



Research Article

What Possibilities, Problems and Barriers Do Patients, Suffering from Severe Mental Illness or Alcohol Use Disorder, Perceive Towards Lifestyle Changes or Treatment Seeking to Prevent Cardiovascular Health Problems

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Abstract

Patients suffering from either severe mental illness or alcohol use disorder thus lose 13 to 30 years of life expectancy. The leading cause of death is insufficient detection, diagnoses and treatment of cardiovascular disease. Several interventions aimed at reducing the risk of cardiovascular disease have been developed and tested in randomized controlled trial studies. The interventions tested so far has not shown to have a long-term impact on the health of these patients. Only a few studies have investigated this particular patient group's perspectives and recommendations on how to prevent and treat risk factors for cardiovascular disease. The aim of this study was to learn about the patients' perception of physical health problems, have them identify potential barriers for lack of treatment and prevention of cardiovascular disease, and to obtain knowledge for future interventions. The study was designed as a qualitative study and consisted of semi-structured interviews with patients. Two main themes, motivation and continuity/flexibility, and a number of subthemes were identified. Patients wanted healthcare professionals to be more aware of somatic health and that physical health could be better integrated into psychiatry and in the alcohol treatment facility and the possibility of flexible courses adapted to the individual patient.

Keywords: Alcohol use disorder; Cardiovascular health problems; Lifestyle changes; Mental illness; Patient experiences

Introduction

The physical health problems of patients with Severe Mental Illness (SMI) such as schizophrenia, bipolar disorder, and severe depression and patients with Alcohol Use Disorder (AUD) are of increasing concern [1,2]. Mortality rates for patients suffering

from SMI are around twice that of the general population [3], and for patients with AUD, the mortality rates are three-fold in men and four-fold in women [2]. The patients suffering from either SMI or AUD thus lose 13 to 30 years of life expectancy [2-6]. The leading cause is insufficient detection, diagnoses and treatment of cardiovascular disease (CVD) [2,7-10]. CVD includes high blood pressure, heart attack, lipid abnormalities and disorders, heart arrhythmias and myocardial ischemia. Lifestyle and environmental factors, such as poor dietary intake, smoking, obesity, and low

levels of physical activity, play a part [3] as does treatment with antipsychotics [11]. Smoking rates are nearly three times as high in patients with schizophrenia compared with the general population, and the prevalence of obesity is up to four times higher than that of the non-mentally ill population [3].

Several interventions aimed at reducing the risk of CVD have been developed and tested in randomized controlled trial (RCT) studies regarding patients with SMI [12]. However, no studies have been performed on the prevention of CVD in patients with AUD. A wide range of interventions in patients with schizophrenia as diet, exercise, cognitive behavioral interventions, and mixed interventions have been shown to reduce weight and improve physical health, especially during the study period [13]. In addition, alcohol-related hypertension increases the risk of CVD and early intervention for excessive alcohol use offers the promise of lower levels of blood pressure and reduced risk of adverse cardiovascular outcomes [14]. Lifestyle modifications can be more effective than treatment as usual (TAU) even when of short duration [12]. However, a systematic review of individualized life style interventions aimed at reducing weight in patients with SMI showed that experimental interventions reduced the mean difference in BMI compared to the control groups but at post intervention follow-up the effect was no longer significant [15]. The results of the existing studies on lifestyle interventions thus indicate that long-term effects can be a challenge [13]. In conclusion, the interventions tested so far has not shown to have a long-term impact on the health of patients, suffering from SMI or AUD.

The nature of the mental illness itself may affect motivation to change lifestyle, and cognitive impairment may lead the patients to less healthcare seeking. Still, motivational aspects for participation are rarely involved in planning, for instance, an exercise intervention for patients with AUD and SMI [3,11,16]. The organizational structure with the division into a somatic and a psychiatric health care system is also reported to be a significant challenge for these patients, and lack of collaboration among mental health care professionals and general practitioners (GPs) hinders optimal care [17,18]. A Danish study has shown that both staff and patients wanted less fragmentation of the system and cooperation between psychiatric and somatic healthcare [11].

