer ik nu ook niet als buitengewoon gezond, maar dat is meestal plat gekookte groenten. Het eten dat is bijna overal gewoon vies en dan gaan mensen snoepen, ongelooflijk veel snoepen, koffie drinken en sigaretten roken.”



Physical activities

In every setting physical activities were offered but the range of activities differed, as well as the degree of encouragement to participate. This varied from strictly obligatory to completely voluntary.

« Il y a des choses qui sont positives. Il y a des ateliers, on appelle ça, même marche rapide ou des promenades, des semi-marathons, il y a de tout. On doit s'inscrire évidemment et avant il faut faire un test d'effort. Mais il y a moyen dans certaines [unité de] psychiatrie, si on fait la demande, d'entretenir son physique. »

« En ja, bijvoorbeeld in de PAAZ was dat regelmatig eens een wandeling, dus een sessie volledig een wandeling maken ofzo. Dat vond ik wel altijd prettig, gewoon met de groep een wandeling in het bos gaan maken. »

“Daar was er wel een informatie... dat was eigenlijk een therapie over gezonde voeding en ja, een gezonde geest in een gezond lichaam... zoiets. En ja, sportactiviteiten zijn er overal, die heb je altijd. »

“Respondent: Sporten wel, sporten daar wordt wel in sommigen wel aandacht aan besteed, vooral in Duffel was dat heel fanatiek. Ja, ik weet nog dat ik dat absoluut vervelend vond.

Interviewer: Voor jou was het een beetje teveel?

Respondent: Ja, ik vond dat, en het was een soort drill sessie, ik vond dat echt vervelend, ik vond dat helemaal niet fijn.

Interviewer: En was je verplicht om daar naar toe te gaan?

Respondent: Ja, ja, ja en er waren, er stonden strenge straffen op als je niet ging.”

Nevertheless, the appropriateness of a physical activity in relation to the health status of the resident was not always verified before participation e.g. unfit patients, patients with a medical conditions like emphysema. Obviously, this may have led to an increase of somatic complaints.

« Moi j'ai ni vu de coach sportif, ni kiné, ni qui que ce soit, il y avait une infirmière qui faisait la marche mais on n'a pas fait passer de test à l'effort avant, pourtant je fais de l'emphasis. »

Healthy food

Participants described the food in psychiatric settings as unhealthy with high fat and sugar content. In addition, there were many opportunities to eat pastries, e.g. during cooking activities. Coffee and sweets were reported as very popular among residents. However, one patient mentioned the availability of fresh fruit.

Gezonde voeding? Ja daar moet ik nu om lachen. Dat was een keer op de week zo op vrijdagochtend werd er met een groepje patiënten tiramisu, waffels, pannenkoeken, cake gebakken, en dan was het vrijdagmiddag cake op de week en dat werd verdeeld met de hele afdeling gedaan. Ja, nee gezonde voeding is iets dat jammer genoeg ontbreekt, en dan denk ik we zijn hier in een ziekenhuis en we krijgen allemaal gepaneerde, ik kreeg dan vegetarische dingen, veel gepaneerde dingen, de vegetarische gyros was zo vetig dat ik echt daarna op de pot zat met niet echt buikloop maar het scheelde toch niet veel, en dat ik dacht van OMG! Ja, nee, gezonde voeding niet echt, integendeel. »

Smoking behaviour

Smoking is a well-known problem in psychiatric settings. Nevertheless, patients did not reveal hospital efforts regarding smoking prevention or smoking cessation. Smoking cessation was not mentioned as a priority for the medical staff during hospitalisation, rather the message conveyed was 'it's not the right time to stop smoking'.

« (...) ook, want vaak zeggen ze dan tijdens de opname dat het een slecht moment is om te stoppen met roken bijvoorbeeld. »



6.2.4.8 Prevention and screening activities

Preventive medicine was mostly limited to vaccination against the flu. Recurring prevention programs such as screenings (e.g. breast and cervix cancer) were considered most relevant in settings where patients stayed for a long time, i.e. several years or even lifelong. The fact that patients did not report about it could be due to the type of patients in our sample, i.e. patients with hospitalisations lasting a couple of months.

Information leaflets about fall or suicide prevention were available to residents.

Also regarding health promotion and preventive medicine, participants pointed out differences between settings.

“En op sommige plekken wordt daar helemaal niets aan gedaan en sowieso gezond is wel een beetje een contradictie met de psychiatrie, als ik het eerlijk zeg. »

“Interviewer: En tijdens uw verblijf werd er dan ook aandacht besteed aan dingen zoals screenings, dus, dat wil zeggen... testen die aan iedereen aangeboden worden zoals bijvoorbeeld testen op baarmoederhalskanker, darmkanker... die grote screenings, mammografie... Nee, dat werd niet opgevolgd?”

Respondent: Nee, alleen als je een probleem hebt. (...) Het griepvaccin wel. Dat werd gevraagd of je dat wou of niet, dat wel. “

6.2.5 Opportunities to improve the somatic care in psychiatric settings

Respondents made suggestions to improve the management of somatic issues during their stay.

6.2.5.1 Listen to patients

Physicians should work on their listening skills, take their patients seriously and plan examinations to exclude somatic health problems.

“Maar dokters moeten ook wel “luisteren”, ook die specialisten naar de patiënt en misschien toch een onderzoek doen ook al denken ze dat

het tussen de 2 oren zit. Misschien kunnen ze het op die manier bewijzen aan de patiënt dat het tussen zijn 2 oren zit, maar de patiënt is dan wel gerust gesteld en dat gebeurt veel te weinig. »

“Ik vind vooral dat... ik heb nog altijd het idee dat psychiaters of specialisten, ik heb dat vorige week ook gezegd denk ik, dat die beter moeten luisteren eerst. En niet eerst al een oordeel vormen omwille van wat er in je dossier staat.”

6.2.5.2 Involve family members

Family members should be involved more and could play a facilitating role. However, in this line of thought two barriers were reported by patients:

- Family members of the patient were not interested or felt unsure about how to approach the patient, hence they abandoned their support.

« Moi, par contre, ma famille s'est désintéressée de moi à partir du moment où je suis rentrée en hôpital psychiatrique. Je crois qu'ils ont eu peur, ils m'ont pas comprise, ils n'ont pas compris, j'étais en burn out, je buvais, j'étais devenue un déchet pour eux quoi. Donc c'est moi qui ai dû faire toutes les démarches avec l'assistante sociale du service.»

- The professional confidentiality (secret professionnel/beroepsgeheim) made it difficult to communicate with the patient's family members.

“Interviewer: Ok. Vous parliez justement de votre épouse qui était là pour vous aider dans les papiers et cetera. (...) Est-ce que pour garantir que tout se passe bien dans la prise en charge des aspects physiques, la famille est importante, les proches sont importants ou justement vous disiez “on dit rien aux enfants” donc ils peuvent pas être aidants non plus par rapport à ça ?

Respondent: Moi j'ai trois mots à dire. Secret professionnel partagé. (...) Donc la plupart du temps, l'information n'arrive pas aux proches. »



6.2.5.3 Surveillance of medication

To solve the problem of the difficult acquisition of pain killers and other medication, patients proposed to be allowed to keep and administrate certain medication themselves but under surveillance.

« Ce qu'il faudrait plutôt améliorer, c'est justement quand on le demande, ou bien d'avoir certains médicaments sur soi par exemple qu'on utilise mais à bon escient, on n'en fait pas des abus, qu'on utilise à bon escient, c'est qu'on puisse garder une partie de ses médicaments avec autorisation des médecins et de l'équipe médicale. Quitte à ce qu'ils viennent vérifier si effectivement, on a encore à la fin de la journée tous ses médicaments ou qu'il y en a juste deux qu'on a pris ou trois par exemple. Je préférerais ça, que de devoir aller demander et de pas avoir de réponse, de devoir attendre, de souffrir d'être pliée en deux. Ça c'est atroce, je trouve, parce que c'est pire physiquement, c'est mal vécu en hospitalisation. »

6.3 Discussion qualitative research part on healthcare professionals' and patients' perspectives

The barriers and facilitators in the organisation of somatic care for persons with psychiatric health problems are the central focus of this report. In order to complement and deepen the findings from the Belgian and international literature, we conducted interviews with healthcare professionals and patients in four psychiatric settings: psychiatric hospitals, psychiatric nursing homes, psychiatric wards of general hospitals and sheltered housing initiatives.

Before discussing the main findings of this qualitative research part (chapter 5 and 6), we address its limitations.

Firstly, we were not able to recruit as many participants as intended because the COVID-19 pandemic interfered with the data collection phase. Consequently, we did not reach data sufficiency. However, patients' and healthcare professionals' accounts and the Belgian literature converged to a large extent. This triangulation makes us confident that the findings cover the most important issues.

Secondly, due to the small number of participants we could not do setting specific analyses. In other words we could not differentiate between psychiatric wards of general hospitals, psychiatric hospitals, psychiatric nursing homes and sheltered housing initiatives. Barriers presented were less applicable to the sheltered housing initiatives. Nevertheless, other aspects of coordination and the need for holistic somatic care are still very relevant and therefore very much applicable to this setting.

Finally, during the interviews as well as in this chapter most attention was paid to what went wrong, leaving positive accounts largely unaddressed. However this does not mean positive experiences are non-existent.

Despite these shortcomings, five main findings emerge from this investigation.

Firstly, care for persons with psychiatric and somatic health problems should happen at the nexus of psychiatric and somatic health care, but instead the subject under study highlighted the lack of integration between these two healthcare sectors. From the interviews with healthcare professionals and patients two separate but interdependent worlds emerged, the psychiatric and the somatic. This organisational divide completely runs counter the unity of body and mind. Despite the efforts made by healthcare professionals to make these two worlds collaborate, we identified several shortcomings hindering collaboration and by extension the delivery of good quality of care. Psychiatry and somatic health care are so specialised that healthcare professionals of the first specialty lack basic knowledge and skills about the second, and the other way round. Psychiatrists specialise in mental health early on in their training program. Already during the internship, technical acts are preferably performed by trainees from somatic specialities. The somatic part of their training tends to degrade to passive knowledge. During their further career course, somatic care skills are no longer practised, nor kept up to date. Also psychiatric nurses lost their somatic care skills (e.g. wound care, injections or blood sampling). Because of a lack of experience with somatic care, they feel unsure and uncomfortable performing them. The lack of exercise and knowhow of somatic nursing skills clearly hampers the management of somatic care for persons with a psychiatric health problem.

Secondly, the interaction between patients and healthcare professionals seems to be troublesome: on the one hand, persons with a psychiatric health



problem feel not being listened to, nor being taken seriously when experiencing somatic health problems. Somatic problems are then attributed to stress or the psychiatric illness, patients' somatic complaints are not being believed, are being denied or patients even get patronising reactions of healthcare professionals. On the other hand, patients do not get timely information, for example about side effects of drug treatment or changes in the medication schedule.

Thirdly, psychiatric settings are insufficiently staffed and equipped to provide high quality somatic care. Psychiatric nurses cannot provide the quality of care they aspire, because they are overloaded. For example, although they know that accompanying patients to consultations or examinations outside the psychiatric ward facilitates continuity of care and compliance, they often have to refrain from it, because it is too time consuming. Other tasks being insufficiently taken care off because of insufficient staffing are keeping electronic medical files up to date, coordination of care, prevention and health promotion activities.

Fourthly, because somatic healthcare knowledge and skills are lacking in psychiatric settings, the staff of psychiatrists and nurses spends a lot of time trying to find this knowledge and these skills elsewhere. However, the collaboration with somatic healthcare professionals, necessary to transcend the divide between psychiatric and somatic health care, is hampered by several difficulties: first, communication and information transfer between both healthcare sectors is hindered by the lack of shared electronic platforms, the presence of stigma and prejudice towards psychiatry, and unadjusted financial rewards. Second, somatic healthcare professionals seem reticent to treat residential psychiatric patients. The staff of psychiatric settings reported it was not self-evident to find dentists, GPs or specialists able and willing to see residential psychiatric patients. The lack of a regular GP, and by extension the absence of an up to date electronic medical file complicate the management of somatic health care.

Finally, the pivotal and bridging role of GPs is undervalued. They bring in the somatic expertise in psychiatric settings (including psychiatric wards of general hospitals), which is not only essential for patients with somatic health problems to get high quality and timely care, but also to support and relieve the psychiatric staff of tasks outside their field of expertise (e.g. to interpret blood sample results, discuss with other specialists).

These shortcomings in the organisation of somatic care result in psychiatric patients not receiving the same quality of somatic care compared to other patients, delayed somatic health care, worse health conditions, long waiting times, and additional costs and distress for psychiatric patients. Psychiatric patients with somatic health problems run the risk to find themselves in no man's land. For example, faced with patients with complicated psychiatric and somatic care needs the psychiatric staff feels their skills and/or equipment fall short to provide good somatic care, while the staff at the somatic ward fears not being able to manage the psychiatric disorder.

In sum, from our findings we conclude that sufficient and adequate staffing and financing, shared communication tools, the elimination of stigma and prejudice, the valuation of the patients' voice and the somatic expertise of GPs in psychiatric settings are needed to bridge the gap between psychiatric and somatic health care. Even more, from our findings we hear the call for integrated care, in accordance to the well known adagium "a healthy mind in a healthy body".



7 GUIDELINES ON SOMATIC HEALTH CARE FOR PERSONS WITH SMI

7.1 Methods

To identify the literature for this chapter we performed a pragmatic search for guidelines, consensus statements, and guidance documents. We analysed and summarised the documents in excel for country of origin, scientific body or organisation writing the guidance, somatic and psychiatric health care focus, aims, patient population, methodology (search strategy, use of GRADE for recommendations), assessment and examination schemes, and presentation of tools used. The status of guidance available by country, for Europe and for the International bodies was summarised. A quality evaluation with an AGREE on the identified guidelines was performed. Content summary tables for 'lifestyle factors', 'assessments at first contact and follow-up', 'coordination aspects for healthcare providers', and other aspects were created.

7.2 Search for documents

7.2.1 Search strategy

We performed a search for evidence to document and understand what good somatic care for the patient with SMI consists of. These factors of good care were needed to form the baseline for the comparison with the topics identified in chapter 4; the qualitative interviews of healthcare providers and patients on barriers and motivators in the somatic care of persons with a SMI. The aim was to identify good quality guidelines on the somatic care of the patient with SMI. Guidelines on the treatment of psychiatric illness reviewing somatic care as a sub-topic were also considered as were recent guidance documents from International or European bodies.

7.2.2 Selection of guidelines

We identified 55 documents of which 25 with a primary focus on the somatic health of the patient with SMI (Appendix 6). Of these 25, six were guidelines and five^{101-2, 155-157} were selected for an evaluation of quality with AGREE, one guideline¹⁵⁸ was an old version. Three guidance documents with systematic review of the evidence were also evaluated for their quality.^{3, 159, 160} The remaining 16 documents were consensus documents describing the evidence as a narrative summary^{161-164 5, 165, 166} (one educational module¹⁰⁰). Two used the Delphi method^{167, 168}. Other documents had a focus of policy guidance¹⁶⁹⁻¹⁷¹, commission guidance¹⁷², tools to implement guidelines¹⁷³, and evaluation of guidelines¹⁷⁴. Twenty-five of the remaining 30 documents had a focus on diagnosis of medication of psychiatric illness. For three guidelines in this group the somatic care of the patient with SMI was discussed as an important sub-topic, including systematic review of the evidence and grade recommendations.¹⁷⁵⁻¹⁷⁷ These three guidelines were evaluated for their quality.

The remaining documents were not evaluated for their quality but relevant discussion point were taken forward in section 0. The guidelines evaluated for their quality with AGREE are presented in section 0 and discussed in section 7.5.

7.3 Quality appraisal

The Appraisal of Guidelines Research and Evaluation (AGREE) II instrument was used to evaluate the methodological quality of the identified international guidelines (www.agreetrust.org) (see Appendix 7). Each guideline was scored by one researcher (Vicky Jespers, KCE). The results are presented in Appendix 8 and summarised in Table 19. Ten out of the eleven retrieved documents were of high quality as assessed with AGREE with a score between 7.5 and 9.5. The recent guideline by the WHO had the highest score.



Table 19 – AGREE II scores of included guidelines and consensus guidance

Organisation - author	Title	Final Appraisal /10
WHO²	Guidelines for the management of physical health conditions in adults with severe mental disorders - 2018	9.5
Canadian Psychiatric Association¹⁷⁵	Physical Health and Drug Safety in Individuals with Schizophrenia - 2017	8.2
Royal Australian and New Zealand College of Psychiatrists¹⁷⁶	Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders - 2016	8.2
Verpleegkundigen & Verzorgenden Nederland¹⁵⁶	Multidisciplinaire richtlijn 'Somatische screening bij patiënten met een psychische aandoening' - 2015	8.1
Verpleegkundigen & Verzorgenden Nederland¹⁵⁵	Multidisciplinaire richtlijn 'Leefstijl bij patiënten met een ernstige psychische aandoening' - 2015	8.1
Federatie Medisch Specialisten Nederlandse Vereniging voor Psychiatrie¹⁷⁷	Richtlijn Psychiatrische Diagnostiek - Wat is de rol van de psychiater bij het somatische onderdeel van de psychiatrische diagnostiek? - 2015	7.9
The Lancet Psychiatry Commission³	The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness - 2019	7.8
British Association for Psychopharmacology¹⁰¹	BAP guidelines on the management of weight gain, metabolic disturbances and cardiovascular risk associated with psychosis and antipsychotic drug treatment - 2016	7.8
Fédération Française de Psychiatrie¹⁵⁷	Recommandation de bonne pratique en psychiatrie: Comment améliorer la prise en charge somatique des patients ayant une pathologie psychiatrique sévère et chronique - 2015	7.5
European Psychiatric Association¹⁵⁹	EPA guidance on physical activity as a treatment for severe mental illness: a meta-review of the evidence and Position Statement from the European Psychiatric Association (EPA), supported by the International Organization of Physical Therapists in Mental Health (IOPTMH) - 2018	7.5

The categories of evidence and the strength of recommendations used in the guidelines are described in Appendix 9.



7.4 Results of guidance by country

The guidelines evaluated for their quality with AGREE are identified with (A). For several countries no guidelines exist therefore consensus documents are presented to fill this gap to provide background information.

7.4.1 Belgium

Except for a consensus statement on the management of antipsychotics for psychiatrists, no guideline exists for Belgium.¹² The consensus document was created by psychiatrists, endocrinologists and pharmacists at workshops in 2004. Guidance is given on managing metabolic risk before and after starting treatment detailing the components of assessments inclusive counselling for diabetic risk factors and lifestyle issues. A schedule over time is presented for the monitoring of weight and waist circumference, fasting blood glucose, fasting blood lipids, and blood pressure. Responsibility between carers states that the psychiatrist initiates the screening and follow-up measures. If tests, however, indicate impaired glucose metabolism, diabetes, dyslipidaemia, or hypertension, the future management of these physical diseases should be primarily provided by a GP or specialist.

Close communication should be maintained by the psychiatrist and GP, especially concerning change or maintenance of medications.¹²

7.4.2 The Netherlands

A Dutch guideline (A) covering the psychiatric diagnosis and aimed at Dutch psychiatrists considers the somatic anamnesis and examination as part of the psychiatric diagnosis.¹⁷⁷ The guidance stipulates to perform a somatic examination within 24 hours of admission of a patient with SMI but in severe illness as soon as possible. The aim is to include the physical state of health of the patient in the integral psychiatric diagnostics, by, sufficiently mapping out somatic factors and involving them in the diagnostics, and remaining alert to changes in somatic factors and the influence these can have on psychiatric diagnostics and vice versa. From a point of view of the federation of internal medicine, it is expected that the psychiatrist and general practitioner screen the patient with SMI, especially those using

antipsychotics, for the development of diabetes mellitus or metabolic syndrome on an annual basis.¹⁷⁸ Patients with SMI and diabetes mellitus should be entitled to regular somatic care appropriate to the condition, namely good diabetes regulation and treatment of the risk factors. General practitioner, specialist and psychiatrist have the responsibility to ensure that this happens.

The slightly older guideline on schizophrenia stipulates the following recommendations on somatic care: Diagnostic examination for somatoneurological disease and comorbidity should be performed as soon as possible after registration; Somatic screening for cardiovascular risk factors and other side effects during antipsychotic treatment should be performed annually, and in the first year at least after six weeks and three months of institutionalisation; Regionally, the mental health institution should make agreements with general practitioners about the somatic screening for and treatment of risk factors and side effects; Lifestyle, dietetics and smoking cessation interventions are important, provided they are of sufficient duration and intensity; Patients should be supported for somatic screening and treatment by the second or first line, or by family members if necessary; Complements to the annual somatic screening in the non-metabolic domain should be multidisciplinary and vigorous.¹⁷⁹

Two Multidisciplinary guidelines, one on lifestyle and one on somatic screening in patients with a serious mental disorder, were developed by the Trimbos Institute and supported by a multidisciplinary group of healthcare professionals.^{155, 156} The screening guideline describes screening instruments and how they should be applied, how often, and how follow-up should be organised (A). The role of the family and others involved in general somatic screening and medication monitoring mean is described. Conditions for good care in an institution and what is needed from a team in order to give somatic screening to people with a serious mental disorder, in terms of knowledge, cooperation, coordination and continuity of care are presented.¹⁵⁶ The lifestyle guideline recommends to appoint a nurse in the role of case manager to be primarily responsible for the continuity and coordination of lifestyle guidance to the individual patient (A).¹⁵⁵ Items discussed in the guideline are the following: 1. Nutrition and diet (including coffee and energy drinks) 2. Exercise and sports 3. Well-being and relaxation (the balance between load and capacity) 4. Drug use (tobacco,



alcohol, coffee, non-prescription medication, drugs) 5. Sleeping (day and night rhythm, getting up) 6. Sexual behaviour and Sexually Transmitted Infection (STI) prevention 7. Hygiene (including oral hygiene).¹⁵⁵

7.4.3 France

A 'Fédération Française de Psychiatrie – Conseil National Professionnel de Psychiatrie' guideline approved by Haute Autorité de Santé (HAS) answers to 'How to improve the somatic management of patients with severe and chronic psychiatric pathology' (A).¹⁵⁷ At the time the topic was proposed to the HAS in 2009, no research or data collection for France was available. The recommendations address the medical health professionals, and cover a broad number of topics such as: assessment items (proactively screen for and monitor somatic comorbidities, investigate diabetes, high blood pressure, dyslipidaemia, metabolic syndrome, obesity, smoking, evaluate the patient's lifestyle: sedentary lifestyle, eating habits, social withdrawal, perform an initial baseline electrocardiogram, a somatic examination in the emergency room, measure Body Mass Index (BMI) and abdominal girth), coordination aspects (coordination of care with all actors, risk-benefit balance of medication in close collaboration with a psychiatrist / general practitioner or other specialist, improve the communication (mail, reports) between specialists and the attending physician), who takes on responsibility for somatic health follow-up, search for and manage addictions, and set up somatic follow-up psycho-education groups for patients and their families.¹⁵⁷ The guideline published in 2015 provides assessment schedules and practical tools.

7.4.4 Germany

The Association of the Scientific Medical Societies in Germany (AWMF), the German Cancer Society and the German Cancer Aid jointly launched the German Guideline Program in Oncology (GGPO) in 2008. The program aims to foster the development, implementation and evaluation of evidence-based clinical practice guidelines in oncology for physicians and give guidance to patients. The German Guideline Program in Oncology is exclusively dedicated to the development of S3 guidelines, the guideline 'Psychiatrische Komorbiditäten bei tabakbedingten Störungen' is one of them but as evidence for patients with SMI is low recommendations are

mostly consensus based. The guideline discusses how to approach tobacco cessation in patients with SMI and states that psychiatric patients are motivated to quit, and tobacco cessation is not generally less successful among smokers with mental disorders than among mentally healthy persons. Specific tobacco cessation programmes for psychiatric patients in inpatient and outpatient settings are costly and complex, but effective. Essentially, the same intervention measures should be used for patients with SMI as for mentally healthy persons. However, smokers with mental comorbidity often require psychotherapeutic accompanying interventions of higher intensity and often drug support such as nicotine replacement therapy.¹⁸⁰

7.4.5 United Kingdom

The British Association for Psychopharmacology (BAP) together with the Royal College of Psychiatrists reviewed the evidence for risk factors for cardiovascular and metabolic disorders in people with psychosis, including: assessment of risk factors; the evidence of ongoing failure to monitor relevant risk factors adequately and the evidence relating to suggested strategies for the management of weight gain (A).¹⁰¹ Although this guideline originates from a focus of antipsychotic related side effects, it builds on several National Institute for Health and Care Excellence (NICE) guidelines to come to comprehensive recommendations on 'monitoring for physical health risk factors', 'interventions for overweight and obesity', 'interventions for smoking and alcohol misuse', 'management of the increased risk for diabetes and cardiovascular disease', and 'service delivery issues'.^{101, 181-185}

The NICE guidelines overarching advice is for people with SMI, especially those taking antipsychotics and long-term medication, to be offered a combined healthy eating and physical activity programme by their mental healthcare provider.^{183, 186} If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, all patient factors (medication, mental state, other physical health and lifestyle factors) should be taken into account and interventions offered in line with the NICE guidance on obesity, lipid modification or preventing type2 diabetes.^{181, 182, 184, 185} A care programme should be in place where professionals in secondary care should ensure that people with SMI receive physical health care from primary care after responsibility for monitoring has



been transferred from secondary care (monitoring of weight and cardiovascular and metabolic indicators of morbidity). GPs and other primary healthcare professionals should monitor the physical health of people with SMI when responsibility for monitoring is transferred from secondary care, and then at least annually. The health check should be comprehensive: monitoring for cardiovascular disease, diabetes, obesity and respiratory disease. Results should be sent to the care coordinator and psychiatrist, and put in the secondary care notes.¹⁸⁷

A consensus among clinicians from emergency departments made recommendations to optimise the diagnosis of physical illness in patients with mental illness: Recommendations were to have a psychiatric liaison team staff available 24 hours a day; to develop detailed guidelines regarding intoxicated patients and regarding parallel assessment of patients by emergency and psychiatric staff; and to have regular meetings between representatives of both departments.¹⁶²

7.4.6 Sweden

A consensus document originated in 2010 from seven Swedish specialist medical societies.¹⁶⁵ The focus was on the prevention and management of metabolic risk in the patient with SMI. Topics of prevention discussed include: at the start of treatment to provide information on weight gain, healthy lifestyle, smoking and correct follow-up, to offer systemic monitoring (scheme provided) of metabolic risk, and how to manage metabolic disease once it manifests. Further, the collaboration between health professionals was put forward as an important point. The guideline was to be implemented by the different specialties.

7.4.7 Spain

A consensus by psychiatrists was made for recommendations on detecting and giving advice on risk factors for cancer (smoking, diet, physical activity, sun exposure, etc), cardiovascular disease, metabolic health, and respiratory disease.¹⁶⁷

7.4.8 Europe

The European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (ESC) issued a consensus statement to support cardiovascular risk screening and prevention of diabetes in a psychiatric population.⁵ The intention was to initiate cooperation and shared care between the different healthcare professionals and to increase the awareness of psychiatrists and primary care physicians caring for patients with severe mental illness to screen and treat cardiovascular risk factors and diabetes. A selection of cardiovascular risk assessment and management tests, assessments and time points (baseline and follow-up) are proposed which psychiatrists should coordinate, ideally as part of shared care arrangements with general and specialist healthcare services. Further, the management of risk factors of cardiometabolic disease are discussed and an algorithm is proposed.⁵ The EPA supported by the International Organization of Physical Therapists in Mental Health (IOPTMH) performed a review in 2018 investigating the benefits of exercise or physical activity on the severity of symptoms of people with SMI (A).¹⁵⁹ From this review clinical practice recommendations were formulated as follows: 1. Physical activity should be used as a treatment for mild-moderate depression to improve symptoms and physical fitness (good evidence, A); 2. Physical activity should be utilised as an adjunctive treatment for schizophrenia-spectrum disorders, to improve symptoms, cognition and quality of life (good evidence, B); 3. Physical activity should be used to improve physical health in people with SMI (Some evidence, C); 4. People with SMI should be screened for physical activity habits in primary and secondary care (Based on expert opinion, D).¹⁵⁹

7.4.9 Australia

A clinical practice guideline for the management of schizophrenia and related disorders was published in 2016 by the Royal Australian and New Zealand College of Psychiatrists. Graded recommendations and consensus statements regarding assessment, treatment and ongoing care are given with emphasis on early intervention, physical health, psychosocial treatments, cultural considerations and improving vocational outcomes (A).¹⁷⁶ Based on this guideline, strategies that health professionals should use to treat, manage and monitor the physical health of people with an



enduring psychotic illness were defined with a Delphi method.¹⁶⁸ Clinicians as well as patients and families took part in this process to develop a consensus statement. It includes the following aspects. Health professionals should recognise the factors affecting the health and well-being of people with enduring psychotic illness focusing on tobacco use, diet and weight, and oral health. Collaboration, partnership and support is needed from all involved to take on a role in the physical health of the patient; help to get a lifestyle related programme going, ensure that medical tests are carried out, support adherence to treatment, encourage dental hygiene and check-ups. Education needs to be provided by medical personnel to achieve the aforementioned items. Health professionals should participate in the screening, detection, management and follow-up of patients to avoid the worsening of physical health: cardiometabolic screening of diabetes and lipids, cancer risk, dental health, osteoporosis risk, respiratory disease, depression and anxiety risk. The consensus states the assessments to be performed at first contact and at follow-up inclusive of a personal management plan, and the need for procedures to relay information between mental and physical health service providers.¹⁶⁸

7.4.10 United States

A narrative consensus document describes the role of psychiatrists in the provision of primary care to the patients and this at three levels of complexity.¹⁶³ It details the physical conditions and examinations. The levels are described as follows: Level 1—Universal Basic Psychiatric Primary Care: All psychiatrists, including solo practitioners (with or without treatment team or support staff): Assessment of basic medical needs (active medical issues medications, etc.), Health promotion (exercise, diet, and tobacco cessation), Health monitoring (vital signs, weight, blood chemistries, etc.). Level 2—Enhanced Psychiatric Primary Care: Community based care with some treatment team or support staff available: Health promotion, screening and monitoring (as in Level 1), Basic laboratory assessments, Unobtrusive physical examinations as required, Management of uncomplicated physical conditions (i.e. hypertension) by psychiatrist. Level 3— Fully Integrated Primary Care and Psychiatric Management. Level 3 Integrated primary care and behaviour health clinic settings with support staff: Health promotion, screening and monitoring (as in Level 1), Full primary care services.

A task force of the American Association for Emergency Psychiatry (AAEP), consisting of physicians from emergency medicine, physicians from psychiatry and a psychologist, was convened to form consensus recommendations for the medical evaluation of psychiatric patients presenting to United States emergency departments (EDs).¹⁶¹ Eight consensus statements covered various topics, including goals of medical screening in the ED, the identification of patients at low risk for co-existing medical disease, key elements in the ED evaluation of psychiatric patients including those with cognitive disorders, specific language replacing the term “medical clearance,” and the need for better science in this area. In summary, a thorough history and physical examination, including vital signs and mental status examination, are the minimum necessary elements in the evaluation of psychiatric patients. With respect to laboratory testing, the picture is less clear and much more controversial.

7.4.11 Canada

The Canadian Schizophrenia Guideline was developed using the ADAPTE process on NICE, the Scottish Intercollegiate Guidelines Network (SIGN), the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the European Psychiatric Association guidelines. They include recommendations focusing on physical health of individuals with schizophrenia and the monitoring of drug safety in this population. Recommendations addressing the detection, prevention, and treatment of antipsychotic-induced adverse effects on physical health are provided (A).¹⁷⁵

The Canadian Network for Mood and Anxiety Treatments (CANMAT) published a treatment guideline for bipolar disorder in collaboration with the International Society for Bipolar Disorders (ISBD). The guideline’s focus is on diagnosis and management with a short section on safety of the medication and consensus statements on their monitoring.¹⁸⁸



7.4.12 International bodies

One of the earliest documents is from the World psychiatric association which provided a consensus overview on the physical illness in the patient with SMI discussing barriers to care, monitoring and treatment guidelines, plus recommendations at the system and individual level as an educational module in 2011.¹⁰⁰

The most recent evidence based consensus statement originates from the Lancet Psychiatry Commission discussing: risk factors for physical diseases in mental illness such as smoking, excessive alcohol consumption, sleep disturbance, physical inactivity, and dietary risks which are common at onset of diagnoses, across various economic settings, and from illness onset. Also presented are the interplay between psychiatric medications and physical health, the multidisciplinary lifestyle interventions in mental health care, and innovations in integrating physical and mental health care (A).³

The World Federation of Societies of Biological Psychiatry (WFSBP) has a section on safety of medication and monitoring of metabolic side effects in their guideline for schizophrenia treatment.¹⁸⁹ This guideline stipulates interventions for side effects of treatment only. A summary document for primary care is available.¹⁹⁰ They argue in favour of specific interventions such as dietary programs, surveillance programs and a specific treatment of somatic comorbidities for patients with schizophrenia. A proposal for the timing of monitoring of side effects of antipsychotics is presented in table format. Prevention should be part of psychosocial interventions and include awareness programs, diet plans, CBT to reduce weight (aim at < 7% increase) and increase physical activity.

