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Title: An exploration of clinician attitudes towards older adults experiencing mental and physical health problems in the UK

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Abstract

It has been suggested that agism, stigma and other forms of discrimination lead to older adults with serious mental illness (SMI) being invisible in policy, practice and research. This paper explores and critically examines stakeholders' attitudes and perceptions concerning older adults with serious mental illness also experiencing physical health needs based on research conducted in the UK.

A qualitative case study approach was utilised and a purposive sample of 24 staff involved in the commissioning, managing, planning and provision of services for older adults with SMI were recruited. Data collected from ten semi-structured interviews and two focus groups was analysed using a framework analysis and four themes emerged: Defining the patient group and their journey in care; seeing the whole person; Devolving care (falling through the gap); and Making it happen and moving forward.

Although participants held positive attitudes towards older adults with SMI with an emphasis on the provision of holistic care, gaps in service provision and organisational structures were apparent. Service users appeared to be moved through services dependent on presentation rather than need, without a coordinated approach. Practitioners felt it was becoming increasingly challenging to manage physical healthcare needs in addition to managing more pressing mental health issues and many older adults with SMI and physical health needs were falling through the gap. However, the hospital trust was seen to be making steady progress with the implementation of early warning systems, recognition of the importance of education for all healthcare professionals and early signs of linkage between services.

It is suggested that more collaborative working between relevant services is required, and it is proposed that the establishment of a community psychiatric liaison service to coordinate care could prevent crisis situations arising for patients with co-morbidities.

Introduction

The aim of the study on which this paper is based, was to examine the attitudes and perceptions of clinicians and other key stakeholders, working in the English National Health Service (NHS), who have responsibility for treating people experiencing mental illness and associated physical health conditions. In the United Kingdom the NHS is responsible for providing care and treatment, free at the point of delivery, to people with both mental and physical health problems. However, despite having a responsibility for both mental and physical health services the NHS is often criticised for decoupling these aspects of care with mental health services receiving considerably less attention and considerably less funding. For example in the United Kingdom mental illness causes 22.8 per cent of the burden of disease but only receives 11 per cent of NHS funding, giving rise to the notion that mental health is the "Cinderella" service of the NHS (Mitchel 2013).The paper will begin with outlining the nature of the problem and why this particular issue in the United Kingdom requires more focus and attention. Consideration in this section will be given to the construction of a theoretical framework that accounts for the lack of treatment provision for people who have a physical health condition and experience serious mental illness. The remainder of the article will outline the methodology adopted for the study, present the findings and conclude with a discussion of the implications of these findings. The empirical findings of this study will inform part of a theoretical perspective with the intention of explaining the accelerated aging of older adults with SMI.

Serious Mental Illness and Aging

The definition of serious mental illness (SMI) with the widest consensus is that of the National Institute of Mental Health (NIMH) (Schinnar et al. 1990) and is based on diagnosis, duration and disability (NIMH 1987). People with serious mental illness have conditions such as schizophrenia or bipolar disorder, over a protracted period of time, resulting in erosion of functioning in everyday life. They often have a higher morbidity and mortality from chronic diseases than the general population, resulting in a significantly reduced life expectancy (Robson and Gray 2007).

With population projections indicating that the number of older adults in the United Kingdom (UK) (those aged 65 years and over) will increase from 9.6 million in 2005 to 12.7 million in 2021, the numbers of those growing older with SMI is likely to rise. Godfrey (2005) highlights the "layers of invisibility" that older adults with SMI face, suggesting that they are the "most complex, vulnerable, resource poor and high risk long-term service users in society today." Although age is a continuous variable and there is no point at which populations become discretely separate, age does affect the prevalence and nature of illness. While individuals differ, as people grow older, certain needs become more common and this changes the context in which mental illness occurs (RCP 2009a). For example, as well as having physical health needs as a result of their mental health diagnosis and its subsequent treatment over time, older individuals are more likely than younger adults to have physical co-morbidities, thus requiring complex individualised treatment and management.

Older people with mental illness, regardless of other factors, are more likely to die, stay in hospital longer, lose independent function and be discharged to a care home (RCP 2009b). It is suggested that ageism, stigma and other forms of discrimination such as gender differences, sexual orientation, disability or religion/belief combine to make: "those growing older with severe mental illness invisible in policy, practice and research" (Age Concern 2007). In the United Kingdom the Equality Act (2010) and the New Horizons (2009) mental health policy have made important steps towards tackling discrimination, it has been argued that urgent action is needed to raise awareness of the needs of individuals growing older with SMI (Druss 2007).

Consideration should be given to how services are delivered and developed locally to effectively meet the needs of older adults with SMI experiencing physical health care needs (RCP 2009a). Unlike the United States of America (USA), there has been little research on aging with SMI in the UK. Exploratory research therefore is required to clarify "the problem", share areas of good practice and to develop initial hypotheses or research questions which are meaningful, relevant and feasible for clinical practice and for service users themselves (Clifton, Marples and Clarke 2013).

