PHYSICAL HEALTH OF PEOPLE WITH SEVERE MENTAL ILLNESS

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INSPECTOR OF MENTAL HEALTH SERVICES
Vision, Mission and Values

Our Vision
The highest quality mental health and decision support services underpinned by a person’s human rights.

Our Mission
Regulate and engage to promote, support and uphold the rights, health and well-being of all people who access mental health and decision support services.

Our Values

Dignity and Respect
We believe that everyone deserves to be treated with dignity and respect.

Person-Directed
We believe in person-directed support and care.

Confidentiality
We respect and protect the confidentiality of all persons whose rights we uphold.

Human Rights
We believe that everyone is entitled to have their human rights respected and protected.

Accountable and Transparent
We are accountable and transparent.

Quality
We expect the highest standards of ourselves and of all those we regulate.
‘People with mental health problems should receive the same quality of physical healthcare as those without a mental health problem’

It is hard to believe that in the 21st century, someone with a mental illness will typically die between 15 and 20 years earlier than someone without and that mentally ill people continue to suffer unnecessarily with undiagnosed or poorly managed conditions.

People with mental illness deserve the same rights as everyone else, to live healthier and longer lives. The nursing and medical professions have a vital role in helping to achieve this and need to set the standard in raising aspirations for mentally ill people and in challenging discrimination.

Central to this is addressing the division between mental and physical health. Our health services are often designed as if there is no connection between them. Doctors appear to be trained without due consideration to the linkages between physical and mental health. Achieving parity of outcomes requires all doctors to have a better understanding of the relationship between physical and mental health. It is evident from our inspections that this is not always the case. While speciality training focuses on skilling the doctor in the speciality of mental health, it should not lose sight of the need to treat the ‘whole’ patient, and to recognise both physical and mental illnesses. It is also about addressing the way services are delivered and the underfunding of mental healthcare services relative to the funding of general healthcare. Parity in access and provision of health care should be conceived as a basic human right, but convergence of patient, provider, treatment and system factors has created a situation in which access to and quality of physical health care is problematic for individuals with serious mental illness.

In 2017, during our inspections of in-patient mental health units, we found that the compliance for Regulation 19 General Health1 had decreased from 75% to 73%. In addition, it was obvious that monitoring of the physical health of people with severe mental illness who were in hospital for more than six months, was not in line with best practice and did not meet international guidelines. In view of this, in early 2018, we added the specific monitoring required to the guidance for approved centres in achieving compliance with regulations, the Judgement Support Framework.

In 2018, I found that there was disregard for international best practice guidelines for monitoring the physical health of in-patients who are resident in mental health units and those who are on antipsychotic medication. There is a large amount of evidence-based research over many years on the importance of such monitoring in people with severe mental illness to identify metabolic syndrome, a cluster of the most dangerous heart attack risk factors. People with severe mental illness and on antipsychotic medication have a higher than normal risk of developing metabolic syndrome. The excess mortality rates in persons with serious mental illness are largely due to modifiable health risk factors. Therefore, the monitoring and treatment of these factors should be a part of clinical routine care of the psychiatrist and GP. It is unacceptable that people with severe mental illness are not afforded this essential monitoring.

I found that there was unequitable access to such services as speech and language therapy, physiotherapy, dietetics and seating assessments for people with severe mental illness in comparison to other healthcare patients. This is despite clear assessed need for these services and that harm is done to these people by denying them these services.

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1 S.I. No. 551 Mental Health Act 2001 (Approved Centres) Regulations 2006
Introduction

People with a serious mental illness will typically die between 15 and 20 years earlier than someone without a mental illness and their physical illnesses are largely preventable. The interrelationship between mental illness and poor physical health is well established. In 2015, researchers conducted a systematic review and comparative meta-analysis of twenty-five studies including 145,718 individuals with schizophrenia and 4,343,407 controls. They found people with schizophrenia are at least double the risk of developing Type 2 diabetes compared to the general population. The authors recommended that proactive lifestyle and screening programmes should be given clinical priority. Similarly, high rates of, and risk for, metabolic syndrome (described below) have been documented in bipolar disorder, depression, and other mental disorders such as post-traumatic stress disorder. Specific to psychosis, the rate of metabolic syndrome is 32.5 percent, with rates of up to 60 per cent observed in those with a longer duration of illness and use of antipsychotic medication. People with serious mental illness are four times more likely to die of respiratory disease and 2.5 times more likely to die of cardiovascular disease.

