Health risks of people with schizophrenia

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Schizophrenia affects around 1% of the population (Rethink, 2015) and is considered a disability according to The Equality Act 2010, and a severe mental illness (SMI). Symptoms include apathy, passivity and social withdrawal related to lack of motivation (World Health Organization, 1992).

People with SMI have higher mortality rates than the general population, which appears to be largely related to high-risk lifestyle choices, use of antipsychotic medication and compromised access to good physical healthcare. This study aimed to find out the awareness levels of people with schizophrenia about their physical health needs and risks. Overall, services users had good awareness of their physical health risks and needs but were unable to motivate themselves to act on them and needed help from nurses.

Mortality and morbidity

Connolly and Kelly (2005) highlighted the predominant risk factors affecting physical health in people with SMI as diabetes, hyperlipidaemia, obesity and cardiovascular disease, while studies in Sweden and the UK found that smoking, poor diet and alcohol consistently contributed to early mortality (Brown et al, 2010; 2000). Brown et al (2010) found mortality was higher in men, with the most significant contributors being circulatory disease (33% of deaths) and respiratory disease (19% of deaths), while Vancampfort et al (2012) found that people with schizophrenia and cardiovascular disease (CVD) had a mortality rate that was twice that of the general population.

A Cochrane review on general physical health for people with SMI (Tosh et al, 2014) found only six good-quality studies...
but concluded that physical healthcare advice for those with SMI could improve their quality of life in relation to their mental health.

Introduction of second-generation antipsychotic medications was initially associated with better quality of life (Saha et al, 2007) but there is now increasing concern that these are linked to adverse effects, such as weight gain and metabolic syndrome (White et al, 2009; Saha et al, 2007).

The nurse’s role

Mental health nurses need more training in physical health monitoring and medication management, and their impact on physical health (White et al, 2009). A Mental Health in Higher Education and Middlesex University (2008) survey revealed that some service users were not asked about their physical health and felt practitioners needed more expertise in health promotion, physical side-effects of medications and disability awareness.

Ratcliffe et al’s (2011) audit reinforced findings from other studies relating to the higher risk of CVD in this patient group and the need for better integration between mental and physical healthcare. This lack of integration has been found to be a barrier to good physical health care for people with mental illness (Blanner Kristiansen et al, 2015; Happell et al, 2012), as has the effects of stigma (Happell et al, 2012).

“Mental health nurses need more training in physical health monitoring and medication management”

Happell et al (2014) also found that nurses sometimes assume service users’ expressed worries about physical health are part of their mental illness; this ‘diagnostic overshadowing’ results in medical staff treating service users in a less thorough and effective manner (Thorncroft, 2011). However, people with schizophrenia have been found to be less likely to spontaneously report physical symptoms (Connolly and Kelly, 2005), highlighting the need for nurses to be proactive in this area.

Lifestyle factors

Connolly and Kelly (2005) argued that the higher morbidity and mortality of people with SMI was preventable through lifestyle modification, and the identification and treatment of common diseases. They suggested that those with schizophrenia may fail to recognise early signs of physical ill health or avoid contact with services.

Hardy et al (2012) found that people with schizophrenia were not aware of their increased risk of CVD. When addressing physical ill health, training should emphasise the opinions of those with schizophrenia (Hardy et al, 2012; Connolly and Kelly, 2005).

Smith et al (2007) offered a wellbeing physical support programme to patients with severe and enduring mental illness; 34 of 966 people were found to require urgent medical referrals. Baseline data showed a high prevalence of obesity, hypertension, cigarette smoking, poor diet and lack of exercise; by the end of the consultations, risk factors for CVD had been significantly reduced. Haf Roberts and Bailey (2013) showed that such programmes can also improve social relationships, which can act as a motivator to engagement, but social anxiety was a key problem preventing initial attendance.

Participants in Hardy et al’s (2012) study found it helpful to have the same nurse on each visit and wanted more information on blood tests and medication.

Buhagiar et al (2011) found that people with psychosis did not consider their physical health a priority, and had poorer knowledge about physical activity, dietary habits and chronic physical problems compared with the general population. In contrast, Hardy et al (2012) found good awareness of the importance of a healthy diet and exercise in people with SMI attending physical health checks in primary care.

Buhagiar et al (2011) argued that it is possible that people with psychosis may prioritise their physical health differently and exhibit different levels of motivation to change high-risk behaviours associated with coronary heart disease. Participants might feel they have little control over their physical illness, much as they report a lack of control over their mental health (Wang, 2011; Allan and Dixon, 2009). Those with non-psychotic illnesses had better physical health and saw this as a priority, possibly due to feeling more control over this area of their health (Buhagiar et al, 2011).

Buhagiar et al’s (2011) study emphasised the need to focus on lifestyle issues when working with people with SMI. However, Blanner Kristiansen et al’s (2015) findings suggested that people with mental illness do not have sufficient energy to do this, while Fraser et al (2015) found lack of motivation and fatigue were barriers to engaging in physical activity.