The International Organization of Physical Therapy in Mental Health commissioned a systematic review to describe the contribution of physical activity in the prevention of cardio-metabolic risk factors in people with schizophrenia (A).¹⁶⁰ The authors concluded that there is insufficient evidence for the relative contribution of physical activity reducing cardio-metabolic risks in people with schizophrenia. Nevertheless, demographical, biological, psychological, cognitive-behavioural, emotional, social and environmental barriers for physical activity could be identified. Benefits of physical activity as part of a larger lifestyle programme are sufficient for the recommendation that persons with schizophrenia should do or access the

following: at least 150 min a week of moderate intensity, or 75 min of moderate- to vigorous-intensity aerobic activity; the promotion of a healthy lifestyle should be the shared responsibility of all healthcare providers under supervision of general practitioners and psychiatrists; each patient with schizophrenia should have access to high quality physical health services with a high quality physical assessment and follow-up; the choice between the two equally effective training alternatives should be based on the patients' preference, and availability of equipment and resources; healthcare providers should consider illness symptoms, side effects of antipsychotic medication, low self-efficacy and the lack of social support when motivating patients to a healthy lifestyle.

WHO published a guideline with the aim to 'improve the management of physical health conditions in adults with SMI and to support the reduction of individual health behaviours constituting risk factors for these illnesses, with the aim of decreasing morbidity and premature mortality amongst people with SMI' (A).² This evidence based guideline provides recommendations and best practice statements on tobacco cessation, weight management, substance use disorders, cardiovascular disease and risk, diabetes, hiv, other infectious diseases. The guideline is targeting healthcare workers providing services for people with SMI at all levels of the health care system, including outpatient and inpatient care at first-level, second-level, district and tertiary healthcare facilities. In parallel WHO advises policy makers to develop interventions at the individual level (Management of mental disorder, Physical health checks and treatment, Advice on healthy lifestyle), the health system level (integrated care), and the societal level (access to social services, and stigma reduction).¹⁷⁰ Actions are proposed for policy makers (Develop policies for the integration of physical and mental health services, Establish partnerships with multiple sectors to address the health and social needs of people with severe mental disorders, Monitor mortality rates, trends and risk factors, Increase investment in mental health), health programme managers (Enhance training of healthcare professionals, Provide care for physical conditions to people with severe mental disorders in inpatient facilities of psychiatric hospitals and general hospitals, Shift care for people with severe mental disorders from long-stay hospitals to the community, Develop and implement quality improvement mechanisms as a continuous process in mental health services, Increase awareness and



address issues of stigma and discrimination towards people with severe mental disorders), health-service providers (Improve clinical care for people with severe mental disorders by detecting and monitoring physical illness, Focus on preventable risk factors for physical illness among people with severe mental disorders and enhance disease prevention, Provide continuing care, Involve people with severe mental disorders and their carers in all management decisions), and patients and carers (Partner in the organisation, delivery, and evaluation and monitoring of services so that care and treatment are more responsive to needs).

7.5 Summary of content of included guidelines

7.5.1 Focus of the guidelines

From the section above it becomes clear that the focus of the guidelines is broad. Three guidelines originate from diagnostic or treatment aspects of the mental illness but have a sub-section on somatic health:

- Consensus statements on the psychiatrist's role in the somatic component of psychiatric diagnosis¹⁷⁷
- Guideline on schizophrenia management¹⁷⁶
- Guidelines on the dosing of antipsychotics and antipsychotic polypharmacy, screening for adverse effects of antipsychotics, and management of metabolic and extrapyramidal side effects¹⁷⁵

One evidence based guideline covers risk factors for somatic health, weight gain, and monitoring of side effects of medication. It also presents a summary of NICE guidelines on diabetes and smoking that is applicable to all patients.¹⁰¹

Three guidelines focus on somatic health of the patient with SMI:

- To improve the management of physical health conditions in adults with SMI and support the reduction of individual health behaviours constituting risk factors for these illnesses, with the aim of decreasing morbidity and premature mortality amongst people with SMI.²
- Recommendations in the format of an educational module.¹⁵⁷

- A summary of advances in understanding on the topic of physical health in people with mental illness, and clear directions for health promotion, clinical care, and future research.³

Two guidelines focus on the care by nurses of people with serious mental illness: how can a nurse, in collaboration with other mental health care disciplines, screen for general somatic disorders and promote a healthy lifestyle?^{155, 156}

Finally, the benefits of physical activity and exercise for SMI is studied in detail in one guideline.¹⁵⁹ Exercise is defined as a planned, structured, repetitive characteristic and has a final or intermediate objective of improvement or maintenance of physical fitness.

The categories of evidence and the strength of recommendations used in the guidelines and mentioned in the tables of the following paragraphs are detailed in Appendix 9.

7.5.2 A recovery oriented plan including family and social support, lifestyle and psychoeducation

Family, personal and social support, housing aspects and income support are important aspects not only when patients are at home but also when residing at a care facility. These aspects have been recognised to affect the risk for developing physical illness. Three guidelines stipulate key considerations for support, how to use a lifestyle plan and the need for education.^{155, 156, 176} The following statements were based on the evidence-based recommendations in Table 20 and Table 21 (which are the exact formulations from the guideline).¹⁷⁶

- Family, personal and social support, a safe environment and an adequate standard of living are critical for people with an acute relapse of psychosis, because they are at risk of being marginalised and demoralised.
- Secure, safe housing and income support are key priorities for people with severe persistent illness.



- Sub-optimal care for patients with severe persistent or unremitting illness increases their **risk of developing physical illness**, social isolation and marginalisation.

A recovery-oriented practice includes clinical recovery (lessening of symptoms), functional recovery and personal recovery. This approach will affect the general wellbeing of the patient.¹⁷⁶ A plan should be created with the patient, the family and involved peers identified, to help with general somatic screening, medication monitoring and lifestyle history, with follow-up examination(s), treatment of somatic complications and lifestyle interventions.¹⁵⁶ A care plan has to be set up with respect and the participation and involvement of the patient.¹⁰¹

Table 20 – Recommendations on social support and lifestyle

Recommendations on the management of acute relapse	Type recommendation	Level of evidence
Poor adherence with treatment plans, side effects (including obesity and metabolic syndrome), depression, substance use, complications of polypharmacy and the quality of the social environment should be considered and addressed.	EBR	II
Treatment should include a focus on developing illness self-management skills.	CBR	N/A
Cognitive remediation should be offered when cognitive deficits are affecting recovery and function. If deficits in social cognition are impeding an individual's social function, offer therapies to address these deficits.	EBR	I
Recommendations on the management of severe persistent or unremitted illness		
A recovery plan should be negotiated and agreed upon with the individual and reviewed regularly. Psychosocial interventions should be provided.	CBR	N/A
The treatment plan should be concordant with the recovery model. It should be reviewed regularly to identify modifiable illness or lifestyle risk factors such as non-adherence or substance use.	CBR	N/A
Encourage people with schizophrenia to see their GP regularly. Mental health service clinicians should communicate with each patient's GP at least once every 6 months.	CBR	N/A
Mental health services should develop partnerships with non-governmental organisations that can assist in providing lifestyle support and encouraging social inclusion for people with schizophrenia.	CBR	N/A
Optimal, comprehensive evidenced-based biopsychosocial care should be made available to all people with severe, unremitted psychotic illness.	CBR	N/A

EBR: evidence based recommendation; CBR: consensus based recommendation; N/A: not applicable; Level I: systematic review of level randomised controlled trials (RCTs); Level II: RCTs

**Table 21 – Recommendations on illness self-management and psychoeducation**

Recommendations on illness self-management and psychoeducation	Type recommendation	Level of evidence
People with schizophrenia and their carers should receive psychoeducation about the impact of the illness on cognition and function.	EBR	I
Consider providing integrated social cognitive therapies and cognitive remediation to optimise functional outcomes.	EBR	II
Cognitive behaviour therapy (CBT) should be routinely available, especially when an individual's positive symptoms are slow to respond or refractory to drug treatment.	EBR	I
Intervention programmes addressing social cognition (e.g. meta-cognitive training, social skills training and/ or SoCog) should be available to improve social function.	EBR	II
Wellness recovery action planning, the Illness Management and Recovery programme or a similar peer education programme should be made available.	EBR	I
An educational programme that promotes the person actively managing their own recovery should be a core component of service delivery.	EBR	I
Psychoeducation for people with schizophrenia reduces relapse (probably through improved adherence), increases satisfaction with treatment and improves knowledge. Psychoeducation should be offered as a core intervention.	EBR	II
Family psychoeducation is effective and should be offered routinely in the comprehensive care of schizophrenia.	EBR	I
Engage the individual and carers in strategies to ensure healthy living (e.g. diet, exercise).	EBR	III-1

EBR: evidence based recommendation; CBR: consensus based recommendation; N/A: not applicable; Level I: systematic review of level randomised controlled trials (RCTs); Level II: RCTs; Level III-1: A pseudo-randomised controlled trial (i.e. alternate allocation or some other method)

7.5.3 Assessment of somatic health at first presentation

The physical assessment and investigations for people with SMI presenting for the first time is considered an important aspect in all guidelines. Table 22 summarises the assessments that are to be performed. The focus is mostly on cardiovascular risk factors and the safety somatic aspects of medication but other factors of performing assessments e.g. timing and place, coordination and lifestyle aspects are also brought forward.

**Table 22 – Assessments at first presentation of the patient**

Country	Assessment	Other information
UK¹⁰¹	Before starting an antipsychotic, or as soon as possible afterwards: • Body mass index (BMI), take ethnicity into account • In the early weeks of treatment measure glucose. • The lipid profile should be assessed. • Tobacco smoking and alcohol use should be enquired about.	A random, rather than fasting, sample can be used if a fasting sample cannot be obtained.
Australia and New Zealand¹⁷⁶	At first assessment of a patient with schizophrenia / psychosis: • Physical examination including neurological examination • Full blood count and ESR • Electrolytes, liver function tests • Fasting glucose, cholesterol, triglycerides • Thyroid function tests • Hepatitis screen (with tests for other blood-borne diseases, for example, HIV if indicated) • Anti-NMDAR, Anti-VGKC, Anti-GAD antibodies^a • Urine drug screening • ECG • EEG (if indicated) • MRI scan of the brain^b • Psychometric testing (if possible)^c • Screening for sexually transmitted diseases (if indicated) Recommendations on medication in first-episode psychosis: • Discuss management plan with the individual and their family/carers • The benefits and risks of drug therapy should be explained in a non-coercive manner. EBR II • Provide an adequate duration of treatment. Monitor treatment and adverse effects appropriately. EBR II	^aLiaise with neurology colleagues on the interpretation of test results. ^bExpert opinion is divided about whether MRI scan of the brain is necessary for all people with first-episode psychosis. ^cIt may be necessary to wait until the mental state is stable before performing psychometric testing.
France¹⁵⁷	Systematically investigate cardiovascular risk factors: • Diabetes • high blood pressure • dyslipidaemia • metabolic syndrome • obesity • smoking • perform an initial baseline electrocardiogram • systematically perform a somatic examination in the emergency room and during hospitalisation.	Monitor the ECG for cardiovascular risk factors. The somatic examination has to be traceable in the medical file.



Country	Assessment	Other information
Netherlands ^{155, 156}	Screening to consist of three parts: 1. general somatic screening: • Asking questions about the main complaint: VALTIS (history, nature, location, time, intensity, relationship of the complaints) • General questions: well-being, pain, weight change, visits abroad, allergies, intoxications, vaccinations. • History of vulnerability • Family history • Physical examination based on anamnesis (physical complaints and use of medication) and risk areas, including: ○ BMI, waist circumference, blood pressure, pulse, temperature of teeth and mouth, ○ eye control: vision, retinal abnormalities (diabetic retinopathy) ○ skin control, ○ basic neurological examination (including examination for movement disorders) • Standard specific laboratory measurements: sober glucose (or HbA1c), sober cholesterol, HDL cholesterol ratio, triglycerides. 2. medication monitoring: • systematic mapping of prescribed medication and medication use. How does the patient handle the medication, how and when (before, after or with food) is it taken and what medication does the patient take (occasionally); • systematic mapping of the subjective experiences surrounding medication use: complaints and therapy compliance; • systematic identification of the side effects of the medication. Minimal attention is paid to movement disorders, cardiovascular and metabolic problems, and sexual problems; • relate the findings to the results of the general somatic screening. 3. lifestyle history: • Nutrition and diet (including coffee and energy drinks) • Exercise and sports • Well-being and relaxation (balance between load and capacity) • Drug use (tobacco, alcohol, medication available without prescription, drugs) • Sleeping (day and night rhythm; getting up) • Sexual behaviour and STI prevention • Hygiene (including oral hygiene)	Recommendations for lifestyle advice should be repeated once every six months.
Netherlands ¹⁷⁷	Collecting somatic information: • read the preliminary information from the file; • request information (including medication overview) from the general practitioner, and/or the referrer and/or other practitioners;	



Country	Assessment	Other information
	- record (further) somatic anamnesis in the patient and/or collecting hetero-anamnestic information; - request and record the medication data, any intoxications and the somatic history. Indications for a physical examination: - the degree of urgency; - the degree of extensiveness (exploratory checks, monitoring, status localis, exploratory internist examination, extensive internist examination including neurological examination); - who carries out the examination and what is done with the results (make agreements about this in advance and coordinate between doctors). Place and time of the somatic examination: - upon clinical admission or as soon as possible, but at least within 24 hours; - the more serious the psychiatric illness, and/or the more evidence that there is a somatic cause, the quicker this examination should be performed. - Determine whether somatic diagnostics can take place on the psychiatric ward or whether the patient should be referred to a somatic ward. Carry out laboratory tests (or request results from laboratory tests already carried out elsewhere): - in case of acute and severe psychiatric illness; - for the detection or exclusion of (comorbid) somatic disorders; - in psycho-pharmacotherapy.	
Canada ¹⁷⁵	Recommendations - Routinely monitor weight and cardiovascular and metabolic indicators of morbidity in people with psychosis and schizophrenia. - Suggested monitoring schedule for antipsychotic medication safety - Individual and family history of physical illness - Smoking history - Body mass index/ weight/waist circumference - Blood pressure - HbA1C/fasting glucose - Random lipids/fasting lipids - Prolactin - History and examination for extrapyramidal symptoms - Local arrangements for physical health monitoring should be put in place at the time of antipsychotic prescribing. - Before initiating or changing antipsychotic medication, depending on the medication being considered and the clinical situation, an ECG is suggested particularly if specified in the summary of product characteristics, a physical examination has identified specific cardiovascular risk (such as diagnosis of high blood pressure), there is a personal history of cardiovascular disease, or if there is a family history of QT prolongation.	[Modified recommendation from NICE] [Modified recommendation from SIGN] [SIGN (Good Practice Point)] [Modified recommendation from NICE]



Country	Assessment	Other information
European Psychiatric Association ¹⁵⁹	People with SMI should be screened for physical activity habits in primary and secondary care.	expert opinion, evidence D
WHO ²	Initiating a psychotropic medication: Medication with lower propensity for weight gain should be considered for people with severe mental disorders who are overweight or obese or at risk of becoming overweight or obese (Best practice statement)	

ESR: erythrocyte sedimentation rate; HIV: human immunodeficiency virus; NMDAR: N-methyl-d-aspartate receptor; VGKC: anti-voltage-gated potassium channel; GAD: glutamic acid decarboxylase; ECG: electrocardiogram; EEG: electroencephalogram; MRI: magnetic resonance imaging.

7.5.4 Assessments during follow-up

The guidelines stipulate at which intervals measurements should be performed for patients on long-term medication (mainly antipsychotics and anti-bipolar drugs). A schematic flow diagram is proposed by the Trimbos Institute.¹⁵⁶ It combines medication follow-up with lifestyle-factors and indicates which healthcare worker should be involved by stage and results of measurements (Table 23). A strong focus of all guidelines is on the follow-up of risk factors for diabetes and the metabolic syndrome. The Australian guidelines include guidance on specific interventions and for the long-term recommend a holistic approach (see also Table 21). Other guidelines refer to existing guidelines for cardiovascular disease, hypertension and cholesterol.

Other side effects than metabolic and cardiovascular are encountered with the prescribed medication for patients with SMI. An increased awareness is

needed for less common but serious side effects e.g. movement disorders, sexual disorders, intestinal occlusion, osteoporosis, polydipsia, or vitamin D shortage. An important good practice therefore is to prescribe the most appropriate medication and the lowest effective dose.¹⁷⁵ There should be detailed discussion with patients outlining the potential benefits and harms of individual medications. Patient preference should be elicited and taken into account.

Screening patients for cancer e.g. breast cancer, bowel cancer and cervical cancer and sexually transmitted infections should be performed at the same interval as for all persons. WHO recommends testing and setting up for the management of people with severe mental disorders and hiv, tuberculosis, hepatitis B and C. Organisational aspects and counselling of the patient has to be adequate to attain this goal. Similar to this dental care is often neglected and less of a priority in the acute phase of illness but should be addressed and can stimulate the wellbeing of the patient.

**Table 23 – Assessments during follow-up**

Country	Assessment
UK¹⁰¹	The measurements below should be assessed at the intervals indicated or when there is a change in antipsychotic medication. • Body mass index (BMI) frequent measurement of weight during the early stages of treatment: ideally weekly for the first 4–6 weeks and then every 2–4 weeks up to 12 weeks; but, as a minimum, once every 4 weeks for the first 12 weeks' of treatment. • Weight (and BMI) should then be assessed at 6 months and at least annually thereafter, unless the clinical situation demands more frequent assessment. • Blood glucose control should be monitored using glycated haemoglobin (HbA1c). Glucose control should be further assessed at 12 weeks, 6 months and then annually. • The lipid profile should be assessed at 12 weeks, 6 months and then annually. • Blood pressure should be monitored at 12 weeks, 6 months and annually thereafter. • Tobacco smoking and alcohol use should be enquired about at all opportunities.
Australia and New Zealand¹⁷⁶	Regular screening and intervention for cardiometabolic problems in people with schizophrenia should be mandatory: Recommendations relating to physical health of people with psychosis: • Engage the individual and carers in strategies to ensure healthy living (e.g. diet, exercise). EBR III-1 • If the person is gaining weight or has other metabolic complications of treatment, switch to a weight-neutral antipsychotic agent. EBR II • Consider the use of agents such as metformin to reduce weight gain and insulin sensitivity in people taking antipsychotic agents associated with obesity. EBR II • Liaise with the GP to ensure optimal treatment for hypertension, elevated cholesterol and other cardiometabolic conditions. CBR N/A • For people who do not attend a GP, consider undertaking investigations, monitoring and prescribing as needed to treat physical health problems within the mental health service. CBR N/A • Liaise with an endocrinology specialist or other specialist colleagues as appropriate. EBR IV • All mental health services should provide evidence-based programmes to address obesity and lack of exercise. CBR N/A • All mental health services should provide evidence-based programmes to help smokers to quit. CBR N/A • Ensure that regular dental care is provided. CBR N/A
France¹⁵⁷	In bipolar patients, prevention of endocrine disease should be carried out, regular TSH dosage is recommended. Systematically perform a somatic examination during hospitalisation with traceability in the file. An evaluation of risk factors and preventive behaviours of intestinal occlusion in patients treated with 2nd generation antipsychotics is recommended. Osteoporosis is common in schizophrenia, it is recommended to prevent risk factors: prolactin monitoring, control of physical inactivity, prevention of smoking, alcohol abuse and drug addiction, ensuring a vitamin-rich diet, prevention of polydipsia and reasonable sun exposure (Good sun exposure - for good vitamin D absorption - should not lead to photosensitization linked to conventional antipsychotics and lithium, nor increase the risk factor for the development of melanomas). Cancers: many factors are associated with an increased risk of breast cancer, it will be necessary to ensure that women suffering from schizophrenia benefit from screening by encouraging them to have regular gynaecological follow-up. Cervical cancer: as the risk is increased, it is necessary that patients are encouraged to have regular smears.



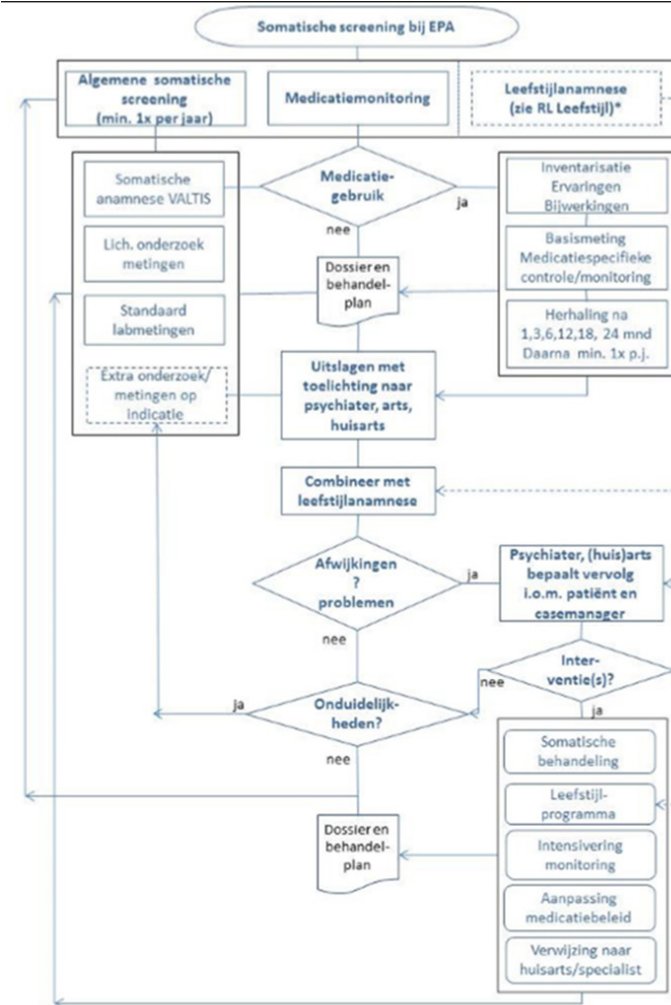
Country

Assessment

Screening for sexually transmitted infections related to risky behaviours is recommended, as well as information and education strategies tailored to patients with severe mental disorders.

Netherlands^{155, 156}

The screening of somatic health should be repeated at least once a year. The flow diagram should be followed:





Country	Assessment
	Take a lifestyle advice report once every six months: • Nutrition and diet (including coffee and energy drinks) • Exercise and sports • Well-being and relaxation (balance between load and capacity) • Drug use (tobacco, alcohol, medication available without prescription, drugs) • Sleeping (day and night rhythm; getting up) • Sexual behaviour and STI prevention • Hygiene (including oral hygiene) Recommendations medication monitoring activities: • Systematic mapping of prescribed medication and medication use. How does the patient handle the medication, how and when (before, after or with food) is it taken and what medication does the patient take (occasionally)? • 2. Systematic mapping of the subjective experiences surrounding medication use: complaints and therapy compliance. • 3. Systematic identification of the side effects of the medication. Minimal attention is paid to movement disorders, cardiovascular and metabolic problems, and sexual problems. • 4. relate the findings to the results of the general somatic screening. Frequency of screening and monitoring General: • Screen at least once a year on all aspects of general somatic screening and medication monitoring. • Carry out checks more frequently when starting or adding (new) medication (psychopharmaceuticals) and when there is a specific reason for more intensive monitoring. • In the event of no or slight symptoms or side effects: Monitor all components once a year. Take certain parts more often if there is reason to do so. • In the case of mild to moderate complaints or side effects: Monitor once every 6 months. Take certain parts more often if there is a reason to do so. • For moderate to severe symptoms or side effects: Monitor after 6 weeks, then after 3, 6, and 12 months. If no abnormalities occur, monitor at least once a year. For lithium, carbamazepine or clozapine, the relevant multidisciplinary guideline should be followed. • In case of serious complaints or side effects or start with an antipsychotic: Monitor once every 1-3 months. Take certain parts more often if there is a reason for it. Recommendations for preventing unsafe and unhealthy sexual behaviour • Offer people with a serious psychological disorder and (risk of) unhealthy sexual behaviour individual information about preventing unsafe and unhealthy behaviour, partly aimed at the occurrence of sexually transmitted diseases and unwanted pregnancies. If necessary, offer a "safe sex" package of contraceptives. Recommendations dental health • Promote oral hygiene • Refer people with serious mental illness with poor oral hygiene for a consultation with the dental hygienist or dentist to support better oral hygiene. • Support and motivate the patient in line with the oral hygienist's recommendations to perform proper oral care.
Netherlands ¹⁷⁷	Carry out laboratory tests: • in patients who are under long-term treatment (>1 year) at least once a year.



Country

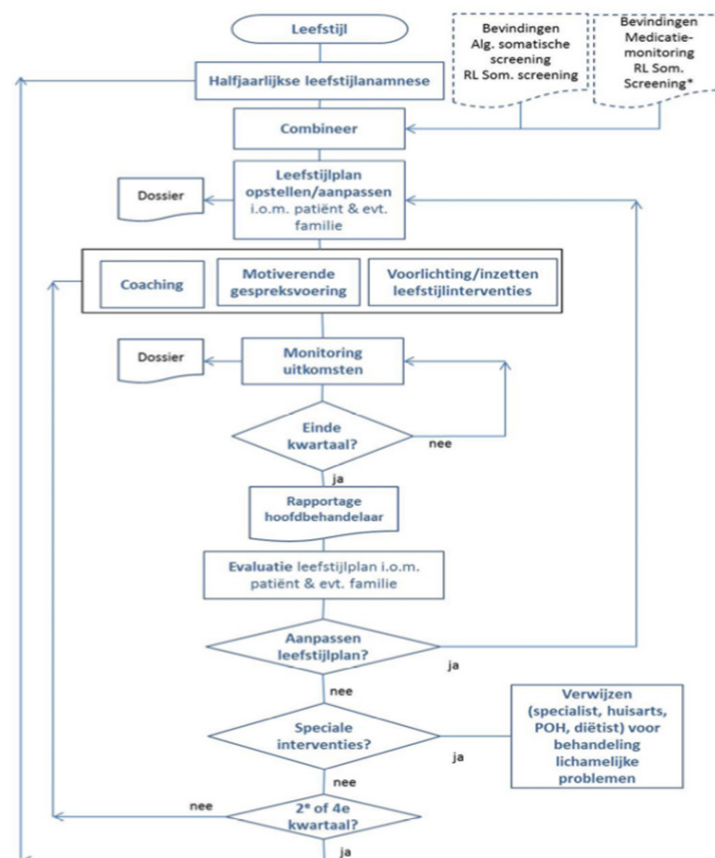
Assessment

Work together with a patient's general practitioner and other doctors.

- Consult where possible and necessary. Agree who carries out, applies for and interprets additional research.
- In any case, inform the patient's general practitioner and other physicians:
 - striking somatic findings (intake);
 - significant changes (treatment);
 - of emergency referrals to a medical specialist.

Write down your findings and/or considerations in the file, especially if it is decided not to carry out somatic diagnostics.

Samenvattingskaart
multidisciplinaire richtlijn Leefstijl bij patiënten met een ernstige psychische aanc
(V&VN, 2015)





Country

Assessment

Canada¹⁷⁵

Recommendation:

- General practitioners and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia at least annually. The health check should be comprehensive, including a cardiovascular risk assessment. [Modified recommendation from NICE]
- Suggested monitoring schedule:

Table 3.

Suggested Monitoring Schedule for Antipsychotic Medication.

Test	Baseline	At 1 Month	At 3 Months	Annually
Individual and family history of physical illness	✓			✓
Smoking history	✓		✓	✓
Body mass index/weight/waist circumference	✓	✓	✓	✓
Blood pressure	✓	As clinically indicated	✓	✓
HbA1C/fasting glucose	✓	As clinically indicated	✓	✓
Random lipids/fasting lipids	✓	As clinically indicated	✓	✓
Prolactin		As clinically indicated		
History and examination for extrapyramidal symptoms	✓	✓	✓	✓

Recommendation on medication and side effects:

- Healthcare professionals and patients should work together to find the most appropriate medication and the lowest effective dose. There should be detailed discussion with patients outlining the potential benefits and harms of individual medications. Patient preference should be elicited and taken into account. [SIGN (Good Practice Point)]
- There should not be routine use of multiple antipsychotic medications. Where polypharmacy is being considered for an individual clinical situation, the benefits and harms should be discussed with the service user. [SIGN (Good Practice Point)]
- Patients should be informed of the risk of extrapyramidal side effects and encouraged to report any symptoms suggestive of extrapyramidal side effects (at every visit). Healthcare professionals should be vigilant for the presence of



Country	Assessment
	extrapyramidal side effects, even if this is not mentioned by the patient, for example, by use of a validated side effect scale (at least annually). [Modified recommendation from SIGN (Good practice point)] • If extrapyramidal side effects are of particular concern to a patient, then second-generation antipsychotics (SGAs), especially olanzapine, quetiapine, clozapine, or asenapine, or low-potency first-generation antipsychotics (FGAs) should be considered. [Modified from SIGN (Grade B)] • Where tardive dyskinesia is a specific concern, an SGA should be considered. [SIGN (Grade B)]
Europe¹⁵⁹	Benefits of exercise or physical activity - recommendations: • Physical activity should be used as a treatment for mild-moderate depression to improve symptoms and physical fitness (good evidence, A); • Physical activity should be utilised as an adjunctive treatment for schizophrenia-spectrum disorders, to improve symptoms, cognition and quality of life (good evidence, B); • Physical activity should be used to improve physical health in people with SMI (Some evidence, C); • People with SMI should be screened for physical activity habits in primary and secondary care (Based on expert opinion, D).
WHO²	Recommendations • Behavioural lifestyle (healthy diet, physical activity) interventions should be considered in all people with severe mental disorders who are overweight or obese or at risk of becoming overweight or obese in accordance with WHO's Package of Essential Non-communicable Disease Interventions (WHO PEN) for primary care in low-resource settings (2010). These interventions should be appropriate and tailored to the needs of this population. (Strength of recommendation: Strong; Quality of evidence: Very low). • Additional psychosocial support for treatment adherence should be provided to people with HIV and severe mental disorders in accordance with the WHO consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. (Strength of the recommendation: Strong; Quality of the evidence: Moderate) Recommendation 1: For people with severe mental disorders and TB, pharmacological management should be considered in accordance with the WHO guidelines for the treatment of drug-susceptible tuberculosis and patient care and the WHO treatment guidelines for drug-resistant tuberculosis. (Strength of the recommendation: Strong; Quality of the evidence: Low). Recommendations for people with severe mental disorders and the following infections: • Tuberculosis: social, and psychological management should be considered in accordance with the WHO guidelines for the treatment of drug-susceptible tuberculosis and patient care and the WHO treatment guidelines for drug-resistant tuberculosis. (Strength of the recommendation: Strong; Quality of the evidence: Low) • Hepatitis B: treatment should be considered in accordance with the WHO guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection. (Strength of the recommendation: Strong; Quality of the evidence: Low). • Hepatitis C: treatment should be considered in accordance with the WHO guidelines for the screening care and treatment of persons with chronic hepatitis C infection. (Strength of the recommendation: Strong; Quality of the evidence: Low).



7.5.5 Weight management

Several guidelines specify behavioural, lifestyle and dietary evidence-based recommendations for the prevention and treatment of weight gain (Table 24). Weight gain is mostly problematic at the initiation of antipsychotics which is exactly when the patient is acutely unwell. Starting interventions at this point in time may be very challenging for the patient and the healthcare worker. The UK guideline by the British Association for Psychopharmacology summarises clearly the importance of involving the patient: "It is important to remember that any decisions regarding monitoring of a person's physical health risks, and the decision regarding possible intervention for such risks, should always be carried out in collaboration with that individual and, where appropriate, a carer or family member. This is perhaps particularly relevant for some of the interventions discussed which

require significant cooperation from the person involved."¹⁰¹ It is clearly recommended in all the guidelines that early monitoring is indicated, as are prevention interventions at the start of treatment. Unfortunately, the evidence and examples of specific interventions are less present. These are indeed needed to justify the extra monitoring efforts both for the patient as for the healthcare provider.