As a general rule, meeting the medical needs of any patient will reduce the amount of emergency care they need relative to planned care. People with mental illness have 10% fewer planned medical admissions than the general population. Instead, they have three times more Emergency Department attendances and almost five times more emergency admissions. Less than one in five of these emergency admissions among people with mental illness are to address their mental health needs; most are for the potentially preventable complications of common illnesses such as high blood pressure, heart disease, epilepsy and various infections. Individuals with underlying mental illness are more likely to be admitted overnight and they generally remain longer in hospital.

The UK National Health Service has estimated that some 40,000 deaths might be avoided each year if individuals with serious mental illness were afforded the same amount of physical healthcare as the general population. The equivalent number of deaths annually based on Ireland’s population would be almost 3,000. The WHO asserts that people with serious mental illness die earlier, not because of their psychiatric illness per se, but "because of the discrimination and lack of access to good health services." The WHO further asserts that stigma is the biggest barrier preventing people with severe mental illness accessing general healthcare.

9 QualityWatch Focus on: People with mental ill health and hospital use 2015. Nuffield Trust
10 QualityWatch Focus on: People with mental ill health and hospital use 2015. Nuffield Trust
Metabolic Syndrome

Metabolic syndrome (MetS) is a cluster of the most dangerous heart attack risk factors: diabetes and raised fasting plasma glucose, abdominal obesity, high cholesterol and high blood pressure. MetS is often associated with other medical conditions, notably fatty liver, cholesterol gallstones, obstructive sleep apnoea, gout, depression, musculoskeletal disease, polycystic ovarian syndrome. Internationally, the prevalence of metabolic syndrome (MetS) and its components, such as abnormal blood lipids, obesity, high blood pressure and raised blood glucose, among patients with serious mental illness is higher than the general population. The worldwide prevalence of MetS in the general population is estimated to be 25%. The overall prevalence of MetS among patients with serious mental illness ranges between 25% and 50%, with a relative risk of up to 2.0 compared to the general population. The prevalence of MetS rate was estimated at 32.5% to 36.8% among patients with schizophrenia, 37.3% among patients with bipolar disorders, and 30.5% to 31.3% among patients with depressive disorders.

Metabolic syndrome may be diagnosed if there are three or more of the following symptoms:

- a waist circumference of 94 cm (37 inches) or more in European men, or 90 cm (35.5 inches) or more in South Asian men
- a waist circumference of 80 cm (31.5 inches) or more in European and South Asian women
- high triglyceride levels (fat in the blood) and low levels of HDL ("good" cholesterol) in the blood, which can lead to atherosclerosis (where arteries become clogged up by fatty substances such as cholesterol)
- high blood pressure that's consistently 140/90 mmHg or higher
- an inability to control blood sugar levels (insulin resistance)
- an increased risk of developing blood clots, such as deep vein thrombosis (DVT)
- a tendency to develop inflammation (irritation and swelling of body tissue)

Antipsychotic-induced weight gain can affect more than 80% of people treated with antipsychotic medication, and particularly younger patients and those with limited previous use of antipsychotic medication. Varying patterns of weight gain are observed with different medications and there is growing evidence that rapid changes in key metabolic measures are observed in healthy volunteers after even short-term exposure to some antipsychotics. People with schizophrenia are six times more likely to smoke heavily, while approximately half are significantly overweight. Up to 15% have diabetes and 58% have elevated blood pressure.

15 D.T. Bressington, J. Mui, E.F. Cheung, J. Petch, A.B. Clark, R. Gray The prevalence of metabolic syndrome amongst patients with severe mental illness in the community in Hong Kong—a cross sectional study BMC Psychiatry, 13 (2013), p. 87
19 https://www.nhs.uk/conditions/metabolic-syndrome/
Mortality Gap

Serious mental illness such as bipolar disorder and schizophrenia are associated with increased mortality relative to the general population and this mortality gap widening\(^2\).