In their randomised control trial, Scheewe et al (2012) found that cardiorespiratory fitness levels were lower in people with schizophrenia compared with controls, and suggested that poor cardiorespiratory fitness is a key risk factor for them developing CHD. They found that exercising for one hour twice a week improved cardiorespiratory fitness and could lower mortality rates, and recommended that exercise therapy become part of the usual care of this patient group. Fraser et al (2015) found a preference for walking, which can be done alone as part of a set routine.

Method

This study aimed to focus on inpatient service users’ perspectives of their physical health needs and risks. A phenomenological framework was developed to ascertain what a group of people living in a rehabilitation inpatient unit thought about their physical health risks and needs. Nursing staff were briefed on the research so that they could answer questions.

Posters and personal letters were used to invite service users to participate in the study; letters were accompanied by an information sheet setting out expectations. Ethical and governance approvals were given by the University of Salford, the
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**BOX 2. FOCUS GROUP**

- Do you think John is at risk of physical illness?
- Do you feel those involved in John’s care see his physical health as important? If yes, how? If no, why do you think this is?
- How do you think John’s physical health needs can be better looked after?
- Do you feel those involved in John’s care can better support him to look after his physical health? If yes, how? If no, what do they do that fully supports John?
- What aspects of his lifestyle do you think John can change to improve his physical health?
- If John wanted to learn more about physical health what way do you think is the best way for this information to be delivered and who do you think the best person to do this is?

Lifestyle choices

All participants made some reference to lifestyle factors. Most common was lack of exercise and poor diet:

“I eat a lot of fried foods, you see it is a concern for the staff, they always tell me to cut things down and, like, cook meals” (Service user ANR8 interview)

There was also an awareness of possible behaviour change; one participant mentioned they could “Do things in a bit more moderation I suppose” (L51 T2). Concerns about smoking were also indicated:

“I find it really hard to stop… I have tried everything… I have come off heroin, I have come off crack cocaine, I have come off hashish, come off every drug under the sun, valium etc. But I can’t get off nicotine for some reason. You know it’s so addictive it’s unbelievable.” (Service user ANR9 interview)

Weight gain

Participants repeatedly raised concerns about weight gain:

“I keep piling on the weight sometimes, I don’t know where it is coming from; you know I am about 16 or 17 stone when I should be about 12 or 11.” (Service user ANR6 interview)

They were concerned about its impact on their physical health and cited lack of exercise and side-effects of prescribed medications as contributing factors.

Motivation

Participants indicated feeling responsible for implementing changes to improve their physical health:

“... really it is up to you to help yourself, your wellbeing.” (Focus group member ANR3)

They felt staff members’ role was: “to motivate you to be independent” (P:ANR3L86T1). One said staff could motivate “even if it be a pest: ‘come on, come on, out the door, get five minutes’ walking and fresh air’” (Focus group member ANR3).

Focus group participants discussed how much mental health staff should help motivate them balanced against their own responsibility to look after their physical health. Generally, they felt they should take the lead in their physical healthcare but were open to input from mental health services.

**Addressing physical health concerns**

Participants had ideas about how to address the problem and felt that:

“Maybe information that you can decide for yourself, that would be alright… it’s not always good to have too much knowledge” (Service user ANR8 interview)

They also thought it important to understand that “you shouldn’t bombard a person with… telling them what to do… but let them make their own decisions” (Focus group member ANR3) but agreed with the researcher’s summary of the nurse’s role.

The researcher suggested giving the participant information, letting them make a decision and supporting them in taking action, which they agreed with.

**Discussion**

The use of the vignette in the focus group may have affected the findings as it may have influenced participants’ thoughts and opinions on the topic but it was a useful way to elicit participants’ thoughts. It provided a tool for reflection and comparison, and prompted discussion for people who were ‘disabled’ by their mental illness.

Overall, participants were aware of side-effects of medication and its effect on physical health, but indicated a sense of helplessness. This could be a result of their inability to motivate themselves or the conflict that can be experienced when doubts about continuing medication are met with a “powerful message from support...” (Roe et al, 2009). Control over one’s life is associated with better mental and physical health (DH, 2011) so, this lack of control can have an adverse effect. This sense of control can be enhanced as individuals indicated feeling responsible for looking after their physical health and were open to interventions.

In this study, leaflets were acknowledged as a way of providing information, but access to healthcare is a major challenge due to problems negotiating systems, and information being inappropriate or not received (Ratcliffe et al, 2011).
Dedicated health promotion interventions must be offered to service users

Conclusion
Participants in this study have a good awareness of their physical health risks and needs but rely on others to motivate them to act. Dedicated health promotion interventions must be offered and targeted towards this client group; they must be developed around service users’ opinions, consistent delivery, expressed need and a firm understanding that any assumptions must be put aside. NT

References


Implications for practice
The findings appear consistent with themes in existing literature and offer a key message: people with schizophrenia have knowledge and awareness about what is needed to improve physical ill health and ideas about how it can be achieved, but are not motivated to act. This suggests that engaging with their opinions about their physical health is not only necessary but also achievable.

Interventions like those suggested in NICE (2014) guidance - for example, healthy eating and physical activity programmes - can be developed based on the findings of this study to maximise the potential for success.