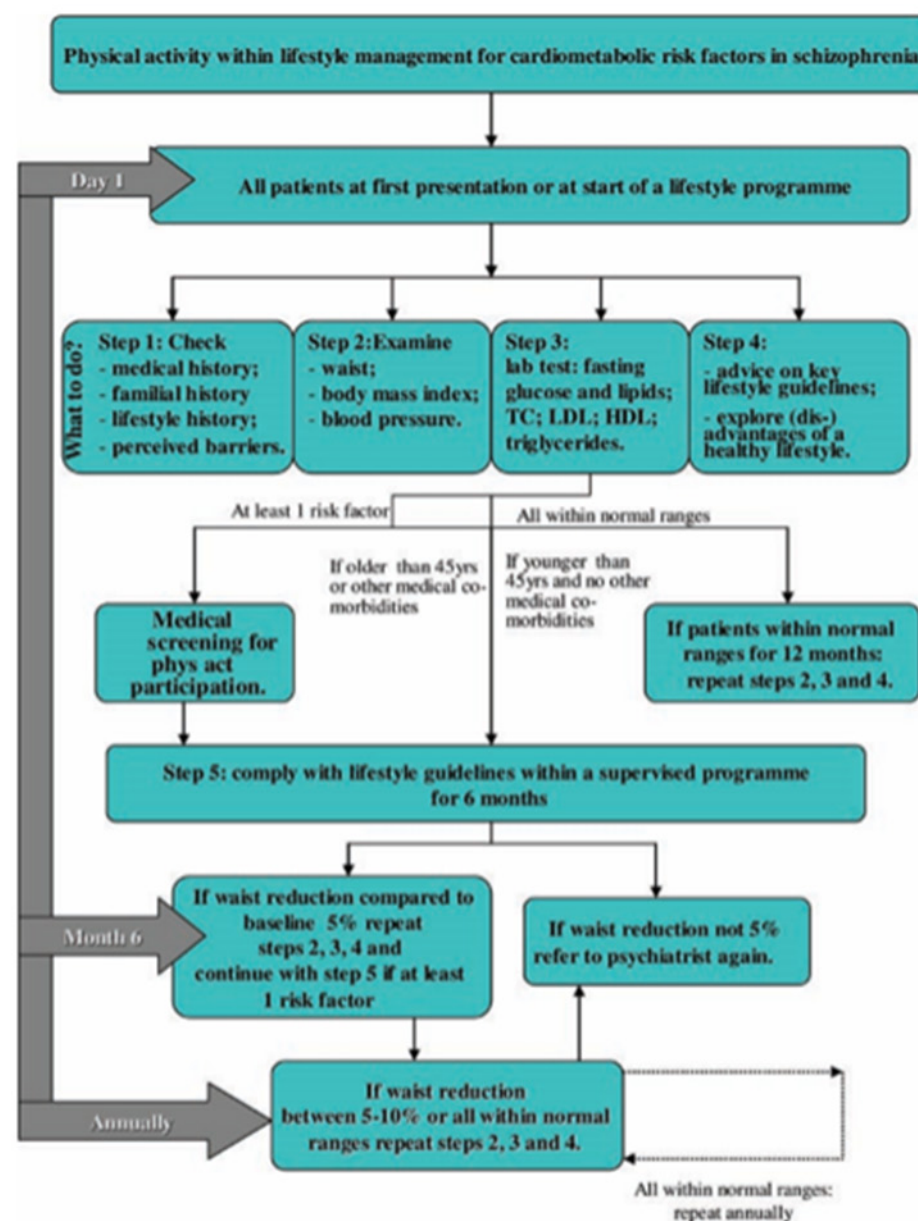
Another option proposed for weight management for those patients on antipsychotic medication is to switch to medication with less propensity for weight gain (Table 25) or to add in aripiprazole to clozapine or alanzapine. Finally, metformin can be used for those patients at high risk of diabetes (Table 25). For patients with confirmed diabetes, WHO strongly recommends behavioural lifestyle interventions and cognitive behaviour therapy.

Table 24 – Interventions for weight management

Country	Assessment
UK ¹⁰¹	Lifestyle interventions (mostly of the 'behavioural lifestyle intervention' type) • Lifestyle interventions are recommended as they have a positive effect in the majority of RCTs (A). These should almost always be part of the first line of approach and in most circumstances should be continued in addition to any additional intervention (Standard of good practice) • They will attenuate weight gain in first-episode initiations of antipsychotics (B). • There is no clear evidence regarding the optimal duration of engagement with such interventions. Evidence regarding maintenance of effects is limited in both those with long-standing and first episodes of illness. 'Booster sessions' may be required to maintain effects (C). • A limited amount of evidence suggests that programmes work best if designed specifically for those with psychosis and if they combine elements of group and individual patient approaches (C).
Australia and New Zealand ¹⁷⁶	Use lifestyle interventions to prevent weight gain. EBR II: Recommendations relating to weight gain of people with psychosis: • Engage the individual and carers in strategies to ensure healthy living (e.g. diet, exercise). EBR III-1 • If the person is gaining weight or has other metabolic complications of treatment, switch to a weight-neutral antipsychotic agent. EBR II • Consider the use of agents such as metformin to reduce weight gain and insulin sensitivity in people taking antipsychotic agents associated with obesity. EBR II • Liaise with the GP to ensure optimal treatment for hypertension, elevated cholesterol and other cardiometabolic conditions. CBR N/A



Country	Assessment
	• For people who do not attend a GP, consider undertaking investigations, monitoring and prescribing as needed to treat physical health problems within the mental health service. CBR N/A • Liaise with an endocrinology specialist or other specialist colleagues as appropriate. EBR IV • All mental health services should provide evidence-based programmes to address obesity and lack of exercise. CBR N/A
Netherlands ¹⁵⁵	Psychopharmaceuticals - weight management interventions related to medication use in the lifestyle plan. Immediately at the start of psychopharmacy and during treatment • in direct consultation with the patient: Plan (preventive) interventions in direct cooperation with the patients who are (or will be) using antipsychotics in order to prevent (further) weight gain, and promote the implementation of these interventions. • plan preventive interventions ○ consider preventive consultation with a specialist dietitian psychiatry ○ followed by further guidance from the dietitian, individually or as a group treatment ○ nutritional education: individually or as a group treatment, • exercise: ○ the norm is 30 minutes of exercise a day, in blocks of at least 10 minutes, at least 5 days a week, moderately intensive (slightly increased heart rate and breathing). ○ for people with high BMI, the norm is twice 30 minutes of exercise per day. Bear in mind that every minute of extra activity, for example walking around for a short time, is already a gain. ○ fun should be paramount in exercise programs, which should preferably be feasible, attractive, local and accessible ○ Individualise lifestyle interventions and tailor them to the patient's abilities, limitations, complaints, motivation, goals and preferences or hobbies. This may involve starting to work on one health aspect in order to maximize the chances of a successful experience. ○ Preferably use exercise interventions for which there is scientific evidence, for example a combination of cardio and strength training. • Caregivers can make an important difference by motivating the patient to walk or participate in other non-sitting activities.
Canada ¹⁷⁵	Recommendation (see algorithm below): People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider. [NICE (Strong)] Recommendation: Lifestyle interventions (incorporating physical activity, dietary change, and behavioural components) should be considered for patients who are experiencing weight gain on antipsychotic medications. [SIGN (Grade A)]





Country	Assessment
WHO ²	Recommendation on behavioural lifestyle (healthy diet, physical activity) interventions: • should be considered in all people with severe mental disorders who are overweight or obese or at risk of becoming overweight or obese in accordance with WHO's Package of Essential Noncommunicable Disease Interventions (WHO PEN) for primary care in low-resource settings (2010). These interventions should be appropriate and tailored to the needs of this population. (Strength of recommendation: Strong; Quality of evidence: Very low). Diabetes mellitus in people with severe mental disorders, recommendations • interventions in accordance with the WHO Package of Essential Non-communicable (PEN) Disease Interventions for Primary Health Care in Low-Resource Settings should be considered for diabetes management. (Strength of recommendation: Strong; Quality of evidence: Low). • Behavioural lifestyle interventions should be considered for all people with severe mental disorders and diabetes mellitus. These interventions should be appropriate and tailored to the needs of this population. (Strength of recommendation: Strong; Quality of evidence: Very low). • In people with depression and comorbid diabetes mellitus, cognitive behaviour therapy for treatment of depression may be considered. (Strength of recommendation: Conditional; Quality of evidence: Very low). Diabetes mellitus in people with severe mental disorders, best practice statements • Initiating an anti-psychotic medication with lower propensity for producing hyperglycaemia should be considered, taking into account clinical benefits and potential adverse effects. • Switching to an anti-psychotic medication with lower propensity for producing hyperglycaemia is a strategy that may be considered, taking into account clinical benefits and potential adverse effects. • Prescribers should be aware of potential interactions between prescribed medicines for diabetes mellitus and prescribed psychotropic medicines, which may affect glycaemic control. Glycaemic control should be monitored and dose adjustment of medicines may be required.


Table 25 – Antipsychotic medication and metformin for weight management

Country	Assessment
UK ¹⁰¹	Switching to one of the antipsychotic medications with lower propensity for weight gain is a strategy that should be considered (B). - Hierarchy of antipsychotic medications with respect to weight gain: - lowest propensity for weight gain: haloperidol, ziprasidone, lurasidone, aripiprazole, amisulpride and asenapine (asenapine is only licensed for bipolar mania in the UK) (A). - Only four RCTs have directly examined antipsychotic switching for the specific purpose of weight reduction. These supported switching from olanzapine to either aripiprazole or quetiapine with an approximately 3 kg greater weight reduction with switching compared to no change (B). - Clinicians must balance the possible benefit on weight of switching antipsychotic medication against the risks of inducing relapse of core psychotic symptoms (Good practice). Adjunctive aripiprazole - is recommended as a possible intervention for weight gain associated with clozapine and olanzapine (B). - Three RCTs of the addition of aripiprazole to clozapine or olanzapine, only one of significant size, found a mean difference in weight loss for aripiprazole over placebo of just over 2 kg (B). - Extrapolation of this effect to weight gain induced by other antipsychotic medications is not supported by current evidence. Metformin as an adjunct to attenuate or reduce weight gain following antipsychotic medication: - For groups at high risk of diabetes in NICE PH38, metformin should be considered as an adjunct to attenuate or reduce weight gain following antipsychotic medication (A). First though, lifestyle interventions should have been fully explored. - Metformin has been compared to lifestyle intervention for weight reduction in a large 3-year RCT of people at high risk of diabetes in the general population. Metformin leads to a modest reduction in weight (approximately 2 kg) over the short and long-term but is less effective than intensive lifestyle intervention (A). - Its use in certain situations in people at high risk of diabetes is supported by NICE PH38 (S). - In people taking antipsychotic medications, short term trials have shown that metformin reduces weight, compared to placebo, by approximately 3 kg (A). It attenuates weight gain in first-episode initiations of antipsychotic medication by approximately 5 kg, compared to placebo (A). - There are some risks attached to metformin that require appropriate monitoring (renal function and vitamin B12) (S).
Australia and New Zealand ¹⁷⁶	If the person is gaining weight or has other metabolic complications of treatment, switch to a weight-neutral antipsychotic agent EBR II Consider the use of agents such as metformin to reduce weight gain and insulin sensitivity in people taking antipsychotic agents associated with obesity. EBR II
WHO ²	BEST PRACTICE STATEMENTS: - For people with severe mental disorders who are overweight or obese or at risk of becoming overweight or obese, initiating a psychotropic medication with lower propensity for weight gain should be considered, taking into account clinical benefits and potential adverse effects. - For people with severe mental disorders who are overweight or obese, switching to a psychotropic medication with a lower propensity for weight gain may be considered, taking into account clinical benefits and potential adverse effects



7.5.6 Tobacco smoking and alcohol use

Tobacco smoking is an important additive risk factor for diabetes and CVD and should therefore be addressed. Instigating changes at a time when patients are not well is difficult for both the patient and the healthcare provider.

Table 26 – Guidance on interventions for tobacco smoking and alcohol use

Country	Assessment
UK¹⁰¹	Those who smoke should be referred to smoking cessation services (S). Evidence suggests that all of the treatments below are most effective if delivered as part of an overall smoking cessation programme (A). • Use of nicotine replacement therapy (NRT) in smokers with psychosis is supported by open label studies (B). • Individual RCTs of bupropion have small numbers of participants, and most do not demonstrate statistically significant effects, but meta-analysis of these support its use in psychosis (A). • Only one of three RCTs of varenicline demonstrates a statistically significant effect, but meta-analysis of these RCTs suggests a significant effect (A). The negative impact of harmful alcohol use, abuse or dependence in people with schizophrenia requires that their alcohol use, as well as use of other substances, is assessed and that treatment is appropriately focused on any harmful substance use, abuse or dependence (S). • Optimisation of antipsychotic treatment, following existing guidance, may have a role to play in reducing substance misuse (D). • Clozapine should be considered in patients with persisting harmful substance use, abuse or dependence because it has been reported to reduce substance use and improve psychosis, but the supporting data are still preliminary (D). • Specific medication for relapse prevention in patients with alcohol dependence should be considered, such as naltrexone or acamprosate (D).
France¹⁵⁷	Proactive smoking prevention is recommended. Systematically search for and manage addictions.
Australia and New Zealand¹⁷⁶	Recommendation on tobacco use with antipsychotic medications: • People should be encouraged to reduce or cease tobacco smoking. If they are able to achieve this, then doses of antipsychotic medications may need to be adjusted. EBR III-3 • All mental health services should provide evidence-based programmes to help smokers to quit. CBR Recommendations on comorbid substance use, including alcohol use disorder: • Assertive treatment of comorbid substance use should be part of every treatment plan. CBR N/A • Motivational interviewing, integrated CBT and anti-craving or replacement medication are recommended interventions for comorbid substance use. CBR N/A



	• For individuals whose substance use is persistent and harmful, consider involuntary admission to hospital and/or referral to a long-term rehabilitation service. CBR N/A • The prescription of stimulant drugs for attention deficit hyperactivity disorder in people who have had an episode of psychosis or are at high risk of developing psychosis is not recommended.
Netherlands ¹⁵⁵	Recommendations • Reduce substance and pleasure use • If possible, before stopping or reducing smoking and other substances (coffee, alcohol, drugs), use interventions developed specifically for people with (serious) psychological problems. Examples are the smoking cessation intervention 'Feel free' and the Liberman module 'Dealing with addiction'.
WHO ²	In the context of tobacco cessation programmes: • Recommendation 1: In people with severe mental disorders, combined pharmacological and non-pharmacological interventions may be considered in accordance with the WHO training package (Strengthening health systems for treating tobacco dependence in primary care. Building capacity for tobacco control: training package). (Strength of recommendation: Conditional; quality of evidence: Very low). • Recommendation 2: In people with severe mental disorders, a directive and supportive behavioural intervention programme may be considered and should be tailored to the needs of the population. (Strength of recommendation: Conditional; quality of evidence: Very low). • Recommendation 3: In people with severe mental disorders, varenicline, bupropion and nicotine replacement therapy may be considered for tobacco cessation. (Strength of recommendation: Conditional; quality of evidence: Very low). BEST PRACTICE STATEMENT: Prescribers should take into account potential interactions between bupropion and varenicline with psychotropic medications as well as possible contra-indications.

7.5.7 Women and older people

The Australian guideline offers evidence based recommendations for women and older people. Specific advice is given on the use of anti-psychotic medication choice and side effects for both groups. The effect on female hormones, hormone replacement therapy and breast cancer and bone density prevention is considered.



Table 27 – Aspects highlighted for women and older people

Country	Assessment
Australia and New Zealand ¹⁷⁶	Recommendations on caring for women with psychoses: • Adopt a gender-specific, tailored approach to the diagnosis and treatment of psychotic disorders experienced by women. CBR N/A • For women who are pregnant or may become pregnant, consider choosing antipsychotic agents that have been associated with fewer foetal adverse effects in available registry data (e.g. olanzapine, quetiapine, risperidone). EBR III-3 • When managing worsening psychosis in women of perimenopausal age, consider prescribing HRT. EBR II • If HRT is used as a treatment adjunct for menopausal women with schizophrenia, provide good medical care and ongoing monitoring. EBR II • Drug doses based on female metabolism and physiology should be considered and a regimen should be established to closely monitor side effects. EBR III-2 • Arrange ongoing breast monitoring and bone density scanning for women who are taking antipsychotic medicines that cause hyperprolactinaemia. EBR III-2 • Consider adding oestrogen or testosterone treatment to antipsychotic medication to assist sexual dysfunction. EBR II • Women with postpartum psychosis should be treated by a team of clinicians who care for the mother and baby together. CBR N/A Key consideration: A care-coordination model, identifying a leading agency and facilitating input from a broad multidisciplinary team, is an effective model for providing care for older people with schizophrenia. Recommendations on services for older people with schizophrenia • Streamlined, accessible, high-quality medical and physical health care services should be made available for older people with schizophrenia. CBR N/A • Health care for older people with schizophrenia should be provided by multidisciplinary teams coordinated by a service that is identified as the leading agency. The choice of whether care is provided by a general adult mental health team or a specialised older age mental health team should be based on the individual's needs, not solely on age and previous service provision. EBR I • Older people with schizophrenia should have a full range of psychological therapies and psychosocial interventions available to them. CBR N/A • Older people with schizophrenia should be provided a range of accommodation options with appropriate levels of support, ranging from independent living to quality residential aged care environments. CBR N/A • Antipsychotic medicines should be down-titrated to the lowest effective dose when treating older people with schizophrenia, who are more susceptible to adverse side effects than younger people. EBR III-2 • Prescribers should be aware of the effects of polypharmacy when prescribing for older people with schizophrenia, and minimise the potential for adverse pharmacokinetic interactions. EBR III-2 • Older people with schizophrenia should be supported to develop advanced care directives in order to articulate their preferences for all aspects of care as they age through to the end of life. CBR N/A • Focussed research investigating the needs of older people with schizophrenia and developing effective interventions in care should be initiated and funded to improve outcomes for this population. CBR N/A



7.5.8 Organisation and responsibility of somatic health care

To attain the ideal somatic health care as presented in the previous paragraphs, a good organisation with sufficient and well qualified staff is needed. The multidisciplinary approach with clear definition of tasks across time will help to reach the goal of good somatic health care.

The aspects of importance are similar across guidelines (Table 28):

- Responsibility of somatic health care has to be clear including who is responsible, stating what the person is responsible for, and how parts of somatic health care are delegated and followed-up.

- Coordination between the patient, his family and people involved and all professionals involved what concerns the somatic screening and follow-up is needed with systematic feedback of the findings to be provided to all those involved.

Sufficient financial support is necessary for a good organisation of the somatic health care of the patients with SMI.

Table 28 – Organisational aspects of somatic health care from the guidelines

Country	Assessment
UK ¹⁰¹	• Clinical commissioning groups and trusts, working with clinicians in both primary and secondary care, need to ensure that appropriate agreements are in place with regard to who takes the lead responsibility for the monitoring and management of physical health for people with psychosis at the different stages of their care. • This should include sharing of core clinical information between primary and secondary care. • Primary and secondary care services need to consider how best to provide 'lifestyle' type interventions within the context of available local provision.
France ¹⁵⁷	• To clearly identify the caregiver providing somatic follow-up. • Psychiatrists to improve their communication (mail, reports) with other specialists and the attending physician. • To the attending physician to send letters to the psychiatrists on his somatic follow-up. • To set up somatic follow-up psycho-education groups for patients and their families. • Assess the risk-benefit balance in close collaboration with a psychiatrist / general practitioner (or other specialist). • To promote the coordination of care with all actors.
Australia and New Zealand ¹⁷⁶	• Encourage people with schizophrenia to see their GP regularly. Mental health service clinicians should communicate with each patient's GP at least once every 6 months (CBR N/A). • Mental health services should develop partnerships with non-governmental organisations that can assist in providing lifestyle support and encouraging social inclusion for people with schizophrenia (CBR N/A). • Clinicians and mental health services should work in partnership with the individual, their carers, the nongovernment sector and relevant support organisations (EBR I). • Key consideration: People with schizophrenia should have access to specialist continuing care teams, working in partnership with general practitioners and other care providers. Continuing care teams and case management are a key component of long-term care. • Recommendations on service provision :



- Assertive community treatment should be offered after initial contact, during crises and after discharge from hospital (EBR I).
- Service models should include clearly established pathways for transition of patients between services, especially between mental health services (e.g. child and youth services to adult services) and external partners (mental health services to GPs, private psychiatrists, non-governmental organisations) (CBR N/A).
- People with schizophrenia should be strongly encouraged to see a GP for preventative health care and treatment of physical conditions (CBR N/A).
- Mental health services and private psychiatrists must have the ability to monitor physical health and arrange appropriate treatments, particularly for people who refuse to see GPs (CBR N/A).
- Mental health services should develop clear guidelines for clinical communication and shared responsibility between GPs, private psychiatrists and non-governmental organisations (CBR N/A).
- Liaise with the GP to ensure optimal treatment for hypertension, elevated cholesterol and other cardiometabolic conditions (CBR N/A).
- For people who do not attend a GP, consider undertaking investigations, monitoring and prescribing as needed to treat physical health problems within the mental health service (CBR N/A).

Netherlands^{155, 156}

Recommendations coordination, multidisciplinary cooperation and continuity of care

- For each patient with a serious mental illness, a case manager usually a primary care nurse, plays a central position in the care process and is primarily responsible for drawing up and implementing the lifestyle plan and for the continuity and coordination of somatic care and lifestyle guidance under the responsibility of a psychiatrist or general practitioner.
- The lifestyle history, implementation of the lifestyle plan, and somatic screening and follow-up should be carried out in good cooperation with and coordination between all the professionals involved.

Recommendations knowledge and policy

- Inform the entire multidisciplinary team about the Lifestyle in somatic screening in patients with a SMI guidelines prior to its implementation.
- Ensure that the professionals involved in promoting a healthy lifestyle and screening activities are adequately educated and trained.
- The mental health institution should have an explicit policy on screening for somatic illness and lifestyle in a 'healthy' environment.
- Provide a protocol at institutional or practical level in which the lifestyle plan, lifestyle promotion and the implementation of the lifestyle plan are worked out in concrete terms. Realise a good connection with other components of somatic care (somatic screening, medication monitoring and follow-up activities).
- As an institution, offer sufficient facilities to promote a healthy lifestyle. Examples are availability and accessibility of physiotherapy, dietetics and psychological support. Or the provision of a fitness room (intramural and extramural), a cooking room or an internet café.
- As an institution, ensure an adequate supply of healthy food for patients and take responsibility for protecting patients from the unhealthy habits of fellow patients as much as possible.
- As a role model, care providers should set a good example of a healthy lifestyle: do not smoke (at least not in the presence of the patient), pay attention to healthy eating and set an example with regard to exercise.
- Involve experience experts within organisations in the design and implementation of lifestyle projects.



7.6 Appraisal of the guidelines and example of a patient trajectory

7.6.1 Appraisal of the Belgian consensus statement

Although this consensus statement dates from 2005 it is still actual and states several topics that should be considered when caring for **patients on anti-psychotics**. This document guides to psychiatrists looking after patients in need of antipsychotics and describes the increased risks for developing metabolic syndrome when starting the medication. This medical

aspect of somatic health for the person with SMI was described as one of the most important somatic disorders. The recent guidelines are in agreement with the aspects that are described in this guidance.

We can summarise from the Belgian guidance the following aspects to be addressed:

1. Clinical aspects before starting the medication.

These should include counselling of the patient of the risks of the medication.

Table 29 – Aspects to consider before starting medication; Belgian guidance 2005

Examination category	Details of clinical investigations
Medical history	• symptoms and results of laboratory tests related to diabetes • fasting blood glucose, oral glucose tolerance test, HbA1c • family history of diabetes or obesity • eating patterns, nutritional status, weight history • exercise history • drugs affecting glucose levels e.g. lithium • risk factors for CVD: smoking, hypertension, obesity, dyslipidaemia, and family history
History	• Prior nutrition education, attitudes, health benefits • tobacco use, alcohol abuse, substance use
Physical examination	• Height and weight, calculation of body mass index • Waist circumference • blood pressure • full examination
Laboratory examination	• Fasting plasma glucose • fasting lipid profile
Counselling	• On the underlying risk of diabetes associated with the medication • on signs of diabetic ketoacidosis symptoms and diabetic complications • on lifestyle issues: smoking cessation, nutrition, self-monitoring of weight

From Denayer table IV.¹²



The authors stress the importance of teaching the patient and carers about the warning signs of life-threatening diabetic ketoacidosis.

2. Aspects to consider in the **follow-up** of the patients on antipsychotic medication.

A schedule over time is presented for the monitoring of weight and waist circumference, fasting blood glucose, fasting blood lipids, and blood pressure. The schedule indicates that all patients should be seen monthly

for a weight and waist check and for at-risk patients a monthly fasting blood glucose should be performed. This schedule needs careful planning and collaboration between the psychiatrist, the GP, the patient and the carer. The Belgian consensus document foresees for the psychiatrist to initiate the screening and follow-up measures. If abnormal tests are detected the future management of the disorders should be primarily organised by the GP or an internal medicine specialist in diabetes.

Table 30 – Aspects to consider during follow-up of patients on medication; Belgian guidance 2005

Weight and waist	Weekly while in hospital; monthly for ambulatory care
Fasting blood glucose	At risk patients: Monthly in patients with family history of diabetes / obesity or with (new) symptoms of overweight or impaired fasting glucose Not at risk patients: after 6 and 12 weeks then every three months
Fasting blood lipids	Every three months for the first year of treatment, then annually
Blood pressure	every three months

From Denayer table IV.¹²

Aspects that are not included in this consensus guidance but are useful for somatic health care in Belgium are: the timing of a somatic examination at admission, the organisation and agreements between general practitioners and psychiatrists for follow-up of somatic disorders related to psychiatric medication, defining a care programme for the person with SMI, the involvement of family and carers, the role of a nurse as the case manager, addressing and diagnosing addiction to tobacco, alcohol and drugs, the organisation of psychiatric care at emergency departments. Other factors on the health system level such as integrated care, and the societal level e.g. access to social services, and stigma reduction, were not part of this consensus. They are discussed in the international guidance and appraised in the next section.

7.6.2 Appraisal of international guidance

The international guidelines stipulate questioning of medical history and family history in line with the Belgian consensus guidance. As guidelines concern, broader aspects than the treatment with psychosomatics, the supplementary items as advised for the person with SMI are summarised in the following sections. The level of evidence is presented whenever available. Most of the evidence indeed relates to the somatic care of patients taking antipsychotic medication or antidepressants. Nevertheless, we can assume that the same care should be offered to all patients with SMI. We noted that guidance is often written for a certain audience e.g. health promotion is the focus of guidance for nurses, patient management and adverse events of medication is published for psychiatrists.



As a results guidance and knowledge may not be used adequately across healthcare workers looking after persons with SMI.

The guidelines address in depth the actions at the time of admission and shortly after, and at the time of starting medication for the psychiatric condition. These actions are described below. What is missing in the literature is comprehensive guidance on how to deal with already existing chronic illness and acutely presenting interfering disorders. This is highly relevant for settings where patients are admitted for three months and longer needing follow-up and medication management of often co-existing chronic illnesses.

Assessment at the first presentation

The following extra aspects are advised when the person with SMI is admitted for care:

- search for hetero-amnestic information,
- contact the general practitioner which includes asking for a medication overview,
- and look for and review previous admission files.

The **lifestyle history** should also include

- the use of coffee and energy drinks,
- well-being and relaxation,
- sleeping habits,
- sexual behaviour and STI prevention,
- hygiene including oral hygiene.

The **timing** of the **physical examination** depends on the degree of urgency. Good and efficient health care at the **emergency department** needs clear coordination between somatic and psychiatric healthcare doctors and therefore agreements should be made in advance. A medical assessment is important for those patients presenting in an acute state such as for psychosis but similarly a psychiatric assessment can be urgently needed as

a differential diagnosis. Agreements should be in place to determine whether the somatic diagnostic examination can take place in the psychiatric ward or the patient should be referred to a somatic ward.

The **extensiveness of the examination** is related to the clinical severity of the presentation. A baseline examination consists of the following items:

- Physical examination with measurements of
 - temperature,
 - pulse,
 - BMI,
 - height,
 - abdominal circumference,
 - blood pressure,
 - and ECG
- Full blood count and ESR
- Electrolytes, liver function tests
- Fasting glucose, cholesterol, triglycerides
- Thyroid function tests
- Hepatitis screen

Extra clinical investigations for a patient presenting with an acute state e.g. psychosis can be added if a differential diagnosis is required:

- Neurological examination
- Anti-NMDAR, Anti-VGKC, Anti-GAD antibodies (auto-immune encephalitis, consult neurologist)
- Urine drug screening
- EEG (if indicated)
- MRI scan of the brain (consider in first-episode psychosis)



After admission and **post-acute phase** the following **examinations** are suggested in the guidelines:

- History of vulnerability, social isolation, employment, well-being, and pain
- Travel history and vaccination status
- Examination of teeth and mouth
- Eye control: vision, retinal abnormalities
- skin control
- Basic neurological examination including movement disorders
- Screening for sexually transmitted diseases (for example, HIV if indicated; see www.sti.kce.be)
- Psychometric testing (if possible)

Actions required at the start and follow-up of treatment and medication while admitted for care

The actions apply for all patients but extra attention is needed when **starting antipsychotic medication**:

A. Discuss the management plan with the individual and their family/carers. This can include:

- appointing a case manager e.g. nurse or carer
- planning off appointments and medication schedule
- smoking cessation interventions (of sufficient duration and intensity; preferably a programme)
- referral to a dietician
- physical activity (**improvement of quality of life: good evidence, B and improvement of physical health: some evidence, C**)

B. The benefits and risks of drug therapy should be explained in a non-coercive manner (**EBR II**):

- side effects should be explained
- counselling on the underlying risk of diabetes associated with the medication, on signs of diabetic ketoacidosis symptoms and diabetic complications
- counselling on lifestyle issues: smoking cessation, nutrition, self-monitoring of weight

C. Provide an adequate duration of mental treatment. Monitor treatment and adverse effects appropriately and start treatment of somatic disorders (**EBR II & Modified recommendation from SIGN**).

The monitoring of medication for mental illness should include:

- inquiring about subjective experiences: compliance and complaints
- asking how the medication is used and when; in relation to food and other occasional medication
- asking about specific adverse events i.e. movement disorders, extrapyramidal symptoms, intestinal (sub)-occlusion, polydipsia, and sexual problems
- consider interaction effects of polypharmacy especially in the elderly
- a physical examination (see baseline above) with a focus on cardiovascular and metabolic problems (to check BMI, glucose (random if fasting cannot be obtained) or HbA1c, lipid profile, prolactin, thyroid function, vitamin D)
- ECG particularly if specified in the summary of product characteristics (**Modified recommendation from NICE**)
- for obese and overweight patients switch to a psychotropic medication with a lower propensity for weight gain (**EBR II**)
- consider the use of agents such as metformin to reduce weight gain and insulin sensitivity in people taking antipsychotic agents associated with obesity (**EBR II**)



- consider hormone-related issues: start hormone replacement therapy, arrange breast monitoring and bone density when hyperprolactinaemia, consider oestrogens or testosterone for sexual dysfunction
- Liaise with the GP to ensure optimal treatment for hypertension, elevated cholesterol and other cardiometabolic conditions (**consensus recommendation**)

D. Provide for screening and preventive activities as for all persons:

- screening for cancer: breast cancer, bowel cancer and cervical cancer
- screening for sexually transmitted infections

- family planning activities
- Ensure that regular dental care is provided (**consensus recommendation**)

Initially, the monitoring is performed after six weeks, then three-monthly for the first year and then annually.

Lifestyle monitoring

Patients on antipsychotic medication but also other patients benefit from combined healthy eating and physical activity program. Lifestyle items and related interventions are listed in Table 31.

Table 31 – Lifestyle aspects for the prevention of somatic disorder in the person with SMI

Lifestyle aspects	Interventions
General	• Lifestyle monitoring and advice should be repeated and ideally a case manager should be appointed for the continuity and coordination of lifestyle guidance to the individual patient.
1. Nutrition and diet (including coffee and energy drinks)	• Always refer the patient to a dietician • Individual and / group guidance and education sessions
2. Exercise and sports	• the norm is 30 minutes of exercise a day, in blocks of at least 10 minutes, at least 5 days a week, moderately intensive (slightly increased heart rate and breathing). • for people with high BMI, the norm is twice 30 minutes of exercise per day. Bear in mind that every minute of extra activity, for example walking around for a short time, is already a gain. • fun should be paramount in exercise programs, which should preferably be feasible, attractive, local and accessible • Individualise lifestyle interventions and tailor them to the patient's abilities, limitations, complaints, motivation, goals and preferences or hobbies. This may involve starting to work on one health aspect in order to maximize the chances of a successful experience. • Preferably use exercise interventions for which there is scientific evidence, for example a combination of cardio and strength training.
3. Well-being and relaxation (the balance between load and capacity)	Counselling and advice
4. Drug use (tobacco, alcohol, coffee, non-prescription medication, drugs)	Refer for smoking cessation to a programme of sufficient intensity and duration



5. Sleeping (day and night rhythm, getting up)	Counselling and advice
6. Sexual behaviour and STI prevention	Counselling on sexual risk behaviour (see https://www.sti.kce.be/en/). Offer sexual behaviour individual information aimed at the occurrence of sexually transmitted infections and unwanted pregnancies. If necessary, offer a "safe sex" package of contraceptives.
7. Hygiene (including oral hygiene).	Annual dental appointment

Illness self-management, social aspects and support

Ideally, the management plan has a recovery-oriented approach addressing functional and personal recovery.¹⁷⁶ The care plan therefore may address the following functional recovery and personal recovery aspects:

- a recovery plan should be negotiated and agreed upon with the individual in a **respectful and participatory** way and reviewed regularly. Psychosocial interventions should be provided (consensus-based).
- The **treatment plan should be reviewed regularly** to identify modifiable illness or lifestyle risk factors such as non-adherence or substance use (consensus-based).
- a safe environment and an **adequate standard of living** to avoid the risk of being marginalised and demoralised; for this income support may be needed
- to review family, personal and social support
- actions on the **impact of the illness on cognition and function**
 - patient and carer should receive psychoeducation
 - family psychoeducation is effective for schizophrenia
 - psychoeducation for people with schizophrenia reduces relapse (probably through improved adherence), increases satisfaction with treatment and improves knowledge
 - an educational programme that promotes the person actively managing their recovery
 - consider providing integrated social cognitive therapies and cognitive remediation to optimise functional outcomes (**EBR / I**)
 - cognitive behaviour therapy (CBT) should be routinely available, especially when an individual's positive symptoms are slow to respond or refractory to drug treatment
 - intervention programmes addressing **social cognition** (e.g. meta-cognitive training, social skills training and/ or SoCog) should be available to improve social function



7.6.3 Summary table integrating all the evidence and guidance statement from the international documents – example patient trajectory

Table 32 summarises the guidance given by the international guidelines and provides comprehensive lists of interventions that can be considered. Of note, the metabolic disturbances should not only be reviewed for patients on antipsychotics but can also occur for patients on antidepressants or mood stabilisers. Depending on the length of stay of the patient in one of the four settings, interventions may be applicable or can be deferred to a time points when the patient is discharged. Good planning and coordination with

ambulatory care are, therefore, necessary. Part of the coordination will involve defining responsibilities of the healthcare workers involved. Quality of care may be improved by setting quality indicators. Nevertheless, additional funding may have to be provided. For example, in the UK the Commissioning for Quality and Innovation (CQUINs) payments framework was set up in 2009/2010 to encourage service providers to continually improve the quality of care provided to patients and to achieve transparency. CQUINs enable commissioners to reward excellence, by linking a proportion of service providers' income to the achievement of national and local quality improvement goals.

