Physical health and severe mental illness:
If we don’t do something about it, who will?

If you are a mental health nurse working in clinical practice, chances are that you have done or will do a risk assessment sometime today. As practitioners, we worry, quite rightly, about patients with severe mental illnesses, such as schizophrenia, committing suicide. We use risk assessment tools to try and predict patients who are at particularly high risk and then plan appropriate intervention. When our patients do kill themselves, we will often hold an inquiry to determine whether the treating team did everything they could have done to prevent the tragedy occurring. It will come as no surprise then that patients with severe mental illness (SMI) have a dramatically reduced life expectancy compared to the general population. In the USA, adults with severe mental illness die 25 years younger than other Americans (NAMI 2007). What might come as a surprise is that most patients with SMI die from cardiovascular disease (CVD) or from a sequelae of metabolic complications, not suicide, and that life expectancy for patients with SMI is actually decreasing (Fontaine et al. 2001).

One of us vividly remembers caring for a patient who died suddenly in his 50s from CVD; he was overweight, had a terrible diet, smoked, and drank. After his death, there was no inquiry, no questions were asked about the care and treatment the health-care team looking after him provided. This is perhaps the real tragedy of 21st century mental health care. We can imagine no other area of medicine where the life expectancy of a patient population getting worse would be anything other than a scandal. At a public debate about physical health and SMI at the (world famous) Maudsley Hospital in 2003, the debate was not about what we can do to improve physical health and increase life expectancy; instead it was about whether primary or secondary care was responsible. Ultimately, responsibility for the physical health care of people with SMI does lie (in most countries) with primary care, but all nurses have a duty to promote health (Hardy 2009).

Why then do our patients die? Patients with SMI may have an inherent vulnerability to CVD and other comorbidities (Chwastiak et al. 2006; Lawrence et al. 2003); lifestyle risk factors (obesity, smoking, lack of exercise, and a poor diet) are also prevalent (Robson & Gray 2007). Even some of the medications we prescribe increase the risk of cardiometabolic diseases; for example, by causing weight gain, hyperglycemia, dyslipidemia, and hypertension (Allison & Casey 2001; Newcomer 2007). While CVD is the big killer, other physical comorbidities, including respiratory disease, some cancers, and sexually-transmitted infections are also prevalent (Robson & Gray, 2007; Gray et al. 2002). Other common, but overlooked comorbidities include poor eye and dental health, as well as influences from alcohol and drug misuse. Addressing and improving these aspects of health is also important to reverse this increasing trend of early death in our patients with SMI. System issues created by completely different care sites for physical and mental health care create disconnections among providers that limit the continuity of care.

Internationally, there have been a number of impressive examples where mental health nurses have demonstrated that they can have a positive impact on the physical health of patients with SMI. A well-being support programme run by nurses reduced cardiovascular risk factors in patients with SMI (Smith et al. 2007). A number of other authors have shown the potential of weight management programmes for patients with SMI (Lowe et al. 2008). A critique of these programmes is that they are complex with a specific focus (often weight gain) delivered in secondary care by specially-trained nurses. As a consequence, only a minority of patients will receive intervention.

In the UK, there are approximately half a million patients with SMI; in the USA, there are approximately 13 million. In our clinical experience, every single one of these patients is likely to benefit from physical health intervention. In order to reach every patient, we need to think about simple intervention that can be offered to the many and not the few. We are sure that many of you are thinking that although this is a major health issue for our patients, the idea of offering every patient with SMI a well-being intervention is absurd. We would argue that with determination, we (by which we mean nurses) can achieve the goal of a physical health intervention for all patients with SMI. After all, if every patient can have a
suicide risk assessment why can’t they have a physical health risk assessment? This model of a simple physical health risk assessment that can be offered to large numbers of patients has been adopted by White et al. (2009) who describe the health improvement profile (HIP). The HIP is a sex-specific, 28-item physical health risk assessment tool that is completed annually by nurses working either in primary or secondary care mental health services. The profile not only includes items on cardiovascular and metabolic risk factors, such as body mass index, glucose levels, cholesterol, diet, smoking, and exercise, but also addresses other aspects of well-being, such as sexual health and satisfaction, sleep, dental and eye health, and breast, prostate, and testicular self-examination. Each of the 28 items is flagged either green (healthy) or red (not healthy). The HIP then directs nurses to evidence/guideline-based intervention for each of the red flagged items.

Addressing ‘red flag’ items requires the knowledge and skill of nurses across primary and secondary care. Some care and treatment will need to be provided by nurses working in primary care; for example, if a patient requires a statin for raised cholesterol. Promoting lifestyle change requires a coordinated approach across primary and secondary care. Mental health nurses can teach their primary care colleagues how to use the recovery model to identify their role in each patient’s care, allowing them to utilize the medical model as a template to provide the education necessary to improve their physical health (Hardy 2008). For example, the motivation to stop smoking can be created by mental health nurses regularly encouraging the patient to think about quitting smoking. When the patient is ready to quit, nurses in primary care are experts in smoking cessation, but might benefit from talking to mental health nurses about some of the idiosyncrasies of smoking in people with SMI. Furthermore, where sleep is red flagged because the patient is on an antipsychotic that causes sedation, then mental health nurses can discuss with the patient and the prescriber whether switching medication would be beneficial. In the USA, where mental and physical health care is usually separate and under completely different systems, mental health nurses can routinely add a physical health assessment using the HIP with follow up to become standard psychiatric care.

Our patients are dying and we have a duty to act now, not with complex intervention, but with a physical health risk assessment tool that we can easily and quickly learn to use and can offer to every patient. Nurses across primary and secondary care need to work together to provide treatment and promote lifestyle change that promote health. Wouldn’t it be a fantastic achievement if in 5 years time we can see life expectancy increasing? Physical health and SMI, we can do something about it.

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REFERENCES