Theorising aging and serious mental illness

There is no universal definition of aging but according to Vina, Borras and Miquel (2007) almost all physiological functions lose efficiency as we age resulting in some loss of capacity and inevitably death. Positively over the past four decades global life expectancy has increased by 11 years for men and 12 years for women, however, on a more negative note there are marked inequalities in life expectancy among different regions of the world and among different regions of individual countries (The Guardian 2012). Moreover people living with SMI have a reduced lifespan of 10-20 years, compared with the general population, and this excess mortality is mainly due to physical illness with people with SMI experiencing higher incidences of respiratory problems, cardiovascular disease, infectious diseases, obesity and high cholesterol. How then do we theorise or explain this phenomenon, which in an age of increasing global life expectancy, mean that people experiencing SMI, have significantly shorter life spans?

There are many theories of aging although most tend to lean towards biological perspectives, where around 300 different accounts of aging have been put forward (Vina, Borras and Miquel, 2007). In the Handbook Theories of Aging (2009) the authors have categorized particular theories into the following sections: Theorizing Aging Across Disciplines, Biological Theories of Aging, Public Policy, and Theories of Aging, Psychological Theories of Aging, Social Science Perspectives on Theories of Aging, Society, Public Policy, and Theories of Aging, Translating Theories of Aging and The Future of Theories of Aging, giving both readers and researchers an opportunity to consider their research findings in the light of these theoretical perspectives on aging.

The aim of the current study was to explore and examine the attitudes that mental health clinicians have when treating people with a SMI and associated physical health problem. As far as we are aware few researchers have offered a theory, or at least a convincing theory, explaining why people with a SMI are dying 10-20 years earlier than the general population? Okusaga (2014) discusses the potential role of oxidate stress in explaining the accelerated aging process of some people with SMI. The "free radical" theory of aging follows as a result of damage to cells and connective tissue by free radicals arising from oxygen-associated reactions. In people with schizophrenia it has been reported many individuals have abnormal oxidate parameters compared to the general population (Okusaga 2014). However, as Okusaga (2014) suggests the free radical or oxidative theory of aging is not complete as other "potential confounders" such as smoking, diet, anti-psychotic medication and socio-economic status may have an equally significant impact on the aging process.

In the study presented below we have found that there are many interconnected factors which impact on the level of care and treatment older adults experiencing a SMI receive. The participants in this study have indicated that a lack of holistic care, the complex needs of older adults with SMI, the configuration of services, the lack of integrated care working and clinicians not taking responsibility for the "whole person" mean the needs of this group of people are not being met. As people age with SMI several factors impact upon their wellbeing including treatment, lifestyle, illness and service related factors. Illness factors can include cognitive deficits making individuals less aware of physical ill health or a higher than usual pain threshold or reduced sensitivity to pain due to antipsychotic medication. They may also display less help seeking behaviour due to social factors such as stigma and reduced social networks, and lifestyle factors such as increased risk taking behaviours and isolation. Other social and lifestyle factors which impact on physical health include poverty, poor housing and unemployment, increased substance misuse and poor self-care. Individuals aging with SMI experience multiple threats to their wellbeing due to age, mental illness, social deprivation and a lack of coordination between physical and mental health services.

Theoretically these structural, agential and public policy related factors (see **Figure 1** below) should be considered into any explanation of accelerated aging for people with schizophrenia or bipolar disorder. Structural barriers to appropriate holistic services can be overcome. Individual agency issues can be addressed at a personal or organisational level meaning that individuals take responsibility for the patients in their care. Finally policy makers have a responsibility to provide and deliver services for the health related needs of this vulnerable group of people.
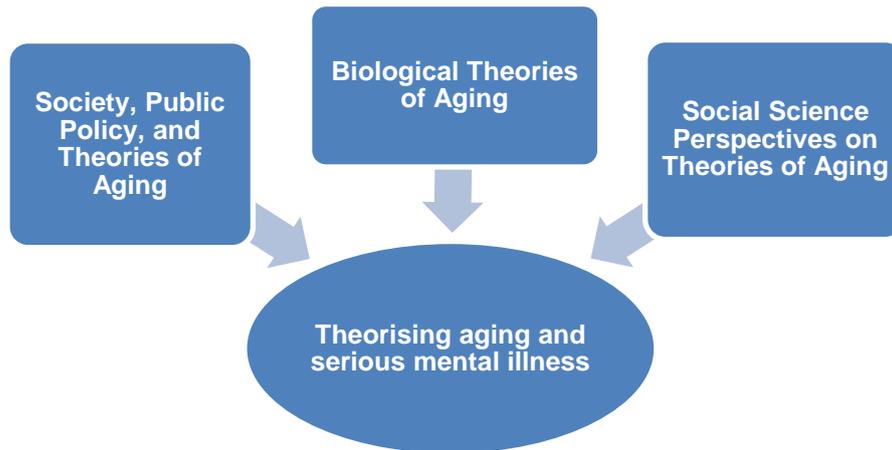
Fig 1: Theorising aging and serious mental illness

Aim of the Study

The aim of the study was to explore and critically examine stakeholders' attitudes and perceptions across Northumberland, Tyne and Wear (NTW) National Health Service (NHS) Foundation Trust concerning older adults with serious mental illness.

