'A positive thing by mentioning it': a qualitative study of experiences of brief physical health interventions for individuals diagnosed with severe mental illness in primary care

Hassan Awan (1)
Mohsin Allah Ditta (2)
Mick McKeown (3)
Karen Whittaker (4)

(1) Campus Day Facilitator, University of Central Lancashire; Wellcome GP Fellow, Keele University; GP, The Robert Darbishire Practice
(2) Family Medicine Specialist, Omar Bin Khatab Health Centre, PHCC, Doha
(3) Professor of Democratic Mental Health, University of Central Lancashire
(4) Visiting Fellow, University of Central Lancashire.

Corresponding author:
Hassan Awan,
Wellcome PhD Fellow
1.76 David Weatherall Building, School of Primary, Community & Social Care,
Keele University
Email: hassanawan@doctors.org.uk

Received: August 2020; Accepted:September 2020; Published: October 1, 2020.
Citation: Hassan Awan, Mohsin Allah Ditta, Mick McKeown, Karen Whittaker. 'A positive thing by mentioning it': a qualitative study of experiences of brief physical health interventions for individuals diagnosed with severe mental illness in primary care. World Family Medicine. 2020; 18(10): 84-90 DOI: 10.5742MEWFM.2020.93878

Abstract

Objectives: The physical health of people diagnosed with mental illness is a significant source of health inequality, with this group being three times more likely to have a physical illness and dying 15-20 years earlier than those without diagnosed mental illness. Unhealthy lifestyles are a major contributor to this. The purpose of this study was to explore the barriers and facilitators of the Making Every Contact Count (MECC) approach, an opportunistic health promotion strategy for improving the physical health of patients with diagnosed mental illness in primary care.

Methods: A qualitative study involving semi-structured interviews in which ten people diagnosed with mental illness from a Lancashire practice and ten GPs including stakeholders within the Clinical Commissioning Group were interviewed. Interview data was subject to thematic analysis.

Results: Themes were identified relating to patient factors, clinician communication, and systemic factors. Patients were more likely to take on brief interventions if they trusted and had good rapport with their clinician. Clinicians, if given the chance, valued opportunities for discussing the effects of unhealthy lifestyles with patients. Systemic factors influencing the MECC approach included provision of continuity of care and the annual review, although some patients viewed the latter as rarely offering fruitful discussion. Some clinicians felt time and workload pressures prevented them from carrying out meaningful interventions. Clinicians felt further training was needed to support them delivering brief interventions. Patients were pleased to focus on physical health.

Conclusion: Poor physical health of patients diagnosed with mental illness can be addressed using a 'making every contact count'-based approach. MECC is a low-resource approach based on building a relationship of trust and casually introducing physical health as a topic of conversation as the opportunity arises. The research highlights barriers and facilitators to doing this within primary care from both patient and clinician perspectives.

Key words: Health promotion, Health inequalities, Mental Health, behaviour Change, Making Every Contact Count, Primary Care

Introduction

Reducing health inequalities is a key goal of public health policy. The physical health of patients diagnosed with mental illness is a source of significant health inequality. People with long-term mental health problems are three times more likely to have a physical illness and die 15 to 20 years earlier than their peers without a mental health diagnosis(1-3) .The gap in life expectancy is worsening (3-4). Main causes of death are heart disease, stroke, liver disease, respiratory disease and cancer(1,5). This may be primarily because of lifestyle factors, harmful effects of psychotropic medication and disparities in healthcare access, utilisation and provision (5). Increased rates of unhealthy lifestyle choices such as higher rates of smoking and obesity may be due to negative symptoms of mental illness and impaired emotional regulation (6-7). The literature indicates that general practice is significant for providing preventative health and medical care for people with mental health problems (8-9).

Health related behaviour change is notoriously difficult to achieve yet extremely important in the context of rising rates of non-communicable disease. The primary care team is well placed to understand patients' economic and social circumstances as they develop relationships with individuals and families over decades and countless practice encounters.

