Practical recommendations for improvement of the physical health care of patients with severe mental illness

van Hasselt FM, Oud MJT, Loonen AJM. Practical recommendations for improvement of the physical health care of patients with severe mental illness.

Objective: Health care for the physical health of patients with severe mental illness (SMI) needs to be improved. Therefore, we aimed to develop policy recommendations to improve this physical health care in the Netherlands based on consensus (general agreement) between the major stakeholders.

Method: A modified Delphi was used to explore barriers and subsequently establish policy recommendations with all key stakeholders. Consensus was sought between patients with SMI, their family carers, general practitioners, and mental healthcare professionals – all experts in the everyday practice of health care.

Results: Consensus was reached on policy recommendations regarding (i) improvements in collaboration between healthcare professionals, (ii) the need for professional education on the specific medical risks of patients with SMI, and (iii) the distinguished responsibilities of general practitioners on the one hand and mental healthcare professionals on the other hand in taking care of patients’ physical health.

Conclusion: This article provides a range of policy recommendations that could lead to considerable improvements in the physical health of SMI patients.

Significant outcomes

There is consensus that to improve physical health care:

- General practitioners should retain an overview of the patient’s health state and are responsible for prevention and treatment of somatic illness and the general process of the physical health care.
- Mental healthcare professionals should assess the capabilities of patients with SMI to look after themselves and to organize health care when necessary.
- Collaboration between professionals needs to be improved, for instance by exchange of direct phone numbers.

Limitations

- Qualitative research studies the opinions of stakeholders in a specific situation and country, in our case the Netherlands. However, the barriers that we have detected are similar to the internationally recognized barriers, suggesting that the findings of this study could serve as an important starting point for future recommendations in other countries and healthcare systems as well.
- This research was conducted among key stakeholders involved with health care of SMI patients in their everyday life, namely patients, families, general practitioners, and mental health professionals. This means that other stakeholders, such as pharmacists and healthcare insurers, were not included.
Introduction

Patients with severe mental illness (SMI) are defined as individuals experiencing a reduction of general functioning due to their psychiatric disease and having received at least 2 years of treatment (1). The life expectancy of these patients is 13–30 years shorter than that of the general population (2). This difference in life expectancy has increased in recent decades (3) and is at least partly due to avoidable causes (4). A minority of the mortality in this group is caused by unnatural deaths including suicide; the majority (60%) dies from natural causes (5). The natural causes of death in people with SMI are mostly related to cardiovascular disease (CVD), for example, myocardial infarction or stroke. Patients with SMI have a 2–3 times higher incidence of CVD than the general population (6).

The poor physical health of patients with SMI is caused by multiple, partially modifiable, factors including medication side-effects, lifestyle choices, and lack of optimal health care (5, 7). Even in high-income countries, optimal health care is lacking for patients with SMI due to barriers in accessing health care (8), limited knowledge of healthcare providers regarding specific risk factors in patients with SMI, and failure of medical specialists involved to cooperate (5). Some programmes have been set up to improve the somatic health of patients with SMI. However, the results of these programmes are hard to interpret because different methods are used for their evaluation (9).

At this moment, there are no specific guidelines available for improving the state of the physical health of out-patients with SMI.

In the Netherlands, out-patients with SMI receive health care through both the GP practice and the mental healthcare service. Both services are largely funded through a healthcare insurance, compulsory for all Dutch citizens (10, 11). A case manager performs the community psychiatric care for out-patients with SMI. This mental health nurse is responsible for several patients with SMI and confers with a psychiatrist whenever necessary. Case manager has weekly to monthly contact with their patients, and if necessary this contact consists of home visits. Another important source of support are patients’ families, who perform informal care. They provide support in recovery and ensure compliance with medication (12).

Aims of the study

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.