For understanding the physical health problems and causes and methods to prevent and treat CVD, the patients' perceptions are important, as are insights on both an individual and system level [11]. Only a few studies have, however, so far investigated this particular patient group's perspectives and recommendations on how to prevent and treat risk factors for CVD [11,17]. Patients with SMI and patients with AUD are combined in this study, as the two groups have the highest mortality and they are both part of the ICD-10. The current study is part of The Psychiatric

Cardiovascular Participatory Study (PsyCaps), which consists of four phases. The overall purpose of the PsyCap study is to develop and test a patient-developed intervention for prevention and treatment of CVD. As a first phase, PsyCaps involved patients with schizophrenia, bipolar disorder, severe depression, and/or AUD in developing an intervention treating and preventing CVD by the user collaboration method [19]. The aim of the present study was to learn about the patients' perception of physical health problems, have them identify potential barriers for lack of treatment and prevention of CVD, and to obtain knowledge to improve proposals for future interventions. The present paper presents the results of the initial interviews and was part of the first phase in the PsyCaps study.

Methods

Design

The study was designed as a qualitative study and consisted of semi-structured interviews and focus group interviews. The combination of focus group interviews and semi-structured interviews provided an opportunity of flexibility for participants to choose the interview method they preferred, and take advantage of the methods' respective benefits and compensate for their individual limitations [20,21]. Focus group interviews are considered to bring out more views and attitudes through the interaction and discussion in the group, while semi-structured interviews may provide opportunities for the individual to give more details, and may also be experienced as more safe and flexible [22,23].

Context and Participants

The study was carried out at the Research Unit for Psychiatry and at the Unit for Clinical Alcohol Research at the University of Southern Denmark. Participants were recruited from three units, a Community Mental Health Care Center, a psychiatric residence, and an alcohol treatment facility. Inclusion criteria were patients aged 20+ years. The inclusion criteria at the outpatient clinic and the psychiatric residence were: 1) ICD 10 diagnosis of schizophrenia (F20.0), bipolar disorder (F31.1-5) and depression (F32.1-2 and F33.1-3 2), at least one unhealthy lifestyle factor such as obesity, smoking, and alcohol dependence, and 3) Danish-speaking. The inclusion criteria at the Alcohol Treatment Facility: 1) ICD 10 diagnosis of alcohol dependence (F10.2) 2) at least one unhealthy lifestyle factor, and 3) Danish-speaking. Exclusion criteria for both groups were current state of being severely psychotic or demented. Recruitment of participants from the three units assumed that the participants supplied a general perspective for the risk groups.

Procedure in the Project

The first phase of the PsyCaps study was designed as a process consisting of information meetings, interviews, and dialogue meetings aimed at collecting the patients' perspectives on

preventing and treating risk factors for CVD, in particular perceived barriers, and potential solutions. Initially, information meetings were held for staff at the involved institutions to inform about the study and its aims. After that, invitations to information meetings for patients were announced via flyers and posters, in addition to staff informing patients about the meetings. The information meetings were open for all interested patients. The content of the sessions was a presentation of state of the art in relation to risk of death due to CVD, existing prevention and treatment strategies, and existing knowledge about risk factors within the target groups. Subsequently, interested patients were invited to participate in the study. In case of interest in participating, and before inclusion, eligible patients received additional information from the head of the project about aim and expectations regarding their participation, and how the results would be used.

Subsequently, the patients participated in a series of semi-structured interviews, focus group interviews, and dialogue meetings aimed at creating a patient-developed intervention to be tested first in a feasibility study (phase 2) and, if feasible, a cluster randomized study will be prepared (phase 3) and carried out in phase 4. The themes identified in the interviews, combined with the existing knowledge, served as tools in the dialogue meetings (Finansministeriet.) [24]. Below, the results of the interviews are presented. A more detailed description of the overall method of user-involvement in the project is described elsewhere.

Three focus group interviews were planned for each treatment unit. The interviews were performed by means of an interview guide. The main areas for the interviews were perceived reasons for/experiences of unhealthy lifestyle and lack of treatment, barriers for participation in potential treatment and prevention of CVD, and suggestions for specific interventions for changing/preventing unhealthy lifestyle.

Data Analysis

The interviews were audio-recorded and subsequently analyzed using a general inductive approach and thematic analysis to identify, analyze, and report themes within the data [25]. The thematic analysis was undertaken by the first author and discussed and interpreted with the co-authors and was done through the following phases: 1) The recordings were transcribed verbatim, read and reread 2) Semantic units of meaning related to the study aim were identified 3) Coding and collating data relevant to each code was done manually 4) Collating codes into potential themes was performed 5) Themes were reviewed and refined 6) Generating definitions and names for each theme was performed.