Methodology

A qualitative case study approach was deployed and key stakeholders views and perspectives were sought to enhance the consistency and depth of understanding of organisational processes (Ritchie and Lewis 2003).Qualitative approaches are particularly appropriate when little is understood about a subject, to facilitate descriptive evidence of a particular shared experience (care of older adults with SMI) and where key questions and areas for further research need to be clarified.

Setting of the study

The study was undertaken in a UK National Health Service Foundation Trust which provides mental health services to a large geographical area in the North of England. Due to the time limit of the study, data collection was undertaken in one geographical locality of the Trust.

Recruitment and sampling

Sampling was purposive and participants were selected in order to provide a variety of views from identified stakeholders, adding breadth and depth to the study. Our sampling strategy was guided by the Older People's Mental Health team at NTW, the local context, and the time limit of the project.

Criteria for selecting staff were those involved in the commissioning, managing, planning and provision of services for older adults with Serious Mental Illness.

Data was collected between May 2013 and September 2013. Face-to-face interviews lasted between twenty and thirty minutes whilst the focus group interviews lasted approximately forty five minutes each. The majority of the interviews were conducted on hospital premises. All interviews were digitally recorded and transcribed for the purposes of data analysis.

Our final sample comprised:

(1) Staff involved in the provision of care to older adults with SMI (n=21).

(2) Staff involved in the commissioning, managing and planning of services (n= 3).

Total sample= 24 (See Table 1 below for more detail).

Ethic approval was gained from the Northumbria Universities Ethics Committee and a Letter of Access was provided by the Mental Health Trust in which the research was undertaken. Written informed and on-going verbal consent was obtained from all participants prior to data collection.

Table 1: Numbers, Characteristics of Sample and Data Collection Method

	Number Interviewed	**Method of Data Collection**	**Participants**
Psychiatric Liaison Team for Older People	2	Dyadic interview	Registered Mental Nurses (RMNs)
Older Adults Psychiatric Day Unit	2	Face-to-face dyadic interview	Registered Mental Nurses (RMNs)
Two Community Mental Health Teams	14	Focus group interviews (x2) (6+8 participants)	Occupational Therapist (OT) and 5 Community Psychiatric Nurse (CPNs) (including CMHT lead)
Consultants in Old Age Psychiatry	3	Face-to-face interview	Doctors (senior level)
Senior Registrar in Old Age Psychiatry (SH5)	1	Face-to-face interview	Doctor
Challenging Behaviour (Older Adult) team members	2	Dyadic interview	Registered mental nurse (RMN) and clinical psychologist

Methods

In keeping with a qualitative approach and recognising practical constraints (such as staffing resources on clinical areas) a combination of data collection methods were used: face-to-face interviews and focus groups. Focus groups were the preferred method of choice since this method generates data by interaction between the group; noted to be particularly useful where creative thinking, strategies and solutions are required (Ritchie and Lewis 2003). For staff who wanted to participate in the study but were unable to attend a focus group, an individual interview was offered. Acknowledging resourcing issues and time constraints for staff, participants were offered the choice of telephone/or face-to-face interviews. A semi-structured interview schedule was used throughout; this was developed to ensure that the objectives of the study were covered, whilst allowing participants to raise issues that were important to them.

Data analysis

Analysis of data was guided by Framework Analysis (Ritchie and Lewis 2003). This is a matrix-based method which allows the systematic analysis of an entire data set divided into themes and sub themes as ideas and concepts are sought from the data. Analysis remains grounded in the views and experiences of the participants, with the flexibility to incorporate new insights into the topic under study. NVivo 10, a qualitative data analysis tool, was used to store and analyse the data. Data analysis was conducted independently by two researchers (GM and JW) and emerging themes discussed with the wider team (AEC and AC).

Key findings from the research study

Following data analysis, four themes emerged:

- Defining the patient group and their journey in care
- Seeing the "whole" person
- Devolving care ("falling through the gap")
- Making it happen and moving forward

These themes are examined below and are illustrated with quotes typical of each theme and, where appropriate, sub-themes are also explored. The identity of participants is anonymised; however, we have ascribed a code to each quote to show professional status and location of work.

Participant codes	
RMN1 DU	Registered Mental Nurse (Day Unit)
RMN2 DU	Registered Mental Nurse (Day Unit)
OAPLS 1	Older Adult Psychiatric Liaison Service team member
OAPLS 2	Older Adult Psychiatric Liaison Service team member
CMHT 1	Community Mental Health Team member (group 1)
CMHT2	Community Mental Health Team member (group 2)
SH5OAP	Senior Registrar (Psychiatry of the Older Adult)
ConOAPsy 1	Consultant in Psychiatry of the Older Adult (1)
ConOAPsy 2	Consultant in Psychiatry of the Older Adult (2)
ConOAPsy 3	Consultant in Psychiatry of the Older Adult (3)
CNS CB team	Clinical Nurse Specialist, Challenging Behaviour team member
ClinPsy CB team	Clinical Psychologist, Challenging Behaviour team member

Defining the patient group and their journey in care

Many of the participants in the study stated that they did not routinely see or assess older adults with a SMI (long-term schizophrenia and bipolar affective disorder) and both nursing and medical staff suggested that the numbers of patients with schizophrenia and bipolar disorder had declined over the preceding years:

> "*Probably not very often, maybe once or twice a year*" (OAPLS 1).
> "*Sometimes, but not as much as before*" (ConOAPsy1).