Material and methods

We used a qualitative study design to elicit expert visions on potential areas for improvement in the organization of physical health care for patients with SMI. The study described in this manuscript is a continuation of a study investigating the preferences of SMI patients and family carers for types of physical health care (13). We used the Delphi method; this is one of the qualitative consensus methods developed for research in fields in which opinions vary due to a lack of conclusive scientific evidence. The Delphi method attempts to assess the extent of agreement (consensus measurement) and to resolve disagreement (consensus development) (14). A modified Delphi (14, 15) was performed in three rounds. We made two modifications to the original Delphi design, which is executed in three written rounds with one group. The first round consisted of interviews of homogeneous groups or individual experts. There were four group interviews and seven individual interviews. The group interviews enabled experts to respond to each other and therefore to express many different barriers as well as possible solutions to overcome them. Some patients were interviewed in a small group, but most were interviewed individually to establish a safe environment to share personal experiences and opinions. Second, we strove for a general consensus between the four different stakeholder groups instead of one uniform group. Although the groups were not equal in numbers of participants, equal weight was given to the visions of the different stakeholder groups.

Expert groups

The expert groups consisted of patients with SMI, family carers of patients with SMI, mental healthcare professionals (MHP), and GPs. Patients were recruited from a list of SMI patients registered at a primary healthcare center and from the caseload of the community outreach teams (FACT) of a mental health service. The family carers of SMI patients were invited through Ypsilon, a national organization that provides support to the families of patients with SMI. Mental healthcare staff members were recruited by an invitation via the FACT registration body. Only staff members who
actively participate in out-patient care for patients with SMI (psychiatrists, mental health nurses, specialized nurses) could take part. GPs belonging to the mental health GP expert group ‘PsyHAG’ were invited to participate in our study. As well as doing regular work in GP practices, these GPs have acquired extra competencies in mental health care. For the second round, invitations were sent to all experts included in the first round as well as those who expressed their interest in the first round but could not take part due to practical reasons. Only the experts from the second round were invited for the third round.

The Delphi rounds

First round. The first round was focused on perceived barriers and suggested solutions for improvement. A topic list was used for all interviews consisting of the following items: experiences with physical care in-patients with SMI, current barriers to care, potential solutions, and responsibilities of professionals. The family carers, GPs, and mental healthcare staff were interviewed in focus group meetings, which were mediated by a professional facilitator. The facilitator was a trained psychologist with about 30 years of experience in working with groups and has previously worked as facilitator in Delphi studies. Individual patient interviews and one small group interview were conducted by FH, who is trained in working with SMI patients. Patients with SMI are a vulnerable patient group; therefore, individual interviews were performed to allow all patients to participate, regardless of verbal communication skills. All participants filled out a form with biographical information and contact details, and specific questions were asked to specific stakeholders. The visiting rate of the primary healthcare patients was based on their file information if present. Family carers were asked about their relation to an SMI patient, and whether they were involved professionally in health care. All healthcare professionals were asked about their work experience.

All interviews were taped, transcribed verbatim, and reviewed for accuracy by one investigator (FH). Two authors (MO, FH) reviewed the transcripts separately to identify common themes, after which discrepancies were resolved through discussion. For the purpose of checking back, a summary was sent to several participants of the group interviews, giving them the opportunity to agree or disagree with the content. During the individual interviews, the interviewer posed another question to check if her interpretation was correct. If this was deemed unclear when analyzed, the respective data were not used. Thematic analysis was used for the barriers to care. Responses were grouped into common topics, and the topics were grouped into themes. This process was supported by Kwalitan software (16). As analysis proceeded, increasingly in-depth coding categories were generated, based on emerging thematic patterns. We selected quotes from the interviews based on their representativeness. A list with potential policy recommendations was formulated based on the recommendations provided in the first round by the different stakeholder groups and ordered by the themes of the coding categories.

Second round. All participants from the stakeholder groups received an email with a link to a web-based questionnaire listing all potential policy recommendations from the first round. The experts were asked to identify on a 5-point Likert scale ranging from ‘completely disagree’ to ‘completely agree’ whether they would advise adding a given statement to the recommendation on improving physical health for patients with SMI. Additional solutions could be suggested, and remarks could be made in free text.

In the first round, multiple views had appeared on who should perform cardiovascular risk screening. Therefore, in this second round, one question on preference for a specific healthcare provider was added. For that choice, free text argumentation was requested.

