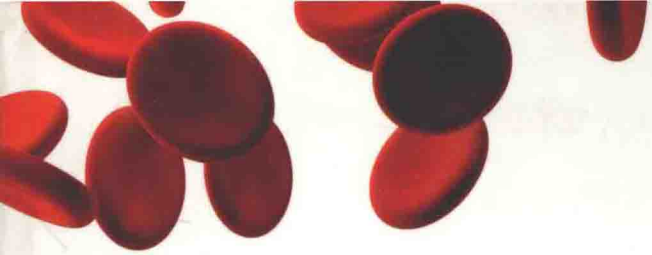
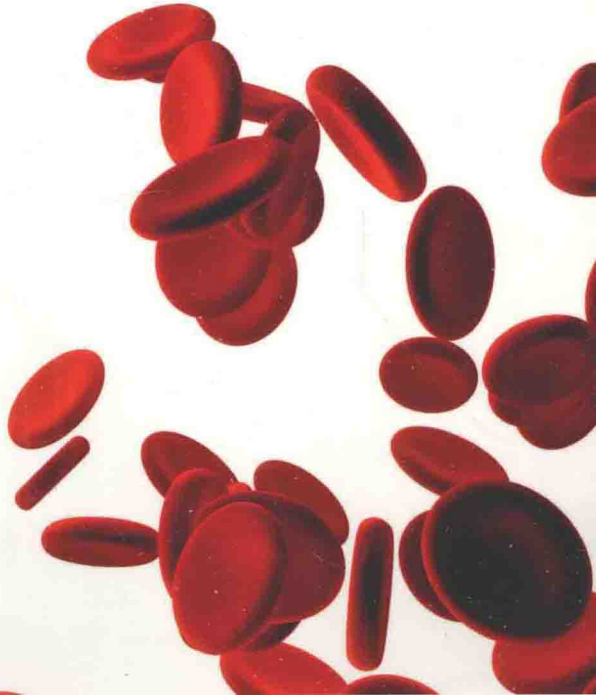
Physical Health and Well-Being in Mental Health Nursing

Clinical Skills for Practice





Michael Nash

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Para mi familia,
mi mujer Maite, y mis hijos Ruben, Érin y Jorge.
Con todo mi amor.

About the author

Michael Nash is lecturer in psychiatric nursing at Trinity College Dublin. His career began in Gransha Hospital, Derry City before moving to London via a few years in the Channel Islands. In London he worked at various levels in both the NHS and private health care sectors. He studied at the University of North London where he obtained a BSc (Hons) in Health Studies then at St George's Medical School, University of London where he eventually obtained an MSc in Health Sciences. He moved into higher education spending happy years at London Metropolitan University where he obtained a Post-graduate Certificate in Learning and Teaching before moving to Middlesex University. At Middlesex he commenced a professional doctorate that is nearing completion and has retained many good friendships from very happy times there.

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Finally, thanks to Rachel for her kind comments and support throughout the lengthy writing and editing process, we got there – eventually.

Abbreviations and acronyms

ABGS	arterial blood gases
ADR	adverse drug reaction
BHF	British Heart Foundation
BLS	basic life support
BMI	body mass index
BNF	British National Formulary
BP	blood pressure
CA	cardiac arrest
CCU	coronary care unit
CHD	coronary heart disease
CMHN	community mental health nurse
COPD	chronic obstructive pulmonary disease
CPA	care programme approach
CNS	central nervous system
DH	Department of Health
DKA	diabetic ketoacidosis
DRC	Disability Rights Commission
DSM IV	Diagnostic and Statistical Manual IV
ECG	electrocardiogram
ECT	electro-convulsive therapy
FBC	full blood count
HDLs	high density lipoproteins
HE	health education
HNA	health needs assessment
HP	health promotion
HPA	Health Protection Agency
ICD 10	International Classification of Diseases 10
IoH	Inequalities of Health
IR	incidence rate
LDLs	low density lipoproteins
LE	life expectancy
MAOIs	monoamine oxidase inhibitors
MHN	mental health nurse
MR	mortality rate
NICE	National Institute of Health and Clinical Excellence
NMC	Nursing and Midwifery Council
NMS	neuroleptic malignant syndrome
NRT	nicotine replacement therapy
NSF	National Service Framework
OH	orthostatic hypotension
OPDM	Office of the Deputy Prime Minister
OT	occupational therapist