Clinicians explained that it was their responsibility to diagnose what constitutes serious mental illness. One of the clinicians interviewed suggested that she might see approximately 5-10 older patients a year with a diagnosis of long-standing schizophrenia. For those diagnosed with bipolar affective

disorder, numbers appeared to be even less. It was suggested that the presentation of patients with bipolar and schizophrenia was less likely to be observed in old age services since they were likely to remain under the care of those services related to working age adults:

> *"…they have got a graduate kind of system where people who are working age adults with chronic or enduring mental health problems and there is great difficulty between working age adults and older people's services in negotiating who takes over their care once they reach this traditional age of sixty five [years]"* (OAPLS 2).

The study's initial focus was on older adults with a SMI, such as bipolar and schizophrenia disorder, although it was apparent from interviewing some of the clinicians that they routinely came across older adults with other conditions, including long-term depression, delirium and dementia so we have included this data in our analysis.

Accessing the services

Participants described how referrals to the older adult mental health service could occur in numerous ways, dependent upon the needs of the person and the urgency of the presenting situation and the service the person was being referred to; for example, patients might be referred by their General Practitioner (GP), a social worker or a general older age physician to the Psychiatric Day Unit for Older Adults or to the Community Mental Health Teams or, possibly, to the Challenging Behaviour Team.

A member of the Challenging Behaviour Team highlighted how staff in the community, for example in nursing or care homes, lacked the skills and training to care for older adults who displayed challenging behaviour. They also described how GPs tended to automatically refer such people to the Challenging Behaviour Team:

> *"The GP would refer to us and again the psychiatrist wouldn't see the person either because they're challenging…"* (CNS CB team).

In general, being able to communicate with patients who were displaying challenging behaviour - for whatever reason - was viewed as being problematic when the person was cared for outside of the Mental Health Trust.

The Psychiatric Day Unit also took referrals from other healthcare professionals such as social workers and specialist nurses. Participants from the Day Unit also suggested that they too saw limited

numbers of the group which had originally been identified as the focus of the study (i.e. patients with long-standing bipolar and schizophrenia disorders).

Where older adults with serious mental illness were being cared for in Acute Hospital Trusts for a physical illness, a referral might be made to a member of the Older Adult Psychiatric Liaison Service (OAPLS) for assessment and advice:

> "*From the ward[s], the ward will refer, particularly if someone's behaviour is challenging as well, the wards are more likely to refer to us…*" (OAPLS 1).

Such referrals often occurred when the needs of the patient were complex and there was an urgent need for rapid assessment of the patient. Referrals could come from any ward which cared for older people. However, participants explained how the OAPLS sometimes received inappropriate referrals, particularly from junior medical staff who, it was felt, when making referrals, failed to appreciate the remit of the OAPL service. Participants felt that these types of referrals were made as a "tick box" type of exercise:

> "*We do get some referrals where people are just generally known to psychiatry…someone picks up on that somewhere in the medical notes. There might not be any new presenting problems, the person's mental health issues might be well managed already but because someone sees "known to the service" they might refer them*" (OAPLS 2).

There appeared to be lack of specific guidance on whose responsibility it was to oversee the care and support of those patients who were admitted from the community onto wards in an Acute Trust when they were diagnosed with a physical illness:

> "*…I don't know if it is written anywhere that they have to [members of the CMHT] …I think…there is still overall responsibility for their care, and I think that some community services will come into hospital to see them. Similarly [with] the elderly…*"(OAPLS 1).

Referrals from within NTW were viewed as being more straightforward. Despite the re-configuration of the Trust and the movement of staff to different locations, participants felt that health staff were more likely to know the most appropriate person or service to contact if they had concerns about a particular patient.

An Old Age Psychiatrist also pointed out that older adults themselves sometimes felt that there was stigma attached to being referred to mental health services which could cause problems in terms of referral and assessment:

"We get all sorts of people saying, 'Well, do I have to go that place? I am not that bad...'
(SH5OAP).

Seeing the "whole" person

Once referred to older adult mental health services, staff described how they used a holistic approach to assessment:

"…it's a double-edged sword…your mental health and your physical health are so closely linked together …if you are a mental health nurse, the patients that we see…that is part of our screening that we do…part of our assessment, we are looking at their nutrition, diet, we are looking at their sleep, we are looking at all the basics…" (CMHT 2).

Clinicians spoke about the essential need to see physical health and mental health as being equal: it was felt that these needs could not and should not be separated:

"I think that it is very difficult to disentangle to what extent the physical health has got an impact on the mental health and also to what extent the mental health has got an impact on the physical health…because, especially, in old age, physical health has got a lot of feedback on the psychological well-being of the elderly" (ConOAPsy1).

There was a perception that within general adult medicine or surgery, staff simply dealt with the presenting problem, rather than considering the holistic picture:

"…and I think that is why mental health is always seen as the lead for older people because we tend to be more holistic, looking at…whereas if you go to say, for example, a consultant for urology or whatever, they will deal with that problem and that's it, whereas we will…" (RMN2 DU).

