



Achieving physical health equity for people with experience of mental health and addiction issues

Evidence update

Equally Well 

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Foreword – Honouring Te Tiriti o Waitangi

This report provides the Equally Well collaborative with the latest evidence to inform and guide actions to achieve physical health equity for people with experience of mental health and addiction issues.

In doing so, it is important to honour Te Tiriti o Waitangi as our founding equity document and keep this at the forefront of our mind as we work to achieve physical health equity for Māori people and all New Zealanders. Te Tiriti o Waitangi provides imperatives for us all to support tino rangatiratanga for Māori people to achieve equity.

Equity recognises different people have different levels of advantage and experience and require different approaches and resources to achieve equitable outcomes. Differential access to power and decision making, resources, service access, and quality services on the basis of social identity (eg ethnicity, age, gender, disability) are key drivers of health inequity (Ministry of Health, 2020).

While this is a narrative review of international literature, preference was given to published and grey literature from Aotearoa New Zealand. Search terms included Māori and Pacific/Pasifika along with physical health, mental health, and addiction issues.

The intersection of ethnicity with physical health disparities

Physical health inequities exist for people with experience of mental health and addiction issues. However, in Aotearoa New Zealand, there is a significant and often unrecognised intersection of ethnicity, mental health, addiction, and physical health with further health inequities for Māori and Pasifika peoples (Cunningham et al., 2020). This intersection is clearly illustrated in the *Wai2575 Health Trends Report* (Ministry of Health, 2019b), which shows Māori people are more likely than non-Māori to report psychological stress, end their own life, meet criteria for hazardous drinking, and experience poorer outcomes if diagnosed with physical health issues such as cardiovascular disease or cancer.

Inequity in Aotearoa New Zealand has been ingrained through colonisation, the consequences of which have been passed to current generations (Hobbs et al., 2019). Māori people have been politically, economically, and socially undermined, leading to lower income, poorer education, health outcomes and life expectancy, higher rates of rangatahi (young people) taking their own life and stigmatisation within health care, among other consequences (Health Quality & Safety Commission, 2020; Hobbs et al., 2019).

In mental health and addiction services, Māori people experience inequities in the quality of support received, which is particularly evident in the higher rates of compulsory treatment and restrictive practices (McLeod et al., 2017; Ministry of Health, 2019a).

Māori people experience inequities in physical health care (Kerr et al., 2014; Rahiri et al., 2018), and young Māori are less likely than non-Māori to visit a GP (Jury et al., 2020).

Accounts of health system experiences indicate inequities for Māori people are frequently related to direct interactions, particularly with clinicians, and the cultural competencies of clinicians and the system (Palmer et al., 2019). Many Māori people experience the existing public health system as

hostile and alienating. Whānau members provide support to mitigate this but it comes at a cost, with whānau members sacrificing time, money and their own emotional wellbeing to provide support (Graham & Masters-Awatere, 2020).

Improving Māori experiences could focus on actions such as building Māori leadership in health service development, increasing investment in cultural competencies across the health workforce, and supporting health literacy (Palmer et al., 2019).

A trauma informed system, where past experiences such as the impacts of colonisation are acknowledged, is a step in the right direction.

Public health can make positive contributions to the dialogue on health inequities through reorientation of systemic health determinants and equity-focused policies and practices (Hobbs et al., 2019).

Gaps in the literature

This review includes comparatively few articles specifically focused on the physical health of Māori people with experience of mental health and addiction issues. In addition, international studies largely involve participants from white ethnicities. This has significant implications for drawing conclusions on the effectiveness and value of solutions for other groups, such as Māori and Pasifika peoples.

Continuing to drive change

This report highlights the intersection of ethnicity and health issues, particularly the gaps in the physical health literature on issues and solutions for Māori people with experience of mental health and addiction issues. As part of our commitment to Te Tiriti o Waitangi, we highlight available research and the gaps throughout this report and will continue to advocate for the prioritisation of investment in research and actions to drive change in this area.

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2020 evidence update

Introduction

Te Pou published the last evidence review on the physical health of people with experience of mental health and addiction issues¹ in 2017.

Since then, Firth and colleagues published a notable comprehensive international evidence review - *The Lancet Psychiatry Commission: A blueprint for protecting physical health in people with mental illness* (2019). This summarises advances in understanding on the physical health of people with experience of mental health and addiction issues,² and presents future directions for health promotion, clinical support, and research.

In this evidence update, key findings from *The Lancet Psychiatry Commission* are combined with additional research published between January 2018 and April 2020.³

This evidence review aims to keep Equally Well champions up to date with the best available evidence to improve practice and inform policy making.⁴

What is the issue?

The physical health inequities for people with experience of mental health and addiction issues are globally acknowledged and have multiple contributing factors. As well as an increased risk of physical health issues and significantly reduced life expectancy, people with experience of mental health and addiction issues often have reduced access to quality health support. Achieving physical health equity must be a priority.

Interpreting the information for you or your whānau

The information presented in this report may be alarming to people and whānau members directly affected by mental health and addiction issues, due to the risks and range of health issues presented. It is therefore important to highlight that physical health issues are not inevitable, and many are preventable and treatable if picked up early. The data presented on risks is based on averages from groups of people. Information to identify and minimise risks is important as it allows us to be proactive in ensuring people have better outcomes, improved wellbeing, and quality of life.

¹ We have chosen to use both 'people with experience of mental health and addiction issues' and 'people experiencing mental health and addiction issues' as strengths-based language preferred by people with lived experience, depending on the context. This also acknowledges people who have experienced mental health and addiction issues in the past and how this impacts their current and future physical health.