The causes of this mortality gap can broadly be divided into five categories\(^3\).

1. Patients with serious mental illness have a higher rate of suicide, accidental, or violent death.
2. Several risk factors combine to adversely affect health such as smoking, lower levels of exercise, and obesity, which may be caused by the medications used to treat serious mental illness. These, in turn, increase the rates of cardiovascular disease, chronic obstructive pulmonary disease (COPD), and cancers.
3. Antipsychotic medication itself adds to the burden of long-term physical illness mediated by iatrogenic weight gain, hyperlipidaemia, and diabetes.
4. Patients with serious mental illness experience reduced access to health care either through delayed presentation, reduced uptake of health screening and preventive care, difficulty coping with the demands of monitoring and treatment, or misattribution of symptoms. Both patients and health professionals may interpret symptoms of physical disease, possibly even red-flag symptoms, as just another manifestation of their mental illness, a process known as ‘diagnostic overshadowing’.
5. Stigmatising attitudes towards people with severe mental illnesses, held by healthcare professionals, may play a significant role.

It would be reasonable to assume that with improvements in psychiatric care, in medical care, and in the economic wealth of society, the serious mental illness mortality gap would be decreasing. Evidence has shown that, far from narrowing, the gap has widened. In a 30-year study from Denmark, mortality in the general population had fallen substantially, such that mean life expectancy increased over the study period by 6.3 years\(^4\). In contrast, over the same period life expectancy in the population with schizophrenia declined by 1.3 years. In a UK study over the period 2000 to 2014, the mortality gap between individuals with bipolar disorder and schizophrenia, and the general population was shown to be widening\(^5\).

Table 1. Prevalence and relative risk of modifiable cardiovascular disease risk factors in schizophrenia and bipolar disorder compared to the general population\(^6\)\(^,7\)

<table>
<thead>
<tr>
<th>Cardiovascular disease risk factors</th>
<th>Schizophrenia</th>
<th>Bipolar Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>45-55%; 1.5-2 times increased risk</td>
<td>21-49%; 1-2 times increased risk</td>
</tr>
<tr>
<td>Smoking</td>
<td>50-80%; 2-3 times increased risk</td>
<td>54-68%; 2-3 times increased risk</td>
</tr>
<tr>
<td>Diabetes</td>
<td>0-15%; 2 times increased risk</td>
<td>8-17%; 1.5-2 times increased risk</td>
</tr>
<tr>
<td>Hypertension</td>
<td>19-58%; 2-3 times increased risk</td>
<td>35-61%; 2-3 times increased risk</td>
</tr>
<tr>
<td>Dystlipidemia</td>
<td>25-69%; 5 times increased risk</td>
<td>23-38%; 3 times increased risk</td>
</tr>
<tr>
<td>Metabolic syndrome</td>
<td>37-63%; 2-3 times increased risk</td>
<td>30-49%; 1.2-5 times increased risk</td>
</tr>
</tbody>
</table>

The excess mortality rates in persons with serious mental illness are largely due to modifiable health risk factors. Therefore, the monitoring and treatment of these factors should be a part of clinical routine care of the psychiatrist and GP.

\(^3\) Mark Ashworth, Peter Schofield and Jayati Das-Munshi Br J Gen Pract 2017; 67 (663): 436-437.
\(^4\) Nielsen RE, Uggerby SA, Jensen SDW, McGrath JJ Increasing mortality gap for patients diagnosed with schizophrenia over the last three decades — a Danish nationwide study from 1980 to 2010(2013) Schizophrenia Res.
\(^7\) Correll CU, Frederickson AM, Kane JM, Manu P. Metabolic syndrome and the risk of coronary heart disease in 367 patients treated with second-generation antipsychotic drugs. Journal of Clinical Psychiatry. 2006;67(4):575-583)
Monitoring Requirements