Similarly, within the community setting, a member of the CMHT highlighted the case of an older patient with a SMI who had long-term history of deliberate self-harm, who was diabetic and required insulin injections. It was perceived that district nursing staff were reluctant to become involved in the care of such a patient:

"…trying to get through to the district nurses to go in and give the diabetic…it was just an absolute nightmare and the bottom line is that if the person has deformed fingers and arthritis and couldn't [physically] give the injection then the district nurse would go in…you just couldn't script that, could you?" (CMHT2).

Challenges of caring for the physical health needs of patients who also had a SMI

Despite the strong belief that patients should be treated as a "whole", participants felt that it was becoming increasingly challenging to care for the physical health needs of patients who also had a SMI. In the past, they felt that it had been easier to address patients' physical health needs:

"We used to do a quite a lot of that in the past. When I first came here we used to deal with all of it but now we have stopped and we've started to realise that all of the input [necessary] from a physical health point of view, takes away from what we can do from a mental health aspect so we do encourage a lot of people to go and see their GP" (RMN2 DU).

It was perceived that attention to the patient's physical health needs could detract from the main reason the patient was in the care of mental health services in the first place.

CMHT staff indicated that they would like to be able to extend the length of time with which they were involved in a patient's care, but found themselves being compelled to reduce the time spent with patients and to discharge them at an earlier stage than they would like to:

"...we would like to do this, extend the time that we see that person, because it just doesn't happen" (CMHT2).

Growing pressure upon finite resources, in combination with increasing numbers of patients being referred to the older adult mental health services, caused participants to see services as becoming "stretched":

"I get the feeling that it's also more challenging because I think in terms of resources and allocation of resources… I see it day-to-day. We get more and more referrals. So we are being asked to do more, more and more and you just get the sense that really people are just keeping things ticking over and that's it" (SH5OAP).

This, he felt, was more challenging when caring for older patients, because of their complex needs:

"[They are] very vulnerable, not only due to the age they are, but also due to mental health problems" (SH5OAP).

A further perception was that, amongst such patients, physical health needs were becoming more common:

> *"…it's becoming increasingly common and [the] patients we see admitted to our wards have physical co morbidity, or [are] maybe frail and [have] a high degree of complexity and with the aging population that is going to increase. So I think that it is part of our responsibility to be able to manage the physical and mental health aspects on the ward"* (ConOAPsy 3).

Devolving physical care ("falling through the gap")

Participants pointed out that older adults as a result of their complex mental and physical health needs might require input from a number of specialties. This could create the potential for patients to "fall through the gaps" between services due to the absence of an appropriate health care professional overseeing the patient's "holistic care":

> *"The elderly they are under a lot more clinicians than someone who is younger and so, sometimes, I suppose, although the GP should be the orchestra, or conducting the orchestra, sometimes it's just you know with the patients, the number of things that happen to them, that doesn't happen as quickly as it should"* (ConOAPsy2).

Whose responsibility?

The role of the General Practitioner (GP) was seen as crucial to the management of the physical health needs of older adults with a SMI. Participants felt that GPs had a responsibility to be involved in the care and support of their patients, not least because they were financially re-numerated for the care:

> *"The GP has got the responsibility particularly if the patient has a SMI and a co-morbid chronic health problem"* (CMHT 1).

It was queried whether the older adult mental health services should take on what participants saw as the GPs remit:

> *"I suppose the thing is…with us being a mental health unit, I don't know if we should be taking on any physical health issues because that is the remit of the GP; they are the practitioners who are meant to be dealing with such issues in the community"* (RMN1 DU).

Whilst psychiatrists indicated that they found communication with GPs satisfactory, in contrast, nurse participants commented that it was often challenging to engage with GPs:

> *"From the remit of a physical health problem here, with us being a mental health unit, I suppose that it is difficult to do a lot of things. We have difficulty getting GPs on board to do things for our patients"* (RMN2DU).

It was acknowledged that some GPs were very good at responding to requests that nurses made, but others suggested that GPs' responses were less favourable or, indeed, totally absent, even after numerous requests, for example, for changes in medication.

Participants from the Community Mental Health Team described how on the occasions when they discharged patients back to the GP, the care that was provided was "only as good as the GP Practice or as good as the District Nurses:

> "*You don't have a lot of confidence when people go back into Primary Care….*" (CMHT 1).

It was suggested that this was because such patients were perceived as difficult to manage, whilst patients themselves might not have the capability to manage their own health care needs:

> *"We have patients who have physical health problems and who aren't necessarily compliant or who are difficult to manage in the community and they don't get the care they need because of their mental health issues. So sometimes, I think that it's a bit of a let-down. Sometimes, patients with dementia have no family and they are living alone, they are not remembering to go to GP appointments, they are not remembering to go and get their medications and if we are not involved, who is doing that? Who chases that up? That is a concern*" (RMN2 DU).

She went on to ask who should take the responsibility for this, if GPs did not co-ordinate the physical and mental health needs of older patients with SMIs:

> *"…my concern is that if you are a bit more vulnerable and you have mental health issues unless you've got someone "fighting your corner" you aren't going to get the care. I think that is what my concern is*" (RMN2 DU).