² The UK definition of 'mental illness' includes addiction issues therefore we refer to 'mental health and addiction issues' where *The Lancet* refers to 'mental illness'.

³ For a summary of the methods, see the Appendix.

⁴ It is advised to read this report in conjunction with the two previous evidence reviews (Te Pou 2014; 2017).

Overview of findings

Findings of this literature review align with those from the Te Pou 2017 evidence review and support previous recommendations and actions. For people with experience of mental health and addiction issues, disparities in physical health remain. Achieving physical health equity requires a multi-faceted approach with actions across the health and health-related social systems.

1. Physical health inequities exist across the range of addiction and mental health experiences and diagnoses.

Recent evidence reinforces the extent of physical health disparities in prevalence and outcomes. While physical health inequities are largest for people in contact with specialist mental health and addiction services, there is now clear evidence that disparities in physical health exist across the range⁵ of addiction and mental health experiences and diagnoses.

2. Multiple interacting factors contribute to physical health inequities.

More research is available exploring and acknowledging the many factors contributing to physical health disparities and how they interact. This includes the interactions between socioeconomic factors, psychotropic medications, appetite, exercise, and sleep quality. Lived experience narratives demonstrate that people are motivated to improve their physical health, but other factors such as the environment or medications can make this difficult.

3. Evidence-based prescribing and shared conversations continue to be important.

This update reinforces previous findings on the importance of prescribing for wellbeing. As physical health impacts of medications are common, shared conversations between health practitioners and people being prescribed medications continue to be important.

Health practitioners staying up to date with the literature will support evidence-based prescribing. For example, new research ranks the metabolic effects of certain medications, finding some have less favourable physical health impacts than others (eg increases in blood glucose or cholesterol levels).

4. Achieving health equity requires multiple strategies at system, service, and individual levels.

A growing body of research describes effective ways of achieving equity at different levels. We now have more information on how best to support people, and importantly, what good delivery of support looks like. Service and system insights include the importance of dedicated roles and workforce development initiatives to improve physical health care. Cultural competency, as well as integrated support between general health, mental health and addiction services, and wider wellbeing services also continue to be part of the solutions.

⁵ In this context the term range refers to all the possible diagnoses that fit under the banner of mental health and addiction experiences. We chose to use the term range to move away from the categories mild, moderate, and severe which is used in the literature, as this can be misleading and contribute to discrimination.

5. The way forward is a people-driven seamless system.

A strong message continuing to feature in the literature is the importance of developing a seamless system that is driven by people. The lived experience narratives included in this evidence update improve our knowledge and understanding of the experiences, wants, and needs of people. They are a timely reminder of the need to design and offer support in partnership with the people affected.

There is still more work to do

Gaps in the literature remain. There is minimal published research on the:

- role of the peer workforce in physical health care
- full range of co-occurring physical health issues
- culturally supportive physical health approaches for Māori and Pasifika peoples
- effects of policy changes on achieving equity
- specific physical health needs of people with experience of primarily addiction issues.

More lived experience narratives exploring the perspectives of people about mental health and addiction issues are continually needed.

In Aotearoa New Zealand, there are many examples of initiatives to achieve physical health equity embedded into everyday practice. The New Zealand Equally Well *Taking Our Pulse* 2019 survey⁶ shares innovative and resourceful initiatives already underway. Examples from the survey are provided in this evidence update to complement the knowledge generated from the published literature.

While there is great work happening, there is still more to be done. The continued and significant physical health inequities for people with experience of mental health and addiction issues highlights the need for continued concerted action and the importance of routinely monitoring key indicators of physical health nationally. A systemic approach is needed to achieve equity in physical health. We must all keep Te Tiriti o Waitangi at the forefront of our minds as we work towards a system that is equitable for Māori people.

We are all responsible.

⁶ <https://www.tepou.co.nz/news/taking-our-pulse-survey-findings/1196>

1. Physical health disparities exist across the range of mental health and addiction experiences and diagnoses

People with experience of addiction and mental health issues continue to face unfair and preventable disparities in physical health support and outcomes. This has wide-reaching personal, social, and economic effects.

Whilst inequities are largest for people in contact with specialist mental health and addiction services, recent international literature provides strong evidence that disparities exist across the range of mental health and addiction experiences and diagnoses. This has important implications across all health services including mental health and addiction services, primary care, and somatic health services.

Research since 2017 - the physical health disparities

International and New Zealand research reinforces findings from the Te Pou 2017 update that people with experience of mental health and addiction issues have on average a higher relative risk of many physical health issues, and this risk is present at an earlier age. In addition, these physical health disparities exist across the range of mental health and addiction experiences and diagnoses (Buhagiar et al., 2020; Firth et al., 2019; Lockett et al., 2018; Solmi et al., 2019). The following points emphasise disparities in the literature published since the 2017 evidence review.

- On average, the overall years of life lost due to physical health issues appears to be increasing, not decreasing (Firth et al., 2019).
- For metabolic and cardiovascular diseases⁷ the relative risk is, on average, higher for people experiencing mental health and addiction issues, compared to people who do not, and the outcomes are worse (Cunningham et al., 2019; Firth et al., 2019).
- For cancer the overall relative risk is about the same (varies by cancer type), but for people with lived experience of mental health and addiction issues the health outcomes are on average worse. This indicates timely diagnosis and improvements in our response and quality of support are needed (Firth et al., 2019; Solmi et al., 2019).
- For respiratory and infectious diseases the relative risk is higher than the general population across a range of addiction and mental health experiences and diagnoses (Firth et al., 2019; Momen et al., 2020). Firth et al (2019) also claim that the harmful effects infectious diseases have on the physical health of people with mental health and addiction issues may be underestimated as they often receive less investigation than other physical illnesses.