Ethics

Each patient's anonymity was guaranteed, as well as the strictest confidentiality on behalf of the researchers. During the reporting of the interviews, quotes were extracted anonymously,

thus rendering it impossible to identify individual patients. Contact and meetings occurred on the patient's terms, enabling each patient to experience being heard and understood. Oral and written consent for participation were obtained from each patient. The Danish Data Protection Agency has approved the study (Journal Nr. 20/55366).

Results

Participants

Recruitment of participants for interviews was somewhat challenged, partly due to the reluctance to participate in-group arrangements during the covid-19 pandemic. It was not possible to include patients with depression. Five focus group interviews and three semi-structured interviews were conducted with 17 participants. Three focus groups at the Community Mental Health Care Center (n = 4), one at the psychiatric residence (n = 5), one at the alcohol treatment facility (n = 8), and three semi-structured interviews at the alcohol treatment facility. The sociodemographic characteristics of the participants can be seen in Table 1.

	Participants (n = 17)
Mean age (range), years	46 (23-69)
Female	6
Male	11
Diagnosis (ICD10)	
• F 20	7
• F 31	1
• F 10.2	9

Table 1: Baseline characteristics of included participants.

F20: schizophrenia, F31: bipolar disorder, F10.2: alcohol dependence

Interviews

The findings from focus group interviews and semi-structured interviews were analyzed within the same process. Two main themes were identified: 1) motivation and 2) continuity/flexibility. Motivation included a series of several sub-themes. The sub-themes are presented under the main theme.

Motivation

Motivation was highlighted as the most important factor for changes in lifestyle, even more important than the offering of lifestyle interventions itself. Overall, the patients were aware of the need to change potentially damaging habits as smoking, unhealthy diet, and lack of exercise. However, although health was considered important by most patients, they described how they often felt unable to act, and that potential change in lifestyle would decrease their quality of life:

“Diet and exercise are important to me, and both are equally hard; ultimately, it’s also about feeling comfortable about the fact that, ok - I’ll never ever be skinny like a model, I just don’t want that, it wouldn’t make me happy.”

Rather than changing their lifestyle, some participants, therefore, argued that quality of life might instead increase by accepting who you are:

“What do you want to achieve in your life, to remain on a perpetual diet or obtain some quality of life as the person you really are, and with the resources and challenges you have?”

However, most participants did express a wish to change their lifestyle into a healthier one. Still, they felt they lacked the mental capacity to do so, for example, cooking healthy food, even during periods when they did not experience many symptoms in their mental illnesses. In addition, several patients also mentioned how exercise had had a positive effect on their mental wellbeing during periods when they had managed to initiate physical activities.

“Exercising calms you down; it is almost like a complete system cleanse.”

Overall, the patients found that the motivation to change had to come from themselves, and that they wished for initiatives from the surroundings to prompt the motivation. Several factors were considered to promote motivation, just as a number of factors were considered to inhibit it (Figure 1).

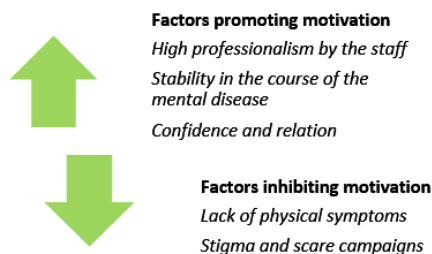


Figure 1: Factors that promote motivation and factors that inhibit motivation.

Factors that Promote Motivation

High Professionalism by the Staff

High professionalism by the staff was highlighted as an essential prerequisite to motivate lifestyle changes. For example, the patients emphasized that a dietitian should advise on diet, and an experienced sleep coach advised on sleep, rather than the therapist responsible for the treatment of the patient’s mental illness or alcohol dependence.

“I like having experts involved - someone to lean on, such as a dietician, someone you trust and believe in.”

At the same time, it was emphasized that these professionals should have some knowledge about mental illnesses or alcohol dependence:

“If this person has no knowledge about psychiatric illness and accidentally says something in a wrong way, one might react to it and, subsequently, really experience hardship over a long period. However, knowledge of the psyche would enable the person to embrace it differently since what lies behind it is known.”

The participants considered experts in prevention strategies preferable. They felt they would ensure that advice and proposals about lifestyle changes were of high quality. However, such professionalism might backfire if the expert cannot communicate appropriately with patients suffering from mental health issues. It was, thus, essential that the staff treating CVD had knowledge of psychiatry and treatment of AUD, enabling them to embrace the individual in need of more than the average person. All patients agreed that it should be someone other than the primary therapist of the psychiatric disease/AUD who was in charge of guidance and advice on lifestyle. It was emphasized that the patients’ own experiences about lifestyle could be utilized as essential aspects and integrated into a future intervention involving peers. Peers were considered to be trustworthy facilitators.