Nurse participants from the Day Unit felt that if the patient had family to support them, it was the family carer's responsibility to take the patient to the GP for physical health needs; however, this was

sometimes a challenge. Nurses perceived a tendency for some carers to develop a dependency on them:

> "*I think that people, their relatives, develop a dependency upon us, on the Day Unit so we do end up being given responsibility for people's physical health needs when we don't need to have that responsibility…they haven't checked them over, they haven't taken them to Accident & Emergency, they haven't got the GP out, they haven't taken them to the walk-in centre and there's an expectation from the relatives, possibly because they feel more comfortable with us that we are going to check their relative over*" (RMN1 DU).

An over-dependence upon staff was perceived as being disadvantageous for both staff and patients. Nurses on the Day Unit said that where possible they encouraged older adults to manage their own physical health care needs; this might involve a family member, if appropriate. Nurses suggested that this type of approach helped empower patients to be involved in the management of their own care where they were capable of doing so:

> "*We may let the family, or the person themselves, if they are capable of doing it, let them chase up the information letter*" (RMN1 DU).

It was a different type of situation when patients did not have anyone who was able to take responsibility for their physical care needs and, on occasions and where necessary, mental health staff described how they would step in and act on the patient's behalf; either as an advocate or, alternatively as a support; for example, by accompanying them to hospitals appointments:

> "*We do get some people who don't like going to see a doctor and won't go and their family won't/can't take them for "love or money". If that person doesn't have anyone to take them …we support when we can. If it is difficult to engage that person with other services just from their physical health, then we may support them or their family to take them. If the person doesn't have family and we don't think that they are capable of doing that*" (RMN1 DU).

Lack of integrated care

A senior clinician described how some patients tended to "come back" into the care of mental health services once they had been transferred due to a failure of provision on behalf of other services:

> "*I believe that [this] is not only a failure of the medical health system but it is also a lack of input from social services and other affiliated services. Because if a patient is discharged with increasing needs and social services are not able to provide for those needs, then there*

would obviously be a failure in the discharge plan and the patients will come back" (ConOAPsy 1).

The lack of available support from social service departments was an issue picked up by the Community Mental Health Teams. It was suggested that having a SMI was not deemed a suitable reason to access such support:

> *"..cos' social services wouldn't give you a bath…let alone take you to an appointment. A SMI isn't deemed a reason, an appropriate reason, you've got to have a broken leg, or you can't use [the service]…"* (CMHT2).

Participants from the Day Unit also described situations where responsibility for the patient's physical needs was passed from the Acute Trust to the Mental Health Trust. The example was given where staff on the Day Unit had been approached by staff from a general acute ward to take responsibility for the monitoring of a patient's blood glucose levels:

> "*We were asked by the diabetic centre to manage the blood glucose levels but we were only seeing them twice weekly and we made a decision not to do it because we thought, 'Well, what, how do we take on the responsibility if the person gets really high blood glucose levels? They're not being monitored five days out of seven'. And this person, in no uncertain terms, would not monitor their own blood glucose levels. So we said that, in that particular situation, it was not practica*l" (RMN1DU).

It was evident that participants tried to ensure that patients, wherever possible, were followed up, either when discharged (viewed as a rare occurrence due to the complex needs of older adults with SMI) or more likely, when they were transferred to another service. Potential problems arose when a patient was "transferred" to care outside of the area:

> *"…meaning that we very rarely will allow people to be discharged and not followed up. I have to say that this system is still not 100% solid and there will be instances where people will not be picked up by the community mental health teams, or, for instance, the majority will not be picked up by community mental health teams if they move out of our area. Then our ability to approach these community mental health teams is relatively sparse*" (ConOAPsy1).

One nurse gave an example of a male patient with a complex diagnosis who was discharged back into the care of a nursing home, revealing the challenges of providing a seamless transition from hospital to the community setting, for older adults with mental and physical health needs:

"(His condition) means that he will continue to deteriorate quite rapidly. What happens is that, physically, the body just starts to shut down. For him I had to …I had a consultant neurologist [involved], the SALT because the condition causes swallowing difficulties and problems with speech and language, breathing difficulties. So when he was discharged, I alerted the DN, the care home he was in, the GP, the consultant neurologist, the community nurse (MHT) and, the SALT " (RMN2DU).

Participants spoke of the difficulty that they sometimes faced when trying to liaise with other health professionals:

"It's also difficult also liaising with other health professionals. You almost think, and keeping everyone in the loop because what happens with some of these patients that they are seen by so many different specialists, and some of the…even sometimes the GP doesn't know in time" (SH5OAP).

Making it happen and moving forward

Within NTW Trust, it was clear from participants' that work was in progress to address the physical and mental health needs of older adults with a SMI:

"There's a huge amount of work that's happening within the Trust around the transformation because…at the same time, [there is] this unrelenting pressure upon the public purse [because of the aging population]" (ConOAPsy 2).