As there are no guidelines for levels of consensus for Delphi studies (15), we defined consensus as at least a mean score of 70% of either point 1 or 2 (strongly disagree or disagree) or point 4 or 5 (agree or strongly agree), and at least 50% consensus within the stakeholder group. The opinions of all groups of stakeholders were equally weighted. Because of the different numbers of experts in the different stakeholder groups, we worked with ratios of agreement per stakeholder group and averaged these to identify the percentage agreement or disagreement in total. After the second round, an overview was made of potential policy recommendations that had reached consensus, recommendations that had not reached consensus, and a thematic analysis similar to the first round was performed on all free text comments.

Third round. As in the second round, all experts received an email with a link to a web-based questionnaire. In this questionnaire, feedback was provided on the findings of the second round, listing all policy recommendations that had reached consensus. Furthermore, the information on the themes of the free text remarks was presented as
feedback in this round. On the potential policy recommendations that did not reach consensus, the total response of all experts as well as the response per stakeholder group was presented. Based on the remarks, some recommendations in this round were reformulated or divided into two or three recommendations to improve clarity. The recommendations without consensus and the rephrased recommendations were presented, and, as in the second round, a Likert scale was used per recommendation. Again, the aim was to obtain strong recommendations that reached consensus in all groups. The consensus criteria and calculation were similar to those used in the second round.

Ethical considerations

According to European Directive 2001/20/EC, this study is not an interventional trial but an exploratory inquiry concerning personal opinions on healthcare quality. Therefore, a medical ethics review is not needed.

Familiar staff members asked the stable patients if they would like to take part in interviews, conducted by an independent interviewer, about their experiences with physical health care. Explanation was given during face-to-face contact, and an information letter was provided. Patients were told that their participation was voluntary and that participation or non-participation did not have any consequences for their treatment (13). Because patients, family carers and healthcare professionals volunteered to join and share their expertise, their participation with the interview after giving information about the research was regarded as consent.

Results

Response

A total of 36 experts gave their opinion in the first round. For the second round, eight patients were invited. Two patients from the first group were not invited, one due to lack of internet access and the other due to the objection of the treating physician that the questions in questionnaire form were too complex and potentially intrusive for this patient. In the family carer group, two extra persons were invited who had been unable to attend the evening of the first round. Similarly, two additional GPs and four additional mental healthcare professionals were invited for the second round. The background of experts is described in Table 1; all extra professionals had expertise comparable to that of experts in the first round. Because the invitation to join this Delphi study had been sent broadly to potential experts through organizations, it was not possible to register which experts could not take part and why. In the second round, five of the eight patients gave their opinions as well as thirteen of fourteen family carers, four of seven GPs, and eight of twelve mental healthcare professionals. In the third round, all experts from the second round gave their opinion, with the exception of one mental healthcare professional. One patient added a free text comment to the second round expressing doubt in his ability to answer the questions due to his depressed mood. However, we decided to include his answers because it was unclear whether this situation might also apply for other experts who did not add such a free text comment, and because patients with SMI have a tendency toward doubting their own capabilities.

Current barriers

Suggestions on improvements to perceived barriers were identified in the first round. Insufficient collaboration between MHPs and GPs was mentioned as the most important barrier. The other perceived barriers were grouped into patient characteristics, specific aspects of GP, and specific aspects of MHP. Generally, there is a need to increase the knowledge of professionals
regarding the specific physical risks to patients with SMI.

Collaboration GP and MHP. All stakeholders agree that there is insufficient collaboration between MHPs and GPs, which is perceived as one of the largest barriers to improving the physical health of patients with SMI. Patients and family carers have similar experiences regarding the absence of collaboration. Moreover, it is unclear to them who they should consult in the case of physical symptoms that are potential side-effects. They also report that medication changes are not communicated between professionals. Professionals mention that feedback from MHPs to GPs is rare and that there is no structural means to communicate regarding physical symptoms. Also, the results of screening for cardiovascular risks by MHPs are not always fed back to GPs. GPs feel undermined when some MHPs refer their patients with physical health problems to other medical specialists without consulting the GP. GPs and MHPs mutually experience the absence of structural collaboration and agreements on who delivers care as a barrier to improving health care.

