Many people with mental ill health or learning disability die early, preventable deaths but steps can be taken to ensure their physical health needs are not overlooked

Reducing inequalities in health and life expectancy

In this article...

- Life expectancy of those with mental illness/learning disabilities
- Reasons why there is a greater risk of early death
- Strategies to address health inequality

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The risk of premature death in people with severe mental illness or learning disabilities is significantly higher than the general population. This is mostly caused by treatable long-term conditions. This article describes research conducted to establish the evidence base and draw up priorities for action, along with the competencies mental health and learning disability nurses need to improve service users’ physical healthcare.

The risk of premature death in people with severe mental illness aged under 50 is 4.1 times higher than the general population. There is also a much higher prevalence of certain common long-term conditions (Rethink Mental Illness, 2013). Research suggests a reduced life expectancy of 20 years for people with mental illness – the same as general life expectancy in the 1950s – with no sign of the gap narrowing (RMI, 2013). As Thornicroft (2011) said: “There would be an outcry if [this] existed in a less stigmatised group.”

Although some of this poor life expectancy is due to higher rates of suicide and accidental death, a report by the Royal College of Physicians and Royal College of Psychiatrists (2013) shows it is mostly caused by treatable long-term conditions associated with modifiable risk factors.

From January 2014 to January 2015, in response to national reports on NHS care failings, directors of nursing in the nine mental health and learning disability trusts in the North West embarked on a project to improve service quality, including physical support for service users by mental health and learning disability nurses.

Project aims

The project set out to:

- Conduct a literature review to establish service users’ physical health needs and priorities for action;
- Identify nurses’ core competencies and roles relating to physical health;
- Identify and share good practice;
- Compile recommendations for trusts on improving services.

Method

Physical health leads were identified in each trust to form a steering group, eight of whom attended five meetings between...
March 2014 and December 2014.

The literature review focused on research and reports published since 2012. It addressed the following questions:
- Why do people with serious mental illness and/or learning disabilities have a shorter life expectancy?
- What core conditions contribute to these?
- What physical health competencies do mental health and learning disability nurses need?

Information on good practice was already available from a questionnaire sent to local trusts in 2013. This was updated and projects demonstrating good practice (Box 1) were showcased at a launch event.

**Literature review: mental illness**

**Smoking**

People with mental health problems are 70% more likely to smoke, and smoke more heavily, consuming up to 42% of the tobacco smoked in England (RCP and RCPsych, 2013). Smoking is the biggest cause of reduced life expectancy in people with severe mental illness and the most important modifiable risk factor (RCP and RCPsych, 2013; Jarvis, 2003). However, there has been no prioritisation of smoking cessation services for this group and no improvement in smoking rates in recent decades, despite smoking halving in the general population (Jarvis, 2003).

Although heavier dependence can make it harder for people with mental illness to quit, they are as motivated to stop as the general population (Siru et al, 2009). One problem is the acceptance of smoking in mental health settings (RCP and RCPsych, 2013). Staff may believe:
- Smoking is one of this group’s few pleasures (RMI, 2013);
- Cessation worsens mental health symptoms (RCP and RCPsych, 2013);
- Service users are unable or unwilling to quit (Hall and Prochaska, 2009).

Despite incentives, GPs appear less willing to offer smoking cessation services to this group (RCP and RCPsych, 2013).

The National Institute for Health and Care Excellence (2013) says evidence-based smoking cessation interventions are effective for people with mental ill health. The benefits are also greater for this group than the general population, including improved physical, mental and financial health, and reduced doses of some medicines (National Centre for Smoking Cessation and Training, 2014). There is no evidence that cessation increases mental health symptoms or adverse incidents. With appropriate management it can reduce anxiety and depression (RCP and RCPsych, 2013); some studies suggest the improvements are at least as significant as anti-depressant treatment (Taylor et al, 2014).

**Obesity**

People with mental illness are more likely to be obese, increasing their risk of coronary heart disease, type 2 diabetes and stroke (Bradshaw and Mairs, 2014). This is partly due to poorer diet and taking less exercise (Simonelli-Munoz et al, 2012), but anti-psychotic medication can also lead to substantial weight gain and increased cardiometabolic risks (Foley and Morley, 2011).

Too often service users are not informed about these risks, involved in prescribing decisions or monitored post-prescription (RMI, 2013); the National Audit of Schizophrenia found only 48% received medication information, 44% were involved in prescribing decisions and 33% were monitored for the five cardiometabolic risk factors over 12 months (RCPsych, 2014).

Systematic reviews of pharmacological and non-pharmacological interventions suggest they can reduce weight gain in this population, but non-pharmacological interventions such as cognitive behavioural therapy seem the more effective (Faulkner et al, 2007). Lifestyle interventions are effective if prioritised in the early phase of illness (Caenmerer et al, 2012).