Table 32 – Summary of health checks and interventions

Main items	Health checks and interventions	Details of clinical investigations
First contact assessment	1. Medical and family history 2. Lifestyle history including substance use 3. Baseline physical examination 4. Baseline investigations 5. Extra investigations for differential diagnosis 6. Post-acute phase examinations Social and vulnerability interview	Medical history and family history may include: • A search for hetero-amnestic information • Contacting the general practitioner which includes asking for a medication overview, • Look for and review previous hospital admission files • Family history of diabetes or obesity • Symptoms related to diabetes • Previous results of laboratory tests related to diabetes: fasting blood glucose, oral glucose tolerance test, HbA1c • Medication affecting glucose levels e.g. lithium • Risk factors for CVD: smoking, hypertension, obesity, dyslipidaemia, and family history Lifestyle history: • eating patterns, nutritional status, weight history • the use of coffee and energy drinks • well-being and relaxation • sleeping habits • sexual behaviour and STI prevention • hygiene including oral hygiene • exercise history • prior nutrition education, attitudes, health benefits • tobacco use, alcohol abuse, substance use Baseline physical examination:



Main items	Health checks and interventions	Details of clinical investigations
		- Physical examination with measurements of - temperature, - pulse, - height and weight, calculation of body mass index - abdominal waist circumference, - blood pressure, - and ECG - Full blood count and ESR - Electrolytes, liver function tests - Fasting glucose, cholesterol, triglycerides - Thyroid function tests - Hepatitis screen Extra investigations for differential diagnosis: - Neurological examination - Anti-NMDAR, Anti-VGKC, Anti-GAD antibodies (auto-immune encephalitis, consult neurologist) - Urine drug screening - EEG (if indicated) - MRI scan of the brain (consider in first-episode psychosis) Post-acute phase examinations: - History of vulnerability, social isolation, employment tearful system specialities to new, well-being, and pain - Travel history and vaccination status - Examination of teeth and mouth - Eye control: vision, retinal abnormalities - skin control - Basic neurological examination including movement disorders - Screening for sexually transmitted diseases (for example, HIV if indicated; see www.sti.kce.be) - Psychometric testing (if possible) Social and vulnerability interview: History of vulnerability, social isolation, employment, education, relationships, and well-being and pain
Starting medication - management plan	- Discuss management plan with the individual and a family member or carer - Explain the benefits and risks of drug therapies	Discussion management plan: - Appointing a case manager e.g. nurse or carer - planning off appointments and medication schedule - smoking cessation interventions (of sufficient duration and intensity) - referral to a dietician



Main items	Health checks and interventions	Details of clinical investigations
	3. Foresee and plan an adequate duration of treatment with monitoring of treatment effect and adverse events	- physical activity (improvement of quality of life: good evidence, B and improvement of physical health: some evidence, C) Benefits and risks medication - Side effects should be explained - Counselling on the underlying risk of diabetes associated with the medication, on signs of diabetic ketoacidosis symptoms and diabetic complications - on lifestyle issues: smoking cessation, nutrition, self-monitoring of weight Monitoring treatment - Initially the monitoring is performed after six weeks, then three-monthly for the first year and then annually - a physical examination (see baseline above) - ECG particularly if specified in the summary of product characteristics (Modified recommendation from NICE) - asking how the medication is used and when, in relation to food and other occasional medication - adverse events i.e. movement disorders and extrapyramidal symptoms, cardiovascular and metabolic problems (to check BMI, glucose (random if fasting cannot be obtained) or HbA1c, lipid profile, prolactin), and sexual problems inquiring about subjective experiences: compliance and complaints
Review the need for somatic interventions	- Physical activity - Dietary advice and weight intervention activities - Smoking cessation - Oral hygiene and dental care - Sexual health consultation and family planning - Vaccination status	- Screen patients for physical activity habits (expert opinion). Set up physical activities for all patients. For patients with mild and moderate depression there is good evidence that this works therapeutic. - Referral to a dietician; self-monitoring of weight; information on specific interventions is missing though - Referral for smoking cessation interventions of sufficient duration and intensity - Referral for dental check-up, dental care and orthodontic care - Review medical history and refer to a GP or specialist for consultation. - Review medical history and refer to a GP or specialist for consultation.
Yearly monitoring	- Review the management plan and medication beneficial effect and adverse effects - The 5 CVD risk factors which should be monitored: smoking status, BMI, blood glucose control, blood lipids and blood pressure - Ask about alcohol and substance misuse including non-prescribed medication	Develop tools and monitoring algorithms: For examples the UK organisation Rethink Mental Illness developed a toolkit of resources (https://www.rethink.org/get-involved/campaign-with-us/influencing-the-nhs/physical-health-resources-for-healthcare-professionals/). Algorithm for cardio metabolic risk assessment: example from the UK. A Dutch translation is available in the Appendix 10.



Main items

Health checks and interventions

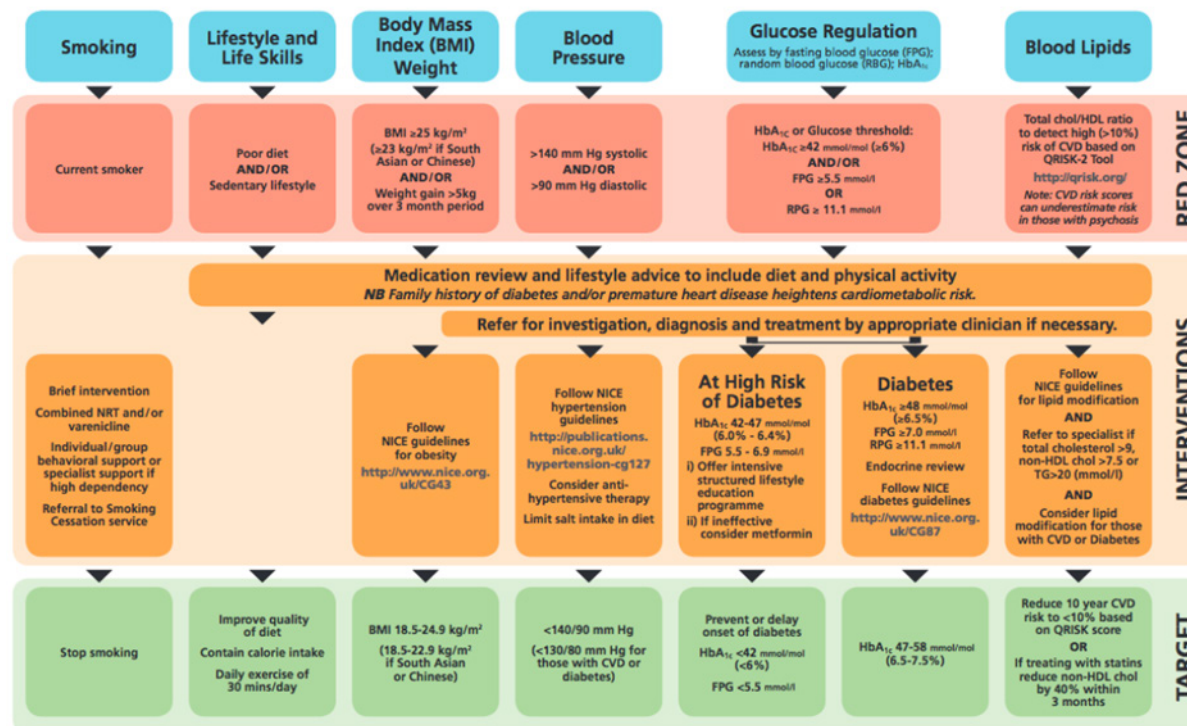
Details of clinical investigations

4. Perform a physical examination
5. Review the need for somatic interventions (above)

Lester UK Adaptation | 2014 update

Positive Cardiometabolic Health Resource

An intervention framework for people experiencing psychosis and schizophrenia



FPG = Fasting Plasma Glucose | RPG = Random Plasma Glucose | BMI = Body Mass Index | Total Chol = Total Cholesterol | HDL = High Density Lipoprotein | TRIG = Triglycerides



8 DISCUSSION

We set out to define answers to the following questions and this in relation to one of the four psychiatric settings:

- What is the prevalence of somatic problems in persons with a severe mental illness?
- What are the barriers perceived and experienced by healthcare professionals when delivering somatic care for the person with SMI while admitted for care?
- What are the barriers perceived and experienced by the person with SMI when receiving somatic care while residing in a psychiatric setting?
- How is the somatic health care for persons with an SMI organised and financed in Belgium?
- Do guidelines exist on the somatic health care of persons with SMI and how are barriers and motivators for somatic health care addressed?

In this chapter we summarise important aspects to consider for the formulation of the recommendations presented in the synthesis which is published on the KCE website in Dutch and French.

As set out in the introduction, this report focuses on the four settings studied and does not include the ambulatory sector e.g. involvement of mobile teams, follow-up of patients in primary care by GP. Nevertheless, we realise and learnt from the interviews that good collaboration with clear organisation of tasks is needed for good somatic care of the person with SMI. In this context, we did not study or discuss possible models for collaborative care, the use of the GP's electronic medical file or ICT support in general.

8.1 The prevalence of somatic problems in persons with a severe mental illness

From the international literature, we can summarise that **somatic disorders** are **very much present** across the entire spectrum of mental illnesses. We learned from the international data that the disorders and their related risk factors, listed in Table 33, are highly prevalent and more so than in the general population. Estimates show that one out of three persons with SMI suffer with hypertension, metabolic syndrome, and obesity while diabetes is present in one out of ten. Osteoporosis (13%), asthma, and chronic obstructive lung disease (9%) but also the communicable diseases hepatitis B (16%) and hepatitis C (7%) are prevalent in persons with SMI. Although persons with SMI experience more risky behaviours, such as poor diet and smoking, the relationship between mental illnesses and cancer risk is uncertain. The co-occurrence of physical health conditions is common for patients admitted with a mental or substance use disorder and twice as high (84% vs. 42%) as compared to patients admitted with a physical health principal diagnosis. Mortality is increased in persons with SMI, mostly due to premature death from cardiovascular diseases.

On the preventive side, persons with SMI are more likely to experience social risk factors, such as poverty, unemployment, homelessness, and disability, and poor health behaviours, such as smoking, alcohol consumption, low physical activity and diet which are all associated with increased risk of poor health outcomes.

The frequently recorded disorders in the Belgian psychiatric data are the same as identified in the international literature. Nevertheless, for most disorders, a significantly higher prevalence is noted internationally. The Belgian minimal psychiatric data are considered of limited value for drawing conclusions about somatic health care for neither the healthcare professionals nor policy makers. This was confirmed by the experts consulted: the psychiatric diagnosis data are reliable but somatic diagnosis data are not sufficiently sound. We conclude that Belgian minimal psychiatric database is not suitable for studying the prevalence of somatic disorders in this population.

**Table 33 – Common disorders in person with SMI**

Disorder group	Disorder	Risk factors
Cardiovascular disease	Hypertension, stroke, heart infarction, angina, hyperlipidaemia, atrial fibrillation	Lifestyle factors: Lack of physical activity, poor diet, smoking, alcohol abuse. Social risk factors: poverty, unemployment, homelessness, and disability.
Metabolic disorder	Metabolic syndrome, obesity, diabetes, osteoporosis	
Cancer	Lung cancer, liver cancer	
Respiratory disorders	Asthma, chronic obstructive lung disorder	
Infectious diseases	Hepatitis B, hepatitis C	

8.2 Barriers and facilitators of somatic health care

Somatic health care may be compromised or facilitated by the factors summarised in the sections below. Foremost, the concept and the regard of the patients should be one of 'global health'. Presently, and witnessed by this report, the dichotomy between psychiatric and somatic health is the overarching barrier for the patient's total health. An integrated and holistic approach should be the starting point for the care of the patient. The barriers, therefore, should in the future be tackled with this basic idea in mind.

The guidelines we evaluated state that this aspect of integrated care and coordination (section Table 28 in 7.5.8) and a holistic approach (see Table 20 and Table 21) is very important.^{155, 156, 176} Together with carers and family involved, the responsibilities, the coordination and a management plan have to be defined. A holistic approach, considering all factors of health and social and community aspects will decrease the patient's risk of being isolated, demoralised and marginalised. Engaging and responsive, integrated care services are required with flexibility from individual clinicians and service planners. As a minimum level of integration, health providers should communicate with each other frequently to ensure the safety and effectiveness of treatment.³

Obviously, some of the proposed measures can be implemented earlier than others. An arbitration is therefore necessary between the great numbers of proposed actions. The decision should ideally not sacrifice proposals that take longer to implement, such as starting a training programme for specialist nurses or for carers, to the benefit of structural proposals, which are easier to implement.

Changing attitudes about health-related issues is a long-term process. It would imply for instance changes in the initial teaching of future health carers about somatic issues in SMI. Openness to patient's well-being and health choices should be encouraged and identifying personal attitudes towards their patients mental and behavioural composure should be part of the curriculum. Health professionals should take time to explore their patients' personal well-being and health values and learn to involve the patients in the management plan. This includes deciding on a lifestyle plan and identifying priorities for action and informed choices made by the patient.

8.2.1 Holistic integrated care with respect for the patient and psychiatric staff

To arrive at integrated care driven in a holistic way several changes will be necessary. Experts pointed out that during the COVID-19 crisis with limited time and more acute situations, this became very clear. Care was hampered by the absence of care coordination, a complete medical file, the patient and family not being involved optimally (as a partner), and the constrained collaboration between actors.

Our project data reveal that stigma and prejudice towards the psychiatric patient are very well known and present across the literature; actions on a community level have already been set up across Belgium.^{7,27} The ongoing socialisation of care e.g. mobile teams, may have already improved this aspect. Nevertheless, during the interviews we learned that the patients were approached lacking the necessary sensitivity resulting in their health needs being rejected by somatic staff. It was suggested by patients that more training of all physicians could improve mutual respect.



Whereas the patients' stigma is not new, we learned from the healthcare workers interviewed (HCPI) that somatic health care was also influenced by stigma and prejudice by other professionals directed to themselves and all psychiatric staff. Psychiatric professionals experienced they had to defend their patients' right to good care. It was suggested that stigma could be reduced by increased contacts between the somatic and psychiatric professionals during their training and permanent education. An integrated model of care will automatically enhance knowledge for all physicians and improve collaboration.

An important aspect in the realisation of 'global health' for the patient in a respectful way is by increasing the autonomy and self-care of the patient. We learned from the HCPI that for the patient dichotomised care does not answer his needs. The international literature proposes evidence based recommendations (see Table 21) for the patient and family to take on more responsibility and be actively involved and participate in the care process; developing the management plan of the patient. For example, adherence to medication, which was in all sections of the report reported as a barrier, has been shown to be improved by the relationship alliances between the psychiatrist and the patient and the communication style. Agreement on the tasks of treatment, utilising collaborative styles of communication and discussion of treatment specifics may be important for clinicians in promoting cooperation with regimens.¹⁹¹ However, the benefits of shared decision making for adherence in mental health are less conclusive than in general medicine. One aspect that patients felt strongly about was the self-management of personal medication for small ailments (minor pain, vitamins), which was confiscated at the time of admission in order to be managed by the healthcare professionals. It was suggested by patients to rethink this patronising process. This of course has to be in line with the hospital legal requirements.

8.2.2 Access to somatic health care

From the literature we learned that access to somatic health care is influenced by organisational and logistical issues (making and managing appointments, transport), limited on-site equipment, negative workforce beliefs, and high workload of healthcare professionals. Often financial constraints were put forward as an explanation for limited access.

8.2.2.1 A shortage of somatic physicians in psychiatric settings

Experts repeatedly declared that GPs and specialists are vital for the somatic 'integrated' care of patients. Psychiatrists appreciated the role of GPs following up the patient's results, organising the necessary and timely examinations, and foreseeing a good medical file. Unfortunately, the experts reminded us that the nomenclature was restricted and as a result some GPs and specialists were reluctant or hesitant to provide somatic care to persons with a psychiatric disorder. They felt that due to high workload, complex patients, or poor support e.g. medical files, access to results it was difficult to provide good care. These aspects were confirmed by the GPs among the HCPI.

On a personal level, somatic physicians were not keen on seeing psychiatric patients: they had a feeling of ambivalence when taking up physical health care (see Table 11); they experienced limited training, lack of confidence and felt uncertain and apprehensive leading to identify physical complaints as mental symptoms.

The HCPI (including GPs) reasoned that somatic physicians might have been hesitant or refused seeing patients due to: insecurity in dealing with psychiatric patients, the anticipation that patients would be reticent and not comply with treatment, the unkempt presentation of patients, the already high workload and not being prepared to accept complicated patients, the extra time from the somatic physician to listen and comprehend the somatic complaint, or not accepting new patients due to full patient list e.g. dentists.

8.2.2.2 A shortage of time and staff to organise somatic health care

Although HCPI felt very motivated to provide optimal somatic and psychiatric health care to patients, the organisation of a consultation with a specialist was often very time consuming. The HCPI pointed out that a consultation with an external somatic physician asked for extra time from staff to accompany the patient to ensure the patient was understood and follow-up was arranged, and extra time to arrange the logistics for transport to the external facility. HCPI at the hospital argued that clear agreements with somatic physicians to review patients at the psychiatric ward reduced their workload, and the patients' waiting time and anxiety.



8.2.2.3 *Limited attention for the somatic complaint*

The interviewed patients felt not been listened or taken seriously when expressing a somatic health problem to any healthcare professionals. The presenting complaint was regarded as not worthy of attention or was blamed on the psychiatric pathology. This perceived lack of due consideration of somatic health problems resulted in delayed health care and additional health care costs for both the patient and the health care system, said the patients. To improve the attention for somatic complaints, patients advised healthcare workers to improve their listening and communication skills including empathic conversations and involve family members more readily to better understand the situation.

From the literature we learned that social support and access to information is often limited which is amplified by a lack of social skills resulting in difficulties of communicating health needs by the patient (see Table 15). This implies that the physician has to be aware that an extra effort is needed to listen carefully to understand the presented somatic complaint. Patients, on the other hand, need sufficient support to be able to express their concern. The guidelines present the evidence that social support can improve these aspects (see Table 20).

8.2.2.4 *Insufficient funding for somatic health care*

Financial aspects were raised by the HCPI and the patients as a barrier for delivering optimal somatic care. From the patients' viewpoint, and confirmed throughout the Belgian and international literature, a lack of resources led to: understaffing in psychiatric residential care settings with high workload of psychiatric and non-psychiatric staff as a result, insufficient psychiatric staff with somatic competences, insufficient on-site non-psychiatric personnel with a specific somatic knowledge e.g. physiotherapist, dietician etc. It implied the absence or shortage of equipment and inappropriate buildings to provide somatic care.

The nomenclature was insufficient to fund appropriate care, follow-up, and coordination by the GP. None of the organisational solutions we encountered during the interviews were regarded as sufficiently responding to the financial problem. The experts stressed that only by integrating the GP-work into the psychiatric hospital structurally appropriate care would be

provided. Experts added that the current funding is also insufficient for the GP or specialist to attend team meetings, and work on patient electronic files. This was confirmed by HCPI, GPs attending patients at the settings received no funding to participate in staff meetings, coordinate care, and manage an appropriate patient medical file. Experts proposed to create a new function similar to the coordinating and advising professionals (CRAs) in general nursing homes, which have shown positive effects, for a PH and PSGH setting.

The GPs of the HCPI caring for psychiatric patients in residential care were confronted with overwork; this left the patients with the impression that due to the limited time available, patients with specific somatic complaints related to the psychiatric condition (addiction, anorexia) or patients with pre-existing chronic complaints received more attention from the GP compared to patients with acute problems. As a result, patients felt they were left waiting longer for an appointment with their complaint than necessary. This aspect was not encountered in the literature.

HCPI stated that understaffing of psychiatric staff in the settings resulted in external consultations, examinations or dental appointments not being organised or being postponed.

To attract staff with somatic competences, the residential settings interviewed said that staff pay was better in the hospital setting and good qualified staff was difficult to find. To underscore the positive aspects of somatic actions, the international literature cited that the recruitment of additional support team members trained in a non-psychiatric discipline (nutrition, physiotherapy, educator) improved somatic care for the patient with severe mental illness e.g. the integration of qualified exercise professionals into mental health services improved knowledge of all staff on how to give clear advice on exercise.

The experts pointed out that as patients with chronic problems were nowadays more frequent and the somatic problems worsened over time, the decreasing fees (with the decrease associated with the time the patient is admitted) for daily surveillance were even more insufficient. It is true, from the literature, that the co-occurrence of physical health conditions is common for patients admitted with a mental or substance use disorder and



twice as high (84% vs. 42%) as compared to patients admitted with a principal physical health diagnosis.

Whereas patients mentioned the increased costs due to poor continuity of care for somatic problems, the experts mentioned that patients often were not aware of the access to the financial support for patients with chronic illnesses (<https://www.cm.be/professioneel/zorgverleners/artsen/forfaits-chronisch-zieken>).

8.2.3 *Applying evidence in somatic health care*

We identified an array of guidelines internationally and nationally that can be applied in the Belgian context. It is clear that even with all the guidance available, it is not always easy for practitioners, psychiatric and non-psychiatric to implement the knowledge and the advice. This is not only the case for Belgium but is an internationally recognised problem.

8.2.3.1 *Applying guidelines improves somatic health care*

In the Belgian literature we retrieved, the need for a consensus describing: which examinations should be performed as 'a standard' and when additional physical examinations are necessary and useful. And this at the time the adult patient is admitted to a psychiatric ward, to form a correct diagnosis and start appropriate treatment.^{22, 23} The literature also stated that guidelines are not used by general practitioners in Belgium^{107, 113} and the psychiatrist performs infrequent baseline, subsequent physical examination, and continuity of care of the patient.¹⁶ Psychiatrists in the Belgian literature explain that their task is complex compared to other disciplines: literature and evidence is limited; patients' presentations are complex and individual; the diagnostic possibilities and the relation with the patient make it more difficult.^{113, 114}

The literature describes several interventions that can be applied to improve somatic health care. Interventions typically focus on somatic health problems related to psychiatric medication or on somatic health in general (see section 7.5).

The early detection of side effects of antipsychotic medication is advised by the existing Belgian and international (detailed) guidance. Clinicians who prescribe antipsychotics should counsel and inform the patient on the metabolic risk of the underlying disease and the risks associated with the planned drug treatment. Guidelines also advise for the treatment plan to include a comprehensive lifestyle screening assessment to assess a range of behavioural risk factors (e.g., exercise, diet, substance use, and sleep), and hence identify key drivers of poor physical health. Finally, guidance states that professionals have a duty of care to ensure that the patients are given access to evidence-based lifestyle interventions from the start of treatment. HCPI advocated for a consensus on a list of standard clinical tests specifically at the time of admission but also during follow-up and at the time of discharge.

The literature advocated for training of healthcare staff for patients with chronic conditions and to increase the awareness of multi-morbidity. Tools to detect and follow-up physical health have proven helpful: a Dutch mental health nurse monitoring tool exists and the Australian computerised Positive Cardiometabolic Health Algorithm was developed.

8.2.3.2 *Training of healthcare professionals*

Although Belgian healthcare professionals felt very motivated to provide optimal somatic and psychiatric health care to patients, both psychiatric and non-psychiatric professionals interviewed stated that refresher training, including somatic skills training, for medical professionals and attention to both somatic and psychiatric viewpoints for students in training was needed to improve the somatic health care of persons with SMI.

While patients (as HCPI) recognised that the priority skills for the mental healthcare team were on mental health and comprehended the resulting limited competences in the domain of physical health, they nevertheless stated that the somatic health care they received could have been better if somatic skills and competences had been present.

The literature agrees that training of healthcare professionals on somatic health care including practical aspects, screening and prevention is beneficial.



8.2.3.3 *Prevention and health promotion are underused*

While access to physical activities or flu vaccination was frequently organised by HCPI, health promotion and lifestyle interventions were limited. Patients were instructed on healthy eating, but access to healthy food was not always available or encouraged, neither were interventions for smoking cessation. The management of weight gain was insufficient and patients interviewed would have liked effective interventions. Unfortunately, effective interventions are as yet not available in the literature. Smoking cessations programmes, on the other hand, have shown promise but mostly when organised as intense individual sessions (see Table 26).

International innovative public health programmes describe: a policy-level ban on smoking on mental health wards and hospital premises, primary prevention strategies adapted for people with mental illness, and improvement of socially deprived areas e.g. local green spaces with walking routes.^{3, 142}

8.2.4 *Care coordination aspects*

Care coordination and integrated care is internationally regarded as very important and is said to lead to improved care overall. It can reverse the underuse of evidence-based medical services, e.g. individuals with schizophrenia and diabetes received diabetes care that is significantly sub-optimal compared with patients without schizophrenia concerning guideline-concordant testing for HbA1c, lipid testing and eye exams. It may halt overuse of some types of services (such as increased rates of intensive-care-unit admissions, ambulatory care, and emergency department visits), and it may reduce the risk of medical errors. Each and every healthcare worker will have to be convinced that integrated care is the way forward and the new standard of care before change is to happen. Some ideas that have been presented in the Belgian and international literature as important for integrated care are: communication, collaboration and agreements for continuity of care.

8.2.4.1 *Collaborations and communication between healthcare professionals*

According to the Belgian literature, the collaboration between somatic and psychiatric physicians at the hospital (psychiatric and general) was experienced as limited. Referrals between psychiatric and specialist wards need better collaboration: HCPI described a high number of admissions through casualties with a high frequency of inappropriate inpatient referrals and that this was due to the difficult communication between the physicians. On the other hand, early referrals without two-way communication, from a somatic ward to the psychiatric ward happened, leaving HCPI frustrated. It was noted during the interviews that a liaison person between the specialties improved communication and led to better somatic health care.

GPs with a special interest for psychiatry were highly regarded by their psychiatric colleagues (HCPI). The role of the GP in the care for somatic health problems was recognised as very important e.g. clarifying and following up of test results, liaison person between psychiatric wards and other specialists in the hospital setting, facilitating communication between primary and secondary care. Clear division of responsibilities facilitated the collaboration between psychiatrist and GP. Whenever no GP was available e.g. psychiatric ward of a general hospital, a dedicated internal physician was highly regarded by HCPI. Psychiatric staff at the hospital argued that clear agreements with physicians to review patients at the psychiatric ward could reduce their workload, and the patients' waiting times and anxiety.

The literature referred to a shared budget for liaison psychiatry services to be beneficial for the collaborations on somatic health care. Improved information technology to support professionals: computer prompts on medication with pharmacy support, electronic tools like EBM PracticeNet and shared electronic patient health records (with flag systems) might have to be developed and / or used. The literature also advised to set up a care trajectory (personalised, integrated, multidisciplinary care) with interdisciplinary meetings (protected time) and before discharge to organise a meeting including the pharmacist and the GP.



The HCPI recognised that the management and sharing of the medical file of the patient (e.g. access to previous admission medical files, information sharing with GPs at the time of admission or discharge) was an important mean of communication and stated that this could be reinforced.

8.2.4.2 Improving the communication with patients

HCPI were confronted with issues of medical secrecy when sharing information with the family and also with external healthcare professionals. This secrecy impaired the involvement of the family. Often family was identified by the HCPI and patient as the knowledgeable person(s) for the patient's past medical history and medication. HCPI realised that collaboration with the family was unfortunately not possible when the patient did not consent.

Patients reported that good communication between physicians, family and caregivers and information sharing about their somatic disorder and psychiatric illness was essential to guarantee good somatic health care. Patients noticed that they lacked full information e.g. timing of follow-up visits, psychiatric or somatic diagnoses, the prescribed treatment including changes in medication schedule and possible side effects, and who to contact in case of a somatic health problem during their stay.

Although side effects of the psychiatric medication were followed up, they were not always communicated at the start of the treatment leaving the patient confronted with unexpected feelings or changes and making medication adherence a struggle, said the patient. Patients even reported not being informed about changes in their own 'somatic' medication schedule.

At the time of discharge, patients noted a less than optimal planning of somatic health care with patients having to cope alone: to find a GP outside the hospital, to have to provide in their medication (no supply from the hospital), to make follow-up appointments for their somatic health care with the GP or specialist.

8.2.4.3 Continuity of care

HCPI stated that at the time of admission the management of existing or chronic somatic problems was often delayed and complicated by the absence of the medical history of the patient. At the time of discharge, HCPI provided onward patient medication information rather on ad hoc than on a systematic base. Psychiatric staff but also somatic physicians at the hospital pointed out that sharing of information between primary and secondary care would facilitate somatic health care and that the role of a regular GP and an up to date electronic file for each person with SMI is very important. As set out in section 8.2.2.4, HCPI regretted that the current financing of the management of the medical file did not allow allocated time for these tasks.

The international literature specified that referral pathways for targeted interventions across primary and secondary care to manage cardiovascular risk factors which are commonly encountered when antipsychotic medication is prescribed, are beneficial.

8.2.4.4 Limited access to ambulatory prescribed medication and self-medication

According to patients and HCPI, the access to ongoing ambulatory prescribed medication for existing conditions was not always assured or took several days before being available. The hospital pharmacy medication list defined what medication was accessible. This sometimes implied discontinuation of the regular medication resulting in distress for the patient e.g. pain. Further, over-the-counter self-medication was not allowed or restricted. Hospital pharmacies do follow strict rules on the provision of medication and this is governed by law. This aspect was not mentioned in the literature reviewed.



8.3 The guidelines present sufficient evidence

As already discussed in section 8.2.3.1, from our review of the literature and search for guidelines, sufficient evidence is available to set up a good management plan for the person with SMI to take care of somatic health. Although this knowledge is available, it should be applied by psychiatrists, internal medicine specialists and GPs, and other healthcare workers involved. We refer to the appraisal of the guidelines in section 0 with the summary table in 7.6.3 that can be used as an example. The respective specialist professional organisations, GP organisation, and patient groups should actively translate the guidance into documents adapted to the Belgian situation. It is true that the evidence base is limited on certain aspects, but this should not stop the development of consensus based guidance for the settings studied, for primary care, and for the coordination between primary and secondary care.

Mental health settings, patient organisation or knowledge centres can use the guidelines or examples from abroad as a reference to develop tools and algorithms. To continually improve quality mental health, providers may want to set up quality indicators as a next step.

8.4 Limitations of the project

The scope of the project was limited to the four settings, decided at the stakeholders meeting at the beginning of the project. This obviously is a limitation as we did not include the ambulatory patients as such. This said, the clinical aspects of standard of care as gathered from the guidelines in chapter 7, do apply to any patient independent of the setting. Good clinical practice does not stop at the door of the hospital. We would therefore urge any clinician involved in the care of the person with a severe mental illness, from primary or secondary care, to apply what we learned from the guidelines and guidance and summarised in section 7.6.3.

Some of the barriers and proposals for improvements in this report cannot easily be extracted from the scientific literature as they relate specifically to the health system organisation in Belgium. Similarly, given the multiplicity and difficult natures of issues related to mental illness e.g. the inclusion of the family, social and sociological context, general aspects are difficult to

extract from the scientific literature. We therefore used the WHO guideline as a basis and to structure this complex topic.

We did not aim to study the Belgian societal aspects in detail for this project. This information could have helped to understand some of the barriers related to the decrease in healthcare availability. For example, the decreased number of healthcare workers, in particular GPs, reduced number of hospital beds, is further aggravated by the weakening of social protective factors such as unemployment, isolation, low income, and increased social stressors.

For the qualitative research part of this research project (chapter 5 and 6) we were not able to recruit as many participants as intended because the COVID-19 pandemic interfered with the data collection phase. Consequently, we were not able to gather the necessary variation and certainly we did not reach data sufficiency. However, patients' and healthcare professionals' accounts and the Belgian literature converged to a large extent. This triangulation makes us confident that the findings cover the most important barriers.

In addition, due to the small number of participants we could not do setting specific analyses. In other words we could not differentiate between psychiatric wards of general hospitals, psychiatric hospitals, psychiatric nursing homes and sheltered housing initiatives. Barriers presented were less applicable to the SHI. Nevertheless, other aspects of coordination, holistic somatic care etc. are still very relevant and therefore very much applicable to this setting.

Finally, during the interviews as well as in this chapter most attention was paid to what went wrong, leaving positive accounts largely unaddressed. However this does not mean positive experiences are non-existent.