Making Every Contact Count (MECC) is an approach to behaviour change that capitalises upon these routine interactions between patients and health professionals to encourage positive change to physical health and mental wellbeing. It is an opportunity to achieve an integrated approach to addressing health inequality as part of a range of interventions(10-13). It is an approach consistent with principles of person-centred healthcare that makes the most of opportunities for health promotion specific to individual need' (14). Through the MECC approach professionals can act on opportunities to introduce physical health and well-being into conversations, without offending the individual (15-16). Brief interventions typically involve using behaviour change techniques to support patients to take action around unhealthy lifestyle behaviours (16). Research has shown that opportunistic health promotion such as MECC has the potential to improve the overall health of the population at a low cost (16). Application of the MECC approach has been argued to impact health inequality by engaging people who would not otherwise engage in brief interventions (17-18).

However, there is little research evaluating the implementation of the MECC approach to health behaviour change in primary care, and no such evaluation has been undertaken for people with mental health problems in this context, nor have the views and experiences of patients and clinicians been investigated. The purpose of this study was to explore the barriers and facilitators of implementing the MECC approach for primary care clinicians and patients who are under psychiatric services.

Methods

Participants were purposively recruited from a single General Practice (GP) surgery in Lancashire. Prospective patient participants were invited using a poster in the surgery reception as well as via the patient participation group Facebook page. The inclusion criteria for patients were adult patients aged 18 to 65 with capacity who were under or had previously been under the care of psychiatric services, this was to focus the research on patients with severe and enduring mental illness who are worst affected by physical health inequality (5). Purposive sampling ensured patients with a variety of mental disorders were included, from different age groups and genders. Clinically active GPs were recruited via email, diverse with regard to gender and age and the practitioner sample also included GPs with a role in commissioning. Semi-structured interviews explored experiences, perceptions, and acceptability of the MECC brief intervention model. All interviews were face-to-face, at the Practice for patients and at the place of work (or another preferred venue) of GPs. With participant consent, all interviews were audio recorded and transcribed. Field notes were written during and shortly after interviews. These included comments on what interviewees said, salient points and the emotions and reflections of the interviewer and were referred to during data analysis. Sample size was based on principles of data saturation (19); ten patients and ten clinicians were interviewed.

Patients were asked to describe their journey of care with reference to brief interventions. Their views and clinician' views were sought of current services, gaps in provision, and perceived barriers and facilitators to delivering brief interventions within primary care. Aspirations for future service delivery, including referral mechanisms, components and approach to delivery were also sought. Six key questions were considered:

- What experience do people with mental health problems have of receiving brief interventions to improve their physical health?
- What experience do clinicians have of delivering brief interventions to people with mental health problems to improve their physical health?
- What are the facilitators for people with mental health problems to engage with brief interventions to improve their physical health?
- What are the facilitators for clinicians to implement brief intervention approaches to improve the physical health of people with mental health problems?
- What are the barriers for people with mental health problems to engage with brief interventions to improve their physical health?
- What are the barriers for clinicians to implement brief intervention approaches to improve the physical health of people with mental health problems.

Ethical approval was obtained via NHS HRA processes (IRAS ID 200959) and UCLan university ethics committee. Patients who had given their details to be interviewed were given a participant information sheet and a minimum of 24 hours 'cooling off' period prior to obtaining written consent. Support was on hand should an individual become upset or distressed during an interview, though this was not required. Data was stored in locked filing cabinets in a locked office, held on password-protected computers and encrypted accordingly. Identifiable information held about participants was destroyed 6 months after final data collection.

Thematic data analysis was undertaken according to principles set out by Bazeley (20). Each transcript was anonymised. Transcripts were initially read briefly in completeness to gain a broad understanding capturing the essence of the interview, and then re-read in further detail. The data was coded, labelled, summarising and linking discrete portions of data, and then grouped into categories, linking together 'families' of codes which shared some characteristics. These categories were later organised into themes; higher-level and abstract concepts which were drawn out in the course of analytical reflection. Investigator triangulation occurred whereby the research team reviewed the raw data, discussing codes, categories and themes in regular meetings, enhancing the depth and nuance of analysis.