The recent National Institute for Health and Clinical Excellence (NICE) guidelines on schizophrenia recommend that 'GPs and other primary healthcare professionals should monitor the physical health of people with schizophrenia at least once a year'. Regarding monitoring of physical health in secondary care, NICE recommends: ‘As part of the care programme, health-care professionals in secondary care should ensure that the regular physical health checks mentioned above are being carried out as in primary care’.28

Those on antipsychotic medications need regular monitoring of various parameters including weight, blood pressure, blood sugar, lipids, electrocardiogram (ECG), full blood count, urea and serum electrolytes, liver function tests and prolactin, depending upon the individual psychotropic agent.29

Table 2 Monitoring requirements for residents on antipsychotic medication at least annually

<table>
<thead>
<tr>
<th>Family history</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal medical history</td>
</tr>
<tr>
<td>Dietary intake</td>
</tr>
<tr>
<td>Activity level and exercise</td>
</tr>
<tr>
<td>Use of tobacco and alcohol or other substances;</td>
</tr>
<tr>
<td>Cardiovascular disease (CVD) risk</td>
</tr>
<tr>
<td>Blood pressure</td>
</tr>
<tr>
<td>Dental health;</td>
</tr>
<tr>
<td>Weight gain and obesity using body mass index (BMI); waist circumference, (WC);</td>
</tr>
<tr>
<td>Fasting blood levels of glucose or HbA1c.</td>
</tr>
<tr>
<td>Fasting blood levels of lipids, especially triglycerides and high-density lipoprotein (HDL)-cholesterol;</td>
</tr>
<tr>
<td>Prolactin levels (depending upon the individual psychotropic agent);</td>
</tr>
<tr>
<td>Liver function tests, blood count, thyroid hormone, electrolytes</td>
</tr>
<tr>
<td>Electrocardiographic (ECG) parameters</td>
</tr>
</tbody>
</table>

The WHO has published evidence-based guidelines for managing physical health conditions in adults with severe mental disorders.33 The guidelines include recommendations on healthy lifestyle behaviour (e.g. healthier diet, more physical activity and tobacco cessation), psychosocial support and considering possible interactions between different medications prescribed for mental and physical health conditions. The majority of deaths amongst people with serious mental illness are attributable to physical health conditions. People with serious mental illness often lack access to health services or receive poor quality care, including promotion and prevention, screening and treatment.

The Mental Health Commission carried out a census on the 28 November 2018 of inpatients in approved centre. Information provided included residents’ status with regard to smoking on that day. There were 2,266 inpatients on the day of the census and 38% smoked one or more tobacco cigarettes a day. Of those, 17% were on a tobacco cessation programme. The prevalence of smoking in adults over 15 years of age in Ireland is 20% (Healthy Ireland Survey 2018).

31 Marc De Hert et al. Physical illness in patients with severe mental disorders. II. Barriers to care, monitoring and treatment guidelines, plus recommendations at the system and individual level WPA Action Plan 2008-2011 (World Psychiatry 2011;10:138-151)
33 Management of physical health conditions in adults with severe mental disorders WHO Guidelines 2018
Review of physical healthcare monitoring and access to essential health care for people in long-term care in mental health in-patient units

In 2018, I reviewed the physical health care and monitoring for 100 residents in 10 mental health in-patient continuing care centres. Continuing care centres are approved centres under the Mental Health Act 2001. They provide ongoing psychiatric care for people who are in residing in these centres for lengthy periods of time, sometimes for decades. Many have spent much of their adult lives in wards in old asylums prior to their closure. Others are admitted to these centres because of ongoing severe mental illness. The majority of residents in the review were over 60 years of age.

Table 1

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>45</td>
<td>52</td>
</tr>
</tbody>
</table>

![Age of residents](image.png)

![Diagnosis: Percentage](image.png)
In this sample, 71% of residents were on antipsychotic medication. Forty-two percent had one or more symptoms of metabolic disease, including cardiac problems.

There was poor adherence by the mental health services to best practice guidelines referenced above and also to the Regulation in General Health (Regulation 19) under the Mental Health Act 2001. While most doctors (either non-consultant hospital doctors or GPs providing a primary care service to the centres) carried out a physical examination every six months for each resident, none of the doctors carried out adequate monitoring in accordance with regulations and best practice guidelines.