⁷ Most available research focusses on metabolic and cardiovascular disease in high income settings.

Using administrative data to understand the extent of physical health issues

[Analysis of data](#) from the New Zealand Health Survey indicates people with a diagnosis of depression, anxiety, or bipolar disorder have a 1.5–2.3 times greater risk of:

- a stroke
- cardiovascular disease
- chronic pain
- asthma
- high cholesterol levels (Lockett et al., 2018).

A Danish study analysed data from 5.9 million people, assessing 10 different mental health and addiction diagnoses with 31 specific physical health conditions. The study indicates people experiencing a mental health or addiction issue have, on average, a higher risk for many physical health conditions than people without. For some physical health conditions this risk can be up to 3.6 times greater. Of particular note, is the study's inclusion of the specific co-occurring physical health issues for people experiencing alcohol and drug issues (Momen et al., 2020).

Both these studies indicate the reported risk may be underestimated given many physical health issues remain undiagnosed.

2. Multiple interacting factors contribute to physical health inequities

At an individual level, people experience different physical health risks. Many of these are influenced by wider systemic and socioeconomic issues that widen the gap. Health is closely linked to the social determinants of health - the conditions in which people are born, grow, live, work and age as well as inequities in power, money, and resources (Institute of Health Equity, 2020). This is why action is needed across the health and health-related social systems that impact on health (eg housing and employment).

At a systems level, the availability and quality of health care, as well as stigma, discrimination, racism, and diagnostic overshadowing⁸ contribute to poorer physical health outcomes.

Two important factors that support early identification of contributing factors and effective physical health management are health promotion and preventative screening approaches.

⁸ Diagnostic overshadowing is when symptoms of a physical condition are assumed to be related to a person's mental health or addiction experiences, often resulting in missed or delayed physical health screening and diagnoses.

The interplay of multiple contributing factors

In line with the Te Pou 2017 update, the 2019 *Lancet Psychiatry Commission* highlights the higher prevalence of known contributing factors to physical health issues for people with experience of mental health and addiction issues. These include alcohol and tobacco use, lower levels of physical activity, and reduced diet quality.⁹ In addition, something not examined in detail in our previous evidence update but highlighted in the *Lancet Psychiatry Commission* review, is the increased prevalence of disrupted sleep patterns and reduced sleep quality. This area warrants further exploration including people's perspectives on sleep and the importance of health practitioners having conversations about sleep.

Recent studies from New Zealand and other countries outlined below highlight the complex interactions between contributing factors.

- While people experiencing mental health and addiction issues have spoken about the effects of psychotropic medications on appetite and food habits, there has been little quality research in this area to date.
 - A meta-analysis conducted in 2019 summarises evidence on dietary intake in more than 35,000 people diagnosed with psychosis or bipolar disorder. They found medications prescribed for managing symptoms are negatively associated with changes in dietary intake and eating behaviours (including appetite and food type preferences), with higher energy and salt intake compared to people without these diagnoses (Teasdale et al., 2019).
- A cohort study of over 100,000 adults in Finland reinforces the known impact of low socioeconomic status on physical health risks and shows low socioeconomic status increases the risk of 18 types of mental health, substance use, and physical health issues. These issues appear interconnected and have a cascading effect. Mental health, addiction issues, and self-harm tend to occur earlier, followed in later life by increased physical health issues (Kivimäki et al., 2020). It is important to note that socioeconomic disadvantage is compounded and worsened by targeted advertising and the higher density of alcohol and gambling outlets in higher deprivation areas in Aotearoa (Cameron et al., 2016).
- A New Zealand study found people with methamphetamine-associated cardiomyopathy, a condition where the heart muscles find it difficult to pump blood to the body, are more likely to be younger,¹⁰ male, Māori and from low socioeconomic backgrounds (Wang et al., 2019).
- An Australian review indicates the risk of premature mortality is three times higher for people with experience of mental health issues in rural settings compared to major cities (Roberts et al., 2018).

⁹ The authors (Firth et al.) were however very careful to state: “we focused on behavioural risk factors in affective and psychotic disorders, rather than on mental health illnesses that are characterised by emotional issues that have a direct impact on physical health, such as eating disorders and substance or alcohol use disorders.”

¹⁰ Median age 41 years vs 48 years for controls.

- Although previous research indicates that experiencing co-existing issues increases the risk of poorer outcomes, the impact of experiencing multiple health issues on compounding psychological distress is less clear and requires further investigation (Firth et al., 2019).

The interactions between contributory factors mean there are significant costs across the health system arising from physical health inequities. For example, cost of illness studies show people who experience co-occurring physical health issues with mental health and addiction issues have on average higher general hospital costs, increased readmission rates, and higher total health sector costs compared to people without mental health and addiction issues (Firth et al., 2019). Metabolic health issues such as diabetes or obesity may also increase the likelihood of hospital admission or relapse for people experiencing high mental health and addiction needs (Firth et al., 2019).

Listening to what people say

Two recent studies examined the perspectives of people with experience of mental health and addiction issues. They demonstrate people are generally motivated to improve their physical health, but other issues such as the environment or medications can make this difficult.

- Interviews with New Zealanders in long stay or rehabilitation mental health services found people consider their weight issues result from factors such as medication, hospitalisation, and institutional constraints which make it difficult to access nutritious food or exercise. Many people in the study felt weight loss is not achievable but were interested and had thought about it, with three-quarters of people previously attempting to lose weight (Every-Palmer et al., 2018).
- Interviews with Australians in mental health services found people wanted to improve their physical health and talked about factors contributing to physical health issues, such as low fruit and vegetable intake, tobacco smoking, alcohol consumption, and physical inactivity. ***Eighty per cent of people surveyed agreed it would be acceptable to receive advice and support from staff to reduce physical health risks*** (Bartlem et al., 2018).

