Mental health and long-term conditions 1: physical health

Why mental health service users are at greater risk of physical illness than the general population

Morbidity and mortality is high among this group

What nurses can do to improve service users’ health

Author Mike Nash is a lecturer in psychiatric nursing, Trinity College, Dublin; Justin McDermott is a lecturer in mental health, Middlesex University.


Poor diet, smoking, a lack of physical activity and excessive alcohol intake are just some of the factors that can contribute to a range of debilitating long-term conditions.

Lifestyle risk factors can have a disproportionate impact on more vulnerable groups within society, such as people with mental health problems.

Recent government policy takes a two-pronged approach to this subject with a commitment that fewer people with mental health problems will die prematurely, and more people who are physically ill will have better mental health (Department of Health, 2011).

Sometimes, realising this commitment is not straightforward and the way health services are organised, or the attitudes of practitioners, can be unwitting barriers to ensuring good physical health.

Physical health of mental health service users

In the UK, a large proportion of mental healthcare is delivered in primary care, so most psychiatric care occurs in non-psychiatric settings with non-mental health-care staff. Mental health service users tend to have poorer physical health than the general population (Phelan et al, 2001).

Prevalence

Mental health service users are at greater risk of physical illness than the general population, partly because of their greater exposure to risk factors. For example, obesity is a serious public health concern because it can be both a cause and a symptom of long-term conditions such as coronary heart disease and diabetes. Citrome and Vreeland (2009) found obesity is the most common physical health problem in mental illness.

People with schizophrenia have higher than expected rates of cardiovascular disease, infectious diseases, non-insulin-dependent diabetes, respiratory disease, some forms of cancer, and a variety of other illnesses (Dixon et al, 1999).

Physical health of mental health service users

In the UK, a large proportion of mental healthcare is delivered in primary care, so most psychiatric care occurs in non-psychiatric settings with non-mental health-care staff. Mental health service users tend to have poorer physical health than the general population (Phelan et al, 2001).

This is despite many being in contact with a range of health professionals.

Poor physical health is manifested in two principal ways: higher morbidity (illness) rates and mortality (death) rates. Other indicators of poor health include health outcomes such as reduced life expectancy following diagnosis.

Morbidity relates to the levels of illness in a population. One of the most common measures of morbidity is prevalence – the number of all known cases of an illness or risk factor in a defined population. For example, Goddard (2006) suggested the prevalence of smoking is 22% in UK adults.

Keywords: Mental health service user/Long-term conditions/Mortality/Morbidity

● This article has been double-blind peer reviewed
Opportunities to take part in exercise would improve service users’ physical health such as CHD, which can also reduce life expectancy.

Women mental health service users’ health is a particular concern. In 2005, the Disability Rights Commission (DRC, 2006) found women with schizophrenia were 42% more likely to develop breast cancer than other women. Smoking is probably the biggest contributing factor to this.

Breast screening is important in the early detection of breast tumours so that treatment can be initiated. However, Werneke et al (2006) noted that women with severe mental illness were less likely to attend breast screening than the general population of eligible women. This illustrates an opportunity for nurses to engage in health education and health promotion in this area.

Physical activity and diet
Mental health service users tend to be less active and more sedentary than the general population, especially if they are in hospital, because they may have less opportunity to engage in physical activity (Grant, 2000).

A survey of service users’ diets found an average fruit and vegetable intake of 16 portions per week – a stark contrast to the five a day recommended in the UK (McCreadie, 2003). This might be a contributing factor to the high risk of bowel cancer reported in people with schizophrenia (DRC, 2006).

Adverse drug reactions
All medication used in mental healthcare carries the risk of side-effects, while some of which are minor and will recede, others can be serious, contributing to disorders like type 2 diabetes, hyperlipidaemia and obesity (Taylor et al, 2009). With so much mental healthcare taking place in non-mental health settings, nurses need to be aware of adverse drug reactions as they constitute a unique risk factor for poor physical health.

Morbidity is an important indicator as it can highlight long-term conditions that are particularly problematic. But it only indicates the number of people with a certain condition, not how serious that condition is. The late detection of long-term conditions means their severity is likely to be greater when they are eventually diagnosed (Nash, 2010).

Mortality
Suicide is a significant cause of mortality in mental healthcare. Mental health service users also have higher than average death rates from a range of physical conditions. For example, people with schizophrenia have elevated death rates due to cardiovascular disease, tuberculosis, and lung, kidney and digestive diseases (Dixon et al, 1999).