Only 25% of residents had a body mass index (BMI) recorded. Waist circumference was only carried out in 9%. Monitoring of blood lipids and ECGs were done in two thirds of residents. While some physical health needs were outlined in some of the residents’ individual care plans, these did not include annual monitoring. Other information is vital in assessing the risk of metabolic syndrome and cardiac disease for people with severe mental illness. This includes obtaining a family history of medical problems; smoking status; amount of exercise; nutritional status and diet. In many cases, this was not done, or was documented in various places in the clinical file, often difficult to find, and not referred to in the six monthly physical review documentation.

**Table 2 Percentage of residents who had monitoring of essential health indices**

<table>
<thead>
<tr>
<th>Monitoring</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>45</td>
</tr>
<tr>
<td>BMI</td>
<td>25</td>
</tr>
<tr>
<td>Waist circumference</td>
<td>9</td>
</tr>
<tr>
<td>Cardiovascular examination</td>
<td>80</td>
</tr>
<tr>
<td>Glucose</td>
<td>72</td>
</tr>
<tr>
<td>Lipids</td>
<td>66</td>
</tr>
<tr>
<td>ECG</td>
<td>65</td>
</tr>
</tbody>
</table>

These findings are of serious concern and show that residents in long-term care in mental health in-patient units are not adequately monitored for serious physical illness, which they have a higher risk of developing than the general population.

Another serious finding in this review was that of discriminatory practice in accessing certain types of healthcare. There was widespread lack of access to essential healthcare such as physiotherapy, dietetics, speech and language therapy and seating assessments in the centres reviewed. These services are available to the rest of the population in the community and in general hospitals but are refused in many cases to residents in continuing care mental health units, because they are mental health patients. This is a breach of human rights. I found a significant number of residents who had been assessed as needing these services but had no access to them. Healthcare professionals reported spending many hours advocating and lobbying for their patients, in order to gain access to these services. Where services had been out-sourced to private providers, this was unsatisfactory in a number of ways: lack of follow-up, the practitioner not being part of the treating team, sometimes not attending despite an appointment to do so.
Conclusion

It is concerning to find that physical health monitoring for people with severe mental illness in the sample surveyed fell far below an acceptable standard. It is particularly concerning as most of these people are vulnerable, elderly, often with poor communication abilities, with a high risk of metabolic syndrome and cardiac disease and are dependent on healthcare staff to manage their physical healthcare needs and to advocate for them.

It is utterly unacceptable and a breach of human rights that access to essential healthcare services such as physiotherapy, speech and language therapy, dietetics and seating assessments are denied to people with serious mental illness. As a matter of urgency, the HSE must provide equitable access to these areas of healthcare and the Inspectorate Team will monitoring this closely during their inspections.

No part of the HSE should tolerate professional attitudes, behaviour or policies that stigmatise mental illness and thus contribute to the discrimination experienced by people with mental health problems.

Addressing these serious concerns should focus on the following key areas:

- promoting prevention, monitoring and early intervention strategies for physical health in people with severe mental illness
- delivering 'joined-up' mental and physical health care
- enhancing training for medical staff and workforce planning
- encouraging a greater research focus on mental-physical multi-morbidity\(^3\).\(^4\)

Government, policy-makers, healthcare providers, healthcare professionals and the public are urged to think in terms of the whole person – body and mind – and to apply a ‘parity test’ to their activities and attitudes. A ‘parity approach’ would enable the HSE and other mental health providers to provide a ‘whole person’ response to each individual, whatever their needs, and should ensure that all publicly funded services, including those provided by independent and private organisations, give people equal status to their mental health and physical health needs. Central to this approach is the fact that there is a strong relationship between mental health and physical health, and that this works in both directions: poor mental health is associated with a greater risk of physical health problems, and poor physical health is associated with a greater risk of mental health problems.