■ APPENDICES

APPENDIX 1. STAKEHOLDERS AND EXPERTS

Appendix 1.1. Stakeholders and experts at the scoping meeting

First Name	Name	Institution/Organisation
Dien	Cuypers	Psychiatrisch ziekenhuis Bethaniënhuis, Zoersel
Paul	De Bock	FOD Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu
Marc	De Hert	UPC KU Leuven (Universitair Psychiatrisch Centrum)
Jan	De Lepeleire	Medisch Centrum - UPC KU Leuven en Department of Public Health and Primary Care, General practice
Raf	De Rycke	Broeders van Liefde
Kristien	De Vos	FIHP
Benjamin	Delaunoit	Intergruppe circuits de soins internés de l'IPF de concertation en SM
Martin	Desseilles	Université de Namur
Sylvie	Gérard	Centre supérieur de la santé (CSS)
Ariane	Ghekiere	Vlaams Instituut voor Kwaliteit van Zorg vzw (VIKZ), Agentschap zorg & gezondheid
Benoit	Gillain	Conseil fédéral des professions de soins en santé mentale
An	Haekens	Alexianen Zorggroep Tienen
Harmen	Lecok	Interkabinetten werkgroep GGZ
Muriel	Lindekens	Intergruppe circuits de soins internés de l'IPF de concertation en SM
Suzy	Maes	FIHP
Nicolaas	Martens	Uantwerpen
Chantal	Mathy	RIZIV – INAMI
Charlotte	Seaux	UPC Leuven
Karen	Smets	Domus Medica
Hilde	Stoop	PC Bethanie Zoersel



Emmanuel	Thermolle	Fédération des Initiatives d'Habitations Protégées (FIHP)
Lindsay	Van Belle	UZ Gent
Kris	Van den Broeck	Vlaamse Vereniging voor Psychiatrie (VVP)
Rik	Van Nuffel	Steunpunt Geestelijke gezondheid
Frans	Vandendriessche	Psychiatrisch ziekenhuis van Duffel
Alexis	Vanderlinden	CRéSaM
Patrick	Vanneste	Agence wallonne de la santé, de la protection sociale, du handicap et des familles (AVIQ)
Tamara	Visser	UZ Gent

Appendix 1.2. Stakeholders and experts interviewed and mailed

Stakeholder organisation	Names	Date
Psychiatrisch Centrum Multiversum Boechout	Joris Heirbaut, Directeur Organisatie en HR René Van Mieghem, manager administratie, ICT en financiën Wendy Hallemans, coördinator Onthaal en secretariaat Gillian De Boey, coördinator Klantendienst	25 th July 2019
Cel Kwaliteit en Patiëntveiligheid' en van de 'Dienst Psychosociale Gezondheidszorg', DG Gezondheidszorg	Annelies Scheppers, coördinator QS-projecten (meerjarige programma Kwaliteit en Patiëntveiligheid voor de psychiatrische ziekenhuizen en het ondersteuningsprogramma voor de algemene en psychiatrische ziekenhuizen) and 'werkgroepen patiëntveiligheid en psychiatrie', Cel Kwaliteit en Patiëntveiligheid Hilde Peleman, Attaché Kwaliteit, Cel Kwaliteit en Patiëntveiligheid Magda Coture, Adjunct federaal coördinator geestelijke gezondheidszorg, Dienst Psychosociale Gezondheidszorg	18 th July 2019
Centre Régional de soins Psychiatriques Les Marronniers	Dr Benjamin Delaunoit, Directeur médical Dr Xavier Christiaens, general practitioner Muriel Lindekens	8 th August 2019
Fédération des Initiatives d'Habitations protégées (IHP) Tournai	Mme Virginie Delarue, Présidente	9 th October 2019
UPC KU Leuven (Universitair Psychiatrisch Centrum)	Marc De Hert	mail and telephone
Algemeen Ziekenhuis Sint-Maarten	Herwig Van Dijk	mail and telephone



Appendix 1.3. Expert meeting

Experts	Names	Date
Expert meeting	Jan De Lepeleire , Medisch Centrum - UPC KU Leuven (Universitair Psychiatrisch Centrum) en Department of Public Health and Primary Care, General practice Raf De Rycke, Broeders van Liefde Benjamin Delaunoit, Intergroupe circuits de soins internes de l'IPF de concertation en SM Martin Deseilles, Université de Namur An Haekens, Alexianen Zorggroep Tienen NicolaasMartens, Uantwerpen Pierre Oswald, Centre Hospitalier Jean Titeca A.S.B.L. Bruxelles Kris Van den Broeck, Vlaamse Vereniging voor Psychiatrie Frans Vandendriessche, Psychiatrisch ziekenhuis van Duffel	January 12 th 2021

Appendix 1.4. Stakeholders meeting at the end of the project

First Name	Name	Institution/Organisation
Mario	Barremaecker	ZNA
Sabine	Corachan	LUSS
Paul	De Bock	FOD Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu
Jan	De Lepeleire	Medisch Centrum - UPC KU Leuven en Department of Public Health and Primary Care, General practice
Raf	De Rycke	Broeders van Liefde
Kristien	De Vos	FIHP
Isabelle	De Wispeleir	NVKVV - werkgroep geestelijke gezondheidszorg
Benjamin	Delaunoit	Intergroupe circuits de soins internes de l'IPF de concertation en SM
Svin	Deneckere	Vlaams Instituut kwaliteit van zorg
Maarten	Desimpel	NVKVV - werkgroep geestelijke gezondheidszorg
Martin	Deseilles	Université de Namur
Ariane	Ghekiere	Vlaams Instituut voor Kwaliteit van Zorg vzw (VIKZ), Agentschap zorg & gezondheid
Benoit	Gillain	Conseil fédéral des professions de soins en santé mentale
Marie-Clotilde	Lebas	Province de Namur



Suzy	Maes	FIHP
Nicolaas	Martens	Uantwerpen
Chantal	Mathy	RIZIV – INAMI
Isabel	Moens	Kabinet Vandenbroucke
Maxime	Résibois	CRéSaM
Ann	Van De Vloet	Uylenspiegel vzw
Rik	Van Nuffel	Steunpunt Geestelijke gezondheid
François	Vilain	Psytoyen



APPENDIX 2. LIST OF ALL SOMATIC DISORDERS REPORTED BY OTHER PSYCHIATRIC GROUPS IN PH AND PSGH - 2018

ICD-9 categories	Substance related disorders		Adjustment disorders		Other disorders		Cognitive disorders		Personality disorders		Anxiety disorders		Disorders youth	
N number per somatic group; n number per disorder	N	%	N	%	N	%	N	%	N	%	N	%	N	%
All N=26 528	7502	100	2615	100	1876	100	1702	100	1079	100	932	100	700	100
ENDOCRINE N=4601	894	11,9	480	18,4	269	14,3	192	11,3	256	23,7	176	18,9	140	20,0
DIABETES n= 1594	344	4,59	193	7,38	62	3,30	86	5,05	69	6,39	46	4,94	42	6,00
OBESITY n=1141	172	2,29	126	4,82	71	3,78	9	0,53	95	8,80	36	3,86	49	7,00
HYPOTHYROIDISM n=589	84	1,12	52	1,99	28	1,49	36	2,12	36	3,34	22	2,36	20	2,86
LIPOID METABOLISM n=525	119	1,59	38	1,45	18	0,96	29	1,70	20	1,85	33	3,54	5	0,71
MALNUTRITION n=77	<5	0,03	<5	0,08	64	3,41	.	.	.	.	.	.	.	.
NERVOUS SYSTEM N=3473	894	11,9	338	12,9	267	14,2	469	27,6	108	10,0	113	12,1	169	24,1
EPILEPSY n=1268	381	5,08	126	4,82	163	8,69	112	6,58	39	3,61	27	2,90	88	12,57
CEREBRAL DEGENERATIONS n=260	29	0,39	10	0,38	<5	0,21	160	9,40	.	.	<5	0,43	15	2,14
NEUROPATHY n=254	176	2,35	17	0,65	7	0,37	6	0,35	11	1,02	<5	0,21	<5	0,29
PARKINSONS n=241	17	0,23	11	0,42	16	0,85	67	3,94	7	0,65	7	0,75	<5	0,14
MIGRAINE n=215	32	0,43	35	1,34	6	0,32	.	.	9	0,83	26	2,79	<5	0,14
EXTRAPYRAMIDAL n=156	22	0,29	9	0,34	8	0,43	40	2,35	6	0,56	7	0,75	7	1,00
DIGESTIVE SYSTEM N=3267	1728	23,0	181	6,9	103	5,5	67	3,9	116	10,8	71	7,6	39	5,6
LIVER DISEASE n=1413	1180	15,73	33	1,26	11	0,59	22	1,29	26	2,41	6	0,64	<5	0,43
ESOPHAGUS n=521	161	2,15	35	1,34	21	1,12	10	0,59	27	2,50	11	1,18	12	1,71
FUNCTIONAL DIGESTIVE n=378	48	0,64	40	1,53	21	1,12	6	0,35	23	2,13	13	1,39	16	2,29
CIRCULATORY SYSTEM N=2841	724	9,7	237	9,1	96	5,1	493	29,0	71	6,6	87	9,3	63	9,0
HYPERTENSION n=1335	381	5,08	138	5,28	35	1,87	87	5,11	35	3,24	48	5,15	23	3,29
OCCCLUSION CEREBRAL n=126	8	0,11	<5	0,08	8	0,43	86	5,05	<5	0,19	.	.	<5	0,14
CEREBROVASCULAR DISEASE n=115	18	0,24	8	0,31	8	0,43	42	2,47	6	0,56	<5	0,32	<5	0,43
CVA n=68	9	0,12	7	0,27	<5	0,05	37	2,17	<5	0,09	.	.	.	.
TIA n=65	<5	0,04	.	.	.	.	54	3,17	.	.	.	.	.	.



MUSCULOSKELETAL SYSTEM N=2626	584	7,8	322	12,3	268	14,3	49	2,9	137	12,7	108	11,6	37	5,3
DISORDERS OF BACK n=509	119	1,59	74	2,83	24	1,28	5	0,29	27	2,50	19	2,04	7	1,00
SOFT TISSUES n=499	50	0,67	86	3,29	132	7,04	<5	0,18	22	2,04	30	3,22	<5	0,29
INTERVERTEBRAL DISC n=409	103	1,37	34	1,30	25	1,33	6	0,35	19	1,76	17	1,82	9	1,29
SYMPTOMS & ILL-DEFINED N=1882	273	3,6	273	10,4	501	26,7	36	2,1	42	3,9	83	8,9	36	5,1
GENERAL SYMPTOMS n=833	56	0,75	68	2,60	445	23,72	<5	0,24	9	0,83	27	2,90	6	0,86
UNKNOWN CAUSES n=266	37	0,49	115	4,40	8	0,43	<5	0,12	9	0,83	<5	0,43	12	1,71
RESPIRATORY SYSTEM N=1488	477	6,4	134	5,1	53	2,8	33	1,9	86	8,0	73	7,8	37	5,3
CHRONIC BRONCHITIS n=534	195	2,60	45	1,72	12	0,64	7	0,41	28	2,59	30	3,22	11	1,57
ASTHMA n=450	111	1,48	54	2,07	17	0,91	6	0,35	35	3,24	25	2,68	10	1,43
INJURY AND POISONING N=957	283	3,8	87	3,3	44	2,3	146	8,6	33	3,1	27	2,9	36	5,1
INTRACRANIAL INJURY n=72	11	0,15	<5	0,04	<5	0,05	49	2,88	.	.	<5	0,21	.	.
INFECTIOUS DISEASES N=702	303	4,0	77	2,9	26	1,4	11	0,6	19	1,8	19	2,0	11	1,6
VIRAL HEPATITIS n=322	199	2,65	14	0,54	<5	0,16	<5	0,12	6	0,56	5	0,54	<5	0,14
NEOPLASMS N=686^a	183	2,4	74	2,8	30	1,6	55	3,2	26	2,4	21	2,3	10	1,4
NEOPLASM FEMALE BREAST n=133	28	0,37	19	0,73	<5	0,21	8	0,47	<5	0,19	<5	0,32	<5	0,14
GENITOURINARY SYSTEM^a N=484	97	1,3	50	1,9	24	1,3	45	2,6	12	1,1	17	1,8	11	1,6
SKIN SUBCUTANEOUS^a N=389	119	1,6	34	1,3	17	0,9	<5	.	16	1,5	13	1,4	8	1,1
CONGENITAL ANOMALIES^a N=242	39	0,5	39	1,5	7	0,4	10	0,6	14	1,3	9	1,0	25	3,6
BLOOD AND FORMING ORGANS^a N=165	44	0,6	18	0,7	5	0,3	9	0,5	17	1,6	9	1,0	<5	.
COMPLICATIONS OF PREGNANCY^a N=114	26	0,3	6	0,2	5	0,3	6	0,4	<5	.	<5	.	8	1,1
PERINATAL PERIOD^a N=7	.	.	.	.	<5	.	.	.	<5	.	<5	.	.	.
MENTAL DISORDERS N=1428	461	6,2	129	4,9	113	6,0	69	4,1	59	5,5	52	5,6	50	7,1
V-CODE[*] N=1176	373	5,0	136	5,2	47	2,5	10	0,6	64	5,9	49	5,3	17	2,4

Data source: Federal public service; ^a individual items below 2% of total; ^{*}Supplementary Classification Of Factors Influencing Health Status And Contact With Health Services; CVA cerebrovascular accident; TIA transient ischemic attack.



APPENDIX 3. EXAMPLES OF FEES

Appendix 3.1. Example of Surveillance fee over time

Example the nomenclature of “surveillance fee” for a patient in a T service.

598183	Toezicht door een geneesheer die erkend is als specialist voor neuropsychiatrie of voor psychiatrie op een in een dienst T of een dienst Sp-psychogeriatric van een psychiatrisch ziekenhuis opgenomen rechthebbende : door een geaccrediteerde geneesheer specialist, de eerste twaalf dagen, per dag	25,37 €
598522	Toezicht door een geneesheer die erkend is als specialist voor neuropsychiatrie of voor psychiatrie op een in een dienst T of een dienst Sp-psychogeriatric van een psychiatrisch ziekenhuis opgenomen rechthebbende : de eerste twaalf dagen, per dag	22,15 €
598544	Toezicht door een geneesheer die erkend is als specialist voor neuropsychiatrie of voor psychiatrie op een in een dienst T of een dienst Sp-psychogeriatric van een psychiatrisch ziekenhuis opgenomen rechthebbende : van de dertiende tot en met de zestigste dag, per dag	20,36 €
598566	Toezicht door een geneesheer die erkend is als specialist voor neuropsychiatrie of voor psychiatrie op een in een dienst T of een dienst Sp-psychogeriatric van een psychiatrisch ziekenhuis opgenomen rechthebbende : vanaf de eenenzestigste dag tot op het einde van de zesde maand hospitalisatie, per dag	12,73 €
598622	Toezicht door een geneesheer die erkend is als specialist voor neuropsychiatrie of voor psychiatrie op een in een dienst T of een dienst Sp-psychogeriatric van een psychiatrisch ziekenhuis opgenomen rechthebbende : vanaf de zevende maand hospitalisatie tot en met het einde van de twaalfde maand hospitalisatie, per dag	8,48 €
598684	Toezicht door een geneesheer die erkend is als specialist voor neuropsychiatrie of voor psychiatrie op een in een dienst T of een dienst Sp-psychogeriatric van een psychiatrisch ziekenhuis opgenomen rechthebbende : vanaf de dertiende maand hospitalisatie, per dag	3,53 €



Appendix 3.2. State intervention fees for the stay in a PNH

Séjour dans une maison de soins psychiatriques : intervention dans le prix

Intervention de l'État

Catégorie	Description	Montant par jour (EUR)
Système à partir du 1 ^{er} janvier 2003	Personnes qui soit ont des personnes à charge, soit sont personnes à charge	15,41
	Toutes les personnes ayant droit à l'intervention majorée	9,25
	Toutes les autres personnes	4,63
Système pour les admissions avant le 1 ^{er} janvier 2003 pour autant que ce système est plus avantageux	Personnes ayant un revenu d'intégration, un revenu garanti aux personnes âgées, une allocation pour personnes handicapées et leurs ayants droit	9,91
	Personnes ayant droit à l'intervention majorée et personnes ayant d'autres personnes à charge et leurs ayants droit	7,44
	Toutes les autres personnes	4,96

Intervention supplémentaire à partir du 1^{er} octobre 2013

Charge de famille	Intervention majorée	Allocation d'intégration	Invalidité	Montant par jour (EUR)
OUI Personnes qui soit ont des personnes à charge, soit sont personnes à charge				7,59
NON	OUI	Pas d'allocation ou catégorie 1	Travailleur irrégulier ou garantie de revenus aux personnes âgées ou revenu d'intégration	13,95
			Pas d'invalidité ou personne autre que travailleur irrégulier	10,95
		Catégorie 2 ou 3	Travailleur irrégulier	8,25
			Pas d'invalidité ou personne autre que travailleur irrégulier	5,75
		Catégorie 4 ou 5	Travailleur irrégulier	5,75
			Pas d'invalidité ou personne autre que travailleur irrégulier	4,75
	NON			4,27

Source: RIZIV-INAMI. Costs for stay in a psychiatric care home.

<https://www.riziv.fgov.be/fr/professionnels/etablissements-services/maisons-soins-psychiatriques/Pages/maisons-soins-psychiatriques-20181231.aspx#.XUKzBXuxWUk>



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APPENDIX 5. DOCUMENTS QUALITATIVE RESEARCH

Appendix 5.1. Patient recruitment text

French version

Madame, Monsieur,

Le Centre fédéral d'expertise des soins de santé (KCE) mène actuellement une étude sur les soins de santé physique chez les personnes atteintes d'un trouble mental.

Le KCE est un organisme d'intérêt public qui formule des recommandations scientifiques aux décideurs politiques en matière de soins de santé. Vous trouverez plus d'information sur le KCE sur le site www.kce.fgov.be.

L'étude du KCE se focalise sur les personnes atteintes de trouble mental vivant (ou ayant vécu) dans un contexte résidentiel : hôpital psychiatrique, service psychiatrique d'un hôpital général, maison de soins psychiatriques (MSP) ou initiative d'habitation protégée (IHP).

L'objectif du projet est de mieux comprendre l'organisation de ces soins physiques et de voir s'il est possible de l'améliorer. Le vécu des patients est un élément important que le KCE souhaite intégrer.

L'équipe de recherche souhaiterait mener une enquête qualitative auprès d'anciens résidents.

Concrètement le KCE, en collaboration avec Psytoyens est à la recherche de personnes qui accepteraient de participer à une discussion en groupe de 6 à 8 personnes autour de leur expérience quant à la prise en charge de problèmes de santé physiques durant leur séjour en hôpital, maison de soins psychiatrique ou initiative d'habitation protégée.

Pour pouvoir participer vous devez avoir plus de 18 ans, savoir souffert ou souffrir d'un trouble mental d'une durée de 2 ans minimum et avoir séjourné depuis moins de 5 ans dans un ou plusieurs types d'institution psychiatrique.

Les groupes de discussion se feront en français à Bruxelles le 21 avril ou le 30 avril ou à Namur le 24 avril ou le 27 avril. La discussion débutera à 13h durera maximum 3 heures.

Afin de faciliter votre participation, vos frais de transports seront remboursés et nous vous verseront un montant forfaitaire de 30€ afin de vous remercier pour votre participation.

Si vous souhaitez participer à cette étude nous vous invitons à le signaler :

- par téléphone au XXXX
- Par email XXXX
- Via le lien XXXX

En mentionnant :



- vos nom et prénom
- votre sexe,
- votre âge,
- votre commune de résidence
- le(s) type(s) d'institution fréquenté depuis 5 ans (HP HG IHP MSP)
- votre adresse email (ou courrier si pas d'email)
- votre numéro de téléphone

et ce avant le 27 mars 2020.

Dutch version

Geachte heer of mevrouw,

Het Federaal Kenniscentrum voor de gezondheidszorg (KCE) voert momenteel een studie uit over de fysieke gezondheidszorg voor mensen met een ernstige psychiatrische aandoening.

Het KCE is een organisatie van algemeen belang die wetenschappelijk advies geeft aan beleidsmakers in de gezondheidszorg. Meer informatie over het KCE is te vinden op www.kce.fgov.be

De KCE-studie richt zich op mensen met een ernstige psychische aandoening die in een residentiële woonomgeving wonen: psychiatrische ziekenhuis, psychiatrische afdeling van een algemeen ziekenhuis, een psychiatrisch verzorgingstehuis, of een initiatief beschut wonen. Het doel van het project is om de organisatie van deze fysieke zorg beter te begrijpen en te kijken of deze kan worden verbeterd. Patiëntervaring is een belangrijk element dat het KCE wil integreren.

Het onderzoeksteam wil graag een kwalitatief onderzoek uitvoeren onder voormalige bewoners.

Concreet betekent dit dat het KCE op zoek is naar mensen die bereid zijn om deel te nemen aan een groepsgesprek van 6 à 8 personen over hun ervaring in het omgaan met fysieke gezondheidsproblemen tijdens hun verblijf in een psychiatrische ziekenhuis, psychiatrische afdeling van een algemeen ziekenhuis, een psychiatrisch verzorgingstehuis, of een initiatief beschut wonen.

Om in aanmerking te komen voor deelname moet u ouder zijn dan 18 jaar, een ernstige psychische aandoening hebben en minder dan 5 jaar geleden in een of meer soorten psychiatrische instellingen hebben verbleven.

De gespreksgroepen worden in het Nederlands gehouden in Brussel, d.w.z. XXXX, of op een plaats die het best bereikbaar is voor de deelnemers (nog te bepalen) en duren maximaal 3 uur in de maand maart 2020.



Als u aan deze studie wilt deelnemen, laat het dan weten aan uw patiëntenorganisatie:

- per telefoon op XXXXXXXXXXXX
- Per e-mail XXXXXXXXXX
- Via de link XXXX

Gelieve te vermelden:

- uw voor- en achternaam
- je geslacht,
- jouw leeftijd,
- het type instelling(en) waar je verbleef in de voorbije 5 jaar
- de gemeente waar u woont...
- uw mailadres (post of e-mail)
- uw telefoonnummer

En dit bij voorkeur voor XX/XX/2020.



Appendix 5.2. Informed consent

French version

Titre de l'étude : Expérience des usagers de soins psychiatriques résidentiels par rapport aux soins de santé physique (somatique)

Promoteur de l'étude : Centre fédéral d'Expertise des Soins de Santé

Investigateurs locaux : Cellule qualitative du KCE

Information essentielle à votre décision de participer

Nous vous remercions d'avoir manifesté votre intérêt pour notre étude sur la prise en charge des problèmes somatiques (en lien avec le corps) des personnes souffrant de trouble mental sévère en Belgique. Voici quelques informations nécessaires à prendre en compte pour prendre votre décision de participer ou pas à cette étude.

Introduction

Nous vous demandons de pouvoir collecter des informations relatives à vos coordonnées postales, téléphoniques, et électroniques afin que nous puissions vous contacter pour fixer une date et un lieu appropriés pour la discussion de groupe.

Hormis l'entretien en groupe relatif à vos expériences quant à la prévention, la prise en charge et le suivi de problèmes de santé physique pendant votre/vos séjours résidentiels en institution de soins, aucune autre procédure ne vous sera proposée.

Avant que vous n'acceptiez de participer à cette étude, nous vous invitons à prendre connaissance de ses implications en termes d'organisation, avantages et risques éventuels, afin que vous puissiez prendre une décision en toute connaissance de cause. Ceci s'appelle donner un « consentement éclairé ».

Veuillez lire attentivement ces quelques pages d'information et poser toutes les questions que vous souhaitez à l'investigateur ou à la personne qui le représente (voir section contact).

Ce document comprend 3 parties : l'information essentielle à votre prise de décision, votre consentement écrit et des informations complémentaires (annexes) qui détaillent certaines parties de l'information de base.

Si vous participez à cette étude vous devez savoir que :

- Cette étude est mise en œuvre après évaluation par le comité d'éthique Erasme-ULB.
- Votre participation est volontaire et doit rester libre de toute contrainte. Elle nécessite la signature d'un document exprimant votre consentement. Même après l'avoir signé, vous pouvez arrêter de participer en informant l'investigateur. Votre décision de ne pas ou de ne plus participer à l'étude n'aura aucun impact sur vos relations avec vos prestataires de soins.
- Les données recueillies à cette occasion sont confidentielles et votre anonymat est garanti lors de la publication des résultats.
- Une assurance a été souscrite au cas où vous subiriez un dommage lié à votre participation à cette recherche.
- Vous pouvez toujours contacter l'investigateur ou un membre de son équipe si vous avez besoin d'informations complémentaires (voir contacts plus loin).



Un complément d'informations sur vos « Droits de participant à une étude » est apporté en annexe.

Objectifs et déroulement de l'étude

Cette étude est organisée par le Centre Fédéral d'Expertise des Soins de Santé en collaboration avec Psytoyens et Steunpunt Geestelijke Gezondheid. Elle a pour objectif de proposer des pistes d'amélioration la prise en charge des problèmes somatiques (en lien avec le corps) des personnes souffrant de trouble mental sévère en Belgique en étudiant, notamment, le vécu des patients pendant leur séjours en institution de soins. Elle consistera à connaître et questionner lors d'un entretien en groupe le parcours de prise en charge des problèmes somatiques depuis la prévention jusqu'au suivi une fois de retour au domicile. Les types de prestataires impliqués, l'organisation des soins, la transmission des informations, les difficultés éventuelles rencontrées sont autant de thématiques qui seront abordées lors de l'entretien de groupe.

Nous vous proposons de participer à cette étude parce que vous avez manifesté votre intérêt pour cette étude après avoir été informé de celle-ci par votre association de patient. Cette étude devrait inclure environ 36 personnes réparties dans 6 groupes de discussions unilingues (francophone ou néerlandophone).

Pour pouvoir participer à l'étude vous devez être âgé de 18 ans ou plus, parler le français ou le néerlandais, avoir un trouble mental sévère d'une durée de 2 ans minimum et avoir séjourné il y a moins de 5 ans dans une ou plusieurs institutions psychiatriques résidentielles du type hôpital général (service de psychiatrie), hôpital psychiatrique, maison de soins psychiatrique et/ou initiative d'habitation protégée.

Votre participation à l'étude durera environ 2 à 3 heures, le temps de l'entretien de groupe. Ce dernier se déroulera par visio-conférence. Aucune demande d'information additionnelle ne vous sera demandée après l'interview.

Description des risques et bénéfices

Aucun risque, en termes de santé, ne peut être lié à votre participation à cette étude. Si toutefois vous ressentez un inconfort durant l'interview, nous vous invitons à l'interrompre immédiatement et à prendre contact avec votre médecin généraliste ou votre psychiatre ou psychologue. Si cet inconfort survient après l'interview, nous vous invitons également à prendre contact avec une personne de confiance, votre médecin généraliste ou votre psychiatre ou psychologue pour en discuter avec elle/lui.

De même, vous ne devez pas vous attendre à des bénéfices personnels du fait de votre participation à l'étude. Sachez seulement que votre participation nous permettra de mieux comprendre les points forts et les points faibles de l'organisation des soins somatiques chez des patients atteint de maladie mentale sévère en Belgique et donc de proposer de meilleures prises en charge à l'avenir.

Toutefois, afin de faciliter votre participation, nous vous verseront un montant forfaitaire de 30€ afin de vous remercier pour votre participation.

Retrait de consentement

Votre participation est volontaire et vous avez le droit de retirer votre consentement à participer à l'étude pour quelque raison que ce soit, sans devoir vous justifier.

Si vous participez à cette étude, nous vous demandons :

- De collaborer pleinement à son bon déroulement.
- De ne rien masquer comme information au sujet de votre état de santé, de médicaments que vous prenez ou de symptômes que vous ressentez qui pourrait rendre l'interview inconfortable pour vous.

**Contact**

Si vous avez besoin d'informations complémentaires, mais aussi en cas de problème ou d'inquiétude, vous pouvez contacter l'investigateur (Dr Vicky Jespers) ou un membre de son équipe de recherche (Mme Laurence KOHN) au numéro de téléphone suivant 02/ 287-33-88.

Soins de santé physique (somatique) des usagers de soins psychiatriques résidentiels

Consentement éclairé**Participant**

Je déclare que j'ai été informée de la nature de l'étude, son but, sa durée, et ce que l'on attend de moi. J'ai pris connaissance du document d'information et des annexes à ce document.

J'ai eu l'occasion de poser toutes les questions qui me sont venues à l'esprit et j'ai obtenu une réponse satisfaisante à mes questions.

J'ai compris que ma participation à cette étude est volontaire et que je suis libre de mettre fin à ma participation à cette étude sans que cela ne modifie mes relations avec mes prestataires de soins.

J'ai compris que des données me concernant seront récoltées pendant toute ma participation à cette étude et que l'investigateur et le promoteur de l'étude se portent garants de la confidentialité de ces données.

Je consens au traitement de mes données personnelles selon les modalités décrites dans la rubrique traitant de garanties de confidentialité (page 4/6).

J'accepte / n'accepte pas (biffer la mention inutile) que les données de l'étude récoltées pour les objectifs de la présente étude puissent être traitées ultérieurement pour autant que ce traitement soit limité au contexte de la présente étude.

J'ai reçu une copie de l'information au participant et du consentement éclairé.

Nom(s), prénom(s),

Date

Signature du volontaire

Investigateur

Je soussignée, KOHN Laurence, investigateur, confirme avoir fourni oralement les informations nécessaires sur l'étude et avoir fourni un exemplaire du document d'information au participant.

Je confirme qu'aucune pression n'a été exercée pour que le candidat accepte de participer à l'étude et que je suis prête à répondre à toutes les questions supplémentaires, le cas échéant.

Je confirme travailler en accord avec les principes éthiques énoncés dans la « Déclaration d'Helsinki », dans les « Bonnes pratiques Cliniques » et dans la loi belge du 7 mai 2004, relative aux expérimentations sur la personne humaine.

Nom, prénom, date et signature de l'investigateur



Soins de santé somatiques chez les personnes atteintes de maladie mentale sévère

Annexe « Droits et protection du participant »

Selon le RGPD (Règlement général sur la protection des données), vous disposez d'un certain nombre de droits concernant le traitement de vos données (voir Garanties de confidentialité). Si vous avez d'autres questions à ce sujet, vous pouvez prendre contact avec votre médecin investigateur. Le délégué à la protection des données du centre d'étude est également à votre disposition. Voici ses coordonnées : [stephan.devriese@kce.fgov.be].

Vous avez le droit de consulter vos données de l'étude détenues par le médecin de l'étude et de rectifier des erreurs au niveau de vos données. Vous avez le droit de déposer une réclamation auprès de votre autorité de protection des données : Autorité de protection des données (Rue de la Presse 35, 1000 Bruxelles, Belgique ; tél. : +32 2 274 48 00 ; e-mail : contact@apd-gba.be ; site Internet : www.autoriteprotectiondonnees.be).

- Comité d'Ethique

Cette étude a été évaluée par un Comité d'Ethique indépendant, à savoir le Comité d'Ethique Erasme^{ULB}, qui a émis un avis favorable. Les Comités d'Ethique ont pour tâche de protéger les personnes qui participent à une étude interventionnelle. Ils s'assurent que vos droits en tant que patient et en tant que participant à une étude interventionnelle sont respectés, qu'au vu des connaissances actuelles, l'étude est scientifiquement pertinente et éthique.

En aucun cas vous ne devez prendre l'avis favorable du Comité d'Ethique comme une incitation à participer à cette étude.

- Participation volontaire

Avant de signer, n'hésitez pas à poser toutes les questions que vous jugez utiles. Prenez le temps d'en parler à une personne de confiance si vous le souhaitez. Votre participation à l'étude est volontaire et doit rester libre de toute contrainte: ceci signifie que vous avez le droit de ne pas y participer ou de vous retirer sans justification même si vous aviez accepté préalablement d'y participer. Votre décision ne modifiera en rien vos relations avec l'investigateur ou prestataires de soins.

Si vous acceptez de participer à cette étude, vous signerez le formulaire de consentement éclairé. L'investigateur signera également ce formulaire et confirmera ainsi qu'il vous a fourni les informations nécessaires sur l'étude. Vous recevrez l'exemplaire qui vous est destiné.

- Garantie de confidentialité

Votre participation à l'étude signifie que vous acceptez que l'investigateur recueille des données vous concernant et les utilise dans un objectif d'étude. Les interviews sont enregistrées et retranscrites mot à mot. Lors de la retranscription, toutes données d'identification et de contact seront effacées. Après publication du rapport, les enregistrements seront détruits.



Vous avez le droit de demander à l'investigateur quelles sont les données collectées à votre sujet et quelle est leur utilité dans le cadre de l'étude. Vous disposez d'un droit de regard sur ces données et le droit d'y apporter des rectifications au cas où elles seraient incorrectes^w.

L'investigateur a un devoir de confidentialité vis à vis des données collectées.

Ceci veut dire qu'il s'engage non seulement à ne jamais divulguer votre nom dans le cadre d'une publication ou d'une conférence mais aussi qu'il prendra toutes les mesures indispensables à la protection de vos données (protection des documents sources, code d'identification, protection par mot de passe des bases de données créées)^x. Les données personnelles collectées ne contiendront pas d'association d'éléments qui puissent permettre de malgré tout vous identifier^y.

Soins de santé somatiques chez les personnes atteintes de maladie mentale sévère

L'investigateur et son équipe seront les seuls à pouvoir faire le lien entre les données de recherche et votre identité^z.

L'investigateur utilisera les données collectées dans le cadre de l'étude à laquelle vous participez mais souhaite également pouvoir les utiliser dans le cadre d'autres recherches menées dans le même contexte.

- Assurance

Dans une étude interventionnelle, le seul risque éventuel serait une faille dans les mesures prises pour protéger la confidentialité des renseignements à caractère privé vous concernant. Le promoteur assume, même sans faute, la responsabilité du dommage causé au participant (ou à ses ayants droit) et lié de manière directe ou indirecte à la participation à cette étude. Dans cette optique, le promoteur a souscrit un contrat d'assurance (Ethias, nr de police 45.428.668 et 45.437.341, Rue des Croisiers 24 à 4000 Liège Tel : 04 220 31 11) ^{aa}.