I received medication from my psychiatrist, but my GP was totally uninformed. (Patient)

There is no communication, these are separate spheres. (MHP)

It turned out my patient already had regular laboratory controls. Yet I had sent that patient to the lab as well. The patient hadn’t notified me on the double controls, which set me thinking that this was not really coordinated. (GP)

Patient characteristics. Mental healthcare staff emphasized that a single prototypical ‘severely mentally ill patient’ does not exist. For each patient, the need for support in improving physical health depends on the severity of the disease and the phase of treatment. All stakeholders agree that these patients are easily stressed. Additionally, these patients experience problems in organizing the health care that they need. These problems are caused by a patient’s distress about speaking with their GP or waiting for their turn in the waiting room, but might also be caused by a patient’s apathy or paranoid ideations.

You think that you are a bore. When I have a physical symptom, I feel very bad as well. I fear that mental health care or the GP will think ‘It’s her again’. That hurts and holds me back in making appointments. (Patient)

I cannot knock my son down or hold him with ten men to enable drawing a blood sample. He does not want to cooperate; he thinks that they are stealing his blood. (Family carer)

I have learned that coping skills are not only related to activities of daily living, but also reflect the ability to visit the GP. (MHP)

Patients are anxious about a visit to the GP. They cannot quickly phrase their symptoms, the waiting area is often already a stressful experience. So there is giant threshold to visit the GP. (GP)

General practitioners. Patients consider their GP to be the central person for the care and treatment of their physical health. They expect the GP to have up-to-date knowledge of their mental and physical health as well as their treatment. Yet, making appointments is often a major obstacle to them. As mentioned above, this is perceived to be a stressful moment for these patients, and additional stress sometimes arises due to the complexity of the questions asked of them or the postponement of their appointments. Family carers and MHPs recommend that when patients are not able to come to the practice due to psychiatric symptoms, the GP should make a house call. GPs agree that extra care is needed but currently find the lack of time and funding a barrier to actually delivering this care. MHPs and GPs both expressed that the lack of comfort and confidence that GPs feel in caring for patients with SMI is also a current barrier to providing these patients with the care that they need.

There are GPs who have extra patience with these patients, who feel that it is their business. There are other GPs who don’t want any fuss in their practice. (GP)

If people can’t walk or can’t come to the GP because of their physical illness, then the GP can make a house call. However, if someone’s anxious or does not want to come out of their house, the GP does not make house calls, then you have to go to the practice. (Family carer)

It is sometimes an extra burden on the practice. I can imagine if we structurally demand to perform care then there should be a structural reimbursement, so you have more time for it. (GP)

391
van Hasselt et al.