How the system contributes to physical health disparities

Increasing evidence suggests the availability and quality of health care, as well as stigma, discrimination, racism, and diagnostic overshadowing across health systems contributes to poor physical health outcomes (Firth et al., 2019).

The health system for Māori people

Accounts from Māori people experiencing the health system reveal inequities are most frequently related to direct interactions, particularly with clinicians, and the cultural competency of clinicians and the system (Palmer et al., 2019).

For many Māori people, the public health system is experienced as hostile and alienating. While whānau members provide support to mitigate this, it comes at a cost to whānau (Graham & Masters-Awatere, 2020).

Health promotion and adoption of screening integrated into routine care are important ways to identify physical health issues and potential risk factors early (Firth et al., 2019). The Te Pou 2017 update highlights low rates of screening for people in contact with mental health and addiction services. Recent evidence indicates this is the case across the range of mental health and addiction experiences and diagnoses. Disparities exist both for routine screening in mental health and addiction services, as well as population health screening programmes such as cervical and breast cancer screening.

- A meta-analysis of over 4.7 million people from five continents indicates people with experience of mental health issues are on average 24 per cent less likely to be screened for cancer compared to people without mental health issues. Screening rates for women and people diagnosed with schizophrenia are lowest and differ by cancer type (Solmi et al., 2019).
 - The study suggests the gap between people with and without mental health issues is largest for general population screening programmes. People with experience of mental health issues are significantly less likely to be screened as part of screening programmes and less likely (though not statistically significant) to undergo opportunistic screening (eg for bowel cancer) (Solmi et al., 2019).
- A New Zealand audit of primary care enrolment data in Canterbury identifies people experiencing high mental health and addiction needs are less likely to be involved in routine screening programmes, such as mammograms or cervical screening (Mangan & Chin, 2019).
- In a study examining the experiences of 10 New Zealand women with breast cancer and mental health issues, some participants report attending screening but not having their cancer detected (Peterson & Cunningham, 2020).

- An international meta-analysis identifies large variations in how preventative care is measured and used in mental health services. Rates of screening for common risk factors or delivery of preventative support were highest for smoking cessation (78 per cent), and lowest for nutrition related interventions (17 per cent) (Bailey et al., 2019).
- An audit of primary care screening in Waikato and Bay of Plenty shows inadequate and inequitable physical health screening for people diagnosed with schizophrenia taking antipsychotic medications. Of 117 people included in the audit, none were properly screened for the full set of markers recommended in the guidelines from the Royal Australian and New Zealand College of Psychiatrists. Additionally, Māori people, people from urban areas, and younger people were less likely to be screened for markers of blood glucose control (Keenan et al., 2020). This highlights the need for clear guidelines and general practitioner education.
- New Zealand and international research indicates people with experience of mental health and addiction issues experience barriers to accessing diabetes specialist services and fragmented support, which affects the quality of diabetes care available for people (Firth et al., 2019; Mangan & Chin, 2019).

Screening for cardiovascular disease

A study using New Zealand population data highlights the need for equations used by health professionals to predict cardiovascular disease (CVD) risk to consider mental health issues as a risk factor. CVD risk is underestimated by one-third in men and two-thirds in women if mental health issues are not accounted for (Cunningham et al., 2019).

In 2018, the Ministry of Health updated [the guidance](#) on CVD risk assessment and management to prioritise people with experience of high mental health needs. They also recommend CVD risk assessments start from the age of 25, repeating every two years, or annually for people at higher risk (Ministry of Health, 2018). The guidance also makes clear that the standard risk scores will likely underestimate the risk for people experiencing mental health and addiction issues.

Health service utilisation

New Zealand and international studies indicate people experiencing mental health and addiction issues are accessing the health system for physical health issues at higher rates, though access differs between groups.

- A New Zealand Health Survey analysis indicates people with a diagnosis of anxiety, depression or bipolar disorder are 2.6 times more likely to visit a GP compared to people without these diagnoses.
 - Of concern, people with these diagnoses are more likely to report barriers in accessing services such as costs or transport, and are less likely to report positive experiences with health professionals (Lockett et al., 2018).
- A subsequent New Zealand Health Survey analysis looking at GP use among people meeting hazardous drinking criteria shows:
 - young Māori males, regardless of drinking behaviour, are least likely to visit a GP each year
 - younger non-Māori people are more likely to visit a GP compared to non-hazardous drinkers (Jury et al., 2020).
- A UK-based study using data from the Adult Psychiatric Morbidity Survey reports people with a diagnosis of anxiety, depression, phobias or obsessive-compulsive related issues are more likely to access physical health services (both GP and hospital care) compared to people in the general population (Buhagiar et al., 2020).
- A UK public health survey of 28 neighbourhoods with over 4,000 people indicates:
 - people who experience both a physical and mental health issue are more likely to report attending an emergency department (ED) or GP practice, compared to people with either a mental health or physical health issue, or no reported issues
 - people who have more mental health symptoms are more likely to use healthcare services
 - younger age, white ethnicity, unemployment, and having a professional qualification increases the chances of ED attendance (Saini et al., 2019).

A greater understanding of patterns of healthcare use, and people's experiences of support across primary and general hospital services will usefully inform equity of healthcare across health services.