With regard to reflexivity, the interviewer was a research student who also worked as a trainee GP. Recruitment of clinicians was easier than expected, potentially due to the perception of supporting a colleague within their work. Some clinicians gave strong and at times controversial views, which may have been due to feeling able to converse openly with a colleague in a similar position to themselves. Mental health service users were aware of the dual role of the interviewer, as both a researcher and a GP. To be aware of and minimise bias and strengthen awareness of researcher rather than clinician role, a reflexive diary was kept.

Results

Ten patients were interviewed, three men and seven women, with ages ranging from 30s to 60s. Diagnoses included severe depression, paranoid schizophrenia, bipolar affective disorder, schizoaffective disorder and personality disorder. All were taking psychotropic medication. Of the 10 GPs interviewed, seven were male and three were female. All bar one were involved in extra clinical activities, such as with the Clinical Commissioning Group, medical education and out-of-hours work. Interview lengths were commonly around 40 minutes. Key themes identified accounted for patient factors, clinician communication and systemic factors. Participant names have been replaced with pseudonyms and a forename reflective of gender. Clinicians have been given pseudonyms with 'Dr' to differentiate from service users.

Patient factors

Demand for brief interventions: Patients expressed clearly that they wanted brief interventions and that they found them a valuable part of their primary care experience. Thomas felt brief interventions should be *'brought up all the time, yes, because it's good, because it's helping the person* (Thomas).' In fact, even when patients did not feel in a position to make changes, they still felt that the advice should be offered. For example, regarding smoking cessation *'You're doing a*

Figure 1: Themes

positive thing by mentioning it. Whether the patient wants to take it up, it's down to them really but yeah, I think it's good (Teresa).' There was a sense that patients felt better about themselves because their physical health was inquired into, as opposed to feeling only defined in terms of mental disorder.

A minority of patients did not feel they needed brief interventions. For example, *'I think the thing is I haven't asked for a solution… it's the patient's responsibility for me to ask you* (Anna).' This implies that the onus is on patients to raise their unhealthy lifestyles and ask for advice rather than being brought up opportunistically by clinicians.

Patient vulnerability: Vulnerability within this context refers to the increased susceptibility to health problems as well as reduced coping mechanisms or ability to make lifestyle changes without support in patients with severe mental health illness. The demand for brief interventions was felt by clinicians to be stronger in this patient group due to increased vulnerability, as '*mental health patients as a cohort are more vulnerable and a lot of them, there is a reliance on the GP to guide them* (Dr Ahmed).' This highlighted an increased responsibility of clinicians to be proactive when managing this cohort's health. Vulnerability made seemingly simple habitual acts become challenging, as *'it is a big thing for me to have a shower every day, brush my teeth every day.'* If such acts require significant motivation and determination, it can only be assumed that achievements such as stopping smoking and other lifestyle changes would be more challenging.

Mental health: When patients' mental health was stable, clinicians felt more able to take opportunities to deliver brief interventions. Dr Smith explained *'in fact they have just got a mental health issue just like someone (with) a lung problem and they are just getting on with it and managing it fine, so they should be treated exactly the same as all other patients* (Dr Smith).' By having healthier lifestyles patients felt that their mental health improved, for example *'I've certainly seen mental health can be improved greatly by exercise* (Dr Stevens).' In periods of low mood Dr Khan felt it may be beneficial via giving small achievable targets which can boost self-confidence and morale, *'building yourself up'* as dealing with something like smoking can lead to a '*quick win'* that may build confidence and coping ability.

Clinicians were less willing to deliver brief interventions when a patient's mood was unstable. If one were to bring up lifestyle intervention in this stage it could give the impression that *'I am not listening* (Dr Hughes).' If brief interventions were brought up in a crisis *'I would have probably taken it as another insult and that I wasn't worth anything* (Sarah).'