Participants indicated that they were aware of policies and guidelines both within the Trust and nationally which referred to the physical needs of patients with SMI, including those specifically aimed at older adults; for example, relevant reports by the Royal College of Psychiatrists. In terms of practice, one consultant spoke of the use of a 'track and trigger system:' a modified early warning system to monitor the physical health needs of patients on the wards and that a Senior Nurse led on the *Safety Thermometer* for the Trust, to assess risk, for example, of falling. Consultant Psychiatrists and nurses on the Day Unit in particular, indicated that they had good links with Care of the Elderly Physicians in the Acute Trusts. They, together with members of the CMHT, emphasised the crucial role of the OAPLS in providing appropriate support for patients with SMI. In addition, one psychiatrist described how one of the lead nurses in the Trust had undertaken a great deal of work around physical health checks and monitoring, particularly around patients with anti-psychotics whilst physical health clinics were being established within the Trust. Recently, the Trust had employed a specialist

nurse practitioner in the continuing care wards to monitor the physical health needs of patients, some of whom could have been on the wards for many years.

The need for education

In terms of continuing to improving the physical and mental health needs of older adults with a SMI, one clinician spoke of the need for staff in care homes to be educated in the management of challenging behaviour and suggested that, at the present time, such training was, perhaps, "disjointed". It was highlighted that there was "care home liaison" where staff worked with the staff in the care homes to educate them about challenging behaviour and how best to manage it. He further suggested that such an effort should be led by primary care.

On-going education of both medical and nursing staff was seen as a priority for many of those interviewed. This need for education was seen as necessary at both pre-qualifying and post qualifying levels. One of the nurses interviewed felt that there was a lack of awareness among nursing colleagues on Acute Trust wards concerning care for patients with mental health needs:

> "…I've been on to the general wards and I've said "this is pretty much the patient, this is how they are" and they've said "Oh, my God, how do you nurse them?" and it's simple things like "how do you manage that?"…they find it hard to understand like "this is how they ALWAYS are!" and you are, like you know, "yeah, yeah, this is how they present" (RMN2DU).

It was acknowledged that the Day Unit, as well as other appropriate services/units within NTW Trust, recently had begun receiving adult nursing students on placement in an attempt to offer them an insight into the needs and the care of patients with mental health needs, so it was felt that this situation was likely to improve in the future:

> "…I would like to think that it would, that it would help if they did have a little bit of knowledge. One of the things that we are getting is that we have a lot of students on the unit as well, and we are getting adult nurses who are going to do physical medicine or general nursing and a couple of times they have said "We are scared to be here, we don't know what to expect. Are they going to be violent?" and sometimes I think "there are nurses coming up and they are saying "I'm scared" and sometimes, I think that we go on these medical wards and sometimes the staff don't know what to expect…it's quite strange for them, so, yes, I think so" (RMN2DU).

Similarly, one clinician suggested that raising awareness of the physical and mental health needs of the older person needed to be commenced earlier in the medical undergraduate curriculum and continued in post graduate education:

> "*I think that we need to reinforce these issues, even very early on in the education. We start treating, talking about dementia to our second year medical students and we need to be talking about the physical health and the combination very early on. I think that education is one of the initial problems*" (ConOAPsy1).

Whilst he felt that more senior and specialist staff were aware of guidelines and policies concerning good practice for the care of older adults with SMI and physical health needs, he argued that this information needed to be disseminated amongst more junior staff; for example, through the innovative use of technology, such as APPs.

Establishing a community psychiatric liaison service for patients

The complexity of managing older adults with physical needs and SMI was emphasised and it was felt that GPs did not always have the knowledge, skills and experience to handle such cases appropriately:

> "*The GP has the responsibility to make sure that people are seen regularly in their clinics through the recall system, but where things fall down is where mental health teams can help and obviously we know people with SMI don't attend routine appointments and that's more the problem. And that's where the liaison needs to take place*" (CMHT 1).

It was suggested that a community psychiatric liaison service - with a similar function as the OAPLS - could be developed in order to co-ordinate the care of patients with SMI in the community setting. It was felt that this would improve communication channels between relevant services. It was also perceived that the availability of community based psychiatric liaison workers might help to prevent crisis situations arising where patients who were both physically and mentally unwell then needed to be admitted to hospital as an emergency. Another nurse commented on how better liaison with primary care staff might prevent patients from being re-admitted to hospital/re-referred to a service:

"…it would be better if there was some better kind of liaison link with/in the community because sometimes we will ring GPs up and they will do things half-heartedly or not do things, or only do things that they have to and the patient will then come back to us" (RMN1 DU).

Discussion

This qualitative study has highlighted and added to our understanding of health practitioners' attitudes and perceptions from one Mental Health Foundation Trust, concerning older adults with serious mental illness and their physical health needs. Analysis of the data revealed four key themes: defining the patient group and their journey in care; seeing the "whole" person; devolving care ("falling through the gaps"); making it happen and moving forward. Participants in the study had positive attitudes towards older adults with SMI, and they described areas of good practice which addressed the physical healthcare requirements of these service users. Despite these positive overtones, gaps in service provision and organisational structures are apparent.