Actions from the *Taking Our Pulse* survey 2019 - Screening and health promotion

The 2019 Equally Well survey found New Zealand Equally Well champions are active in supporting the identification and management of physical health issues, as well as supporting people to optimise their physical health. Reported activities include routine physical health checks and metabolic monitoring, developing screening tools or resources, providing information to people regarding physical health care, and specific training on screening for the workforce. Nelson Marlborough Health recently won a health excellence award in recognition of their cardiometabolic screening and management tool being used in their specialist mental health and addiction services.

3. Evidence-based prescribing and shared conversations continue to be important

Medications form an important part of a treatment plan for many people experiencing mental health and addiction issues. This update reinforces the 2017 Te Pou review findings which highlight the importance of prescribing for wellbeing. This includes considering the wants and needs of people, other health issues, interactions between medications, and the physical health impacts of medications. As medications commonly have physical health impacts, the shared conversation between health professionals and people being prescribed medications continues to be important (Firth et al., 2019).

Psychotropic medications are prescribed to people in large numbers despite known side effects (Te Pou, 2017). As well as contributing to physical health issues, unwelcome side effects can affect whether people are able to take medications long-term (Firth et al., 2019). Staying up to date with the literature will support evidence-based prescribing.

Physical health impacts of psychotropic medication

- Weight gain is an acknowledged effect of medications used to help manage symptoms of mental health and addiction issues. This can lead to an increased risk of other health issues such as CVD or diabetes (Te Pou, 2017).
 - Weight gain has been reported as one of the most distressing medication side effects by callers to a mental health helpline (Firth et al., 2019). For some people, weight gain is associated with poorer quality of life and is a barrier to social engagement (Firth et al., 2019).
 - Weight gain is common for people receiving opioid substitution treatment who are prescribed methadone. People who are also prescribed psychotropic medications have an even greater risk of gaining weight (Schlienz et al., 2018).
- Other known physical health impacts of psychotropic medications include neurological issues (eg muscle spasms and involuntary movements), hormonal disruptions, heart problems, sedation, bowel, and urinary issues, as well as dry eyes, mouth, and skin (Firth et al., 2019).
- The literature continues to emphasise that smoking cessation, while encouraged, must take into account the effects of nicotine on the metabolism and the effectiveness of some psychotropic medications (Firth et al., 2019). The use of vaping or e-cigarettes is often encouraged to reduce smoking and thereby its impact. However, little is known about the long-term impact of vaping, including how it affects the metabolism of psychotropic medications (Firth et al., 2019; Ministry of Health & Health Promotion Agency, 2020).

Evidence-based prescribing

Prescribers should continue to:

- take into account possible interactions between psychotropic medications, physical health medications, tobacco, nicotine, and alcohol (World Health Organization, 2018)
- understand medication risk profiles, for example:
 - a recent systematic review and meta-analysis ranking the metabolic effects of 18 medications used for experiences of psychosis indicates some have more favourable risk profiles than others. Clozapine and olanzapine are associated with a higher likelihood of metabolic effects (Pillinger et al., 2020)
 - a New Zealand analysis of coronial data shows some medications are associated with higher risks of premature death, in particular, methadone and clozapine (Fountain et al., 2020)
- consider that risk factors may vary for different metabolic effects, for example, Pillinger and colleagues (2020) identify for medications used for experiences of psychosis:
 - increased fasting glucose is more common in men and people with higher weight when starting medications
 - in the US, non-white ethnicity is associated with greater increases in total cholesterol
- monitor key biomarkers, for example:
 - methadone acts similarly to tramadol, which is significantly associated with blood sugar levels below the normal range (hypoglycaemia), indicating blood glucose level monitoring may be important (Makunts et al., 2019)
- refer to available guidelines for reducing or stopping psychotropic medications. For example, Matua Rāki (2017) provides guidelines for [people](#) and [prescribers](#) to assist the safer reduction or cessation of medications.

Actions from the *Taking Our Pulse* survey 2019 – Evidence-based prescribing

The 2019 Equally Well survey found champions are supporting medication literacy in services around the country. Activities include sharing information with people regarding the physical health impacts of psychotropic medications and monitoring medication use.

4. Achieving equity requires multiple strategies at the system, service, and individual levels

The Te Pou 2017 evidence update highlights the need for multiple strategies for achieving equity. This includes approaches at the system, service, and individual levels, and acknowledging and addressing the intersection of culture and equity.¹¹

At an individual level, research on optimising physical health continues to grow, with further understanding of the most effective initiatives (eg nutritional advice, exercise programmes). Recent research helps us to understand the features of effective programmes and how they are best delivered. Any initiative aimed at supporting people's health should incorporate a range of health professionals and be tailored to each person's needs and situation.

At a service level, recent literature suggests the health workforce would benefit from enhancing their skills in related areas. For example, health services could upskill in mental health and addiction issues, while people working in mental health and addiction could upskill in physical health issues and screening. Training should include aspects targeting language, values and attitudes (such as *Let's get real*), as well as cultural competency. Improving Māori leadership and capacity in health service development and workforce should be a priority. Recent evidence suggests specialist roles, such as physical health nurses in mental health and addiction services, may be beneficial.

At a systems level, recent evidence suggests integrated support, working with a diverse team, sharing data from different health settings (such as primary and secondary care), cross sector work, and improving access for certain groups, is important for achieving equity.

Optimising personal health

- The *Lancet Psychiatry Commission* (2019) and World Health Organization (WHO) (2018) guidelines for people experiencing high mental health needs reinforce the importance of multiple evidence-based strategies for managing physical health issues.
 - Evidence-based lifestyle strategies are recommended as an optimal first-line approach for the prevention of physical health issues.
 - Though the ideal approach is to prevent issues before they arise, a combination of lifestyle and medication approaches, tailored to people's needs, are useful for managing different existing physical health issues.