Clinican communication

Rapport: Clinician communication is a core concept in the effectiveness of any brief intervention or any fruitful clinician-patient relationship. If the clinician does not have good communications skills and causes a negative experience for a patient '*they're not going to want to come to the doctors for anything* (Kate).' Rapport was considered as *'half the battle or probably more* (Dr Khan).' Sarah stated her reason for making a lifestyle intervention was that '*you know try and cut down like (Name) says. Because (Name) is nice and very kind* (Sarah).' This positive attitude was felt to come from '*being genuine in what you're doing* (Dr Khan).' There was a concern from clinicians that rapport could be damaged by discussing brief interventions, as *'some people could take offence that you're asking them to stop drinking, stop smoking* (Dr Jones).' This fear of brief interventions damaging rapport appeared to be more of a potential rather than actual experience, as '*I've not known it to go down badly* (Teresa)'.

Dr Jones described how it is necessary to *'tailor-make*' the intervention according to the patient's understanding and interests and provide healthy alternatives. For example, one patient explained the financial cost of cigarettes made her decide to quit. The clinician's role was felt to be an '*agent of change* (Dr Avons)'. Anna felt that brief interventions were only useful in a '*partnership approach*' of joint responsibility and understanding between the patient and clinician.

Holistic care: The essence of general practice should be *'a continuity of holistic care not just your mental health* (Dr Williams)' and '*primary care team are best placed*' to deliver brief interventions (Dr Hughes).' Conversely, patient experiences included routinely feeling their physical ailments were ignored or paled into insignificance in relation to index mental health issues, '*I think my other practitioners had ignored (symptoms of fibromyalgia) because of my mental health problem* (Lucy).' The effect of an enduring mind-body dualism was highlighted as an area where brief interventions were considered less when dealing with people with mental health problems, as *'you are either doing someone's physical health problem or you are doing someone's mental health problem often, that is how people perceive things* (Dr Ahmed).' Aspects of standard medical practice appear to mitigate against an authentic holistic approach such that one practitioner felt that there was an expectation of poor physical health in patients with mental health problems stating, *'there is an acceptance (of) their physical health will be bad* (Dr Williams).'

There was a significant variation in clinicians' sense of importance of delivering brief interventions. Some were very enthusiastic about discussing diet and exercise as, '*the single best intervention for anything is diet and exercise* (Dr Stevens).'This enthusiasm was not perceived to be present amongst all clinicians and did not always translate into practice. Dr Khan described how *'the reality*

is that we are quite poor at brief intervention… quite often it might just be a flying remark that doesn't get anywhere (Dr Khan). Sarah stated *'no-one ever pinpointed the fact that I was overweight. I was very overweight, I was nearly 14 stone* (Sarah).'

Training needs: Patients felt that clinicians were doing well at their jobs and did not need any further training. For example, when asked if any further training was needed William answered, '*not that I can think of, no'* (William).' A clinician training need was felt for the evidence behind the effectiveness of brief interventions, as '*just seeing that evidence in the first instant gives me encouragement to do brief interventions and the value of them* (Dr Hughes).' Motivational interviewing was suggested by a number of clinicians. In terms of delivery, suggestions included '*role play… VTS (GP training scheme) training (Dr Jones),' 'practices to have training (Dr Ahmed)' and a greater push for public health in 'undergrad programmes* (Dr Hughes).'

Systemic factors

Annual review: Dr Jones described how the annual review is an excellent opportunity to discuss lifestyle interventions as patients attend with this expectation. It was considered as *'a perfectly reasonable opportunity because people usually aren't arriving in a crisis* (Dr Jones).' Dr Smith highlighted cases where multiple medical problems needed an annual review, such as diabetes and mental health reviews, with all the problems being reviewed within the same time leading to less detailed reviews. The annual review was felt by patients to be superficial in addressing physical health problems. Anna stated that she was informed she was drinking *'too much*' alcohol without any further advice. Dr Hughes stated *'it is a tick box symmetric culture have you done this tick, if you press tick you get paid* (Dr Hughes).' Dr Avons felt that illness-based reviews constrain holistic care and also render practices less accessible by using up appointments.