Dutch version

^w Ces droits vous sont garantis par la loi du 30 juillet 2018 en application du règlement 2016/679 relatif au traitement des données à caractère personnel, et par les droits des patients définis par la loi du 22 août 2002.

^x En pratique, il constituera 2 bases de données différentes. L'une contiendra des données identifiantes comme vos nom, prénom, numéro de téléphone, et un code d'identification qu'il créera. L'investigateur ou un membre de son équipe seront les seuls détenteurs de cette première base de données. Votre code d'identification sera utilisé dans la 2de base de données en regard de tous les résultats expérimentaux recueillis pendant votre participation à l'étude. Cette 2de base de données peut être conservée indéfiniment. Ces 2 bases de données seront conservées séparément et seront protégées par un mot de passe. Si l'investigateur confie vos données pour traitement statistique, seule la seconde base de données sera confiée à cette tierce personne.

^y La base de données contenant les résultats de l'étude ne contiendra donc pas d'association d'éléments comme vos initiales, votre sexe et votre date de naissance complète (jj/mm/aaaa).

^z L'intégrité dans l'étude scientifique suppose que les résultats d'une étude puissent être vérifiés, même après publication des résultats. Il est recommandé de conserver le lien entre données de l'étude et identité du participant au moins 5 ans après la publication des résultats.

^{aa} Conformément à l'article 29 de la loi belge relative aux expérimentations sur la personne humaine (7 mai 2004)



Titel van de studie: SANESOMA: Ervaringen van patiënten die verbleven in een residentiële psychiatrische voorziening met algemene medische zorgen (somatische zorg)

Opdrachtgever: Federaal Kenniscentrum voor de Gezondheidszorg

Lokale onderzoekers: Cel voor kwalitatief onderzoek

Noodzakelijke informatie voor uw beslissing om deel te nemen

Bedankt voor uw interesse in ons onderzoek naar de behandeling van somatische (lichaams-gerelateerde) problemen van mensen met een ernstige psychische aandoening in België. Hier is informatie die u kan helpen om te beslissen of u al dan niet aan dit onderzoek deelneemt.

Inleiding

We vragen u om via uw patiëntenorganisatie gegevens te mogen verzamelen betreffende uw contactadres, telefoonnummer en uw e-mailadres zodat we u kunnen contacteren om een geschikte datum en plaats vast te leggen voor het groepsgesprek.

Naast het groepsgesprek dat een bevraging is over uw ervaring met de zorg van fysieke moeilijkheden (voorkomen van ziekte, behandeling en opvolging) tijdens een residentieel verblijf, zullen we u geen andere zaken vragen.

Voordat u akkoord gaat om aan deze studie deel te nemen, vragen wij u om kennis te nemen van wat deze studie zal inhouden op het gebied van organisatie, voordelen en eventuele risico's, zodat u een weloverwogen keuze kunt maken. Dit wordt een "geïnformeerde toestemming" genoemd.

Wij vragen u de volgende informatiepagina's aandachtig te lezen. Hebt u vragen, dan kan u terecht bij de onderzoeker of een andere vertegenwoordiger van het onderzoeksteam (zie het gedeelte "contact").

Dit document bestaat uit 3 delen: de essentiële informatie die u nodig heeft voor het nemen van uw beslissing, uw schriftelijke toestemming en een bijlage met meer uitleg over bepaalde onderdelen van de essentiële informatie.

Als u aan deze studie deelneemt, moet u weten dat:

- Deze studie goedgekeurd is door het ethische comité van Erasmus-Université Libre Brussel.
- Uw deelname vrijwillig is; er kan op geen enkele manier sprake zijn van dwang. Voor deelname is uw toestemming nodig door het ondertekenen van dit toestemmingsdocument. Ook nadat u hebt getekend, kan u de onderzoeker laten weten indien u uw deelname wil stopzetten. Deelname aan het onderzoek wordt niet gecommuniceerd aan uw hulpverlener of de organisatie waar u zorg ontvangt; uw zorg wordt door uw deelname niet beïnvloed.
- De gegevens die in het kader van uw deelname worden verzameld zijn vertrouwelijk. Bij de publicatie van de resultaten is uw anonimiteit verzekerd.
- Er werd een verzekering afgesloten voor het geval dat u schade zou oplopen in het kader van uw deelname aan deze studie.
- Indien u extra informatie wenst, kan u altijd contact opnemen met de onderzoeker of een medewerker van zijn of haar team.



Aanvullende informatie over uw “Rechten als deelnemer aan een studie” vindt u in de bijlage.

Doelstellingen en verloop van de studie

Deze studie wordt georganiseerd door het Federaal Kenniscentrum van de Gezondheidszorg in samenwerking met de patiëntenorganisaties UilenSpiegel en Psytovens. Ze heeft als doel de zorg van fysieke (somatische) zorg voor mensen met een ernstige psychiatrische ziekte in België te verbeteren en daarom bestudeert de studie hoe deze zorg tijdens een verblijf in een residentie of ziekenhuis wordt ervaren en beleefd door patiënten. De studie is opgezet als groepsgesprek. De aanpak van de somatische zorg die wordt besproken omvat zowel aspecten van het voorkomen van ziekte (preventie), de behandeling, en hoe de opvolging wordt opgezet wanneer de patiënt terug naar huis gaat. Het soort zorgverleners, de organisatie van de zorg, de overdracht van informatie, de mogelijke problemen die zich kunnen voordoen, zijn allemaal thema's die tijdens het groepsgesprek aan de orde komen.

U hebt interesse getoond bij uw patiëntenvereniging om deel te nemen aan deze studie en daarom sturen we u deze informatie. De studie organiseert 4 groepsgesprekken van elk 3 personen (in totaal 12 personen). Per groep spreekt men ofwel Nederlands ofwel Frans.

Om aan deze studie te kunnen deelnemen, moet u 18 jaar zijn of ouder, Nederlands of Frans spreken, een diagnose hebben van een ernstig psychiatrische ziekte van minstens 2 jaar en in een of meer residentiële zorgorganisaties hebben verbleven in de voorbije 5 jaar: in een psychiatrisch ziekenhuis, psychiatrische afdeling van een algemeen ziekenhuis, een psychiatrisch verzorgingstehuis, of een initiatief beschut wonen.

Uw deelname zal ongeveer 2 a 3 uur duren; dit is de duur van het groepsgesprek. Het gesprek zal online gebeuren via Zoom. Geen enkele bijkomende informatie zal u gevraagd worden na het groepsgesprek.

Beschrijving van de risico's

Uw deelname aan deze studie houdt geen enkel gezondheidsrisico in. Indien u echter tijdens het groepsgesprek ongemak voelt, dan verzoeken we u om dit aan de onderzoeker te melden en indien nodig het gesprek te onderbreken. U kan vervolgens contact opnemen met een vertrouwenspersoon, uw huisarts, uw psycholoog of psychiater.

Uw deelname aan deze studie zal u geen direct voordeel bieden maar zorgt ervoor dat de sterke en zwakke punten in de organisatie van somatische zorg in België beter begrepen worden, zodat het KCE aanbevelingen kan doen om de zorg te verbeteren in de toekomst.

Om u te bedanken voor uw deelname, betalen wij u een forfaitair bedrag van 30€.

Intrekking van uw toestemming

U neemt vrijwillig deel aan deze studie en u hebt het recht om uw toestemming om gelijk welke reden in te trekken. U hoeft hiervoor geen reden op te geven.

Als u aan deze studie deelneemt, vragen wij om:

- Ten volle mee te werken voor een correct verloop van de studie.
- Geen informatie te verzwijgen over uw gezondheidstoestand, de geneesmiddelen die u gebruikt of de symptomen die u ervaart die het groepsgesprek ongemakkelijk zouden maken voor u.

Contact



Als u bijkomende informatie wenst, maar ook ingeval van problemen of als u zich zorgen maakt, kan u contact opnemen met de onderzoeker (Dr Vicky Jespers) of iemand van de onderzoeksgroep (Mevr Wendy Christiaens) op het telefoonnummer 02/ 287 33 88.

De fysieke (somatische) zorg bij patiënten met een ernstig psychiatrische aandoening

Geïnformeerde toestemming

Deelnemer

Ik verklaar dat ik geïnformeerd ben over de aard, het doel, de duur en dat ik weet wat van mij wordt verwacht. Ik heb kennis genomen van het informatiedocument en de bijlage ervan.

Ik heb alle vragen kunnen stellen die bij me opkwamen en ik heb een duidelijk antwoord gekregen op mijn vragen.

Ik begrijp dat mijn deelname aan deze studie vrijwillig is en dat ik vrij ben mijn deelname aan deze studie stop te zetten zonder dat dit mijn relatie schaadt met mijn zorgverleners.

Ik begrijp dat er tijdens mijn deelname aan deze studie gegevens over mij zullen worden verzameld en dat de onderzoeker en de opdrachtgever de vertrouwelijkheid van deze gegevens verzekeren.

Ik stem in met de verwerking van mijn persoonlijke gegevens volgens de modaliteiten die zijn beschreven in de rubriek over het verzekeren van de vertrouwelijkheid.

Ik ga ermee akkoord / Ik ga er niet mee akkoord (**doorhalen wat niet van toepassing is**) dat de studiegegevens die voor de hier vermelde studie worden verzameld, later zullen worden verwerkt op geanonimiseerde wijze, op voorwaarde dat deze verwerking beperkt blijft tot de context van de hier vermelde studie.

Ik heb een exemplaar ontvangen van de informatie aan de deelnemer en de geïnformeerde toestemming.

Na(a)m(en), voorn(a)m(en)

Datum

Handtekening van de deelnemer

Onderzoeker

Ik ondergetekende **Wendy Christiaens**



onderzoeker, verklaar de benodigde informatie inzake deze studie per mail te hebben verstrekt evenals een exemplaar van het informatiedocument aan de deelnemer te hebben verstrekt.

Ik bevestig dat geen enkele druk op de deelnemer is uitgeoefend om hem/haar te doen toestemmen met deelname aan de studie en ik ben bereid om op alle eventuele bijkomende vragen te antwoorden.

Ik bevestig dat ik werk in overeenstemming met de ethische beginselen zoals vermeld in de "Verklaring van Helsinki", de "Goede klinische praktijk" en de Belgische wet van 7 mei 2004 inzake experimenten op de menselijke persoon.

Naam, voornaam, datum en handtekening van de onderzoeker

Wendy Christiaens, 23/09/2020

De fysieke (somatische) zorg bij patiënten met een ernstig psychiatrische aandoening

Bijlage "Rechten en bescherming van de deelnemer"

Volgens de AVG (Algemene Verordening Gegevensbescherming) heeft U een aantal rechten met betrekking tot de verwerking van uw gegevens (zie Garantie van vertrouwelijkheid). Als u nog vragen heeft over dit onderwerp, kunt u contact opnemen met uw behandelend arts. De Data Protectie Verantwoordelijke van het studiecentrum staat ook tot uw beschikking. Zijn contactgegevens zijn als volgt: [stephan.devriese@kce.fgov.be].

U heeft recht op toegang tot uw studiegegevens die in het bezit zijn van de studiearts en op correctie van eventuele fouten in uw gegevens. U heeft het recht om een klacht in te dienen bij uw gegevensbeschermingsautoriteit: Gegevensbeschermingsautoriteit (Drukpersstraat 35, 1000 Brussel, België; tel.: +32 2 274 48 00; e-mail: contact@apd-gba.be; website: <https://www.gegevensbeschermingsautoriteit.be/contact>).

- Ethisch comité

Deze studie werd geëvalueerd door een onafhankelijk ethisch comité Erasmus-ULB dat een gunstig advies heeft uitgebracht. De ethische comités hebben als taak de personen die aan studies deelnemen te beschermen. Ze controleren of uw rechten als patiënt en als deelnemer aan een studie gerespecteerd worden, of de studie wetenschappelijk relevant en ethisch verantwoord is.

U dient het positief advies van de Ethische Comités in geen geval te beschouwen als een aansporing om deel te nemen aan deze studie.

- Vrijwillige deelname

Aarzel niet om alle vragen te stellen die u nuttig vindt voordat u tekent. Neem de tijd om er met een vertrouwenspersoon over te praten, als u dit wenst.

U heeft het recht om niet deel te nemen aan deze studie of met deze studie te stoppen zonder dat u hiervoor een reden hoeft te geven, zelfs al hebt u eerder toegestemd om aan deze studie deel te nemen. Uw beslissing zal in geen geval uw relatie met de onderzoeker of uw zorgverlener veranderen.

Als u aanvaardt om aan deze studie deel te nemen, ondertekent u het toestemmingsformulier. De onderzoeker zal dit formulier ook ondertekenen en zal zo bevestigen dat hij/zij u de noodzakelijke informatie voor deze studie heeft gegeven. U zult ook een ondertekend exemplaar ontvangen.



- Garantie van vertrouwelijkheid

Uw deelname aan de studie betekent dat u akkoord gaat met het feit dat de onderzoeker gegevens over u verzamelt en ze gebruikt in het kader van het onderzoek. Het groepsgesprek zal opgenomen worden en woord per woord uitgeschreven worden. Tijdens het uitschrijven zullen identificatie- en contactgegevens gewist worden. Na publicatie van het rapport zullen alle opnames vernietigd worden.

U hebt het recht de onderzoeker te vragen welke gegevens over u verzameld werden en welk nut ze hebben in het kader van de studie. U hebt eveneens het recht om deze gegevens in te kijken en te verbeteren indien ze onjuist zouden zijn^{bb}. De onderzoeker moet de verzamelde gegevens vertrouwelijk behandelen. Dit betekent dat hij er zich toe verplicht uw naam niet bekend te maken in het kader van een publicatie of een conferentie maar dat hij eveneens alle maatregelen zal nemen noodzakelijk voor de bescherming van uw gegevens (bescherming van de brondocumenten, identificatiecode, bescherming van de gegevens door middel van een paswoord)^{cc}.

De ingezamelde persoonlijke gegevens bevatten geen associatie van elementen die u kunnen identificeren^{dd}. De onderzoeker en zijn team zullen de enige personen zijn die een verband kunnen leggen tussen de studiegegevens en uw identiteit^{ee}.

De onderzoeker zal de verzamelde gegevens alleen gebruiken in het kader van de studie waaraan u deelneemt.

- Verzekering

In deze interventie studie is het enige mogelijke risico een probleem met de maatregelen die werden genomen om de vertrouwelijkheid van uw persoonsgegevens te beschermen.

De opdrachtgever is, ook indien er geen sprake is van fout, aansprakelijk voor de schade die u als deelnemer - of in geval van overlijden uw rechthebbenden - oplopen en die rechtstreeks of onrechtstreeks te wijten is aan de deelname aan deze studie. Hiervoor heeft de opdrachtgever een verzekeringscontract afgesloten (Ethias, nr de police 45.428.668 en 45.437.341, Rue des Croisiers 24 te 4000 Liège Tel : 04 220 31 11)^{ff}.

^{bb} Deze rechten zijn u gegarandeerd door de wet van 30 juli 2018 gevolgd door de richtlijn 2016/679 die het privéleven beschermt en door de rechten van de patiënten bepaald door de wet van 22 augustus 2002.

^{cc} In de praktijk stelt hij 2 verschillende databases op. De eerste bevat de persoonlijke gegevens, zoals uw naam, voornaam, telefoonnummer, en een identificatiecode. De onderzoeker of een lid van zijn ploeg zijn de enige houders van deze eerste database. Uw identificatiecode wordt gebruikt in de tweede database als referentiecode voor de ingezamelde experimentele resultaten tijdens uw deelneming aan de studie. Deze tweede database kan onbeperkt bewaard worden. Deze 2 databases worden apart bewaard en door een paswoord beschermd. Mochten uw gegevens voor statistische verwerking aan een derde toevertrouwd worden, dan zal uitsluitend de tweede database aan deze derde persoon toevertrouwd worden

^{dd} De database met de studieresultaten bevatten dus geen associatie van elementen zoals uw initialen, geslacht en uw volledige geboortedatum (dd/mm/jjjj).

^{ee} Integriteit in het wetenschappelijk onderzoek gaat ervan uit dat de resultaten ook na de publicatie van de resultaten kan worden geverifieerd. Het wordt aanbevolen om de koppeling tussen onderzoeksgegevens en de identiteit van de deelnemer ten minste vijf jaar na de publicatie van de resultaten bij te houden. Voor klinische studies (studies over drugs), bij wet verplicht om deze relatie te houden voor 20 jaar.

^{ff} Conform artikel 29 van de Belgische wetgeving inzake experimenten op de menselijke persoon (7 mei 2004)



Appendix 5.3. Interview guide in French for patients

Nous vous remercions d'avoir accepté de participer à ce groupe de discussion dans le cadre du projet « Soins de santé physiques chez les personnes atteintes de maladie mentale grave », mené par le Centre Fédéral d'Expertise des Soins de Santé. Cette étude a été demandée par les organisations des patients et les professionnels.

Je m'appelle et je suis

L'objectif de notre projet est de comprendre comment les soins de santé somatiques aux personnes atteintes d'une maladie mentale grave se déroulent et sont organisés pour des patients résidentiels, et ce afin de proposer des pistes d'amélioration si nécessaire.

Nous souhaitons enregistrer cet entretien dans le but de faciliter la discussion, de ne pas dénaturer les propos tenus et de retranscrire l'entretien à des fins d'analyse. L'enregistrement sera effacé lorsque les transcriptions seront faites. Le contenu des entretiens sera anonymisé et aucune information permettant d'identifier la personne ne sera publiée.

Je vais brièvement vous lire et expliquer l'information du formulaire de consentement éclairé. Après je vous inviterai à le signer et je le signerai moi-même.

Organisation pratique : 3 chercheurs KCE (modérateur, observateur (prend note de la manière dont l'interaction se passe / gardien du temps), rapporteur). L'observateur se positionne face au modérateur dans la salle.

Rappel des règles de la discussion : confidentialité, respect de la parole, enregistrement des échanges, rappel du but de l'étude et de la durée du focus group.

Tour de table : chacun se présente, comment s'appelle-t-on entre nous ? Comment doit-on nommer les personnes : résidents, patients, usagers, clients ?



Questions	Relance	Thèmes	Objectif	Timing
Tour de présentation : chacun se présente brièvement. Cette étude porte sur les soins de santé physique en milieu résidentiel (par exemple, hôpital psychiatrique, maison de soins psychiatriques, logement protégé ou service psychiatrique d'un hôpital général). Veillez également mentionner le milieu de soins dont vous avez fait l'expérience et la durée de votre séjour.	Comment puis-je vous appeler? Comment doit-on appeler les gens : résidents, patients, utilisateurs, clients ?			
PREMIERE PARTIE : Brise-glace				
Comme je vous l'ai donc dit, nous allons parler ensemble de la prise en charge de la place de la prévention, du traitement et du suivi de problèmes de santé physique lorsque les personnes sont résidents pour la santé mentale, en institution ou en habitation protégée. Vous avez été contacté car nous aimerions apprendre de vos expériences dans ces institutions. Vous pouvez partager vos expériences personnelles si vous vous sentez à l'aise, mais vous pouvez aussi parler de ce que vous avez vu chez d'autres patients, ou donner votre avis ou réflexion de manière générale. Ne vous sentez donc pas obligés de donner des réponses personnelles. 1. Comment avez-vous réagi lorsque vous avez appris le thème de la recherche ?	Vous avez été étonnés ? Vous avez été content ?	Surprise, curiosité, Incompréhension	Intérêt, Rentrer dans le sujet sans « braquer » les personnes	



Maintenant, nous allons parler de problèmes de santé fréquemment rencontrés par les patients

DEUXIEME PARTIE : Identifier les problèmes

2. Quand on parle de problèmes de santé physiques, à quoi pensez-vous?

- A quels problèmes de santé physique pensez-vous ?
- Quels sont pour vous les problèmes de santé physique auxquels on peut être confronté ?

Cfr liste des soins somatiques possibles

Définir ce que sont les problèmes de santé physique évidents pour les patients

TROISIEME PARTIE : Prise en charge

3. D'après votre expérience, quand [quelqu'un/ un résident/ ...] est soigné pour un problème psychiatrique, quelle est la place que les soignants (médecins, infirmiers, psychologues etc.) donnent à la santé physique ?

NB : quand je parle de votre expérience, cela peut se référer à ce que vous avez vécu personnellement ou ce à quoi vous avez assisté pendant vos séjours en institution.

- Comment qualifiez-vous la prise en charge de la santé physique pour des résidents présentant des problèmes de santé mentale ?

Vérifier chaque fois où cela se passe le lieu de soin :

- hôpital psychiatrique
 - service psychiatrique d'un hôpital général
 - établissement de soins psychiatriques
 - initiative d'habitation protégée
- + Spécifier en cas d'endroit plus spécifique : urgence, kiné, radiologie, etc. si nécessaire

4. En ce qui concerna la santé physique, comment cela se passe-t-il concrètement les premiers jours quand une personne intègre un service résidentiel de santé mentale ?

- Quelles informations les soignants demandent-ils de partager sur l'état de de santé physique des résidents ?
- Qu'est ce qui est expliqué sur comment faire si on ne se sent pas bien, -a besoin de soins au niveau physique ?
- Quelles sont les informations qui sont transmises aux résidents sur la manière dont leur santé physique va être prise en charge (au sens large) / sur la manière dont votre état de santé physique va être géré ?

Est-ce que vous avez transmis les coordonnées de votre médecin généraliste ?

Est-ce que vous avez eu un entretien spécifique avec un soignant par rapport à vos problèmes de santé ?

Vérifier chaque fois où cela se passe le lieu de soin. HP HG hab prot,...

Identification des éléments clés au moment de l'entrée



5. Comment cela se passe-t-il concrètement pendant les semaines, voir les mois suivants ?	Comment sont suivis les patients/résidents/etc. ? (Généraliste, interniste, psychiatre, autre ?)	Est-ce que vous avez pu garder votre médecin de généraliste ? Est-ce qu'on vous a proposé un médecin généraliste si vous n'en aviez pas ?	Identification des éléments clés au pendant le séjour
6. Comment cela se passe-t-il concrètement au moment du retour à la maison ?	- Comment l'information est transmise ? A qui ? - Un suivi spécifique est-il prévu ? - Contacts avec les 'groupes de soutien ?		Identification des éléments clés pour le suivi
Présentation de 4 situations concrètes POUR CHAQUE VIGNETTE			
7. Pourriez-vous partager un exemple concret de problème de santé physique, que vous avez vous-même eu, ou que l'un de vos 'co-résident' a rencontré.	- Qu'est-ce qui est difficile pour le résident ? - Qu'est-ce qui est difficile pour les soignants ? - Quelles sont les autres difficultés que vous avez perçues (organisation, financière,...) ?	Vérifier chaque fois où cela se passe le lieu de soin (HP HG hab prot,...)	Identification des barrières à la prise en charge
Comment cela a-t-il été traité ?			
8. Qu'est-ce qui a bien fonctionné, qu'est-ce qui a mal fonctionné ?			
(Il peut s'agir de n'importe quoi : une personne qui est tombée, une personne qui tousse, une préoccupation concernant la prise de poids, un mal de dents, un mal de tête, une grippe, une blessure, un mal de dos, etc.)			
9. Comment expliquez-vous ces difficultés/problèmes ?			
10. Qu'est-ce qui permettrait, selon vous, d'améliorer la situation ?	Si vous aviez une baguette magique, quels seraient les changements que vous apporteriez ?		Identification des pistes d'amélioration
Une patiente de 58 ans a des difficultés à marcher ce matin ; elle est tombée la veille, elle ne peut pas prendre appui sur sa jambe droite.	Qui est la première personne de contact, qui est responsable, comment prendre rendez-vous avec un médecin ou une infirmière, comment référer un patient à un spécialiste ?		



Un patient de 62 ans se sent mal, tousse et se plaint d'avoir des difficultés à respirer

Les mesures physiques de base ont-elles été effectuées : t°, fréquence respiratoire, fréquence cardiaque, fréquence respiratoire, etc. Qui et comment a-t-on décidé d'aller aux urgences....

Un patient de 52 ans s'inquiète d'avoir pris du poids depuis que ses médicaments contre la schizophrénie ont été augmentés. Son pantalon ne lui va plus. Il se demande aussi si sa tension artérielle est bonne parce qu'il prend des médicaments.

Comment s'organise le suivi des médicaments psychiatriques ? Existe-t-il une référence de routine pour des conseils diététiques et de l'exercice ?

Une patiente de 28 ans est anxieuse. Ses règles sont très abondantes, plus abondantes que d'habitude, et elle a des douleurs abdominales.

Existe-t-il une documentation/demande d'antécédents médicaux au moment de l'admission ; oriente-t-on les patients vers un spécialiste pour cesser de fumer ?

11. Dans quelle mesure vous pensez que la manière dont les soins de santé physiques sont pris en charge diffère en fonction des types de lieux de résidence

NB : je parle ici du type de lieu (HP HG...) et pas de l'adresse ou du nom de l'institution

Peut-on parler d'une problématique en général ou doit-on chaque fois préciser où cela se passe.

Faciliter la suite de l'entretien et mettre en évidence les spécificités de chaque type de résidence

SITUATION AU CHOIX (s'il y a du temps) – à choisir parmi les vignettes KCE ou proposition du groupe

CLOTURE

Est-ce qu'il y a d'autres problèmes à aborder par rapport aux soins de santé physique ?

- Est-ce qu'il y a d'autres éléments qui sont importants et que nous devons connaître ?

Vérifier chaque fois où cela se passe le lieu de soin (HP HG hab prot,...

Complétude ?

Nous vous remercions pour votre participation. Comme annoncé, cet entretien sera retranscrit, anonymisé et analysé avec les entretiens des différentes personnes que nous aurons rencontré. Si, dans les semaines qui suivent, vous souhaitez encore nous transmettre des informations, n'hésitez pas à revenir vers nous.

L'ensemble des résultats sera présenté dans un rapport publié sur le site internet du KCE <https://kce.fgov.be/>.

**VIGNETTES POUR LES FOCUS GROUP PATIENTS****CAS POUR TOUS**

Une patiente de 58 ans a des difficultés à marcher ce matin ; elle est tombée la veille, elle ne peut pas prendre appui sur sa jambe droite.

Un patient de 62 ans se sent mal, tousse et se plaint d'avoir des difficultés à respirer

Un patient de 52 ans s'inquiète d'avoir pris du poids depuis que ses médicaments contre la schizophrénie ont été augmentés. Son pantalon ne lui va plus. Il se demande aussi si sa tension artérielle est bonne parce qu'il prend des médicaments.

Une patiente de 28 ans est anxieuse. Ses règles sont très abondantes, plus abondantes que d'habitude, et elle a des douleurs abdominales.

EXTRA AU CHOIX

Un patient de 52 ans atteint de diabète de type II se plaint de pieds froids, de picotements et d'engourdissement des orteils. Il ne sait pas quand il a vu pour la dernière fois son diabétologue à l'hôpital.

Un patient de 55 ans demande s'il peut être dépisté pour le cancer du côlon et pour l'hépatite. Il a parfois de légères douleurs à l'estomac.

Une patiente de 28 ans a l'impression que son asthme s'aggrave quand elle va au fitness. Elle signale qu'elle fume de nouveau depuis son arrivée ici.

Une patiente de 28 ans souffrant de problèmes articulaires chroniques se plaint de douleurs aux poignets et a des difficultés à suivre les séances de thérapie manuelle créative. Elle se demande si des séances de kinésithérapie pourraient l'aider comme cela avait été le cas pour des problèmes de genoux.

Un patient dit que des personnes se sont plaintes de sa mauvaise haleine. Il se sent malheureux à ce sujet et se demande s'il y a quelque chose qui ne va pas avec ses dents.

Qui est la première personne de contact, qui est responsable, comment prendre rendez-vous avec un médecin ou une infirmière, comment référer un patient à un spécialiste ?

Les mesures physiques de base ont-elles été effectuées : t°, fréquence respiratoire, fréquence cardiaque, fréquence respiratoire, etc. Qui et comment a-t-on décidé d'aller aux urgences....

Comment s'organise le suivi des médicaments psychiatriques ? Existe-t-il une référence de routine pour des conseils diététiques et de l'exercice ?

Existe-t-il une documentation/demande d'antécédents médicaux au moment de l'admission ; oriente-ton les patients vers un spécialiste pour cesser de fumer ?

Antécédents médicaux ; suivi de la médication ; aiguillage vers un kinésithérapeute

Antécédents médicaux ; suivi de la médication

Accès au dentiste



Dutch version

Hartelijk dank voor uw medewerking aan dit groepsgesprek in het kader van het project "De fysieke zorg bij personen met een ernstige psychiatrische aandoening", onder leiding van het Federaal Kenniscentrum voor de gezondheidszorg. Dit onderzoek wordt uitgevoerd in opdracht van patiëntenorganisaties en professionals.

Mijn naam is ... en ik ben

We nemen aan deze focusgroep deel met 2 KCE-onderzoekers (moderator, verslaggever (neemt nota))-

Het **doel van ons project** is om te begrijpen hoe de somatische gezondheidszorg voor mensen met een ernstige psychiatrische aandoening wordt aangepakt en georganiseerd voor residentiële patiënten, om zo aanbevelingen tot verbetering te kunnen voorstellen.

- Dit gesprek is vertrouwelijk.
- Iedereen respecteert de inbreng van de anderen. We luisteren naar elkaar.
- Iedereen mag reageren op de inbreng van iemand anders.
- Het gesprek wordt opgenomen om de analyse achteraf te vergemakkelijken. De opname wordt na het project gewist. De inhoud van het groepsgesprek wordt geanonimiseerd en in het uiteindelijke rapport zal niets verschijnen dat tot identificatie kan leiden.
- We hebben 3 uur voorzien voor dit gesprek, maar het kan ook sneller klaar zijn.

Check:

- Toestemmingsformulier ontvangen van iedereen? **Vermelden printprobleem**



Vragen	Andere formulering vraag	Thema's	Objectief
Voorstellingsronde: iedereen stelt zich kort voor. Deze studie gaat over de zorg voor lichamelijke gezondheid in residentiële settings (bijv. psychiatrisch ziekenhuis, psychiatrisch verzorgingstehuis, beschut wonen, of psychiatrische afdeling van een algemeen ziekenhuis) Vermeld ook even met welke zorgsetting je ervaring hebt en hoe lang je er verbleven hebt.	Hoe spreken we elkaar aan? Hoe moeten mensen worden genoemd: bewoners, patiënten, gebruikers, klanten?		
EERSTE DEEL : opening			
Voor deze studie willen we graag weten of er voldoende aandacht is voor lichamelijke gezondheidsproblemen in organisaties die sterk gericht zijn op psychische gezondheid, wat er goed loopt, wat er fout loopt. Jullie hebben ervaring met deze organisaties, en dus willen we graag leren uit jullie ervaringen. Jullie mogen persoonlijke ervaringen delen als jullie zich daar goed bij voelen, maar jullie mogen net zo goed vertellen over wat jullie zagen bij andere patiënten, of algemene bedenkingen geven. Dus voel je niet verplicht om persoonlijke antwoorden te geven.			
Ik wil graag al even horen van jullie wat jullie van deze studie vinden. Raken we met deze studie een probleem aan, of valt het allemaal wel mee?	Ben je verbaasd ? Verrast? Nieuwsgierig?		
TWEEDE DEEL: Behoeftte aan somatische zorg			
Als je opgenomen bent voor een psychiatrisch probleem, ben je dan bezig (of wil je dan bezig zijn) met je lichamelijke gezondheid? Heb je dan behoefte aan			



zorgverleners die aandacht hebben voor lichamelijke problemen? **Of is het dan al moeilijk genoeg en wil je dan eigenlijk liever dat ze je niet lastig vallen over lichamelijke gezondheid (bijv. je gewicht, je tandzorg, eetgewoonten, screenings, vaccinaties, etc.)**

DERDE DEEL: aanpak van de zorg

Kan je je een concreet voorbeeld herinneren van een lichamelijke gezondheidsklacht, die je zelf had, of iemand van je medebewoners. Hoe werd dat dan aangepakt? Wat ging er goed, wat ging er fout?

(het kan vanalles zijn: iemand die gevallen is, iemand met hoest, bezorgdheid over gewichtstoename, tandpijn, hoofdpijn, griep, wonde, rugpijn, etc.)

Indien nodig:

In wat volgt wil ik jullie een aantal concrete situaties voorleggen. Misschien zijn het situaties die je herkent of heb zien gebeuren bij anderen. Kunnen jullie mij voor elke situatie zeggen wat je verwacht dat er zal gebeuren en welke moeilijkheden er zich kunnen voordoen?

Een 58-jarige vrouw vindt het moeilijk om vanmorgen te lopen; ze is gisteren gevallen en nu kan ze niet meer steunen op haar rechter been.

Een 62-jarige man voelt zich onwel, heeft een hoest en klaagt dat hij moeilijk kan ademen.

Een 52-jarige man is bezorgd dat hij verdikt sinds zijn medicatie werd verhoogd. Zijn broek past niet meer. Hij vraagt zich ook af of zijn bloeddruk goed is omdat hij daar medicijnen voor gebruikt.

Een 28-jarige vrouw is bezorgd. Haar menstruatie is erg zwaar, meer dan gewoonlijk, en ze heeft buikpijn.

- Wat is er moeilijk voor de bewoner?
- Wat is moeilijk voor zorgverleners?
- Welke andere moeilijkheden zag u nog meer (organisatie, financieel, ...)?