The findings are consistent with previous literature; however much of this does not focus specifically on older adults, who have even more complex needs than their younger counterparts (RCP 2009a; Clifton, Marples and Clarke 2013).Our findings reflect those of Druss (2007) who highlight the "system issues" which often result in poor quality of care for this marginalised group of service users. Indeed, a recent report produced by the Royal College of Psychiatrists (2013) identifies the inequalities in care that people with mental health problems experience. In addition, a report on the findings from the Mental Health Foundation's Inquiry into integrated health care for people with mental health problems (MHF 2013) recommends that the focus should be on major social and structural influences such as education, unemployment, housing, poverty and discrimination, rather than just on support given to individuals based on a medical diagnosis of mental illness.

The current study revealed numerous factors which influence the service delivery received by many older adults with SMI. Service users appear to be moved through services dependent on their presentation (rather than their need) and, more often than not, are shunted between primary care, mental health services and acute medical services without a coordinated approach.

Some participants felt that they were addressing the physical healthcare needs of older adults with a SMI and many spoke of adopting holistic assessment approaches. In addition, clinicians pointed to the adoption of progressive Trust-wide approaches to address the physical health needs of patients with SMI, such as the 'track and trigger system', the establishment of physical health clinics for patients on long-term antipsychotic medication, and the employment of a specialist nurse practitioner on continuing care wards to monitor the physical health needs of patients. However, on further probing, there was a feeling from some participants, that on balance, it was becoming increasingly challenging to manage physical healthcare needs in addition to managing more pressing mental health issues. Furthermore, there was recognition in terms of commissioning and the growing pressure on resources that, in line with policy guidance, responsibilities of this particular aspect of

care resided with General Practitioners who are indeed remunerated via the Quality and Outcomes Framework (QOF) to take on this responsibility (Hardy and White 2013).

Participants in our study consistently emphasised the important role GPs have in orchestrating the physical healthcare needs of older adults with SMI, although they also voiced concerns about the capacity of primary care services to adequately manage the ever increasing complex needs of this client group. Although this situation could, potentially, be seen as one of "passing the buck" between primary care services (and, perhaps to a lesser degree Acute Trusts) and the Mental Health Trust, it does possibly present a situation for a critical rethink of how best services may be provided to offer the more appropriate support to a growing and increasingly vulnerable group of service users; service users who often do not readily comply with care programme management plans.

It appeared from the information provided by participants that there was a hiatus in what ideally should happen and what actually did happen in practice. From the information that was collected, it was very difficult to establish whether there was any meaningful communication going on between the primary health care services and the Mental Health Trusts. Not being privy to this type of information might have been due to the fact that we were unable to interview those members of staff who would have had this type of information (such as GP Commissioners) but the clinicians we did interview, felt that many older adults with SMI and physical health care needs were falling through the gap, despite their best efforts. Participants were unaware of specific guidance on whose responsibility it was to oversee the care and support of those patients who were admitted from the community onto wards in an Acute Trust when they were diagnosed with a physical illness.

Despite these reservations, many participants remained positive in their attitudes to improving physical healthcare outcomes for older adults with SMI. The Mental Health Trust was making steady progress, particularly with inpatient wards, by implementing early warning systems to monitor physical healthcare needs and there was recognition of the importance placed on pre and post qualifying education for all healthcare professionals to maintain and improve on their skills and knowledge of this area of practice. Finally, there were some early and very tentative signs of linkage between primary, acute medical and mental health services taking shape in the locality. It was suggested that the establishment of a community psychiatric liaison service would improve communication channels between relevant services and help prevent crisis situations arising for patients who were both physically and mentally unwell.

Conclusion

In conclusion, there is evidence that efforts are being made to produce a more integrated system of healthcare to properly manage service users' co morbid physical and mental health care needs. However, there is growing concern that the current structure of services is allowing service users with

more complex needs to 'fall through the gap', due in part to a lack of clarity about where responsibility lies at different points of a service users journey in care. Exploring the potential of establishing a community psychiatric liaison service in order to co-ordinate the care of patients with SMI in the community setting could prevent crisis situations from arising from a lack of integrated care.

More collaborative working between relevant services is needed in order to share expertise, skills and information to facilitate more integrated models of care: for example, Acute Trusts, Mental Health Trusts, Community Trusts, as well as social services.

Ongoing education of all healthcare staff was identified as a priority in order to continue to improve the physical and mental health of older adults with SMI. It is recommended that Trusts work in partnership with Higher Education Institutions, to continually review the content and delivery of pre and post qualifying education for all healthcare professionals to maintain and improve their skills and knowledge in this area of practice.

Statement of ethical approval

Full ethical approval was gained from the appropriate ethical and governance bodies (Northumbria University Ethics Committee) and the relevant governance body at NTW NHS Foundation Trust. Since staff only were included, it was not necessary to gain ethical approval from the local NHS Ethical Review Committee.

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Declaration of contribution of authors

Andrew Clifton (AC) and Amanda Clarke (AEC) conceived the idea. AC, AEC and (GM) Gwen Marples collected data. Data analysis was conducted independently by two researchers Jane Wilcockson (JW) and Barbara Harrington (BH) and emerging themes discussed with the wider team; AC, AEC, GM and DB (Danielle Brady). All authors contributed to writing and approving the final submission.

Statement of conflict of interests

None

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