Stability in the course of the mental disease

All patients agreed that they could not manage to take care of their physical health during the periods when their SMI or AUD dominated everyday life. An important prerequisite for lifestyle changes was stability in the patients’ mental illness or alcohol dependence. It required mental capacity to initiate lifestyle changes, and it was not considered possible if the mental disease dominated everyday life:

“I’m considering quitting smoking at one point, however, I just quit my alcohol dependence – so both things at once would have been incomprehensible.”

The ability to perform small lifestyle changes motivated most patients to continue, and it was considered important that the stability of the mental health had lasted for a period in order to reduce the risk of relapse to unhealthy habits. Some patients experienced relapse or lack of progress in their attempt to change lifestyle:

“Then you give up and think ‘well, never mind’ and you do not get much further until a defining moment makes you face reality: this is what got me started. Once you have given up, it’ll take a lot of effort to get back on track.”

Consequently, lifestyle changes should be planned as small steps with achievable goals for the individual patient.

Confidence and Relation

Confidence and a good relation between therapists and fellow patients were found to be significant elements for motivation in most patients.

“Our target groups - well, they aren't quick on the initiative, are they? It sort of has to be coming from an outside influence.”

Many patients emphasized that the confidence in, and good relationship with, their therapists could well be used to boost a process of increasing motivation and seeking professional help for lifestyle changes and treatment of CVD. Some patients suggested that a good friend, peer, or neighbour might motivate to start lifestyle changes. It was not considered that a particularly close relationship was needed, but rather it was considered to essential that the person in question was trustworthy. Only a few patients wanted to involve the immediate family to be the ones to motivate patients. The patients felt that the family was happy to support them in their changes once they had gotten started. Still, they considered it was important that the patient themselves remained responsible for the change.

There could be an ethical aspect that the staff had to pay attention to. Several patients mentioned how privacy was central to their lifestyle. It could be felt as transgressive if too many people were involved and not least had access to data about them. Most patients wanted some sort of control over who was involved in the course of promoting lifestyle changes and who had access to the patients' data. They wanted only a few people involved, primarily the patient's contact person or professionals, whom the patient trusted. A good relationship with the person who initiated lifestyle changes was a prerequisite, but at the same time, it was important for the patients that it took place at a distance to give the patient co-responsibility:

“It isn't something I feel like sharing with just anybody, but I have a great relationship with her – even from a bit of a distance. She doesn't say stuff just to bug me, but possibly because she's aware that I'm slipping regarding the weight issue, and after reminding me, it's up to me whether I want to do something about it.”

Most patients wanted the lifestyle change offerings to be shared with like-minded people because the relationship created in such groups would be associated with an increased understanding of their disease. Others emphasized that it should be among people without SMI and AUD:

“It is risky in the company with someone from a similar group, chatting about our problems and symptoms, but it's a bit more challenging in the company of someone completely outside our groups. So, it would be cool to spend time someplace where no one necessarily talked about sickness.”

Furthermore, most patients mentioned that it would be a challenge to show up at unfamiliar places. If, on the other hand, the surroundings were familiar to them, it would increase a sense of safety and confidence and make it easier to participate in courses on lifestyle changes.

Factors that Inhibit Motivation

Lack of Physical Symptoms

Patients often knew that they might have or were predisposed to CVD. However, often they do not experience symptoms of CVD in the early stages of the disease, and therefore they do not have regular contact with their GP. However, most participants considered that they would seek medical attention if the symptoms became more pronounced. Several patients were suffering from chronic diseases like diabetes and asthma and had suffered for many years. Although diabetes is associated with an increased risk of developing CVD, a patient expressed the following in connection with contacting a GP:

“This thing they're saying – how everything is going well, if you don't have any late complications after the first 15 years, then you probably won't get any. So, I thought, and then I don't have to work at reducing that blood sugar level, I just continue on the same track.”

Patients also mentioned fear of getting negative results as to why they did not contact their GP. Contrary, they also wished for more focus on their physical health both from their GP and in the clinics where they were treated for their mental illness or alcohol dependence. Finally, the patients expressed a wish for the staff, in general, to be more aware of the somatic health and potential treatment of unhealthy lifestyles.