Wie is de eerste contactpersoon; wie heeft de leiding;

hoe wordt een afspraak gemaakt met een arts/verpleegkundige; hoe wordt een patiënt doorverwezen naar een specialist?

Zijn de fysieke basismetingen uitgevoerd: t° , ademhalingsfrequentie, hartslag, ademhalingsfrequentie, etc. Wie en hoe wordt het besloten om naar de spoed te gaan...

Hoe is de opvolging van psychiatrische medicatie georganiseerd; is er een routinematige doorverwijzing voor dieetadvisering en lichaamsbeweging?

Gebeurt er een documentatie / vraag naar medische voorgeschiedenis bij de opname; bestaat er een

Vraag elke keer de plaats van zorg na: (PAAZ, PZ, PVT, BW)
- psychiatrisch ziekenhuis
- psychiatrische afdeling van een algemeen ziekenhuis
- psychiatrische zorginstelling
- beschermd wonen initiatief
+ Specificeer in geval van een meer specifieke locatie: urgentie, kinésithérapie, radiologie, radiologie, enz.



	verwijzing voor het stoppen met roken?	
Afhankelijk van profiel patiënt: In hoeverre denkt u dat de manier waarop de fysieke gezondheidszorg wordt aangepakt, verschilt naar gelang van het type verblijfplaats? NB: Ik heb het hier over het soort plaats (PAAZ, PZ, PVT, BW) en niet over het adres of de naam van de instelling.	Is dit dan een algemeen probleem (voor elke setting hetzelfde) of moeten we telkens aangeven waar het zich voordoet?	De rest van het interview vergemakkelijken en de specifieke kenmerken van elk type verblijf belichten?
Ik zou graag met jullie drie momenten van een verblijf overlopen, nl. opname, verblijf en ontslag. Bij opname, kreeg je dan vragen over je lichamelijke gezondheid? Werd je ook lichamelijk onderzocht (bijv. een bloedafname, werd je gewogen, etc) Kreeg je bij opname uitleg over wat je kon doen als je lichamelijke klachten zou hebben tijdens je verblijf? Wie je dan moest aanspreken? Kon je blijven beroep doen op je eigen huisarts? Kreeg je informatie over hoe je lichamelijke gezondheid zou opgevolgd worden tijdens je verblijf?		Heeft u de contactgegevens van uw huisarts verstrekt? Heeft u een specifiek gesprek gehad met een verzorger over uw gezondheidsproblemen? <i>Controleer elke keer als dit gebeurt de plaats van zorg. (PAAZ, PZ, PVT, BW)</i>
(Check iedere keer de plaats van zorg)		
Werd je tijdens je verblijf opgevolgd voor lichamelijke problemen? Bijv. diabetes of ... Bij wie kon je terecht met lichamelijke problemen? Werd je au-serieus genomen? Werd er tijdens jullie verblijf aandacht besteed aan screenings, dat wil zeggen testen die aan iedereen aangeboden worden, bijv. voor baarmoederhalskanker, of darmkanker) Waren er initiatieven die gericht waren op preventie, bijv. sportactiviteiten, informatiesessies over gezond eten, etc. Ben je op doorverwijzing in contact gekomen met specialisten tijdens je verblijf? Liep dat goed?	Hoe worden patiënten/bewoners/enz. opgevolgd? (Generalist, internist, psychiater, andere?)	Heeft u uw huisarts kunnen behouden? Werd je een huisarts aangeboden als je er geen had?



Ben je tijdens je verblijf in contact gekomen met spoeddiensten? Liep dat goed?**Toen je terug naar huis mocht, kreeg je dan nog informatie mee, of werden er afspraken gemaakt voor opvolging van bepaalde klachten?****Wat liep goed, wat liep fout of kon beter?**

- Hoe wordt de gezondheidsinformatie doorgegeven? Aan wie?
- Is er iets van opvolgbezoek gepland?
- Werd er contact genomen met patiënten organisaties?

Wat zijn voor jou de belangrijkste problemen inzake lichamelijke gezondheidszorg?

- Als je een toverstaf had, welke veranderingen zou je dan aanbrengen?

Wat moet er gebeuren om die problemen aan te pakken?**SITUATIE NAAR KEUZE (als er nog tijd is)****AFSLUITER****Zijn er nog zaken die nog niet aan bod zijn gekomen en je graag zou willen toevoegen?**

Zijn er nog andere kwesties die volgens u moeten worden aangepakt in verband met de fysieke gezondheidszorg?
Zaken die nog niet aan bod gekomen zijn en die u graag zou willen toevoegen?

- Zijn er andere elementen die belangrijk zijn en die we moeten weten?

Controleer elke keer dat dit gebeurt de plaats van zorg (PAAZ, PZ, PVT, BW)

Dank u voor uw deelname. Zoals aangekondigd zal dit interview worden getranscribeerd, geanonimiseerd en geanalyseerd met de interviews van de verschillende mensen die we hebben ontmoet. Indien u ons in de komende weken nog informatie wenst te sturen, aarzel dan niet om ons te contacteren.

Alle resultaten zullen worden gepresenteerd in een verslag dat op de KCE-website wordt gepubliceerd: <https://kce.fgov.be/>.



Presentatie van situaties voor het groepsgesprek met patiënten

Situaties te bespreken door iedereen

Een 58-jarige patiënte vindt het moeilijk om vanmorgen te lopen; ze is gisteren gevallen en nu kan ze niet meer steunen op haar rechter been.

Een 62-jarige patiënt voelt zich onwel, heeft een hoest en klaagt dat hij moeilijk kan ademen.

Een 52-jarige patiënt is bezorgd dat hij verdikt sinds zijn medicatie voor schizofrenie is toegenomen. Zijn broek past niet meer. Hij vraagt zich ook af of zijn bloeddruk goed is omdat hij daar medicijnen voor gebruikt.

Een 28-jarige vrouwelijke patiënt is bezorgd. Haar menstruatie is erg zwaar, meer dan gewoonlijk, en ze heeft buikpijn.

Wie is de eerste contactpersoon; wie heeft de leiding; hoe wordt een afspraak gemaakt met een arts/verpleegkundige; hoe wordt een patiënt doorverwezen naar een specialist?

Zijn de fysieke basismetingen uitgevoerd: t°, ademhalingsfrequentie, hartslag, ademhalingsfrequentie, etc. Wie en hoe wordt het besloten om naar de spoed te gaan...

Hoe is de opvolging van psychiatrische medicatie georganiseerd; is er een routinematige doorverwijzing voor dieetadvisering en lichaamsbeweging?

Gebeurt er een documentatie / vraag naar medische voorgeschiedenis bij de opname; bestaat er een verwijzing voor het stoppen met roken?

Extra situaties om uit te kiezen

Een 52-jarige patiënt met diabetes type II klaagt over koude voeten en tintelingen en gevoelloosheid van zijn tenen. Hij weet niet zeker wanneer hij voor het laatst de specialist in het ziekenhuis heeft gezien voor zijn diabetes

Een 55-jarige patiënt zou graag getest worden voor darmkanker en hepatitis. Hij heeft soms wat buikpijn.

Een patiënte heeft het gevoel dat haar astma oplaait als ze naar de fitnesstherapie gaat. Ze geeft aan dat ze weer aan het roken is sinds ze hier is aangekomen.

Een 28-jarige patiënt met chronische gewrichtsproblemen klaagt over pijn in haar polsen en vindt het moeilijk om de creatieve manuele therapie sessies te volgen. Ze vraagt u of fysiotherapie haar zou helpen zoals ze die eerder had toen haar knieën zich aan het opspelen waren.

Een patiënt zegt dat de mensen rond hem hebben vermeld dat hij een slechte adem heeft. Hij voelt zich daar ongelukkig over en vraagt zich af of er iets mis is met zijn tanden.

Medische voorgeschiedenis; opvolging van medicatie; doorverwijzing voor fysiotherapie

Preventief testen: hoe organiseren?

Medische voorgeschiedenis; opvolging van medicatie; voorschrijven en begeleiden rookstopmedicatie

Medische voorgeschiedenis; opvolging van medicatie; fysiotherapie

Toegang tot de tandarts



APPENDIX 6. RETRIEVED GUIDANCE AND GUIDELINES

Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E	
Australia	Royal Australian and New Zealand College of Psychiatrists	Galletly	2016	Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders	clinical management of schizophrenia and related disorders in Australia and New Zealand		1	0	0	1	1
	Royal Australian and New Zealand College of Psychiatrists	Lambert	2017	Royal Australian and New Zealand College of Psychiatrists expert consensus statement for the treatment, management and monitoring of the physical health of people with an enduring psychotic illness	Provides items for the treatment, management and monitoring of the physical health of people with an enduring psychotic illness with initial assessment checklist, checklist for equipment and support physical examination, Follow-up assessment checklist. Referral is made to ref Galletly guideline		1	0	1	0	0
	Mental Health Commission of NSW	Mental Health Commission of NSW	2016	Physical health and mental wellbeing: evidence guide,	The guide discusses the evidence for comprehensive lifestyle interventions to help improve the physical health of consumers living with severe mental illness. It provides evidence from proven strategies to improve access to physical health services, as well as health promotion, prevention and early intervention for people with coexisting mental and physical health issues. It links policy with evidence for health interventions for Australia.		1	1	1	0	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E	
	New South Wales Government	New South Wales Govern ement	2017	Physical Health Care of Mental Health Consumers	The Guideline recognises the role of mental health services in the physical health care of consumers; clarifies appropriate linkages with other health care providers; proposes the building of stronger partnerships with key stakeholders; and establishes minimum expectations for the physical health care of consumers		1	1	1	0	0
	Government of Western Australia, Mental Health Commission	Stanley	2011	Clinical guidelines for the physical care of mental health consumers: a comprehensive assessment and monitoring package for mental health and primary care clinicians	To implement the guideline into a screening package: the clinical algorithm, the Clinician handbook , the Psychosocial assessment booklet , the screening forms, a Consumer diary , and a Carer handbook .		1	1	1	0	0
	Government of Western Australia, Mental Health Commission	Stanley	2010	Clinical guidelines for the physical care of mental health consumers: report			1	1	1	1	0
	Government of Western Australia, Mental Health Commission	Stanley	2013	Clinical guidelines for the physical care of mental health consumers: Multi- site Service Evaluation Project 2013	describes continuity of care for SMI patient		1	1	1	0	0
		Waterre us	2009	Screening for the metabolic syndrome in patients receiving antipsychotic treatment: a proposed algorithm			1	0	0	0	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E	
Belgium		De Nayer	2005	Belgian consensus on metabolic problems associated with atypical antipsychotics	guidance metabolic syndrome at initiation and follow up of treatment		1	0	0	0	0
Canada	Canadian Psychiatric Association (and Mathison centre for mental health research - ADAPTE proces)	Pringsheim	2017	Physical Health and Drug Safety in Individuals with Schizophrenia	ADAPTE process to adapt existing guideline recommendations from the National Institute for Health and Care Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN) guidelines on the dosing of antipsychotics and antipsychotic polypharmacy, screening for adverse effects of antipsychotics, and management of metabolic and extrapyramidal side effects to the Canadian context.		1	0	0	1	1
	Canadian Network for Mood and Anxiety Treatments (CANMAT) task force	Yatham	2018	Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder	general management guideline with aspect of safety of the medication		0	1	0	1	0
Europe	European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes (EASD) and	De Hert	2009	Cardiovascular disease and diabetes in people with severe mental illness position statement from the European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes (EASD) and the	The intention is to initiate cooperation and shared care between the different healthcare professionals and to increase the awareness of psychiatrists and primary care physicians caring for patients with severe mental illness to screen and treat cardiovascular risk factors and diabetes.		1	1	1	0	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E
	the European Society of Cardiology (ESC)			European Society of Cardiology (ESC)						
	European Psychiatric Association (EPA), supported by the International Organization of Physical Therapists in Mental Health (IOPTMH)	Stubbs	2018	EPA guidance on physical activity as a treatment for severe mental illness: a meta-review of the evidence and Position Statement from the European Psychiatric Association (EPA), supported by the International Organization of Physical Therapists in Mental Health (IOPTMH)	Physical activity (PA) may be therapeutic for people with severe mental illness (SMI) who generally have low PA and experience numerous lifestyle-related medical complications	1	1	1	0	1
France	French Society for Biological Psychiatry and Neuropsychopharmacology and Fondation FondaMental task force	Charpeaud	2017	[French Society for Biological Psychiatry and Neuropsychopharmacology and Fondation FondaMental task force: Formal Consensus for the management of treatment-resistant depression]	treatment focused guideline	0	1	0	0	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E
	Fédération Française de Psychiatrie, Haute Autorité de Santé (Promoteur Fédération Française de Psychiatrie – Conseil National Professionnel de Psychiatrie (FFP-C	Fédérati on Françai se de Psychia trie,	2015	Recommandation de bonne pratique en psychiatrie: Comment améliorer la prise en charge somatique des patients ayant une pathologie psychiatrique sévère et chronique	Comment améliorer la prise en charge somatique des patients ayant une pathologie psychiatrique sévère et chronique		1	1	1	1
	l'Association nationale pour la promotion des soins somatiques en santé mentale	Sarava ne	2009	Élaboration de recommandations pour le suivi somatique des patients atteints de pathologie mentale sévère	Narative review of risk factors in the context of the new antipsychotic medication side effects. The author is co-authorof the French guideline		1	1	1	0
German y		Muhlig	2016	[Psychiatric comorbidities with tobacco-related disorders]	The guideline states that psychiatric patients are motivated to quit, and tobacco cessation is not generally less successful among smokers with mental disorders than among mentally healthy persons. Specific tobacco cessation programmes for psychiatric patients in inpatient and outpatient settings are costly and complex, but effective. Essentially, the same intervention measures should be used for patients with SMI as for mentally healthy persons. However, smokers with mental comorbidity often require psychotherapeutic accompanying		1	1	0	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E
					interventions of higher intensity and often drug support (bupropion, varenicline, nicotine replacement therapy).					
		Pfennig	2013	The diagnosis and treatment of bipolar disorder: recommendations from the current s3 guideline	treatment focused guideline	0	1	0	1	0
	German version: The guideline was prepared under the responsibility of the German Association for Psychiatry, Psychotherapy, and Psychosomatics (DGPPN) and the German Association for Addiction Research and Therapy (DG-Sucht).	Preuss	2016	Psychische Komorbiditäten bei alkoholbedingten Störungen	specific treatment recommendations for comorbid mental diseases in alcohol use disorders.	1	1	0	0	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E	
	English version: The guideline was prepared under the responsibility of the German Association for Psychiatry, Psychotherapy, and Psychosomatics (DGPPN) and the German Association for Addiction Research and Therapy (DG-Sucht).	Preuss	2018	Psychiatric comorbidity in alcohol use disorders: results from the German S3 guidelines	The treatment guideline “Screening, diagnosis and treatment of alcohol use disorders” aims to extend care for patients with risky, harmful, and dependent alcohol use, to improve their quality of life and ultimately, to save lives [1]. Recommendations on diagnostics and treatment are systematically developed for the relevant therapeutic and care teams, affected patients, and their families. These principles should now be established in diagnostic and therapy areas hitherto not adequately covered in previous guidelines, i.e., comorbidity with mental disorders in alcohol dependence.		1	1	0	1	0
International	World psychiatric association	De Hert	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	to give an overview of barriers to care, monitoring and treatment guidelines, plus recommendations at the system and individual level		1	1	1	0	0
	International Society for Bipolar Disorders Task Force for Older Adults with Bipolar Disorder.	Dols	2016	Do current national and international guidelines have specific recommendations for older adults with bipolar disorder? A brief report	compiled and compared recommendations from current national and international guidelines that specifically address geriatric or older individuals with BD (from year 2005 onwards).		0	1	0	0	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E
	International College of Neuropsychopharmacology (CINP)	Fountoulakis	2017	The International College of Neuropsychopharmacology (CINP) Treatment Guidelines for Bipolar Disorder in Adults (CINP-BD-2017), Part 1: Background and Methods of the Development of Guidelines	review and critical analysis of the literature concerning grading methods and methods for the development of guidelines for bipolar disorder in an effort to critically appraise the literature and provide guidance to clinicians in the form of a precise treatment algorithm.	0	1	0	0	0
	International College of Neuropsychopharmacology (CINP)	Fountoulakis	2017	The International College of Neuro-Psychopharmacology (CINP) Treatment Guidelines for Bipolar Disorder in Adults (CINP-BD-2017), Part 3: The Clinical Guidelines	clinical guidelines for the treatment of bipolar disorder	0	1	0	1	0
	World Federation of Societies of Biological Psychiatry (WFSBP)	Hasan	2017	World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for biological treatment of schizophrenia - a short version for primary care	The purpose of this publication is to offer relevant evidence-based recommendations for the biological treatment of schizophrenia in primary care	1	0	0	0	0
	World Federation of Societies of Biological Psychiatry (WFSBP)	Hasan	2013	World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for biological treatment of schizophrenia, part 2: update 2012 on the long-term treatment of schizophrenia and management of antipsychotic-induced side effects	clinical guidelines for the treatment of schizophrenia	1	0	0	1	



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E	
	The International Society for Bipolar Disorders (ISBD)	Ng F	2009	The International Society for Bipolar Disorders (ISBD) consensus guidelines for the safety monitoring of bipolar disorder treatments	These guidelines aim to provide recommendations that take into consideration the balance between safety and cost-effectiveness, to highlight iatrogenic and preventive clinical issues, and to facilitate the broad implementation of therapeutic safety monitoring as a standard component of treatment for bipolar disorder.		0	1	0	0	0
	International Organization of Physical Therapy in Mental Health	Vancampfort	2012	International Organization of Physical Therapy in Mental Health: consensus on physical activity within multidisciplinary rehabilitation programmes for minimising cardio-metabolic risk in patients with schizophrenia	The aim of this paper is to improve physical activity (PA) within rehabilitation programmes for people with schizophrenia. At this meeting the IOPTMH commissioned a workgroup on schizophrenia to develop a consensus position on the following questions: 1. What is the relative contribution of PA in the prevention and treatment of cardio-metabolic risk factors in schizophrenia? 2. What are the major PA participation barriers in patients with schizophrenia? 3. What are the current PA guidelines on minimising cardio-metabolic risk in schizophrenia? 4. How could PA related interventions best be organised within a multidisciplinary lifestyle programme? 5. What research is needed to better understand the relationship between PA levels and cardio-metabolic risk factors in schizophrenia? 6. What actions need to be taken to implement the PA related guidelines in daily practice?	1	0	1	0	1	



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E	
	WHO	WHO	2018	Guidelines for the management of physical health conditions in adults with severe mental disorders	To improve the management of physical health conditions in adults with SMD and support the reduction of individual health behaviours constituting risk factors for these illnesses, with the aim of decreasing morbidity and premature mortality amongst people with SMD. Existing WHO guidelines for the general population are relevant to the physical health conditions that increase the morbidity and mortality for people with SMD. For example, the Package of Essential Noncommunicable (PEN) Disease Interventions for Primary Health Care in Low-Resource Settings Geneva, WHO, 2010 provides guidelines and recommendations for tobacco cessation, weight management, cardiovascular disease prevention including diabetes management and prevention of complications, treatment and prevention of chronic respiratory diseases in the general population. Other WHO guidelines for infectious disease are also relevant such as the Consolidated guidelines on HIV prevention, diagnosis, treatment, and care for key populations. WHO, 2016 update and Guidelines for treatment of drug-susceptible tuberculosis and patient care, 2017 update. WHO, 2017.		1	1	1	1	1



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E
Netherlands	Federatie Medisch Specialisten Nederlandse Internisten Vereniging,	Federatie Medisch Specialisten Nederlandse Internisten Vereniging,	2014	Diabetesbehandeling bij patiënten met een psychiatrische aandoening	From a point of view of the federation of internal medicine, it is expected that the psychiatrist and general practitioner screen the patient with SMI, especially those using antipsychotics, for the development of diabetes mellitus or metabolic syndrome on an annual basis. Patients with SMI and diabetes mellitus should be entitled to regular somatic care appropriate to the condition, namely good diabetes regulation and treatment of the risk factors. General practitioner, internist and psychiatrist have the responsibility to ensure that this happens.	1	1	0	1	0
	Federatie Medisch Specialisten Nederlandse Vereniging voor Psychiatrie	Federatie Medisch Specialisten Nederlandse Vereniging voor Psychiatrie	2015	Richtlijn Psychiatrische Diagnostiek - Wat is de rol van de psychiater bij het somatische onderdeel van de psychiatrische diagnostiek?)	The guidance stipulates to perform a somatic examination within 24 hours of admission of a patient with SMI but in severe illness as soon as possible. The aim is to include the physical state of health of the patient in the integral psychiatric diagnostics, by, sufficiently mapping out somatic factors and involving them in the diagnostics, and remaining alert to changes in somatic factors and the influence these can have on psychiatric diagnostics and vice versa.	1	1	0	1	1
	Trimbos Instituut. Verpleegkundigen & Verzorgenden Nederland (V&VN)/	Meeuwissen	2015	Multidisciplinaire richtlijn Leefstijl bij patiënten met een ernstige psychische aandoening.	The lifestyle guideline recommends to appoint a nurse in the role of case manager to be primarily responsible for the continuity and coordination of lifestyle guidance to the individual patient. Items discussed in the guideline are the following: 1. Nutrition and diet	1	1	1	1	1



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E
	Werkgroep Richtlijnontwik keling Algemene somatische screening & Leefstijl				(including coffee and energy drinks) 2. Exercise and sports 3. Well-being and relaxation (the balance between load and capacity) 4. Drug use (tobacco, alcohol, coffee, non-prescription medication, drugs) 5. Sleeping (day and night rhythm, getting up) 6. Sexual behaviour and STI prevention 7. Hygiene (including oral hygiene).					
	Trimbos Instituut. Verpleegkundi gen & Verzorgenden Nederland (V&VN)/ Werkgroep Richtlijnontwik keling Algemene somatische screening & Leefstijl	Meeuwi ssen	2015	Multidisciplinaire richtlijn 'Somatische screening bij patiënten met een psychische aandoening' • Onderbouwing 'Somatische screening bij patiënten met een psychische aandoening' • Samenvattingskaart multidisciplinair richtlijn 'Somatische screening bij patiënten met een ernstige psychische aandoening'	The screening guideline describes screening instruments and how they should be applied, how often, and how follow-up should be organised. The role of the family and others involved in general somatic screening and medication monitoring mean is described. Conditions for good care in an Institution and what is needed from a team in order to give somatic screening to people with a serious mental disorder, in terms of knowledge, cooperation, coordination and continuity of care	1	1	1	1	1
		Van Hasselt	2014	Practical recommendations for improvement of the physical health care of patients with severe mental illness	The aim of this research project is to develop policy recommendations that can be implemented in everyday practice in order to improve the physical health of severe mental illness patients. These policy recommendations are based on consensus (general agreement) among the major stakeholders: patients, family carers, general practitioners, and mental healthcare professionals	1	1	1	0	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E
	Nederlandse Vereniging voor Psychiatrie.		2012	Nederlandse Vereniging voor Psychiatrie. Multidisciplinaire richtlijn schizofrenie. 2012	The slightly older guideline on schizophrenia stipulates the following recommendations on somatic care: Diagnostic examination for somatoneurological disease and comorbidity should be performed as soon as possible after registration; Somatic screening for cardiovascular risk factors and other side effects during antipsychotic treatment should be performed annually, and in the first year at least after six weeks and three months of institutionalisation; Regionally, the mental health institution should make agreements with general practitioners about the somatic screening for and treatment of risk factors and side effects; Lifestyle, dietetics and smoking cessation interventions are important, provided they are of sufficient duration and intensity; Patients should be supported for somatic screening and treatment by the second or first line, or by family members if necessary; Complements to the annual somatic screening in the non-metabolic domain should be multidisciplinary and vigorous.	1	0	0	1	0
Spain		Bobes-Garcia	2012	Delphi consensus on the physical health of patients with schizophrenia: evaluation of the recommendations of the Spanish Societies of Psychiatry and Biological	A consensus by psychiatrists was made for recommendations on detecting and giving advice on risk factors for cancer (smoking, diet, physical activity, sun exposure, etc), cardiovascular disease, metabolic health, and respiratory disease	1	1	1	0	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E
				Psychiatry by a panel of experts						
		Montejo	2017	Multidisciplinary consensus on the therapeutic recommendations for iatrogenic hyperprolactinemia secondary to antipsychotics	hyperprolactaemia as side effect medication discussed	1	0	0	0	0
United Kingdom	BAP: British Association for Psychopharmacology	Cooper	2016	BAP guidelines on the management of weight gain, metabolic disturbances and cardiovascular risk associated with psychosis and antipsychotic drug treatment	The British Association for Psychopharmacology (BAP) together with the Royal College of Psychiatrists reviewed the evidence for risk factors for cardiovascular and metabolic disorders in people with psychosis, including: assessment of risk factors; the evidence of ongoing failure to monitor relevant risk factors adequately and the evidence relating to suggested strategies for the management of weight gain. Although this guideline originates from a focus of antipsychotic related side effects, it builds on several NICE guidelines to come to comprehensive recommendations on 'monitoring for physical health risk factors', 'interventions for overweight and obesity', 'interventions for smoking and alcohol misuse', 'management of the increased risk for diabetes and cardiovascular disease', and 'service delivery issues'.	1	1	1	1	1



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E
		Shefer	2015	Improving the diagnosis of physical illness in patients with mental illness who present in emergency departments: consensus study	The aim of this study was to establish consensus among clinicians in order to produce recommendations to optimise the diagnosis of physical illness in patients with mental illness who present in Emergency Departments (EDs). Method: A list of recommendations was derived from qualitative interviews conducted with 39 doctors and nurses working in EDs in four general hospitals in England. Using a modified nominal group technique, we then asked a selected group of 15 doctors and nurses to take part in a group discussion with two voting rounds in order to decide which recommendations are most beneficial and feasible. Results: Five recommendations met the a priori criteria to be considered 'strongly supported'. These included: having a psychiatric liaison team staff available 24 hours a day in the vicinity of the ED; developing detailed guidelines regarding intoxicated patients and regarding parallel assessment of patients by both ED and psychiatric staff; and having regular meetings between representatives of both departments. Conclusion: In addition to suggesting specific recommendations, the study stresses the advantages in increasing the accessibility of psychiatric staff in the ED but also identifies challenges regarding joint work and division of responsibilities between them and the ED acute team.	1	1	1	0	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E
	NICE		2014	Psychosis and schizophrenia in adults: prevention and management	The NICE guidelines overarching advice is for people with SMI, especially those taking antipsychotics and long-term medication, to be offered a combined healthy eating and physical activity programme by their mental healthcare provider.	1	0	0	1	0
	NICE		2014	Bipolar disorder: assessment and management	The NICE guidelines overarching advice is for people with SMI, especially those taking antipsychotics and long-term medication, to be offered a combined healthy eating and physical activity programme by their mental healthcare provider.	0	1	0	1	0
	NICE		2016	Coexisting severe mental illness and substance misuse: community health and social care services	If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, all patient factors (medication, mental state, other physical health and lifestyle factors) should be taken into account and interventions offered in line with the NICE guidance on obesity, lipid modification or preventing type2 diabetes.	1	1	0	1	0
	NICE		2011	NICE Clinical Guideline 115. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.	If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, all patient factors (medication, mental state, other physical health and lifestyle factors) should be taken into account and interventions offered in line with the NICE guidance on obesity, lipid modification or preventing type2 diabetes.	0	0	0	1	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E
	NICE		2012	NICE Clinical Guideline 38. Type 2 diabetes: prevention in people at high risk.	If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, all patient factors (medication, mental state, other physical health and lifestyle factors) should be taken into account and interventions offered in line with the NICE guidance on obesity, lipid modification or preventing type2 diabetes.	0	0	0	1	0
	NICE		2014	NICE Clinical Guideline 189. Obesity: identification, assessment and management	If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, all patient factors (medication, mental state, other physical health and lifestyle factors) should be taken into account and interventions offered in line with the NICE guidance on obesity, lipid modification or preventing type2 diabetes.	0	0	0	1	0
	NICE		2014	Cardiovascular disease: risk assessment and reduction, including lipid modification	If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, all patient factors (medication, mental state, other physical health and lifestyle factors) should be taken into account and interventions offered in line with the NICE guidance on obesity, lipid modification or preventing type2 diabetes.	0	0	0	1	0
	NICE		2016	Transition between inpatient mental health settings and community or care health settings	describes continuity of care for SMI patient	1	1	0	1	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E
US	American Diabetes Association	American Diabetes Association	2004	Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes	Because of the close associations between obesity, diabetes, and dyslipidaemia and CVD, there is heightened interest in the relationship between the SGAs and the development of these major CVD risk factors. To gain a better understanding of this relationship, the American Diabetes Association, the American Psychiatric Association, the American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity convened a consensus development conference 19–21 November 2003 on the subject of antipsychotic drugs and diabetes. consensus position on the following questions: 1. What is the current use of antipsychotic drugs? 2. What is the prevalence of obesity, prediabetes, and type 2 diabetes in the populations in which the SGAs are used? 3. What is the relationship between the use of these drugs and the incidence of obesity or diabetes? 4. Given the above risks, how should patients be monitored for the development of significant weight gain, dyslipidemia, and diabetes, and how should they be treated if diabetes develops? 5. What research is needed to better understand the relationship between	1	0	0	0	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E
					these drugs and significant weight gain, dyslipedemia, and diabetes?					
	American Diabetes Association	American Diabetes Association	2020	3. Prevention or Delay of Type 2 Diabetes: Standards of Medical Care in Diabetes—2020	Recommendations for: Those who are determined to be at high risk for type 2 diabetes, including people with A1C 5.7–6.4% (39–47 mmol/mol), impaired glucose tolerance, or impaired fasting glucose, are ideal candidates for diabetes prevention efforts.	0	0	0	1	0
	American Diabetes Association	American Diabetes Association	2020	8. Obesity Management for the Treatment of Type 2 Diabetes: Standards of Medical Care in Diabetes—2020	The goal of this section is to provide evidence-based recommendations for weight-loss therapy, including diet, behavioral, pharmacologic, and surgical interventions, for obesity management as treatment for hyperglycemia in type 2 diabetes.	0	0	0	1	0
	APA: American Psychiatric Association	Druss	2018	Psychiatry's Role in Improving the Physical Health of Patients With Serious Mental Illness: A Report From the American Psychiatric Association	In 2016, the American Psychiatric Association (APA) Committee on Integrated Care convened an expert panel to address Psychiatry's role in improving the physical health of patients with SMI.	1	1	1	0	0
		Perron	2010	Treatment guidelines for substance use disorders and serious mental illnesses: do they address co-occurring disorders?	Using a public open-access database of treatment guidelines, this study examined the extent to which current guidelines targeting either SUDs or SMIs also addressed co-occurring disorders.	1	1	0	0	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E	
		Sowers	2016	Recommendations for Primary Care Provided by Psychiatrists	This paper examines the role of psychiatrists in the provision of primary care to the patients they treat. Some recommendations are offered for their involvement in the provision of primary care at three levels of complexity: Level 1—Universal Basic Psychiatric Primary Care; Level 2—Enhanced Psychiatric Primary Care; and Level 3— Fully Integrated Primary Care and Psychiatric Management. Some of the obstacles to the provision of primary care by psychiatrists are considered along with some suggestions for overcoming them.		1	1	1	0	0
	American Association for Emergency Psychiatry	Wilson	2017	American Association for Emergency Psychiatry Task Force on Medical Clearance of Adult Psychiatric Patients. Part II: Controversies over Medical Assessment, and Consensus Recommendations	task force on medical examinations of psychiatric patients presenting to EDs. The purpose of this task force was to examine the existing evidence, synthesize it into cohesive guidelines, and examine areas for future research in the areas of emergency medicine (EM) and emergency psychiatry. There are a number of current areas of controversy in the emergency medical examinations of psychiatric patients: -defining adequate medical examination for psychiatric patients; -outlining the role of routine laboratory testing, including urine drug screens and medical algorithms- reviewing the standards of the capabilities of psychiatric receiving facilities.		1	1	1	0	0



Country	Organisation	Author	Year	Title	Aim - scope	schizop hrenia	bipolar	Primary Focus somatic care	Guide line	A G R E E	
Sweden	These guidelines were composed in collaboration between representatives of the Swedish Psychiatric Association, the Swedish Association of Child and Adolescent Psychiatry, the Swedish Association of Family Medicine, the Swedish Association of Diabetology, the Swedish Society of Internal Medicine, the Swedish Society of Cardiology, and the Swedish Association for the Study of Obesity.	Gothefors	2010	Swedish clinical guidelines -prevention and management of metabolic risk in patients with severe psychiatric disorders	The object for these guidelines has been to formulate concrete and practically useful principles for the prevention, detection and management of metabolic derangements by any mental healthcare provider.		1	1	1	0	0





APPENDIX 7. AGREE II EVALUATION SCORE

The AGREE II evaluation score was used to critically appraise guidelines retrieved.

Critical appraisal of clinical practice guidelines - AGREE II

Domain 1. Scope and Purpose

1. The overall objective(s) of the guideline is (are) specifically described.
2. The health question(s) covered by the guideline is (are) specifically described.
3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.

Domain 2. Stakeholder Involvement

4. The guideline development group includes individuals from all the relevant professional groups.
5. The views and preferences of the target population (patients, public, etc.) have been sought.
6. The target users of the guideline are clearly defined.

Domain 3. Rigour of Development

7. Systematic methods were used to search for evidence.
8. The criteria for selecting the evidence are clearly described.
9. The strengths and limitations of the body of evidence are clearly described.
10. The methods for formulating the recommendations are clearly described.
11. The health benefits, side effects, and risks have been considered in formulating the recommendations.
12. There is an explicit link between the recommendations and the supporting evidence.
13. The guideline has been externally reviewed by experts prior to its publication.
14. A procedure for updating the guideline is provided.