¹¹ In this review of the literature, it was noticeable that much of the published research examined programmes targeted at the individual level. Whilst this is important, there is a danger that this bias in research biases knowledge and understanding and in turn, adds to existing discriminatory attitudes and behaviours, and perpetuates stereotypes. In reporting these studies, we have therefore chosen to use the term 'optimising personal health' rather than individual lifestyle or behavioural change.

- A stepped care approach¹² to different support options may be useful, depending on the setting and the person (Firth et al., 2019).
- An international meta-analysis (Vancampfort et al., 2019) reinforces the importance of tailoring support to people's needs and situation. The study indicates the best type of support for people with a diagnosis of schizophrenia depends on the physical health issue. For example, when ranked, individual lifestyle counselling may be most effective for body weight, while medication may be for blood glucose levels.
- An international systematic literature review examining the effectiveness of initiatives to support people with a diagnosis of psychosis with changing diet, exercise, sleep and substance use (Mazoruk et al., 2020) identifies:
 - moderate to strong evidence that weight management, exercise and self-management programmes enhance self-efficacy and improve physical health especially weight, fitness, and cardiovascular risk. There is some evidence of an improvement in mental health as well.

How health support is designed and offered is important

The context in which health programmes are offered, and how and who delivers them, is important.

- The *Lancet Psychiatry Commission* highlights the US-developed diabetes prevention program (DPP) as an example of a high-quality approach that can be used as a model and adapted to different settings and people. Key features of the DPP include frequent in-person contact, structured education, supervised physical activity sessions, maintenance support programmes combining group and individual approaches, individualisation including cultural adaptation of materials and strategies, and an extensive network of clinical support (Firth et al., 2019).
- A systematic review where people experiencing psychosis had autonomy to choose and plan activities reports increases in attendance and persistence engaging in exercise sessions (Mazoruk et al., 2020). This review highlights the role of initiatives which involve modelling, coaching, and building people's skills to support self-management.
- Bringing different specialised expertise into mental health and addiction teams, such as dietitians and exercise professionals, is important to offer a multidisciplinary approach. Programmes or approaches delivered by specialised health professionals are more effective than those delivered by non-specialised health professionals (Firth et al., 2019).
- Utilising peers to deliver health programmes may be a good way to increase acceptability and satisfaction.

¹² Stepped care is a model of matching health treatment and support to need so that the most effective, yet least resource intensive, is delivered first (Ministry of Health, 2017).

- A US study shows the use of peer health navigators significantly improves access to and use of primary health services for people experiencing mental health issues (Kelly et al., 2017).
- An Australian feasibility study indicates a programme to optimise health can successfully be delivered by the mental health peer workforce. All participants in the peer-led programme rated high satisfaction (Kelly et al., 2020).

Workforce development and the different roles people can play in services

Multiple studies highlight the importance of comprehensive workforce development approaches in supporting people's physical health needs. Workers such as nurses, psychiatrists, allied health, and support workers with the right skills, knowledge and attitudes can have a big impact. While we know from the last update and broader literature the importance and potential for peer roles in services (Te Pou, 2017), further investigation examining this role specifically in a physical health context is needed due to the limited quality research available.

The recent literature identifies actions and steps organisations and the workforce can take to improve equity of outcomes (Brown et al., 2018; Druss et al., 2018; Happell et al., 2019; Hennessy & Cocoman, 2018; Maylea et al., 2019; Rodgers et al., 2020).

All people in all roles make a difference and could take up any of the actions outlined.

- Organisational action plans to support and screen for physical health issues.
- Strategic leadership and modelling good physical health delivery.
- Decision support tools including screening and referral pathways.
- Influencing funders, general and public health policy.
- Clinical care integration.
- Recruitment of specialist physical health roles such as specialist nurses' roles.
- Workforce development for all staff.
 - Targeted education and training to improve attitudes, skills, and knowledge related to physical health screening.
- Advocating for equity of access.
- Supporting and modelling quality support.
- Reducing stigma and discrimination for people experiencing mental health and addiction issues.

Other research highlights barriers to the uptake of screening by staff in mental health and addiction services and primary care, the need to improve Māori experiences in the health system and to consider co-existing addiction issues within mental health services and primary care. Research also highlights the value of initiatives which target staff health and attitudes.

- A systematic review of Māori people's experiences of health systems and programmes in Aotearoa New Zealand reveals inequities are most frequently related to direct interactions, particularly person-clinician interactions, and cultural competencies of clinicians and the system. Improving Māori people's experiences could focus on actions to reduce risks of exposure to health-damaging contributory factors. These could include supporting health literacy, increased investment in cultural competency of the health workforce, and building Māori leadership in health service development and workforce (Palmer et al., 2019).
- A review of initiatives to increase access to, or uptake of, physical health screening highlights some common barriers and enablers for staff in primary care and mental health services. Enablers include staff having a sense of ownership of screening processes, team champions, and strong links to primary and specialist services. Barriers include workload issues, resource constraints, and staff resistance. Initiatives that include a behaviour change component may help to overcome staff barriers (Lamontagne-Godwin et al., 2018).
- Training for mental health workers to screen for addiction issues, and addiction workers to screen for mental health issues, needs to include training on screening for physical health issues as well (Firth et al., 2019).
- Targeting staff health may be key to changing attitudes and knowledge about physical health screening and support, which in turn improves the physical health of people they support.
 - An Australian study of 200 staff in a public mental health service shows a lifestyle support programme consisting of exercise and nutrition counselling can increase knowledge and confidence of screening, promoting, and intervening to optimise the physical health outcomes of the people they work with. Staff also saw personal health benefits (Rosenbaum et al., 2020).