The overarching principle of the parity movement is equality – in access to care, in improving the quality of care, and in the way resources are allocated... If we stay true to the principle of treating each person with dignity and respect in our health care system, then we should make no distinction between illnesses of the brain and illnesses of other body systems\(^5\).

34. Recognising the importance of physical health in mental health and intellectual disability. Achieving parity of outcomes BMA May 2014
Appendix 1

Barriers to the recognition and management of somatic illnesses in people with serious mental illness.

<table>
<thead>
<tr>
<th>Patient and illness-related factors</th>
<th>Treatment-related factor</th>
<th>Psychiatrist-related factors</th>
<th>Other physician-related factors</th>
<th>Service-related factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not seeking adequate physical care due to symptoms of the SMI (e.g., cognitive impairment, social isolation and suspicion)</td>
<td>Deleterious impact (e.g., obesity, type 2 Diabetes, Cardiovascular Disease, hyperprolactinaemia, of psychotropic medication on physical health)</td>
<td>Tendency to focus on mental rather than physical health with infrequent baseline and subsequent physical examination of patients</td>
<td>Stigmatization of people with mental disorders</td>
<td>Financial barriers</td>
</tr>
<tr>
<td>Difficulty comprehending health care advice and/or carrying out required changes in lifestyle due to psychiatric symptoms and adverse consequences related to mental illness (e.g., low educational attainment, reduced social networks, lack of employment and family support, poverty, poor housing)</td>
<td></td>
<td>Poor communication with patient or primary care health workers</td>
<td>Physical complaints regarded as psychosomatic symptoms</td>
<td>High cost of (integrated) care</td>
</tr>
<tr>
<td>Severity of mental illness (SMI patients have fewer medical visits, with the most severely ill patients making the fewest visits)</td>
<td></td>
<td>Physical complaints regarded as psychosomatic symptoms</td>
<td>Suboptimal and worse quality of care offered by clinicians to patients with SMI</td>
<td>Lack of access to health care</td>
</tr>
<tr>
<td>Health risk factors and lifestyle factors (e.g., substance abuse, poor diet, smoking, lack of exercise and unsafe sexual practices)</td>
<td></td>
<td>Suboptimal and worse quality of care offered by clinicians to patients with SMI</td>
<td>Lack of assessment, monitoring and continuity of care of the physical health status of people with SMI</td>
<td>Lack of clarity and consensus about who should be responsible for detecting and managing physical problems in patients with SMI</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient and illness-related factors</th>
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<th>Psychiatrist-related factors</th>
<th>Other physician-related factors</th>
<th>Service-related factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less compliant with treatment</td>
<td></td>
<td>Erroneous beliefs SMI patients are not able to adopt healthy lifestyles, weight gain is mainly adverse effect of medications, lower cardiac risk medications are less effective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unawareness of physical problems due to cognitive deficits or to a reduced pain sensitivity associated with AP medication</td>
<td></td>
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<tr>
<td>Migrant status and/or cultural and ethnic diversity</td>
<td></td>
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<tr>
<td>Lack of social skills and difficulties communicating physical needs</td>
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Appendix 2

Mechanisms through which physical and mental health interact
(from Bringing together physical and mental health. A new frontier for integrated care. Kings Fund 2016)

SOCIAL DETERMINANTS

E.G., POVERTY, SOCIAL ISOLATION, DISCRIMINATION, ABUSE, NEGLECT, TRAUMA, DRUG DEPENDENCIES

Mental health impact of living with a chronic condition

- Psychiatric side effects of medication, e.g., steroids
- Direct effects of hormonal imbalances on mental health
- Increased risk of dementia among people with diabetes/cardiovascular disease

Physical health side effects of psychotropic medication, e.g., raised risk of obesity

- Direct effects of chronic stress on the cardiovascular, nervous and immune systems
- Direct effects of eating disorders or self-harm, e.g., electrolyte imbalances
- Higher rates of unhealthy behaviours, e.g., smoking or excessive alcohol use
- Reduced ability or motivation to manage physical health conditions
- Less effective help-seeking
- Barriers to accessing physical health care, e.g., as a consequence of stigma or ‘diagnostic overshadowing’