Stigma and Scare Campaigns

Several patients perceived physicians' attitudes toward physical symptoms as being biased due to the patients' psychiatric diagnosis. They often did not find that their physical symptoms were taken seriously. Their mental illness was often used as an excuse when they sought medical attention with physical symptoms:

“No matter what, healthcare professionals mustn't regard you as a patient with schizophrenia. After all, some doctors perceive the psychiatric illness as the primary factor, and that the physical symptoms are merely a figment of the patient's imagination.”

Several patients highlighted that scare campaigns, stigma, and the expectations of others could have a negative impact. For example, patients mentioned getting upset and sad, causing them to eat - ultimately getting nowhere. The patients wanted the communication about lifestyle issues to take place in a friendly

and optimistic tone, having a high professional level, in addition to being very specific and action-oriented.

Continuity and Flexibility

The division of the health system into separate sectors, treating somatic and mental illnesses, respectively, was perceived as being two different worlds in relation to access to the patient:

“I suppose that if you experience not having to go to two separate places, then greater coherence must have been a thought factor.”

In general, patients missed more focus on physical health and that it could be better integrated into psychiatry. In addition, most patients described it as a barrier if they had to show up at several different places. Interest in the opposite area from the staff was considered essential to create coherence and responsibility. This corresponded to the fact that the psychiatrist had to inquire into the progress of a lifestyle change and that the somatic treatment system had to show interest in mental health. This was considered leading to an increased likelihood of patients participating and complying with future appointments and being more responsible for attending.

The patients emphasized structure and a coordinator as crucial elements in the treatment courses. A coordinator should specifically help make concrete agreements and suggest actions for treatment. In addition, staff should be well informed about the patients' entire situation to avoid forcing the patients to repeat the same story. At the same time, it was essential for the patients to be involved in planning the treatment and prevention initiatives, creating flexibility, and ensuring that concrete agreements and actions were made between visits.

“I have to say - it takes a lot more than a mere hand on the shoulder, you have to have a fixed date, or you don't show up.”

The patients agreed that specific agreements gave increased responsibility to attend the consultations than if the patients themselves had to find time and contact the treatment centers.

The patients suggested that routine examinations, such as blood tests, ECGs, and blood pressure check for chronic lifestyle diseases, could take place in the mental health institutions or at the alcohol treatment centers, subsequently responsible for communicating the results to the somatic wards or the patient's GP:

“An add on would be great – a prick of the finger, for example, blood - and cholesterol tests, since you're already here, where we like coming since some of us find it challenging to go see a doctor.”

Collaboration and communication across sectors gave the patient a sense of holistic approach. Treatment options should take place at the same location, if possible. The participants wished for better knowledge on the possibilities for help from all staff involved.

Further, a flexible approach to the individual patient was also requested. Here, the staff was assumed to have a significant role in sensing how much the patient was able to engage when considering the status of the patient's psychiatric illness or alcohol dependence. Therefore, the requirements had to be continuously adapted to the patient's current situation:

“There may be a period with ongoing ‘handholding.’ However, the staff should bear in mind to gradually relinquish the responsibility to the patient, because it's a well-known fact that society isn't set up to hold anyone's hand all through life.”

The interventions should, thus, be adapted to the individual patient and gradually increased according to the improvement of the patient's illness. Even minor progress was considered to increase motivation because it was essential for the patients to be able to notice the benefits.

Discussion

This study aimed to obtain information about the patient's perception of physical health problems, identify potential barriers for lack of treatment and prevention of CVD, and proposals for future interventions. Motivation was highlighted as a prominent theme, far more important than the offering of lifestyle interventions, and it had to come primarily from the patient himself. High staff professionalism, stability in disease, and confidence and relation were identified as factors promoting motivation, while lack of physical symptoms, stigma and scare campaigns inhibited motivation. The patients expressed a wish for the staff to be generally more aware of the patients' somatic health, and that physical health could be better integrated into psychiatry and in the alcohol treatment facility. The patients wanted continuity, possibility of flexible courses adapted to the individual patient, and concrete agreements and actions being made between visits.

In accordance with other findings, most patients wanted a less fragmented health care system [4,11,25]. Mental illness versus somatic illness and interest in the opposite area from the staff was essential to create coherence and responsibility. Patients highlighted that the staff should be well informed about the entire patient's situation to prevent the patients from having to tell the story repeatedly. An interesting finding in this study was that some patients pointed out that there could be an ethical aspect when too many professionals were involved and had access to data about the patient. The reason was that these patients experienced privacy as a key aspect of lifestyle and that the patients at the same time emphasized trust in the involved professionals.