Domain 4. Clarity of Presentation

15. The recommendations are specific and unambiguous.
16. The different options for management of the condition or health issue are clearly presented.
17. Key recommendations are easily identifiable.

Domain 5. Applicability

**Critical appraisal of clinical practice guidelines - AGREE II**

- 18. The guideline describes facilitators and barriers to its application.
- 19. The guideline provides advice and/or tools on how the recommendations can be put into practice.
- 20. The potential resource implications of applying the recommendations have been considered.
- 21. The guideline presents monitoring and/ or auditing criteria.

Domain 6. Editorial Independence

- 22. The views of the funding body have not influenced the content of the guideline.
- 23. Competing interests of guideline development group members have been recorded and addressed.



APPENDIX 8. AGREE II SCORES OF RETRIEVED GUIDELINES AND CONSENSUS GUIDANCE

Author Country/ Organisation	Title	Standardised Score /100						Final Appraisal /10	Inclusion / exclusion
		Scope	Stakeholder involvement	Rigour of development	Clarity	Applicability	Editorial Independence		
WHO²	Guidelines for the management of physical health conditions in adults with severe mental disorders - 2018	100	83	100	89	100	100	9.5	Included
Vancampfort - IOPTMH¹⁶⁰	International Organization of Physical Therapy in Mental Health: consensus on physical activity within multidisciplinary rehabilitation programmes for minimising cardio-metabolic risk in patients with schizophrenia - 2012	89	33	60	50	38	100	6.2	Excluded
Stubbs – EPA - IOPTMH¹⁵⁹	EPA guidance on physical activity as a treatment for severe mental illness: a meta-review of the evidence and Position Statement from the European Psychiatric Association (EPA), supported by the International Organization of Physical Therapists in Mental Health (IOPTMH) - 2018	100	44	83	83	50	92	7.5	Included
Pringsheim - Canadian Psychiatric Association¹⁷⁵	Physical Health and Drug Safety in Individuals with Schizophrenia - 2017	100	100	69	89	50	83	8.2	Included
Meeuwissen - Verpleegkundigen & Verzorgenden	Multidisciplinaire richtlijn 'Somatische screening bij patiënten met een psychische aandoening' - 2015	100	100	65	78	83	58	8.1	Included



Nederland (V&VN) ¹⁵⁶									
Meeuwissen - Verpleegkundigen & Verzorgenden Nederland (V&VN) ¹⁵⁵	Multidisciplinaire richtlijn Leefstijl bij patiënten met een ernstige psychische aandoening. - 2015	100	100	65	78	83	58	8.1	Included
Galletly ¹⁷⁶	Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders - 2016	94	100	46	100	63	92	8.2	Included
Firth ³	The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness - 2019	89	89	58	83	79	67	7.8	Included
Fédération Française de Psychiatrie ¹⁵⁷	Recommandation de bonne pratique en psychiatrie: Comment améliorer la prise en charge somatique des patients ayant une pathologie psychiatrique sévère et chronique - 2015	78	83	50	61	79	100	7.5	Included
Federatie Medisch Specialisten Nederlandse Vereniging voor Psychiatrie ¹⁷⁷	Richtlijn Psychiatrische Diagnostiek - Wat is de rol van de psychiater bij het somatische onderdeel van de psychiatrische diagnostiek? - 2015	100	67	48	78	79	100	7.9	Included
Cooper - British Association for Psychopharmacology ¹⁰¹	BAP guidelines on the management of weight gain, metabolic disturbances and cardiovascular risk associated with psychosis and antipsychotic drug treatment - 2016	100	61	56	89	79	83	7.8	Included



APPENDIX 9. CATEGORIES OF EVIDENCE AND STRENGTH OF RECOMMENDATIONS USED BY GUIDELINES

Organisation - author	Title	
WHO²	Guidelines for the management of physical health conditions in adults with severe mental disorders - 2018	The GDG considered the relevance of the recommendations for people with SMD based on the GRADE-DECIDE framework (AlonsoCoello et al., 2016). When making a strong recommendation, the GDG was confident that the desirable effects of the intervention outweigh any undesirable effects. When the GDG was uncertain about the balance between the desirable and undesirable effects, the GDG issued a conditional recommendation. Strong recommendations imply that most individuals would want the intervention and should receive it while conditional recommendations imply that different choices may be appropriate for individual people and they may require assistance at arriving at management decisions. The GDG members reached an unanimous agreement on all the recommendations and ratings. The Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology (Guyatt et al., 2011) was used to develop the evidence profiles as well as the WHO Handbook for Guideline Development. The quality assessment of the evidence was performed according to GRADE considering study design (randomized controlled trials or observational studies), risk of bias, inconsistency, indirectness, imprecision and risk of reporting bias. Evidence was characterised as either high, moderate, low or very low. The evidence profiles are available at the WHO website (http:// www.who.int/mental_health/evidence/guidelines_physical_health_and_severe_mental_disorders/en/index.html). In addition to recommendations, best practice statements were formulated which did not rely on systematic reviews of the evidence but rather on good clinical care and were consensus-based from the GDG
Canadian Psychiatric Association¹⁷⁵	Physical Health and Drug Safety in Individuals with Schizophrenia - 2017	The Canadian Schizophrenia Guidelines were developed using the ADAPTE process (The ADAPTE Collaboration. The ADAPTE process: resource toolkit for guideline adaptation. Version 2.0. 2009 [accessed January 1, 2015]. Available from: http://www.g-i-n.net). The guidelines chosen for adaptation scored between

**Organisation - author Title**

75% and 92% in the AGREE II overall guideline assessment:

Table 1. Clinical Practice Guidelines Used for the Canadian Schizophrenia Guidelines.

Guideline Developer	Guideline Title	Year Published
National Collaborating Centre for Mental Health Commissioned by the National Institute for Health and Care Excellence (NICE)	NICE National Clinical Guideline Number 178. Psychosis and Schizophrenia in Adults: Treatment and Management ⁹	2014
National Collaborating Centre for Mental Health Commissioned by the National Institute for Health and Care Excellence (NICE)	NICE National Clinical Guideline Number 155. Psychosis and Schizophrenia in Children and Young People: Recognition and Management ¹⁰	2013
National Collaborating Centre for Mental Health Commissioned by the National Institute for Health and Care Excellence (NICE)	NICE National Clinical Guideline Number 120. Psychosis with Coexisting Substance Misuse: Assessment and Management in Adults and Young People ¹¹	2011
Scottish Intercollegiate Guidelines Network (SIGN)	SIGN 131. Management of Schizophrenia ¹²	2013
European Psychiatric Association	European Psychiatric Association Guidance on the Early Intervention in Clinical High Risk States of Psychoses ¹³	2015
American Psychiatric Association	American Psychiatric Association Practice Guidelines for Psychiatric Assessment of Adults ¹⁴	2016

After reviewing the recommendations from the guidelines, the working groups decided which recommendations to accept and which to reject, as well as which recommendations were acceptable but needed to be modified (e.g., new data may be added to the original recommendation, or the wording might be changed to better reflect the Canadian context). Care was taken when modifying existing recommendations not to change the recommendations to such an extent that they were no longer in keeping with the evidence upon which they were based. Each chapter includes an appendix of how and why recommendations were modified from their original form. Common reasons for modification included when terminology or referral resources differed between the United Kingdom and Canada. The working groups also created de novo recommendations in situations where it was felt a recommendation was needed but none of the existing guidelines provided recommendations addressing the situation or topic. When de novo recommendations were created, the SIGN methodology was followed for the levels of evidence and the grades of recommendation (see Table 2 below).

**Organisation - author Title****Table 2.** Grade/Strength of Recommendation Classification Systems for Included Guidelines.^a

Guideline Developer	Grade/Strength of Recommendation System
NICE	Strength of recommendations Some recommendations can be made with more certainty than others. The Guideline Development Group makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the Guideline Development Group is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation). For all recommendations, NICE expects that there is discussion with the patient about the risks and benefits of the interventions and their values and preferences. This discussion aims to help them to reach a fully informed decision. Interventions that must (or must not) be used We usually use 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally we use 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening. Interventions that should (or should not) be used—a 'strong' recommendation We use 'offer' (and similar words such as 'refer' or 'advise') when we are confident that, for the vast majority of patients, an intervention will do more good than harm and be cost-effective. We use similar forms of words (for example, 'Do not offer...') when we are confident that an intervention will not be of benefit for most patients. Interventions that could be used We use 'consider' when we are confident that an intervention will do more good than harm for most patients and be cost-effective, but other options may be similarly cost-effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values and preferences than for a strong recommendation, and so the health care professional should spend more time considering and discussing the options with the patient.
SIGN	Levels of Evidence 1++ High-quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias 1+ Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias 1- Meta-analyses, systematic reviews, or RCTs with a high risk of bias 2++ High-quality systematic reviews of case control or cohort studies, or high-quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal 2+ Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal 2- Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal 3 Nonanalytic studies (e.g., case reports, case series) 4 Expert opinion Grades of Recommendation A: At least 1 meta-analysis, systematic review, or RCT rated as 1++ and directly applicable to the target population, or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results B: A body of evidence including studies rated as 2++, directly applicable to the target population and demonstrating overall consistency of results, or extrapolated evidence from studies rated as 1++ or 1+ C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results, or extrapolated evidence from studies rated as 2++ D: Evidence level 3 or 4 or extrapolated evidence from studies rated as 2+ Good Practice Points: Recommended best practice based on the clinical experience of the guideline development group

**Organisation - author Title**

European Psychiatric Association	Uses same system as SIGN (see row above)
American Psychiatric Association	Rating the Strength of Supporting Research Evidence In accordance with the Methods Guide of the Agency for Healthcare Research and Quality, the ratings are defined as follows: High (denoted by the letter A) = High confidence that the evidence reflects the true effect. Further research is very unlikely to change our confidence in the estimate of effect. Moderate (denoted by the letter B) = Moderate confidence that the evidence reflects the true effect. Further research may change our confidence in the estimate of effect and may change the estimate. Low (denoted by the letter C) = Low confidence that the evidence reflects the true effect. Further research is likely to change our confidence in the estimate of effect and is likely to change the estimate.

(continued)

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Table 2. (continued)

Guideline Developer	Grade/Strength of Recommendation System
	Rating the Strength of Recommendations Each guideline statement is separately rated to indicate strength of recommendation and strength of supporting research evidence. "Strength of recommendation" describes the level of confidence that potential benefits of an intervention outweigh potential harms. This level of confidence is informed by available evidence, which includes evidence from clinical trials as well as expert opinion and patient values and preferences. As described under "Guideline Development Process," the rating is a consensus judgment of the authors of the guideline and is endorsed by the APA Board of Trustees. There are two possible ratings: recommendation or suggestion. These correspond to ratings of "strong" or "weak" (also termed "conditional") as defined under the GRADE method for rating recommendations in clinical practice guidelines. "Recommendation" indicates confidence that the benefits of the intervention clearly outweigh harms. "Suggestion" indicates uncertainty (i.e., the balance of benefits and harms is difficult to judge or either the benefits or the harms are unclear).

*NICE, National Institute for Health and Care Excellence; RCT, randomised controlled trial; SIGN, Scottish Intercollegiate Guidelines Network.



Organisation - author	Title															
Royal Australian and New Zealand College of Psychiatrists ¹⁷⁶	Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders - 2016	Table 1. NHMRC levels of evidence for intervention studies. <table><tr><th>Level</th><th>Design</th></tr><tr><td>I</td><td>A systematic review of level II studies</td></tr><tr><td>II</td><td>A randomised controlled trial</td></tr><tr><td>III-1</td><td>A pseudo-randomised controlled trial (i.e. alternate allocation or some other method)</td></tr><tr><td>III-2</td><td>A comparative study with concurrent controls: • Non-randomised, experimental trial • Cohort study • Case-control study • Interrupted time series with a control group </td></tr><tr><td>III-3</td><td>A comparative study without concurrent controls: • Historical control study • Two or more single-arm studies • Interrupted time series without a parallel control group </td></tr><tr><td>IV</td><td>Case series with either post-test or pre-test/post-test outcomes</td></tr></table> Source: National Health and Medical Research Council (NHMRC, 2009b). Evidence-based recommendations (EBRs) were formulated when the working group judged that there was sufficient evidence on a topic. For each EBR, the number indicates the level of evidence on which the recommendation was based. Where evidence was weak or lacking, consensus-based recommendations (CBRs) were formulated. CBRs are based on the consensus of a group of experts in the field and are informed by their agreement as a group, according to their collective clinical and research knowledge and experience. Where applicable, key considerations were selected from the recommendations on each topic. The whole working group reviewed the entire manuscript, and discussion occurred via a series of teleconferences. Where members disagreed about clinical advice or interpretation of evidence, the issue was discussed until consensus was reached.	Level	Design	I	A systematic review of level II studies	II	A randomised controlled trial	III-1	A pseudo-randomised controlled trial (i.e. alternate allocation or some other method)	III-2	A comparative study with concurrent controls: • Non-randomised, experimental trial • Cohort study • Case-control study • Interrupted time series with a control group	III-3	A comparative study without concurrent controls: • Historical control study • Two or more single-arm studies • Interrupted time series without a parallel control group	IV	Case series with either post-test or pre-test/post-test outcomes
Level	Design															
I	A systematic review of level II studies															
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IV	Case series with either post-test or pre-test/post-test outcomes															
Verpleegkundigen & Verzorgenden Nederland ¹⁵⁶	Multidisciplinaire richtlijn 'Somatische screening bij patiënten met een	The recommendations follow from the conclusions and other considerations. The conclusions are in turn based on the available scientific evidence. This is a broad concept. Evidence includes not only scientific evidence, but also consensus on the subject in practice and patients' preferences. In addition to the latter two, other so-called														



Organisation - author	Title	
	psychische aandoening' - 2015	'other considerations' are also important. These include issues such as health gains, side effects, risks and organisational aspects. Recommendations are therefore based on the scientific literature, the practical knowledge of care providers, the preferences of clients and other considerations. On the basis of the described literature and conclusions, members of the study group entered into discussions and formulated other considerations and recommendations under the guidance of the project group. These recommendations provide answers to the starting questions. The starting point was in advance, partly on the basis of the bottleneck analysis in the first phase, that there would be limited scientific support for the subjects mentioned.
Verpleegkundigen & Verzorgenden Nederland¹⁵⁵	Multidisciplinaire richtlijn Leefstijl bij patiënten met een ernstige psychische aandoening. - 2015	The recommendations follow from the conclusions and other considerations. The conclusions are in turn based on the available scientific evidence. This is a broad concept. Evidence includes not only scientific evidence, but also consensus on the subject in practice and patients' preferences. In addition to the latter two, other so-called 'other considerations' are also important. These include issues such as health gains, side effects, risks and organisational aspects. Recommendations are therefore based on the scientific literature, the practical knowledge of care providers, the preferences of clients and other considerations. On the basis of the described literature and conclusions, members of the study group entered into discussions and formulated other considerations and recommendations under the guidance of the project group. These recommendations provide answers to the starting questions. The starting point was in advance, partly on the basis of the bottleneck analysis in the first phase, that there would be limited scientific support for the subjects mentioned.
Federatie Medisch Specialisten Nederlandse Vereniging voor Psychiatrie¹⁷⁷	Richtlijn Psychiatrische Diagnostiek - Wat is de rol van de psychiater bij het somatische onderdeel van de psychiatrische diagnostiek? - 2015	The initiative for this directive comes from the Dutch Association for Psychiatry (NVvP). The guideline was drawn up by a working group consisting of psychiatrists. During the development of the guideline, patients were asked in a focus group meeting about points they considered important.
The Lancet Psychiatry Commission³	The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness - 2019	



Organisation - author

Title

British Association for Psychopharmacology¹⁰¹

BAP guidelines on the management of weight gain, metabolic disturbances and cardiovascular risk associated with psychosis and antipsychotic drug treatment - 2016

Table 1. Categories of evidence and strength of recommendations.

Categories of evidence for causal relationships and treatment

Ia: evidence from meta-analysis of randomised controlled trials

Ib: evidence from at least one randomised controlled trial

IIa: evidence from at least one controlled study without randomisation

IIb: evidence from at least one other type of quasi-experimental study

III: evidence from non-experimental descriptive studies, such as comparative studies, correlation studies and case-control studies

IV: evidence from expert committee reports or opinions and/or clinical experience of respected authorities

Proposed categories of evidence for observational relationships

I: evidence from large representative population samples

II: evidence from small, well-designed, but not necessarily representative samples

III: evidence from non-representative surveys, case reports

IV: evidence from expert committee reports or opinions and/or clinical experience of respected authorities

Strength of recommendation

A Directly based on category I evidence from meta-analysis of randomised controlled trials, at least one large, good quality, randomised controlled trial or replicated, smaller, randomised controlled trials

B Directly based on category II evidence from meta-analysis of randomised controlled trials, at least one large, good quality, randomised controlled trial or replicated, smaller, randomised controlled trials, or extrapolated^a recommendation from category I evidence

C Directly based on category III evidence from non-experimental descriptive studies, such as uncontrolled, comparative, correlation and case-control studies, or extrapolated recommendation from category I or II evidence

D Directly based on category IV evidence from expert committee reports or opinions and/or clinical experience of respected authorities, or extrapolated^a recommendation from category I, II or III evidence

S Standard of good practice

^aExtrapolation may be necessary because of evidence that is only indirectly related, covers only a part or the area of practice under consideration, has methodological problems or is contradictory.



Organisation - author	Title																		
Fédération Française de Psychiatrie ¹⁵⁷	Recommandation de bonne pratique en psychiatrie: Comment améliorer la prise en charge somatique des patients ayant une pathologie psychiatrique sévère et chronique - 2015																		
<table><tr><th colspan="2">Grade des recommandations</th></tr><tr><td></td><td>Preuve scientifique établie</td></tr><tr><td>A</td><td>Fondée sur des études de fort niveau de preuve (niveau de preuve 1) : essais comparatifs randomisés de forte puissance et sans biais majeur ou méta-analyse d'essais comparatifs randomisés, analyse de décision basée sur des études bien menées</td></tr><tr><td></td><td>Présomption scientifique</td></tr><tr><td>B</td><td>Fondée sur une présomption scientifique fournie par des études de niveau intermédiaire de preuve (niveau de preuve 2), comme des essais comparatifs randomisés de faible puissance, des études comparatives non randomisées bien menées, des études de cohorte</td></tr><tr><td></td><td>Faible niveau de preuve</td></tr><tr><td>C</td><td>Fondée sur des études de moindre niveau de preuve, comme des études cas-témoins (niveau de preuve 3), des études rétrospectives, des séries de cas, des études comparatives comportant des biais importants (niveau de preuve 4).</td></tr><tr><td></td><td>Accord d'experts</td></tr><tr><td>AE</td><td>En l'absence d'études, les recommandations sont fondées sur un accord entre experts du groupe de travail, après consultation du groupe de lecture. L'absence de gradation ne signifie pas que les recommandations ne sont pas pertinentes et utiles. Elle doit, en revanche, inciter à engager des études complémentaires.</td></tr></table>		Grade des recommandations			Preuve scientifique établie	A	Fondée sur des études de fort niveau de preuve (niveau de preuve 1) : essais comparatifs randomisés de forte puissance et sans biais majeur ou méta-analyse d'essais comparatifs randomisés, analyse de décision basée sur des études bien menées		Présomption scientifique	B	Fondée sur une présomption scientifique fournie par des études de niveau intermédiaire de preuve (niveau de preuve 2), comme des essais comparatifs randomisés de faible puissance, des études comparatives non randomisées bien menées, des études de cohorte		Faible niveau de preuve	C	Fondée sur des études de moindre niveau de preuve, comme des études cas-témoins (niveau de preuve 3), des études rétrospectives, des séries de cas, des études comparatives comportant des biais importants (niveau de preuve 4).		Accord d'experts	AE	En l'absence d'études, les recommandations sont fondées sur un accord entre experts du groupe de travail, après consultation du groupe de lecture. L'absence de gradation ne signifie pas que les recommandations ne sont pas pertinentes et utiles. Elle doit, en revanche, inciter à engager des études complémentaires.
Grade des recommandations																			
	Preuve scientifique établie																		
A	Fondée sur des études de fort niveau de preuve (niveau de preuve 1) : essais comparatifs randomisés de forte puissance et sans biais majeur ou méta-analyse d'essais comparatifs randomisés, analyse de décision basée sur des études bien menées																		
	Présomption scientifique																		
B	Fondée sur une présomption scientifique fournie par des études de niveau intermédiaire de preuve (niveau de preuve 2), comme des essais comparatifs randomisés de faible puissance, des études comparatives non randomisées bien menées, des études de cohorte																		
	Faible niveau de preuve																		
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European Psychiatric Association ¹⁵⁹	EPA guidance on physical activity as a treatment for severe mental illness: a meta-review of the evidence and Position Statement from the European Psychiatric Association (EPA), supported by the International Organization of Physical Therapists in Mental Health (IOPTMH) - 2018																		

B. Stubbs et al./European Psychiatry 54 (2018) 124–144		127
Table 1 Grading of evidence in accordance with SIGN (2011 (and adapted from [24])).		
Grade	Description	
1 ++	High-quality meta-analyses, systematic reviews of RCTs or RCTs with a very low risk of bias	
1 +	Well-conducted meta-analyses, systematic reviews or RCTs with a low risk of bias	
1 – ^a	Meta-analyses, systematic reviews or RCTs with a high risk of bias	
2 ++	High-quality systematic reviews of case control or cohort studies. High-quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal	
2 +	Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal	
2 – ^a	Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal	
3	Nonanalytic studies, e.g. case reports, case series	
4	Expert opinion	

Table 2 Grading of recommendations, modified from the SIGN (2011) and adopted from [66].	
Grade	Description
A	At least one meta-analysis, systematic review, or other study rated at low risk of bias
B	A body of evidence including studies rated as 2, directly applicable to the target population, and demonstrating overall consistency of results; or extrapolated evidence from studies rated as I or II
C	A body of evidence including studies rated as II–III, directly applicable to the target population and demonstrating overall consistency of results.
D	Good practice point recommended good practice based on the clinical experience of the Guidance development group and arrived at through consensus

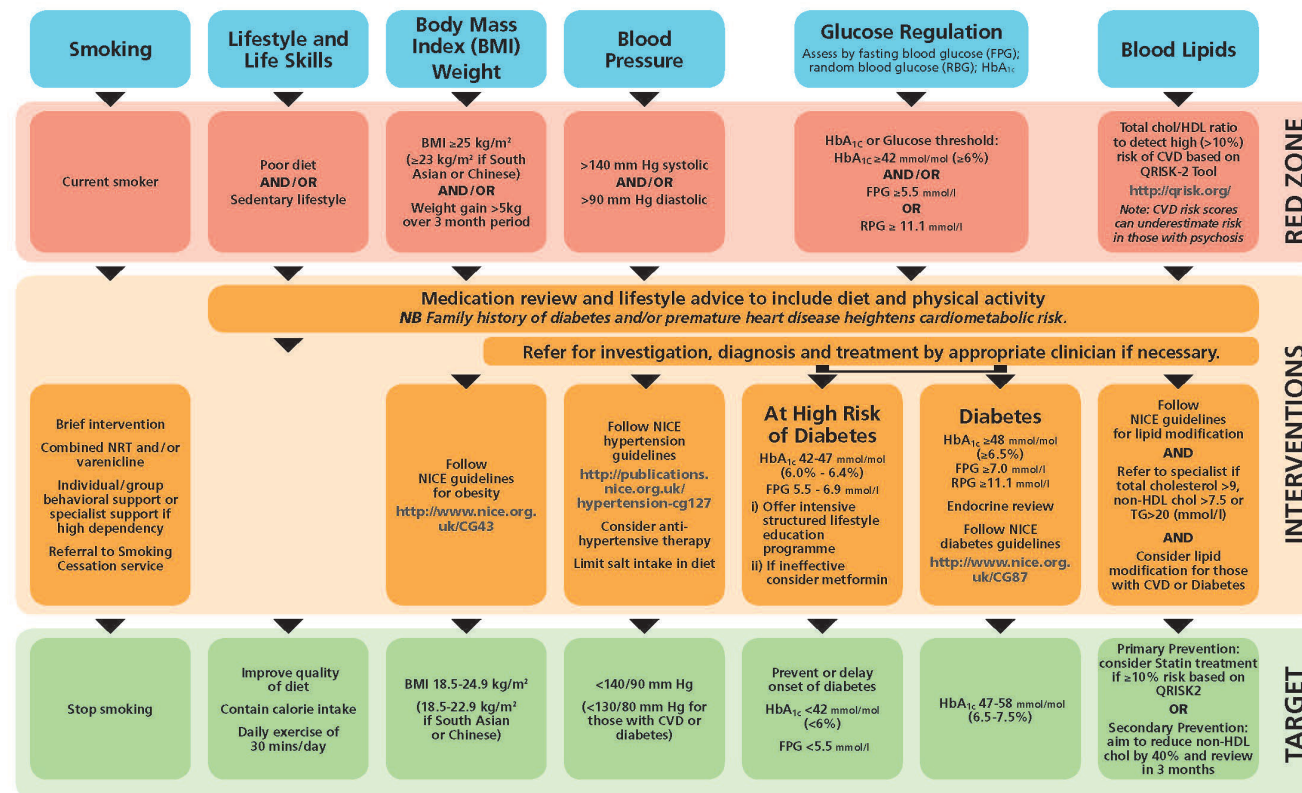


APPENDIX 10. ALGORITHM FOR CARDIOVASCULAR RISK FACTORS

Lester UK Adaptation | 2014 update

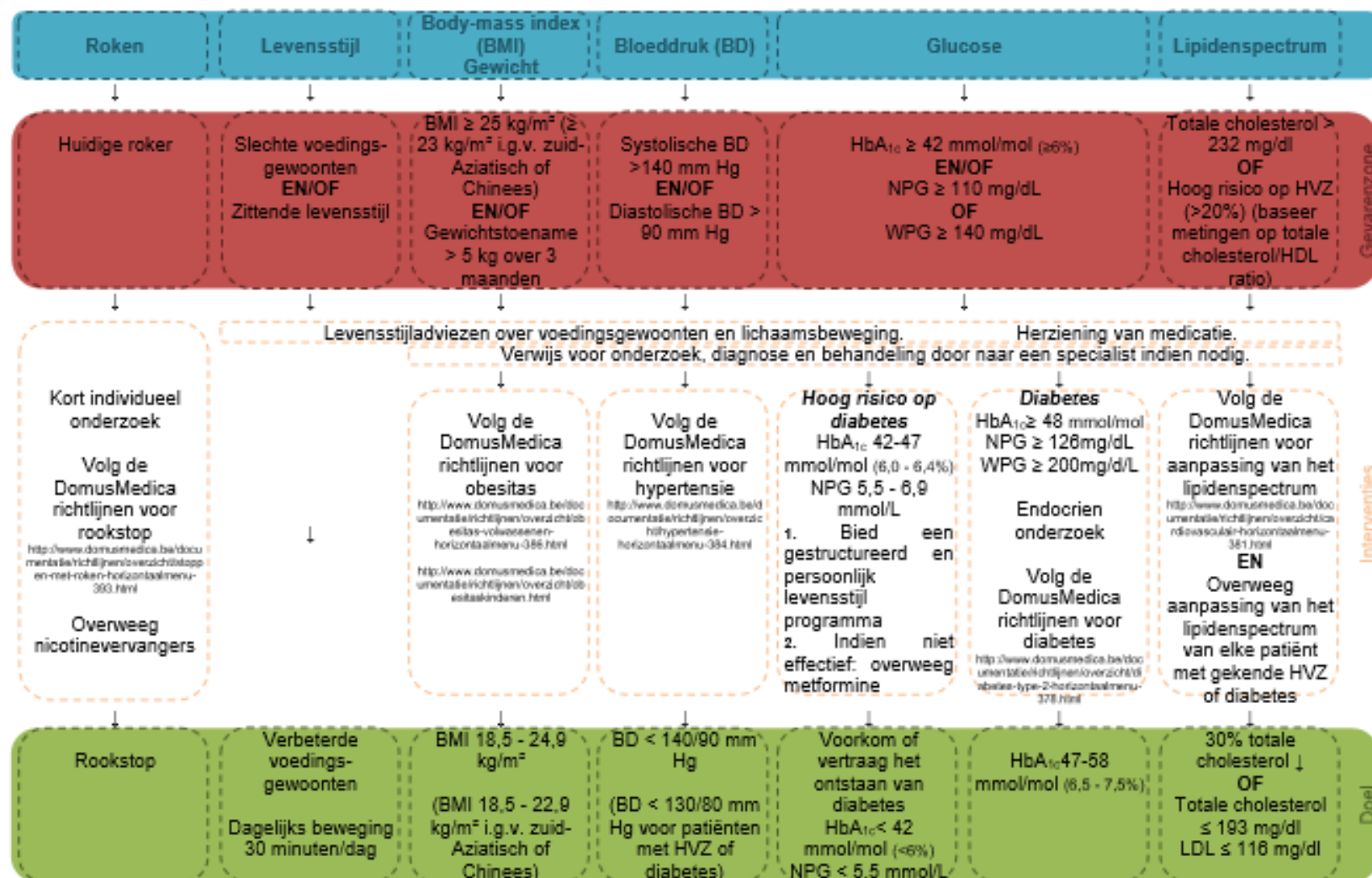
Positive Cardiometabolic Health Resource

An **intervention framework** for people experiencing **psychosis** and **schizophrenia**



FPG = Fasting Plasma Glucose | RPG = Random Plasma Glucose | BMI = Body Mass Index | Total Chol = Total Cholesterol | HDL = High Density Lipoprotein | TRIG = Triglycerides

Shiers DE, Rafi I, Cooper SJ, Holt RIG. 2014 update (with acknowledgement to the late Helen Lester for her contribution to the original 2012 version) Positive Cardiometabolic Health Resource: an intervention framework for patients with psychosis and schizophrenia. 2014 update. Royal College of Psychiatrists, London. https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/ncap-library/ncap-e-version-nice-endorsed-lester-uk-adaptation.pdf?sfvrsn=39bab4_2



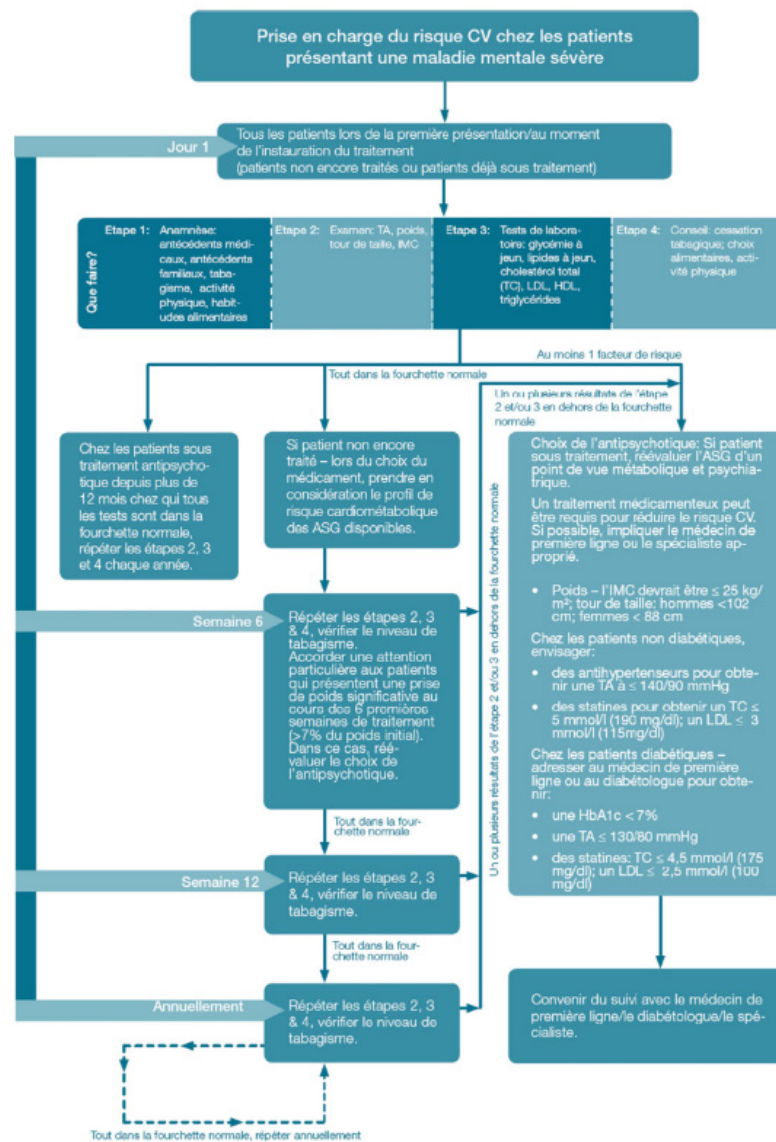


Figure 2 from De Hert, M., Dekker, J. M., Wood, D., Kahl, K. G., Holt, R. I., & Möller, H. J. (2010). *Maladie cardiovasculaire et diabète chez les sujets souffrant d'une maladie mentale sévère. Déclaration de position de l'European Psychiatric Association (EPA), soutenue par l'European Association for the Study of Diabetes (EASD) et l'European Society of Cardiology (ESC).* Eur Psychiatry. doi:10.1016/j.eurpsy.2010.08.001



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