Recent US studies found morbidity and mortality rates far higher in mental health service users than in the general population. Parks et al (2006) found mental health service users died on average 25 years earlier than the general population.

Health outcomes
The health outcomes for mental health service users are particularly poor.

The DRC has given a stark picture of physical health outcomes, stating: “Someone with a major mental health problem is more likely to develop a significant illness such as diabetes, CHD, stroke or respiratory disease than other citizens, more likely to develop it before 55, and – once they have it – more likely to die of it within five years” (DRC, 2006).

Why is mortality and morbidity so high?
While the general population are exposed to similar risk factors, morbidity and mortality rates in mental health clients are generally higher due to lifestyle risk factors.

Behaviours that increase the risk of physical illness such as smoking and alcohol abuse are higher among people with mental illness (DH, 2009).

There are other reasons for poor physical health. One social explanation is that service users tend to come from lower social class groups so are more exposed to material disadvantage, poor housing, lower educational attainment, insecure employment or homelessness that cause inequalities in health (DH, 2008).

Poor social support
Mental health service users are a vulnerable and excluded group. They may have limited support networks and may not access healthcare services until their symptoms have become severe. Low social support means less help with managing physical problems; for example, they may have no one to remind them to take medication or monitor blood glucose levels.
Poor monitoring of physical health

It is generally unknown how effectively NICE guidelines and national service frameworks for long-term conditions have been integrated into mental healthcare.

In 2009, Lambert and Newcomer suggested that, despite the provision of many sets of guidelines and protocols for screening and monitoring of cardiometabolic risks, morbidity and mortality rates for those with psychotic illnesses remained excessive and premature. For example, clinicians often fail to screen and monitor clients for adverse effects of psychotropic medication (National Patient Safety Agency, 2006).

Negative attitudes

Negative attitudes linked to stigma are also a barrier to good physical health. Mental health service users have reported feeling unfairly treated by their GPs because of their mental illness (Mind, 1996).

Research by the DRC (2006) also found perceived negative or discriminatory attitudes of health professionals one of the most significant barriers to healthcare identified by respondents.

Sometimes this stigma manifests itself in nurses not taking reported symptoms at face value, but relabelling them as symptoms of a service user’s mental illness.

For example, someone with a history of depression may report fatigue, lack of energy, poor concentration and low mood. Naturally, due to their past history, depression might be diagnosed again – but this presentation is similar to that of hypothyroidism. Relying on past history alone might be diagnosed again – but this presentation is similar to that of hypothyroidism. Relying on past history alone may therefore fail to screen and monitor clients for adverse effects of psychotropic medication.

Many mental health professionals have indicated that they still lack the relevant knowledge and skills (Gray et al, 1999).

Redressing the imbalance

The physical health needs of mental health service users must be prioritised to redress the high mortality and morbidity rates within this group. Individuals should be screened in line with NSFs and NICE guidelines.

More strategic partnerships need to be developed between acute and primary care and mental health services to offer shared care for complex comorbid conditions.

Screening and prevention initiatives such as flu vaccinations should be targeted at this group. Burns and Cohen (1998) reported evidence of a lack of health promotion advice for these services.

Yearsly health checks could be implemented and used to map unmet needs and identify priorities for commissioning.

Nurses must also reflect on their training needs in this area to develop their skills in communicating and providing quality services to this group.

Conclusion

Some long-term conditions are preventable and manageable with primary health education, promotion and screening.

Many of the risk factors for these conditions are modifiable, so introducing lifestyle changes can reduce the risk of these conditions developing, or if already diagnosed, their impact on health. The government is committed to improving the physical health of these service users by increasing life expectancy and reducing premature deaths (DH, 2011).

The main implication for nursing practice is to begin implementing public health guidance with these individuals, doing the same work with a vulnerable and excluded group as is done with the general population.

Nurses have an ethical obligation to provide high-quality care to all patients, however difficult this might be. We must refrain from being judgemental and not let negative attitudes or stereotypical ideas of mental health service users be barriers to much needed healthcare.

Nursing is an enthusiastic profession that strives to extend practice. The profession is strategically well positioned to improve the health outcomes of this group by increasing opportunistic or targeted screening and monitoring.

Our challenge is, therefore, to paraphrase the government’s strategy - “no mental health without good physical health”. NT

References

London: DH. tinyurl.com/mental-health-strategy


NEXT IN THIS SERIES

5 July Mental health long-term conditions 2: managing depression