Undertaking holistic assessments

The sole use of biological markers for physical health assessment (such as increases in body weight, high blood pressure, and raised cholesterol) may mean we miss the opportunity to prevent issues before they arise. Clinical guidelines increasingly recommend assessments of diet, physical activity, and other health risks are done alongside these biological markers (Firth et al., 2019).

A comprehensive, holistic assessment provides more helpful information than is typically provided by standard biological markers to assess current physical health and future risk more accurately.

Health system changes

- Integrated support strategies can provide seamless access and transitions across the primary, secondary, and tertiary sectors (Firth et al., 2019; Richardson et al., 2020). Primary care is an optimal setting for coordinating the management of physical health issues by promoting primary prevention strategies (Firth et al., 2019), although there is limited research trialling integrated support in primary care settings (Richardson et al., 2020).
 - A systematic review indicates limited studies have investigated effective approaches to integrated support. Of the 25 studies available, most were in the US, and almost exclusively designed for people experiencing mental health issues. Only one study investigates approaches to integrated physical health care for addiction (Richardson et al., 2020). Recommendations are to involve people with experience of mental health and addiction issues in research studies designed to support better outcomes.
- Inequity in Aotearoa New Zealand has been ingrained through colonisation, the consequences of which have been passed to current generations. One of the many consequences is discrimination in health support. The field of public health can make positive contributions to the dialogue on health inequities for Māori people through reorientation of the social determinants of health, and encouragement of equity-focused policies and practices (Hobbs et al., 2019).
- For people with experience of addiction and mental health issues, UK evidence indicates death relating to physical health issues is higher on average in secondary compared to primary health settings. So, reported figures may differ depending on the source used, which may under- or over-represent reality. Linking primary and secondary care data is necessary to better represent the prevalence and outcomes associated with physical health issues in people experiencing mental health and addiction issues. Discriminating between settings is important to inform policy and allocate appropriate resources for support programmes (John et al., 2018). Linking data is useful for many other reasons, including providing more holistic support and better support coordination, though privacy and consent issues need to be considered.
- Improving access to essential health services by breaking down barriers is important. For example, there are many barriers to dental treatment, particularly for Māori and Pasifika people and lower socioeconomic groups. A New Zealand study involving 32 Māori adults in contact with mental health and addiction services demonstrates the interconnection between physical and mental health, and the importance of equal access to dental services. Findings indicate dental treatment positively impacts oral health related quality of life and mental health (Broughton et al., 2020).
- Within the current system, people experiencing both mental health and addiction issues may be excluded from certain mental health or addiction services. This is despite the fact that co-existing issues are common and are associated with poorer physical health outcomes. Therefore priorities should include investment in screening for addiction issues in mental health settings, and mental health issues in addiction settings, as well as physical health issues (Firth et al., 2019).

Importance of a trauma informed system

Participating in health assessments, population screening programmes, and regular physical health checks is crucial to the early detection and diagnosis of physical health issues. The 2017 Te Pou review highlights the importance of these programmes and consultations being trauma informed. In 2019, the workforce centres developed [Weaving Together Knowledge for Wellbeing](#), a short resource describing what trauma is, the effects of trauma, and how to develop trauma informed approaches. Working in a trauma informed way is particularly important for Māori people, recognising the impacts of colonisation passed down to current generations.

Actions from the *Taking Our Pulse* survey 2019 – Workforce and systems

Equally Well champions in 2019 report workforce development initiatives aimed at enhancing workforce capability and capacity. Activities include running specific education and training sessions on Equally Well for health practitioners and students, developing tools for the health workforce, and recruiting dedicated new roles to work within mental health and addiction services. Systems initiatives include plans to better connect with other health services that can support more effective and efficient services, such as collaborative or working groups, mapping initiatives, and shared care arrangements between primary and secondary care.

5. The way forward is a person-driven, seamless system

Previous sections highlight a common theme of the need for changes across the health and health-related social systems. At the centre of this approach is having people and whānau in the driving seat, within a seamless system that works for them.

Innovations and policy changes that break down barriers between physical, mental health, and addiction support are urgently needed. This includes health professionals sharing information and communicating across different systems, providing coordinated and integrated support, and ensuring the safety and effectiveness of treatments. There is a lack of evidence on the impact of policy changes on improving physical health outcomes for people.

Innovations such as digital health technologies can be used to empower people to manage health risks.

Creating a seamless system that works for the person and whānau

Listening to what people say

Focus groups of 31 Australians with experience of mental health issues reveal what is most important to them (Happell et al., 2019), including:

- the need for a **diverse range of services to support wellbeing**, where people can connect with multiple health professionals (both conventional and non-conventional)
- the desire to be at the centre of the interprofessional team who provide holistic support
- more ways to enter the system, **less gatekeeping**, and fewer barriers to access like cost and location.

Closer to home, *He Ara Oranga* (2019) heard people's wishes for a health system that works for them. People called for policies that promote physical, social, cultural, and spiritual wellbeing, and the importance of acknowledging how much mental wellbeing is a function of good physical health and a strong connection to land, culture, and history. People spoke of the frustration of having to navigate the complex boundaries between mental health, addiction, and physical health services.