Continuity of care: Continuity of care was viewed as an important facilitator making patients more likely to act upon brief interventions. When continuity is present *'you're going to know that they're not just bringing it up, just for hell of it, they're doing it for the best* (William).' In this case it is the continuity of care that made the patient feel that they could trust their doctor due to the relationship built, leading to potentially better health outcomes. Clinicians were further supportive of continuity of care as a facilitator in the delivery of brief interventions. Dr Jones felt able to build up interventions in a step-by-step manner during multiple consultations to maintain continuity of care. Sarah felt a lack of continuity of care is more damaging for people with mental health problems due to their vulnerability and past experiences, making it more difficult for them to develop rapport and trust others. As well as continuity of care with the same clinician, there was also a type of institutional continuity of care in respect that patients preferred to be seen by services in the same building as opposed to services outside of the building. Kate preferred to be seen in *'a familiar environment'* (Kate) and Anna described a loss of ownership by being sent to different places.

Time and workload constraints: The most emotive category during all interviews was the issue of time within general practice. Clinicians felt that delivering brief interventions would increase the short-term workload, as *'it (lifestyle interventions) increases the workload and it increases the time* (Dr Jones).' Clinicians described it would potentially decrease the long-term workload, *'that hopefully saves me time in the long run, because they might recover better* (Dr Jones),' which is more difficult to consider during a busy day. 10-minute consultations were felt to be '*certainly a barrier to having more holistic care* (Dr Mahmoud).' Dr Hughes felt that the increased workload was a direct contributor to brief interventions not taking place, explaining that *'It is not happening because people are just trying to get through the working day, they are just trying to manage* (Dr Hughes).' Dr Williams agreed, stating *'GPs are all overworked we try and fight fire and you prioritise things, this I suspect you say right where is patients with mental health physical health on your priority list and I think it would be pretty low near the bottom...*(Dr Williams)'.

Conclusion

The results demonstrated patients valued brief interventions to discuss their physical health in mental health consultations, finding it very helpful and affirming a more positive sense of self which should encourage primary care practitioners to deliver brief interventions more often, especially within a mental health consult and ideally at every contact where appropriate. The embrace of holism evident in the findings of this study concords with the policy narrative of Bringing together physical and mental health: a new frontier for integrated care in 2016 in which the fourth priority of strengthening primary care for the physical health needs of people with severe mental illness states that *'Primary care can play an important role in ensuring that people with mental illnesses receive equitable access to care across the system'* (21).

Despite the potential for patients to experience these interventions in a negative way, they actually reported a positive impact resulting from engagement in talk about physical health problems. Such benefits appeared to be conferred independently of any actual commitment to make lifestyle changes. Good clinician communication, good patient-doctor rapport, a tailored brief intervention with good signposting to additional services were key ingredients for making a MECC approach to brief intervention a positive experience.

Notably, even if a patient was unwilling at the time to make any lifestyle change they still had an appreciation for those aspects of the MECC approach that involved positive and proactive enquiries regarding their wellbeing. This may be due to aspects of identity, whereby self-worth is associated with the desire to be treated as a person

rather than a diagnosis. Clinicians demonstrating concern for holistic care may thus reinforce a more positive sense of personhood and improve trust and relationship variables within the clinical encounter. Timing would appear to be crucial: practitioner attention and prioritising of mental distress at times of crisis was valued, and to do otherwise would seem disrespectful. However, the implied recognition of full personhood(22-23) associated with enquiring into physical wellbeing at other times was welcomed by patients who were arguably used to feeling stigmatised and devalued carrying a mental illness label into other medical encounters and in society at large (24-25), with consequential detriment to self-esteem(26).

Some of the key reasons given by clinicians for not engaging in brief interventions during every mental health consultation were lack of time and workload pressures within primary care. Clinicians spoke of ten minute appointments and the 'one appointment one problem' policy. This is a good indicator that policy makers and commissioners should work towards making mental health reviews and consultations longer to accommodate for the opportunity to deliver brief interventions in an attempt to reduce health inequality in this cohort of patients. It is also pertinent for clinicians to remember that any time invested in brief interventions is likely to result in time saved in the long run from the improved physical health of patients with severe mental health problems.