PEFR	peak expiratory flow rate
PR	prevalence rate
RT	rapid tranquilisation
SMART	specific, measurable, attainable, realistic and timely
SMI	severe mental illness
SMR	standardized mortality ratio
SS	serotonin syndrome
SSRIs	selective serotonin reuptake inhibitors
STD	sexually transmitted disease
T2D	type 2 diabetes
TNA	training needs analysis
WCC	white cell count
WHO	World Health Organization

Contents

1 An introduction to physical health in mental illness

By the end of this chapter you should be able to:

- Define health and health beliefs and illustrate why these are important to clients
- Appreciate the impact of physical illness on our clients
- Identify factors that negatively impact on the physical health of our clients
- Be aware of barriers to physical care of our clients

Box 1.1 Exercise Describe the physical health status of your client group. List the most common physical health problems you encounter.

Physical well-being is important to all of us whether we have a mental health problem or not. Indeed the physical health needs of our clients mirror those of the general population. Physical health of clients has become more prominent in mental health policy and practice arenas. After seemingly years of neglect it became apparent that the physical health of clients under the care of mental health services was not only poor but a largely unaddressed area of need. Nash (2005) suggests that this lack of focus on physical health compromises the notion of holistic care in mental health practice. Therefore physical health must be embraced as part of a holistic assessment that includes social, emotional, economic and psychological needs.

What do we know about physical health in people with severe mental illness?

The focus of this book is the specific issues related to people with a primary mental health problem and a secondary physical problem, e.g. schizophrenia and diabetes. However, we should remain aware that there are issues relating to individuals with a primary physical condition and a secondary mental health problem. The World Health Organization (WHO 2003) suggests high prevalence of co-morbid depression in a range of physical illnesses, for example, depression in hypertension is up to 29 per cent, in cancer up to 33 per cent, in HIV/AIDS up to 44 per cent and in TB up to 46 per cent. This is something community practitioners should be aware of in respect to mental health promotion (MHP) in primary care.

Poor physical health affects our mental well-being while mental illness increases mortality and morbidity. A combination of both can impair the rate or fullness of recovery. Research has

consistently shown that the physical health of people with severe mental illness is frequently poor (Phelan *et al.* 2001). This is evidenced by the following:

- There are higher Standardized Mortality Ratios (SMRs) for cardiovascular disease, deaths due to infections and deaths from respiratory disorders (Harris and Barraclough 1998).
- There exists a higher risk of preventable death, with Farnam *et al.* (1999) estimating that people with mental illness die between 10 and 15 years earlier than the general population.
- People with bipolar disorder and diabetes have a 50 per cent higher risk of dying than someone with diabetes who does not have a mental illness (DRC 2006).
- People with schizophrenia may be at increased risk for Type 2 diabetes because of the side effects of medication, poorer healthcare, poor physical health and less healthy lifestyles (Dixon *et al.* 2000).
- In the UK 62 per cent of people with a psychotic disorder reported themselves as having a long-standing physical complaint as compared to 42 per cent with no psychotic disorder (Singleton *et al.* 2000).

The irony is that in many instances these statistics refer to current service users, in contact with either teams of health and social care professionals, or primary care services. We must therefore ask ourselves how can such severe and chronic physical illness be so prevalent in our client group and yet go undetected? This is not just a question for specialist mental health services. It is also a question for primary care services where, in the UK, people with mental health problems have 13 to 14 consultations with their GP per year (Mentality and NIMHE 2004) yet severe and chronic physical conditions are underdiagnosed.

Concerns regarding poor physical health in mental health are not confined to the UK, it is an international problem. For example, in Western Australia Lawrence *et al.* (2001) found that clients died between 1.3 and 5.4 times more than the general population, for all major natural causes of death while in the USA Parks *et al.* (2006) found clients die on average 25 years earlier than the general population.

What is health?

Box 1.2 Exercise How would you define (a) health and (b) illness? Which models might influence your definitions e.g. medical, social or psychological?