Table 2. Consensus based policy recommendations

<table>
<thead>
<tr>
<th>Collaboration</th>
<th>The GP is the professional with overview and direction of the complete (general and specialist) treatment of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The professional (GP or MHP) who diagnoses a new psychiatric complication should notify the other professional (GP or MHP) providing them with relevant medical information</td>
</tr>
<tr>
<td></td>
<td>The professional (MHP or GP) who diagnoses a new somatic complication should notify the other professional (MHP or GP) providing them with relevant medical information</td>
</tr>
<tr>
<td></td>
<td>The results of cardiovascular risk screening need to be known by the GP and MHP. The performer of the screening should inform the other party in writing</td>
</tr>
<tr>
<td></td>
<td>For the policy on new physical symptoms, MHP should always consult the GP. Consultation with the GP is necessary before referral to a medical specialist by MHP</td>
</tr>
<tr>
<td></td>
<td>Changes in medication should always be reported in writing between MHP and GP. This can be performed by email, fax, or Edifact</td>
</tr>
<tr>
<td></td>
<td>The psychiatrist can delegate the performance of the necessary screening required for some medications used in the treatment of psychiatric disease to the GP, if the patient agrees</td>
</tr>
<tr>
<td>Direct personal contact between MHP and GP is an important prerequisite for improving cooperation. Sharing of direct (cell)phone numbers can contribute in facilitating direct contact</td>
<td></td>
</tr>
<tr>
<td>The pharmacist should notify a mental healthcare professional if the patient does not pick up their medication in accordance with the prescription</td>
<td></td>
</tr>
<tr>
<td>The pharmacist should notify the GP if the patient does not pick up their medication in accordance with the prescription</td>
<td></td>
</tr>
<tr>
<td>Mental health care</td>
<td>If compliance is not optimal, the pharmacist should recommend strategies for improvement</td>
</tr>
<tr>
<td>Mental health care</td>
<td>The MHP should register the individual capacity of every patient with SMI to organize the necessary care for their physical health</td>
</tr>
<tr>
<td>Mental health care</td>
<td>The MHP is responsible for notifying physical health risks for patients with SMI</td>
</tr>
<tr>
<td>Mental health care includes promoting healthy lifestyle choices</td>
<td></td>
</tr>
<tr>
<td>MHPs are responsible for monitoring the side-effects of their prescribed medication</td>
<td></td>
</tr>
<tr>
<td>The MHP has the responsibility of keeping the GP informed on the course of treatment</td>
<td></td>
</tr>
<tr>
<td>MHP (psychiatrist, mental health nurse) needs education on specific somatic health risks that patients with SMI have</td>
<td></td>
</tr>
<tr>
<td>Supporting the patient to consult the GP when necessary is part of mental health care</td>
<td></td>
</tr>
<tr>
<td>It is important that the patient can invite a friend to be present at the treatment plan meeting</td>
<td></td>
</tr>
<tr>
<td>The case load of a MHP should be as such that they can assess the capabilities a patient has in organizing somatic health care</td>
<td></td>
</tr>
<tr>
<td>General practice</td>
<td>The GP is the professional with overview and direction of the complete (general and specialist) treatment of patients</td>
</tr>
<tr>
<td>General practice</td>
<td>People with SMI have an increased risk of cardiovascular disease. These patients should be included in the monitoring programmes by the GP as patients with increased risk</td>
</tr>
<tr>
<td>General practice</td>
<td>It might be necessary for the GP to make a house call if the patient cannot visit the practice due to psychiatric problems</td>
</tr>
<tr>
<td>General practice</td>
<td>It is necessary that GPs receive education on the specific health risks that patients with SMI have</td>
</tr>
<tr>
<td>General practice</td>
<td>Within a GP practice, the care for patients with SMI can be shared among GPs. GPs who do not feel competent in providing this care can transfer the responsibility to colleagues</td>
</tr>
<tr>
<td>General practice</td>
<td>The GP should be reimbursed for the extra care provided patients with SMI, including for a yearly meeting with the MHP and patient or for a multidisciplinary consult</td>
</tr>
</tbody>
</table>

Table 3. Additional questions

| MHP, mental health professional. |

Mental healthcare professionals. Patients experience a barrier to sharing their symptoms because of the changes in the mental health professionals they encounter. Family carers experience a lack of clear notification about physical health risks. MHPs acknowledge that the lack of a structural means to organize their care for the physical health of patients with SMI also acts as a barrier to the patient receiving the care they need. Furthermore, MHPs emphasize that the size of their caseload is sometimes too large to assess the capabilities of all patients to care for their own physical health. MHPs often work in large institutions and GPs find it hard to reach the right professional for consultation within the institution.

Sometimes he is so absorbed in his compulsions, he finds no time to cook or eat. Somebody has to see that and take action. (Family carer)

There is no structure and thus no safeguarding of the process.

As a professional carer I have to fiddle with Excel sheets to find out: oh yes it’s his turn now. (MHP)

Policy recommendations

After three rounds, consensus was reached on 27 policy recommendations on the subjects of collaboration, mental health care, and general practice (Table 2). Consensus was only partially reached on monitoring for cardiovascular risk; this will be discussed in detail below. For 20 policy recommendations of 32, consensus was already reached after the second round. In the third round, we requested the experts’ opinion on sixteen policy recommendation statements, and we added one question concerning which professional should preferably perform physical health screening. These sixteen statements were based on the twelve potential recommendations, which did not reach consensus after the second round. Five of these potential recommendations were divided into multiple recommendations, and four were rephrased based on the feedback from the experts. The other three were left out, because they were overlapping with other statements. Seven additional policy recommendations were added after the third round. Nine policy recommendations did not reach consensus after the third round (Table 3). These
recommendations were mainly related to collaboration.