The findings of this study also suggest that it is almost expected that this cohort of patients will have poor physical health and we need to move away from this fatalism and adopt a more proactive approach in primary care by embracing the ***make every contact count*** approach in the knowledge that this will tend to be well-received.

Patients were more comfortable in engaging in brief interventions with clinicians they were familiar with, in environments they were familiar with and valued the holistic longitudinal relationship that primary care is best placed to develop in the context of coproducing patient centred care (27-29). Improving health in the most vulnerable groups can make important contributions to preventing further increases in health inequalities, including the physical health care of those diagnosed with mental health conditions who have a reduced life expectancy due to a constellation of risks, including or resulting in unhealthy lifestyle behaviors (30).

Lawrence et al. (2016) found that trained practitioners showed significantly better and more regular use of the skills needed to assist behaviour change when compared to untrained peers (31). This should also encourage local commissioning groups and primary care networks to deliver training for clinicians on delivering brief interventions.

MECC is based on the premise that clinicians are able to make use of opportunities to deliver health promotion by way of healthy conversations and continuity of care allows for a context of trust to develop. This builds on the relational ideals professed within general practice settings (32). The strength of the research is that it achieved its objective in exploring barriers and facilitators to delivering brief interventions within primary care, furnishing rich data and findings offering new perspectives. It offers suggestions which may have a positive implication on practice.

A limitation is the selection of patients and clinicians who were interviewed. Due to limited time and resources, patients interviewed were from one practice. Patients who volunteered to be interviewed may have been those most keen to work with medical professionals and more actively involved in looking after their health. They may not be fully representative of the population of people with mental health problems. The clinicians being from the same CCG also meant that their experiences of services and provisions, as well as patient populations, may not be fully transferable throughout the UK. The study would be further strengthened by larger and longer term projects involving patients and clinicians from different practices and localities.

The need for primary care to be a bastion for preventative medicine is clear, and there are many examples of good practice. However, due to the challenges discussed, there is still some way to go for primary care to fully embrace a make every contact count approach to promoting health related behaviour change. MECC is an ideal means for dealing with poor physical health of people with mental health problems. This pragmatic approach has a significant potential to improve physical health if used appropriately. Its strength is that it is a potentially cost-effective ideology and intervention that can be applied to existing practice in a whole manner of contexts. Without addressing the current challenges within primary care, MECC may remain an interesting idea without fulfilling its potential.

References

1) Russ TC, Stamatakis E, Hamer M et al. Association between psychological distress and mortality: individual participant pooled analysis of 10 prospective cohort studies. BMJ. 2012:345; e4933.
2) Wahlbeck K, Westman J, Nordentoft M et al. Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders. Br J Psychiatry. 2011:199,453-8
3) Starace, F, Mungai F, Baccari F et al. Excess mortality in people with mental illness: findings from a Northern Italy psychiatric case register. Soc Psychiatry Psychiatr Epidemiol. 2018: 53:249-257
4) Lawrence D, Hancock KJ, & Kisely S. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population-based registers. BMJ. 2013:346: f2539.
5) De Hert M, Corell CI, Bobes J et al. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. World Psychiatry. 2011:10:52-77
6) Baker AL, Kay-Lambkin FJ, Richmond R et al. Healthy lifestyle interventions for people with severe mental disorders. Mental Health and Substance Use. 2011:4: 144-157