It is over fifty years since the World Health Organization (WHO) was established and the most often cited definition of health originates from them. The WHO (1948) defines health as 'a state of complete physical, mental and social well being and not merely the absence of disease or infirmity'. Saracci (1997) suggests that this is more a definition of happiness than health. He cites an anecdote from Sigmund Freud who, on having to stop smoking for health reasons, wrote 'I am now better than I was, but not happier.'

The WHO definition is certainly one to aspire to but it does not appear entirely holistic. It is a twentieth century definition in a twenty-first century world and omits other factors that are now deemed important for positive health, for example, emotional, environmental and spiritual factors – however, the 'social' aspect might encompass these. In developing the National Aboriginal Mental Health Policy and Plan, Swan and Raphael (1995) found that Aboriginal concepts of mental health are holistic being defined as: 'health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community'.

Defining health is problematic as individual experiences of health and illness will rarely be the same. Health, and indeed, illness are inherently individualized concepts. For example, have you ever gone to work sick? Why? Maybe you felt that you could struggle on, maybe you didn't want the hassle of reporting sick. Nevertheless through a process of rationalization we may underestimate our levels of illness by saying 'it's only a cold' in order to undertake our other social roles. Similarly we may diminish our own ill health, or have our ill health diminished by others through comparison to other people, e.g. 'at least it's not cancer'.

Another way to explore the question 'what is health?' may be to look at what can make us unhealthy or ill. However, again this is controversial as being labelled unhealthy or ill can be stigmatizing and disempowering. Despite being problematic, defining health is important for developing public health strategy, models of health care delivery and diagnosing illness. Being complex to define, we might suggest that holistic definitions of health based on multidimensional models would be best for exploring both risk factors and protective factors for physical illness.

Blaxter (1990) explored the concept of health by surveying 9000 individuals and asking the following questions: (i) Think of someone you know who is very healthy; who are you thinking of? How old are they and what makes you call them healthy? (ii) At times people are healthier than at other times. What is it like when you are healthy? Ten categories of health and the characteristics that typified the responses are outlined in Table 1.1.

Health beliefs

There will always be a tension between what professionals and the public believe about concepts of health and illness. The health beliefs of the general public will influence their help-seeking behaviour and the health beliefs of professionals influence the types of interventions and services they provide. Indeed health beliefs may vary between cultures, for example, the mind–body split that occurs in Western medicine.

One aspect of mental health that can complicate our understanding of clients' health beliefs is the concept of insight. Insight is a frequently used descriptor in mental health. There is no uniform definition of insight as it is not a black and white issue and commonly used descriptors

Table 1.1 Ten categories of health and the characteristics that typified the responses

Health category	Characteristic
1 Negative answers	Health not rated highly as a virtue, a lack of concern for healthy behaviour
2 Health as not ill	Being symptom free, never seeing a doctor
3 Health as absence of disease/ health despite disease	Did not have any really serious illness, 'I am healthy although I do have diabetes'
4 Health as a reserve	The ability to recover quickly
5 Health as behaviour, as the healthy life	Health defined as 'virtuous' behaviour – being a non-smoker or non-drinker
6 Health as physical fitness	Being athletic or sporty, also for women having a good outward appearance
7 Health as energy, vitality	Having 'get up and go'
8 Health as a social relationship	Health defined as having good relationships with others – especially for women
9 Health as a function	Being able to do things with less stress
10 Health as psychosocial well-being	Health as a state of mind

include: lacks insight; partial insight; insightless or; has insight. These measures are rather vague and do little to enhance our understanding or knowledge of insight. This may limit its therapeutic value. We may not know what insight is, but we know when it is not there. Although frequently used in relation to schizophrenia, insight is not a diagnostic category for schizophrenia in the International Classification of Disease 10 (ICD 10).

Having insight means that a person is aware that they are ill, that they need to get help and accept treatment. Gelder *et al.* (1996: 23) define insight as 'awareness of ones own medical condition'. When someone does not have insight they do not recognize they are ill or that they need treatment. Amador (2001) approaches insight in neurological terms – anosognosia – meaning 'unawareness of illness', while David (1990) proposes that insight is composed of three distinct, overlapping dimensions, namely, the recognition that one has a mental illness, compliance with treatment, and the ability to re-label, or attribute, unusual mental events (e.g. delusions and hallucinations) as pathological.