- Some of the main themes relevant to physical health equity in *He Ara Oranga* are a call for wellbeing and community solutions – for help through the storms of life; to be seen as a whole person, not a diagnosis; and to be encouraged and supported to heal and restore one's sense of self.
- For Māori health and wellbeing, recognition of the impact of cultural alienation and generational deprivation, affirmation of indigeneity, and the importance of cultural as well as clinical approaches, emphasising ties to whānau, hapū and iwi.
- For Pasifika peoples, the adoption of 'Pacific ways' to enable Pacific health and wellbeing – a holistic approach that incorporates Pacific languages, identity, connectedness, spirituality, nutrition, physical activity, and healthy relationships.
- People said that unless New Zealand tackles the social and economic determinants of health, we will not stem the tide of mental health and addiction issues.

A study exploring experiences of 10 New Zealand women with mental health issues undergoing cancer treatment found:

- overall experiences of cancer services were more positive than their experiences in mental health services. People found cancer treatment more empowering, especially compared to treatment for mental health issues. This was due to being given information, feeling in control, and being involved in decision-making (Peterson & Cunningham, 2020)

The *Lancet Psychiatry Commission* highlights some ways forward that align with a person-driven system.

- Digital technologies can play a promising role in the future of health through health promotion and management. However, many studies investigating the use of digital technologies do not involve people experiencing mental health or addiction issues. Further studies will determine the benefits for people experiencing these issues (Firth et al., 2019).
- Integrated and collaborative support models are emerging as effective approaches that can simultaneously reduce costs and improve outcomes in the management of mental health, addiction, and physical health issues (Firth et al., 2019).
 - A core component of collaborative support models is the involvement of several health professionals working as an interprofessional team, including doctors, case managers, mental health and addiction practitioners, and allied health professionals. Peer workers can also form an important part of this team (Kelly et al., 2017).
 - Although specific actions vary between models, all collaborative support approaches use structured management plans, schedule follow-ups, and involve extensive interprofessional communication.

Summary

Recent literature continues to highlight the existence of unacceptable physical health disparities for people with experience of mental health and addiction issues.

Implications for practice and future needs

- A whole of systems approach is needed to reduce the gap in physical health care – everyone has a part to play. Action is needed across the health and health-related social systems.
- Let people drive their own care plans – listen to their wants, needs, and be mindful of the importance of culture in healing. Any initiative aimed at supporting people’s health should incorporate a range of health professionals and be tailored to each person’s needs and situation.
- Investment priorities include:
 - building the skills and knowledge of the workforce, including cultural competency, values, and attitudes, along with Māori and peer workforce capacity
 - prevention and screening initiatives to ensure risk factors are identified early and measures can be taken to reduce the risk of developing physical health issues
 - integrated and collaborative approaches to care
 - addressing the socioeconomic and environmental contributors to poor physical health
 - evidence-based approaches or programmes
 - understanding how digital health programmes can improve the physical health of people with experience of mental health and addiction issues.

Gaps in the literature

- Recent literature focusses more on people with experience of mental health issues rather than addiction issues. Further work is needed specifically on the physical health issues affecting people with experience of addiction issues and workforce development needs for the addiction sector.
- Other research indicates peer support workers are invaluable in mental health and addiction services. The 2017 Te Pou update includes a review on the benefits of peer support workers specifically related to the physical health of people experiencing mental health and addiction issues. As the available studies are of low quality making it difficult to draw conclusions (Te Pou, 2017), better quality research investigating peer support roles for physical health is important to inform future workforce development.
- *The Lancet Psychiatry Commission* highlights the need for a greater understanding of the full range of physical health issues affecting people, in an array of settings.
 - The literature on physical health disparities is mainly focussed on metabolic or cardiovascular health in high income countries.

- High quality literature related to respiratory and infectious illnesses across the range of mental health and addiction experiences and diagnoses is lacking.
- Support programmes and workforce development initiatives tailored specifically to support Māori and Pasifika peoples. More culturally appropriate approaches can help achieve greater equity.
- The impact of policy changes on people's physical health outcomes. To advocate for policy changes, information on the impact of previous policy changes is needed to strengthen this.
- While the lived experience narratives included are extremely valuable, more of these studies are needed to strengthen the evidence base and steer the way forward for a system driven by people.

Who is responsible?

We are all responsible. Multiple approaches are needed from people across the system.

Government, health commissioners, policy makers, health providers, and workers must acknowledge their respective responsibilities for improving the physical health of people with experience of mental health and addiction issues (Firth et al., 2019).

Health providers and workers should reflect on the duty of care they have to people experiencing mental health and addiction issues. Working in partnership with people and their whānau will help ensure approaches are tailored to their needs.

We believe that everyone taking small actions in their everyday work can help raise awareness, reduce discrimination and racism, and encourage action.

We must all keep Te Tiriti o Waitangi at the forefront of our minds as we work to achieve physical health equity for Māori people and all New Zealanders. As part of our commitment we will continue to highlight the available research, as well as gaps, and advocate for the prioritisation of investment in research and actions to drive change in this area.

Appendix: Methods

This brief review seeks to answer what research has been published since 2018 which can inform the New Zealand Equally Well collaborative. It is not a systematic literature review. Articles were included based on the availability of full text articles and if the type of publication was a:

- meta-analysis or systematic review
- review article relevant to New Zealand
- relevant single study – preference for New Zealand or Australian studies
- lived experience narrative or qualitative study from New Zealand or Australia
- New Zealand government or non-government organisation report or website.

Search terms (filtered for date range January 2018 to April 2020) on Google Scholar and EBSCO¹³ included:

- physical health, cardiovascular, cancer, metabolic
- mental health, psychiatric
- addiction, substance use
- interventions, services
- Māori, Pacific, Pasifika.

A brief grey literature search was also carried out via Google.

Key findings are summarised based on the key themes in the *Lancet Psychiatry Commission* article.

¹³ EBSCO is a leading provider of research databases. Te Pou has access to some health-related databases through EBSCO.

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