7) Scott KM, Wu B, Saunders K et al. Early onset mental disorders and their links to chronic physical conditions. The burdens of mental disorders. Global perspectives from the WHO World mental health survey.2013:87-89
8) Lester H, Tritter JQ, Sorohan H. Patients and health professionals' views on primary care for people with serious mental illness: focus group study. BMJ:330:1122
9) Collins C, O'Shea MT, Finegan P et al. Mental health consultations in general practice out of hours service-informing the future direction of services. Irish College of General Practitioners. 2016. Accessed on 11th February 2020 from: https://www.lenus.ie/handle/10147/617161
10) Coventry P, Lovell K, Dickens C et al. Integrated primary care for patients with mental and physical multimorbidity: Cluster randomised controlled trial of collaborative care for patients with depression comorbid with diabetes or cardiovascular disease. BMJ: 350:h638
11) Das P, Naylor C, Majeed A et al. Bringing together physical and mental health within primary care: a new frontier for integrated care. J R Soc Med. 2016:364-366
12) Patel V, Belkin GS, Chockalingam A et al. Grand challenges: integrating mental health services into priority health care platforms. PloS Med. 2013:10:e1001448
13) Xiong GL, Iosif AM, Suo S et al. Understanding preventive health screening services use in persons with serious mental illness: how does integrated behavioral health primary care compare? Int J Psychiatry Med. 2015:48:279-98
14) Heath I. Person-centered prevention and health promotion. International Journal of Integrated Care. 2010:10:92-92
15) Health Education England. Making Every Contact Count (MECC) Frequently asked Questions. 2017. Accessed on 11th February 2020: http://www.makingeverycontactcount.co.uk/media/1154/faqs-mecc-final-dated-14-february-2017.pdf
16) Local Government Association. Making every contact count: taking every opportunity to improve health and wellbeing. London. Local Government Association. 2014.
17) Public Health England. NHS England and Health Education England. Making every contact count consensus statement. 2016. Accessed on 11th February 2020 on: http://mecc.yas.nhs.uk/media/1014/making_every_contact_count_consensus_statement.pdf
18) NHS England. Improving the physical health of people with serious mental illness – a practical toolkit. 2016. Accessed on 11th February 2020: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/05/serious-mental-hlth-toolkit-may16.pdf
19) Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, Burroughs H, Jinks C. Saturation in qualitative research: exploring its conceptualization and operationalization. Quality & Quantity. 2018 Jul 1;52(4):1893-907.
20) Bazeley P. Qualitative Data Analysis: Practical strategies. 2013.
21) Das P, Naylor C, Majeed A et al. Bringing together physical and mental health within primary care: a new frontier for integrated care. J R Soc Med. 2016:364-366
22) Ferguson I. Challenging a 'spoiled identity': mental health service users, recognition and redistribution. Disability, culture and identity. 2003:67-87.
23) Rashed MA. Madness and the demand for recognition: A philosophical inquiry into identity and mental health activism. Oxford University Press; 2019 Jan 17.
24) Michaels PJ, López M, Rüsch N, Corrigan PW. Constructs and concepts comprising the stigma of mental illness. Psychology, Society, & Education. 2017 Apr 27;4(2):183-94.
25) Dell, N. A., Vidovic, K. R., Vaughn, M. G., & Sasaki, N. Mental health provider stigma, expectations for recovery, and perceived quality of care provided to persons with mental illness. Stigma and Health. 2020. Advance online publication. https://doi.org/10.1037/sah0000227
26) Link BG, Struening EL, Neese-Todd S, Asmussen S, Phelan JC. Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. Psychiatric services. 2001 Dec;52(12):1621-6.
27) Cegala DJ, Post DM. The impact of patients' participation on physicians' patient-centered communication. Patient education and counseling. 2009 Nov 1;77(2):202-8
28) Harrington J, Noble LM, Newman SP. Improving patients' communication with doctors: a systematic review of intervention studies. Patient education and counseling. 2004 Jan 1;52(1):7-16.
29) Cribb A, Entwistle VA. Shared decision making: trade-offs between narrower and broader conceptions. Health Expectations. 2011 Jun;14(2):210-9.
30) Baxter AJ, Harris MG, Khatib Y et al. Reducing excess mortality due to chronic disease in people with severe mental illness, a meta review of health interventions. Br J Psychiatry. 2016. 208:322-329
31) Lawrence W, Black C, Tinati T et al. Making every contact count: Evaluation of the impact of an intervention to train health and social care practitioners in skills to support health behaviour change. J Health Psychol. 2016:21:138-151
32) Local Government Association. Making every contact count: taking every opportunity to improve health and wellbeing. London. Local Government Association. 2014.