Box 1.3 Case example

Farlo has a 20 year history of schizophrenia. He presents with two main psychotic symptoms – auditory hallucinations and delusions of grandeur. He refuses to accept treatment, maintaining he is not sick. This is confirmed by TV news reports which say he is doing well. 'How can I the great, supreme and magical Farlo be unwell?' he asks the team at the ward round. Farlo currently lacks insight as (a) he is unaware that he is unwell; (b) he does not see the need for treatment; and (c) he does not attribute his psychotic symptoms to a mental illness.

Health beliefs, on the other hand, are our individually held beliefs about our own health and illness status – what causes us to be healthy, what may cause us to be ill, what we must do to stay well or what we must do in order to recover. While these are individual they have also been found to be social as they can be influenced by social factors such as culture (Herzlich 1973). A recurring problem with health beliefs is that clients may not share these with health providers or, in the case of smoking, they share the view that smoking is dangerous but continue to smoke. This clash of beliefs can be very challenging to the development and maintenance of therapeutic relationships, especially in mental health care with the added complexity of insight.

Linden and Godemann (2005) in a study of 364 schizophrenic outpatients assessed lack of insight and health beliefs and found these to be independent of each other. This meant that insight was related to their illness and health beliefs were related to personal life experiences. Although both concepts are associated with patient non-compliance, Linden and Godemann state that they are 'separate clinical phenomena' and as such this distinction should be made. This means that practitioners should not attribute poor lifestyle choices to a lack of insight. It is important for practitioners to know and understand the health beliefs of clients in order to better implement health education (HE) and health promotion interventions. It is also important not to conflate health beliefs with insight as health beliefs will influence responses to health and also the therapeutic nurse-patient relationship.

Box 1.4 Case example

Ruari has a ten year history of schizo-affective disorder. He is currently in hospital due to a relapse caused by non-compliance with antipsychotic medications. Ruari also has a

history of asthma and uses a bronchodilator. At medication rounds he willingly accepts his asthma medication but staff need to continually prompt and encourage him to take his antipsychotic medication. When he is asked why he takes one medication and not the other Ruari replies 'I have asthma and need my puffer to help me breathe. I even cut down on my smoking. But everyone tells me I'm mentally ill and I need to take the other tablets, but I don't feel sick. Mentally I feel fine.'

Ruari is unaware that he has a mental illness as he appears to lack insight. Yet Ruari's health beliefs indicate that he is aware of the need to take asthma medication and that he has even reduced his smoking. His health beliefs seem to be in conflict with insight. However, we must not conflate these as they are separate factors in health and illness. What practitioners need to do is use Ruari's health beliefs about his asthma as a metaphor for his mental illness – the need to take treatment and keep taking it. Ruari may then accept that he requires antipsychotic medication to keep him well, just as he requires his bronchodilator for his asthma.

Physical illness will seldom be caused by one factor, rather it will be an interaction of many risk factors. The challenge for practitioners is to have the knowledge of the risk factors and skills to assess – either for screening or further investigation – using appropriate clinical skills and techniques. However, a further challenge for us is being able to implement the same process across a range of physical conditions prevalent in our clients, e.g. obesity or diabetes.

Factors that influence physical health in people with mental illness

The UK government states the reality of health inequality very clearly when it says 'the poorer you are, the more likely you are to be ill and to die younger' (DH 1999a). This is truer for our clients in a range of physical conditions. However, the government still places some emphasis on the individual's responsibility for improving their own health through physical activity, an improved diet and quitting smoking (DH 1999a). Therefore, while health beliefs play an important role in our decision making, there are three important influences on the physical health of clients:

- Lifestyle factors
- Social factors
- Adverse drug reactions

The impact of lifestyle factors on the physical health of clients

The lifestyle choices we make can directly impact, positively or negatively, on our health. If someone smokes they face an increased risk of ill health or if they exercise and eat healthily they reduce the risk of ill health. Our clients are often exposed to adverse lifestyle choices for example:

- Smoking prevalence is significantly higher among people with mental health problems than the general population. Some studies show rates as high as 80 per cent among people with schizophrenia (McNeill 2001).
- Kendrick (1996) found that of 101 people with SMI living in the community 26 were clinically obese.
- McCreadie *et al.* (1998) found that people with schizophrenia made poor dietary choices characterized by a high fat, low fibre dietary intake.