Patients mentioned that they would benefit from a coordinator in treatment courses. In particular, the coordinator must help the patients make concrete agreements and actions for future treatment. Attaching a coordinator or case manager has been suggested in other studies [11,27]. For instance, patients wished

for an individual case manager in a more comprehensive role to help them structure everyday life, adhere to appointments and lifestyle changes, and be a liaison between different authorities [11]. Care coordination has also been tested in a RCT as an add-on to treatment as usual. In the study, a care coordinator facilitated contact with primary care to ensure optimal treatment of physical health problems. Still, results did not support the superiority of care coordination compared to TAU [27]. However, the results of this study differ from the other studies because the coordinator had to be included in a different and integrated context, as the patients wanted that the treatment options for physical and mental health should take place at the same location. In addition, patients in this study emphasized that they wanted a great deal of responsibility in the course of treatment.

In conformity with other studies, including the general population, motivation for lifestyle change is complex, like in patients with SMI or AUD [28,29]. Support and a greater focus on patient motivation and the quality of motivation seem to be of primary importance in lifestyle interventions for people with type 2 diabetes [28]. However, motivational aspects are rarely involved in planning interventions, even in patients with SMI or AUD. Additional challenges for motivation in patients with SMI or AUD may be lack of mental capacity and that lifestyle changes as quitting smoking can lead to their mental health deteriorating [3,11]. Overall, the patients found that the motivation for change had to come from themselves, but they also wished for initiatives from the surroundings to prompt the motivation. Other studies supported a greater focus on patient motivation, a need for continual external prompting, and a focus on motivational aspects after an intervention to continue support for change [11,28,29].

In the present study, lack of physical symptoms in the early stages of CVD was identified as inhibiting motivation. Furthermore, an interesting finding was the professional's lack of focus on lifestyle issues even if the patient was in a risk group for developing lifestyle disease. In accordance with other studies, staff with negative attitudes towards engaging in physical health is an important finding [11,28,29]. The attitude of the staff is essential when facilitating an intervention, where factors such as encouragement and motivation are crucial for the engagement of the patients [11,30]. In addition, in this study, high professionalism by the staff was highlighted as an essential prerequisite for motivation when changing lifestyles. Other studies mention professional incompetence, especially in the municipality [11]. It cannot be excluded that interventions delivered by trained specialists have more effect than those delivered by research assistants (Speyer et al., 2019).

Strengths and Limitations

The patients are recruited from a Community Mental Health Care Center, a psychiatric residence, and an alcohol treatment

facility and the results represented a broad target group. This may immediately be a limitation, but patients had similar perceptions of physical health problems, barriers for lack of treatment, and proposals for future interventions.

Recruitment of patients was somewhat challenged due to the Covid 19 pandemic. It cannot be ruled out that there may be a selection bias affecting the results, as patients in this study are perhaps more aware of and concerned about their lifestyle. All patients have experienced long-term treatment courses concerning their SMI or AUD, and they had at least one unhealthy lifestyle factor. This may be a strength in relation to the knowledge of preventing and treating CVD. Patients were stable in the course of their mental disease, and they had mental capacity now. We cannot exclude that patients with an early-phase or unstable disease would have expressed different options, as a different stage of disorder could be related to different perceptions of lifestyle disease.

Participants at the psychiatric residence and the alcohol treatment facility did not have the mental capacity to participate in the planned three focus group interviews. However, the areas for the study were discussed in one focus group interview in these places. Participants in two of three focus groups was lower than the recommended 6-10 participants (Morgan, 1996) [31] and only patients with AUD participated in semi-structured interviews. More focus group interviews at the psychiatric residence and the alcohol treatment facility, a larger number of participants in focus groups and semi-structured interviews by patients with SMI might have added further themes.

Conclusion

The findings of this study were that motivation was highlighted as a prominent theme. Some factors promoted motivation, while others inhibited motivation. Patients wanted staff to be more aware of somatic health, that physical health could be better integrated into psychiatry and the alcohol treatment facility, and the possibility of flexible courses adapted to the individual patient. More studies focusing on staff's views and attitudes and qualitative studies, especially among patients with AUD, are needed.

Clinical Implications

The study suggests a less fragmented healthcare system and that physical health could be better integrated into psychiatry and the alcohol treatment facility. Therefore, the treatment options for physical and mental health should take place at the same location with the possibility of flexible courses adapted to the individual patient, and an associated coordinator. In a future intervention, high professionalism by the staff must be ensured.

Declaration of Conflicting Interests

The authors declare that there is no conflict of interest.

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