Consensus was reached on the recommendation that the results of cardiovascular risk screening need to be known to both GP and MHP. The performer of the screening should inform the other party. However, no consensus was reached about which professional should perform this screening. In the first and second rounds, stakeholders gave arguments about which provider they would prefer to give this care. Some stakeholders had no preference but emphasized that the care should be performed structurally. The main arguments in favor of making cardiovascular risk screening part of GP care were as follows: the GP is specialized and trained in this care and already performs it; the GP is the central carer for a patient; the care can be delivered close to where the patient is living; the care can reduce the threshold to visit the GP when patients have already visited the practice for screening; and the GP can use the moment of screening to discuss whether symptoms in need of attention already exist. Arguments for cardiovascular screening by mental healthcare professionals were as follows: MHPs are experienced in caring for patients with SMI; MHPs know their patients; MHPs already perform this screening in some cases; SMI patients experience a higher threshold when choosing to consult the GP.

All these arguments were presented to the experts in the third round, and they were asked to respond to the statement: ‘Which professional should in principle perform the screening for cardiovascular risk? In exceptional cases the screening can be performed by another professional’. The GP was preferred by 80% of patients, 54% of family carers, 29% of MHPs, and 100% of GPs. Performance of the screening in mental health care was preferred by 46% of family carers and 29% of MHPs. The other 43% of MHPs were neutral as to which professional should perform this screening.

All free text additions after the second round were included in the changes to the remaining policy statements in the third round. Family carers, GPs, and MHPs made six general comments. Two personal remarks relating to very specific personal situations are not presented. Multiple experts mentioned that these policy recommendations described an ideal situation, which at the moment represents a utopian dream. They emphasized that these statements should be used for the development of guidelines but that professionals currently cannot perform all of the recommendations due to lack of time, education, and reimbursement. Furthermore, comments were made on the potential use of a shared electronic patient file, the potential role of the specialized mental health nurse, the potential for a specialized treatment facility for side-effects, and the potential benefit of a psychiatric facility that includes primary care.

Discussion

Main results

Patients, families, GPs, and mental health professionals reached consensus on a broad set of policy
recommendations aimed at improving physical health care. Consensus was reached on the role of GPs and MHPs in taking care of the physical health of patients with SMI, and it was agreed that this collaboration is a prerequisite for good practice. The experts agreed that GPs should retain an overview of the patient’s health state and are responsible for the policy and the general process of the physical health care. The role of MHPs is to assess the capabilities of patients with SMI to look after themselves and to organize health care when necessary, to support patients in a healthy lifestyle, and to monitor specific health risks related to psychiatric medication.

The need for structural cardiovascular risk screening and the need to exchange this information between MHPs and GPs were clearly established. Consensus was not reached between the stakeholders regarding how this service could be provided and which professional is responsible for monitoring cardiovascular risk factors. Performing this screening could fit to both professionals based on the description of their role by the Delphi experts. It fits with the role description of the GP as the central person for physical health and it fits with the role description of the psychiatrist and their responsibility for the assessment of side-effects of their prescribed medication. Most patients prefer the monitoring to be performed by GPs, and GPs are willing to perform this care (17). The majority of MHPs were neutral, while the families produced a variety of responses to this statement.

Strengths and limitations

To our knowledge, this is the first study presenting policy recommendations based on the consensus of all stakeholders, including patients and family carers. Our qualitative approach has enabled us to detect barriers at individual and system levels. One strength and limitation of qualitative research is that it studies stakeholders in a very specific situation. The barriers we have detected are similar to the internationally recognized barriers described previously (8). A major strength of this study is that we were able to present policy recommendations tailored to the Dutch healthcare system, although this means that the recommendations are not directly applicable to other healthcare systems. However, specific national adjustments can be developed using our recommendations in discussions with local groups of similar stakeholders.

We designed the consensus process so that all four groups had equal weighting to create as much potential support as possible for the changes. The experts represented the groups of stakeholders involved. The family carer group was recruited through Ypsilon and was mainly first-degree relatives of patients with schizophrenia. Therefore, relatives of patients with other SMI diagnoses are underrepresented in the family carer group. Given the similarity in handicaps to daily living among patients suffering from different SMIs, we do not expect that this will influence our findings. For practical reasons, we limited the stakeholders to these groups, meaning that other important stakeholders, such as pharmacists and healthcare insurers, were not included.