- Lifestyle factors that cause obesity, such as low levels of exercise and poor diet, are present in people with mental illness (Brown *et al.* 1999).

The outcomes of unhealthy lifestyle choices are increased risk of developing severe and chronic long term physical conditions such as type two diabetes, coronary heart disease (CHD), stroke or smoking related respiratory disorders. However, people need to be fully informed about the risks of making unhealthy decisions and research shows that clients seldom receive the same health promotion advice or interventions as the general population (Burns and Cohen 1998). The result is a double whammy of an SMI and a chronic physical problem which can serve to exclude clients from employment or educational opportunities where they may be too ill to avail themselves of these.

How can social factors influence the physical health of our clients?

Having a diagnosis of mental illness negatively impacts on the client's socio-economic circumstances. A UK government report *The Social and Economic Circumstances of Adults with Mental Disorders* (Meltzer *et al.* 2002) found the following:

- Compared with all other groups, those with a psychotic disorder were more likely to have left school before reaching 16 years of age, without qualifications.
- About 60 per cent of the sample assessed as having a psychotic disorder lived in a household with an income less than £300 a week compared with 37 per cent of those with a current neurotic disorder and 28 per cent with no mental disorder.
- Those with a mental disorder were far more likely than those with no disorder to be living in rented accommodation (38 per cent compared with 24 per cent).
- Three of these six specified life events were twice as likely to have been experienced by those with a mental disorder compared with those with no mental disorder: separation or divorce (44 per cent compared with 23 per cent); serious injury, illness or assault (40 per cent compared with 22 per cent); and having a serious problem with a close friend or relative (27 per cent compared with 13 per cent).

Box 1.5 Exercise What factors do you consider are important in determining our health status?

Determinants of health

Wanless (2004) suggests that health and well-being are influenced by many factors including past and present behaviour, healthcare provision and 'wider determinants' including social, cultural and environmental factors. While it is accepted that lifestyle factors are important in determining physical health, practitioners should not overlook other important factors such as social class.

People living in the poorest part of society will be more exposed to determinants of ill health, especially those living in inner city areas where there is an increased exposure to poverty, social deprivation and social exclusion. Typically these neighbourhoods have poor housing, few leisure amenities, higher levels of unemployment and increased crime or the threat of crime and reduced access to education and low educational attainment, for example, more school expulsions.

The UK government recognizes that health inequality is widespread and the most disadvantaged have suffered most from poor health (DH 1999a). Therefore while this type of environment

is not conducive to good health, it is the type of environment where many of our clients will come from. This should prompt us to be more aware of the influence of social factors on physical health.

Inequalities in health

While lifestyle factors offer a biological explanation of health and illness, the social model can offer us alternative explanations. One important factor in the health of any population is Inequalities of Health (IoH). Acheson (1998) contends that where IoH exist we can see great differences in health status in social classes when using occupation as a measurement. This is illustrated by health gradients where those in lower social classes tend to have poorer health (increased morbidity) and poorer health outcomes (increased mortality). The UK Department of Health (2008a) states that health inequalities are the result of a complex and wide-ranging network of factors such as material disadvantage, poor housing, lower educational attainment, insecure employment or homelessness. People exposed to IoH have poorer health outcomes and an earlier death compared with the rest of the population.

Our clients are a socially disenfranchised group, often excluded from the fundamental aspects of society (Nash 2002). Therefore an alternative explanation for a client's poor physical health is their position in the social hierarchy. Coming from the lowest social class they face greater morbidity and mortality than those from higher social classes. This offers us an alternative explanation to lifestyle factors. Figures 1.1 and 1.2 illustrate the class gradient in respect to death rates in general (Figure 1.1) and deaths by suicide (Figure 1.2).