**Barriers to access**

People with severe mental illness are less likely to report physical symptoms (De Hert et al, 2011), find it harder to access healthcare and receive fewer medications for physical problems (Mitchell et al, 2012). One problem is “diagnostic overshadowing” – physical health problems are seen as part of their mental health condition and are not diagnosed or treated (RMI, 2013).

NICE (2014) stresses the importance of annual health screening, monitoring of physical health and clarity over who is in charge of a service user’s physical health. However, lack of role clarity is a barrier (Schizophrenia Commission, 2012). Providers can also fail to make reasonable adjustments required by the Equality Act to help people access services (RMI, 2013).

**Conditions causing early death**

People with severe mental illness are:
- Two to three times more likely to have type 2 diabetes;
- 10 times more likely to die from respiratory disease;
- Twice as likely to die from coronary heart disease (RMI, 2013);
- Less likely to benefit from early diagnosis of cancer because of delays in reporting symptoms (Schizophrenia Commission, 2012).

**Literature review: learning disability**

Reported deaths in people with moderate-to-severe learning disabilities are three times higher than in the general population, and often from preventable causes (Emerson et al, 2012). Heslop et al (2013) estimated that men with learning disabilities die on average 13 years earlier and women 20 years earlier than the general population. Their inquiry into 247 deaths among people with learning disabilities found that 42% were premature, of which 48% were avoidable, and that 97% of preventable deaths resulted from one or more long-term treatable health condition.

**Obesity**

Obesity in people with learning disabilities is 28.3%, compared with 19.8% in the general population (Disability Rights Commission, 2006). Robertson et al (2000) found less than 10% of adults with learning disabilities ate a balanced diet and only 20% engaged in physical activity at recommended levels.

**Delays in diagnosis and treatment**

In Heslop et al’s (2013) study, 42% of relatives reported problems with diagnosis and treatment and 25% said concerns of people with learning disabilities or their families were not taken seriously. Common themes were a lack of:
- Reasonable adjustments to help people access services;
- Effective advocacy;
- Coordination between disease pathways and providers.

**Barriers to healthcare access**

Problems include:
- Lack of disability access;
- Noisy waiting rooms that raise anxiety;
- Less likely to benefit from early diagnosis of cancer because of delays in reporting symptoms.

**BOX 1. GOOD PRACTICE**

**Pennine Care Foundation Trust**

A series of one-day, service-specific courses have been delivered to more than 400 mental health nurses, encompassing theory, essential practical skills and care planning. Feedback has been used to identify further training needs and develop specialist modules. Physical health leads have been identified for every department with many introducing wellbeing clinics, and exceptional audit results have been achieved for physical health monitoring following these initiatives.

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### Conditions causing early death

Heslop et al (2013) found that:

- Heart and circulatory disorders were a leading cause of premature death, occurring at a younger age in this group than in the general population.
- Respiratory infection was the event most frequently leading to death, and respiratory disease the third most common underlying cause of death.
- Cancer was the second most common underlying cause of death, occurring at a younger age in this group than in the general population.

### Implications for practice

Several learning points were identified from the literature review:

- Life expectancy is significantly lower for people with mental illness or learning disabilities.
- Many deaths are preventable and relate to modifiable risk factors.
- The biggest risk factor for people with severe mental illness is smoking and for those with learning disabilities obesity.
- There are physical and practical barriers to accessing healthcare.
- Training staff in physical health is essential, along with improving assessment and monitoring.
- There is a lack of coordination across and between different disease pathways and service providers.
- The impact of antipsychotic medication on physical health must be closely monitored, particularly for cardiometabolic effects.

These themes were used to develop physical health competencies for nurses, available as a self-assessment document, along with recommendations to trusts in the North West (Box 2); the document is being used in personal development reviews and to inform training in 5 Boroughs Partnership Foundation Trust. Mersey Care Trust is using them to help develop a nurse passport to log continuing and developing physical health competencies for nurses, available as a self-assessment document, along with recommendations at the system and individual level.

### BOX 2. RECOMMENDATIONS FOR TRUSTS

- Designate a board-level lead on physical health and support physical leads to share, collaborate and benchmark.
- Work with universities to design pre- and post-registration physical health training for staff, and carry out a training-needs analysis.
- Make core health-promotion interventions part of routine care and agree local pathways for targeted, specialist programmes, such as smoking cessation.
- Work to become smoke-free environments (NICE, 2013).
- Agree and implement guidelines with primary care for physical health monitoring before and after the prescription of anti-psychotic medications.
- Consider using the Lester cardiometabolic tool to evaluate and monitor cardiometabolic risk (Bit.ly/RCPSychLesterTool).
- Clarify local responsibilities in primary and secondary care for assessing, monitoring and managing physical health, ensuring the right information systems to share results.
- Ensure joint strategic-needs assessments address service users’ physical health.
- Have systems to identify, assess and monitor physical health competencies.
- Offer service users accessible information to make informed choices about anti-psychotic medicines, making diet and exercise advice part of the prescription.
- Use robust surveillance to learn from incident reporting, serious incidents, and staff and service-user feedback relating to physical health.

### References

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