Comparison with literature

The barrier formed by insufficient collaboration between mental healthcare professionals and GPs is not unique to psychiatry. Insufficient collaboration between medical specialists and GPs has been observed among different medical specialisms in different countries (5, 18). As with our study, research on the preferences of GPs regarding collaboration with general hospital specialists found that GPs needed adequate organizational support and financial support as prerequisites for collaboration (19). Somatic specialists were found to be primarily interested in collaboration if it reduced the pressure on the out-patient clinic (20). This motive was not mentioned in our study. However, it should be noted that the studies on collaboration studied between somatic specialists and GPs mainly focus on referral and information after discharge from the hospital. The collaboration between MHPs and GPs needed for patients with SMI requires a more long-term collaboration. This long-term collaboration requires other professional skills than the referral of patients to a medical specialist in a hospital for an out-patient assessment and the subsequent reporting back to the GP. Currently, there is no evidence on effective strategies to improve interprofessional collaboration for long-term collaboration (18).

Chadwick et al. (2012) made an overview of barriers from the patient’s perspective. They identified similar barriers, but they also identified barriers related to the costs of health care, transportation, and inabilities in accessing emergency care. They did not identify lack of collaboration between GPs and MHPs as a barrier (8), which can be explained by the differences in the organization of GP care and health insurance between the Netherlands and countries such as the USA and Australia.

From a professional perspective, an overview of barriers to improve somatic health has been made (5). Two notable barriers described in de Hert
et al. (2011) were not present in our study. First, we have not heard the perception from MHPs that guidelines are a threat to autonomy. Second, the stakeholders did not mention that lack of insurance coverage hinders patients with SMI accessing general health care.

The lack of clarity and consensus about who is responsible for detecting and managing physical problems in patients with SMI is an international problem (5). A statement on the specification of the responsibilities of different healthcare providers, for example, by healthcare insurers seems to be necessary to overcome this barrier to optimal care.

Implications for research and practice

Most of these policy recommendations can be implemented directly into daily practice. In particular, the sharing of direct phone numbers between professionals and the written exchange of medication changes. The implementation of other recommendations, such as education, is dependent on the prerequisite of reimbursement for extra care. A statement regarding which professional is responsible for cardiovascular risk screening seems to be necessary to overcome this barrier to optimal care. Healthcare insurers might be in the best position to provide such a statement.

Regarding the other statements that did not reach consensus, mixed stakeholder group (patients, family carers, GP, and MHP) meetings on these subjects could potentially clarify different visions between groups on the need for implementation of these recommendations. In these mixed stakeholder groups, also GPs who do not have special training in mental health should be included. This research should be prioritized because families and other carers consider health services research as an important area of research (21). In these meetings, the recommendations could be differentiated for specific subgroups of patients and clear principal agreements could be established. Furthermore, other important stakeholders involved in the care process of patients with SMI should be involved. These include healthcare insurance companies, pharmacists, and dentists. Currently, there are multiple barriers preventing the realization of optimal care for the physical health of patients with SMI, including lack of professional collaboration. The physical health is a shared responsibility of GPs and MHPs, and good care requires structural collaboration. All stakeholders agree that the GP is the professional that maintains an overview on all aspects of the patient’s health and is responsible for the treatment of physical symptoms. The MHP assesses the capabilities of a patient with SMI to live healthily and to use health care effectively. No consensus could be reached on which professional should monitor the cardiovascular risk.

The policy recommendations supported by patients, family carers, MHPs, and GPs need to be incorporated in the professional guidelines, with the prerequisite that some of these recommendations imply extra funding. However, some other recommendations such as the sharing of direct phone numbers between professionals and the written exchange of medication changes can be implemented directly into daily practice, resulting in an immediate improvement in the care of patients with SMI.

Declaration of interest

None.

References

7. Wildgust HJ, Beary M. Are there modifiable risk factors which will reduce the excess mortality in schizophrenia? J Psychopharmacol 2010;24:37–50.
8. Chadwick A, Street C, McAndrew S, Deacon M. Minding our own bodies: reviewing the literature regarding the perceptions of service users diagnosed with serious mental illness in patients with severe mental disorders. II. Barriers to care, monitoring and treatment guidelines, plus recommendations at the system and individual level. World Psychiatry 2011;10:138–151.
van Hasselt et al.

13. van Hasselt FM, Oud MJT, Loonen A. Improvement of care for the physical health of patients with severe mental illness: a qualitative study assessing the view of patients and families. BMC Health Serv Res 2013;13:426.