Social class and mental illness

People with mental health problems are often over represented in the lower social classes. Those with psychotic disorders are more likely to be of a lower social class (see Table 1.2). The Public Health Agency of Canada (2002) nicely illustrates two theories for this:

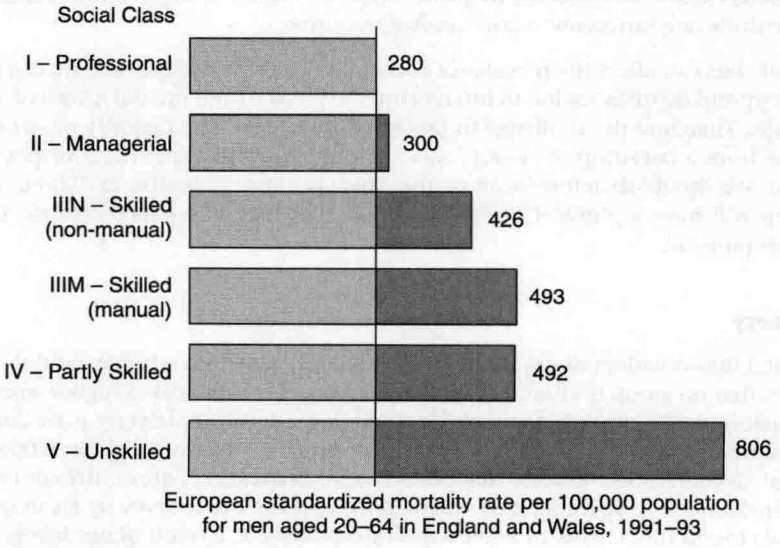

Figure 1.1 Social class and mortality
Source: (DH 1999a)

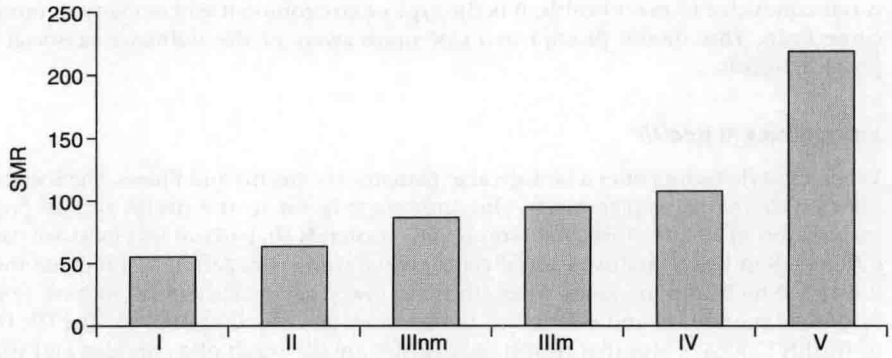

Figure 1.2 Social class and suicide: men aged 20–64, England 1997
Source: DH (2002a)

Table 1.2 Social class and mental illness

	Psychotic disorder	No psychotic disorder
Social Class IV or V	39%	22%
Economically Inactive	70%	30%

Source: Office of National Statistics (2000)

- 'Social drift': this theory suggests that individuals who are predisposed to mental illness have lower than expected educational and occupational attainment and therefore 'drift' down the socio-economic ladder.
- 'Social causation': this theory suggests that social experiences of members of different socio-economic groups influence the likelihood of becoming mentally ill, e.g. members of lower social classes are subjected to greater stress as a result of deprivation and are forced to cope with elevated stress levels with limited resources.

Social class can affect the prevalence of mental health problems. Here we can see the part that poverty and deprivation has in influencing the physical and mental health of socially excluded groups. Therefore the challenge to practitioners is clear. The majority of our client group will come from a backdrop of adverse social conditions with experiences of poverty and deprivation. We should therefore be aware that there is a strong likelihood that our clients from this group will have a physical health condition that may be undiagnosed or may be at risk of developing one.

Poverty

Mental illness seldom discriminates between class, gender or ethnicity and the WHO (2003: 7) states that no group is immune to mental disorders, but the risk is higher among the poor, the homeless, the unemployed and persons with low education. Poverty is an important factor in physical and mental ill health. In Ireland a report by Walsh and Daly (2004) suggested that social class divisions indicate that poverty and disadvantage are contributory factors, both to the incidence and prevalence of mental illness. In the UK a survey by Focus on Mental Health (2001) found that clients suffered significant poverty as a result of not being able to get work. It also asked clients about their experiences of living on a low income and found the following: