Physical health care: Mental health consumers

Dr Dharjinder Rooprai
Head of Psychiatry - Armadale
What is the scale of the problem?
Why do MHC’s have this problem?
What are the barriers to improvement?
How can we fix this problem?
What is the problem?

• Mental Health Consumers (MHCs) suffer with :-
  • Poorer overall physical health
  • Shorter life expectancy
  • Many fold increase in mortality due to preventable causes
  • Poorer access to physical and dental care
What is the scale of the problem?

If you have a serious mental illness you are -

• 2-3x- diabetes

• 6x - die from cardiovascular disease, even if you are aged between 25 and 44 years

• more likely to die from almost all key chronic conditions, and more likely to die within 5 years of diagnosis

• extremely likely - irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome, temporomandibular joint disorder and chronic pelvic pain

• 90% more likely to be diagnosed with bowel cancer if you have schizophrenia in particular

• 42% more likely to be diagnosed with breast cancer if you are a woman with schizophrenia.
Life expectancy

• Overall death rate was **2.5 time higher** than the general population of WA

• The gap between life expectancy in patients with a mental illness and the general population has **widened since 1985**.

• People with serious mental illness typically live between **10 and 32 years less** than the general population.

• Around 80% of this higher mortality rate can be **attributed** to the much higher rates of physical illnesses, such as **cardiovascular and respiratory diseases and cancer** experienced by this population.
Spending in Mental health

Health care spend per capita

- 1999-00: $150
- 2003-04: $200
- 2007-04: $250
- 2011-12: $300
- 2015-16: $350

The graph shows an upward trend in health care spending per capita from 1999-00 to 2015-16.
Life expectancy - WA
WA problem

• between 1985 and 2005
• the gap in life expectancy for people with psychiatric disorders increased
  • 13.5 years to 15.9 years for men
  • 10.4 years to 12 years for women
International experience

- Substance abuse (F1):
  - Denmark: 23.6%
  - Finland: 23.2%
  - Sweden: 21.3%

- Schizophrenia spectrum (F2):
  - Denmark: 20.1%
  - Finland: 15.5%
  - Sweden: 19.9%

- Affective disorders (F3):
  - Denmark: 17.4%
  - Finland: 15.6%
  - Sweden: 17.3%

- Personality disorders (F6):
  - Denmark: 19.9%
  - Finland: 13.0%
  - Sweden: 21.9%
Why do MHC’s have this problem?

• Medication side-effects
• Lifestyle
• Pre-existing and emerging conditions
• Alcohol and substance misuse
• Suicide
SSRI’s

- nausea, diarrhoea, dizziness, tremor, headaches, dependence/withdrawal reactions, sexual dysfunction and hyperglycemia
- serious issues such as Serotonin Syndrome
- weight gain leading to type 2 diabetes
- cardiotoxicity
Medication side effects

**Typical or first generation antipsychotics**
- extrapyramidal side effects such as tardive dyskinesia, and impaired cognitive functioning
- and antipsychotic–induced hyperprolactinaemia causing sexual dysfunction, fertility problems, and bone mineral density reduction

**Atypical (or second generation) antipsychotics**
- moderate to marked weight gain, glucose intolerance and type 2 diabetes, and hyperlipidemia.
- metabolic syndrome -19% to 29% of adults
- QT interval prolongation, adverse cardiac effects
- Clozapine shows the greatest weight gain and cardiotoxic adverse effects such as myocarditis, cardiomyopathy, and pericarditis
Where on the Metabolic Highway Should Psychopharmacologists Monitor Antipsychotics?

- Premature death and loss of 20-30 years of normal life span
- Diabetes
- Cardiovascular events
- Prediabetes
- Beta cell failure
- Insulin resistance
- Hyperinsulinemia
- Obesity and increased BMI
- Triglycerides
- Increased appetite

BEWARE: cardiometabolic risk ahead
Lifestyle

Social barriers
• lack of social support,
• poor social skills,
• poor self-image,
• coping with emotional issues tend to prevent behaviour change and adoption of a healthier lifestyle

Diet
• high in sugars and saturated fat
• diets low in fibre,
Lifestyle

Smoking

• 20% - General population
• 74% - schizophrenia
• 66% - bipolar disorder
• 57% - major depression
• 37% - comorbid diagnoses of anxiety and depression
• 26% - anxiety and depression Figures were higher for at around
Dental Care

Poor hygiene
• a bad odour,
• ulcerated, bleeding and/or inflamed mucous membranes, lips or gums,
• decayed and/or fractured teeth,
• calculus on teeth,

Reasons
• personal neglect,
• other medical conditions,
• poor nutrition,
• low income,
• the consumption of sugary foods and drinks, and medication effects such as dry mouth (causing xerostomia).
• Xerostomia increases the risk of periodontal disease, dental caries, and oral infections
Pre-existing diseases

- HIV – upto 20 % have mental health problems
- STIs – multifactorial
- Hepatitis – lifestyle
- Cancers – higher incidence, higher mortality, poorer uptake of treatment
Alcohol and substance misuse

• Higher incidence
• Less success at quitting
• Higher co-morbidity burden
• Physical health problems
• Higher violence
What are the barriers to improvement?

• Consumer level
• Mental health services level
• Physical health care level
• Systems level
Consumer levels

• **Not seeking** adequate physical care due to symptoms of the serious mental illness (e.g. cognitive impairment, social isolation and suspicion)

• **Difficulty comprehending** health-care advice and/or carrying out the 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)

• Severity of mental illness (serious mental illness patients have fewer medical visits, with the most severely ill patients making the fewest visits)

• Health risk factors and lifestyle factors (e.g. substance abuse, poor diet, smoking, lack of exercise and unsafe sexual practices).

• **Less compliant** with treatment

• Unawareness of physical problems due to **cognitive deficits** or to a **reduced pain sensitivity** associated with antipsychotic medication

• **Migrant status and/or cultural and ethnic diversity**

• Lack of social skills and difficulties **communicating** physical needs
Mental health provider level

- Tendency to **focus on mental** rather than physical health, with infrequent baseline and subsequent physical examination of patients.
- Lack of ability or support to assess the potential trade-offs between treatment aimed at controlling symptoms of mental illness and potential for adverse impacts on physical health
- Poor **communication** with patient or primary care health workers
- Physical complaints regarded as **psychosomatic symptoms**
- Lack of assessment, monitoring and continuity of care of the physical health status of people with serious mental illness
- Deleterious impact (e.g. obesity, type two diabetes, cardiovascular disease, hyperprolactinaemia, xerostomia) of psychotropic medication on physical health
- **Erroneous beliefs** such as suggestions that serious mental illness patients are not able to adopt healthy lifestyles, weight gain is mainly adverse effect of medications, lower cardiac risk medications are less effective
- Unequipped or underfunded teams to handle behavioural and emotional problems of patients with serious
• **Stigmatisation** of people with mental disorders
• Physical complaints regarded as **psychosomatic symptoms**
• Lack of ability or support to assess the potential trade-offs between treatment aimed at controlling symptoms of mental illness and potential for adverse impacts on physical health
• Suboptimal and worse quality of care offered by clinicians to patients with serious mental illness.
• Lack of assessment, monitoring and continuity of care of the physical health status of people with serious mental illness.
• Unequipped or underfunded teams to handle behavioural and emotional problems of patients with serious mental illness.
• Complexity and time intensity of coordinating both medical and psychiatric medications
Systemic level

- Lack of integrated health policy
- No parity of esteem for mental health compared with physical health
- Fragmentation or separation of the medical and mental health systems of care, lack of integrated services
- Fragmented responsibility for funding specialist and non-specialist services.
- Lack of access to health care
- Lack of clarity and consensus about who should be responsible for detecting and managing physical problems in patients with serious mental illness.
- Under-resourcing of mental health care that provides little opportunity for specialists to focus on issues outside their core specialty.
- Lack of health insurance coverage.
- Financial barriers to physical health care, including co-payments and out of pocket expenses for screening and medications
What can we do about this problem?

Mental health services

• Putting physical health care as a high priority
• Care planning processes to support and monitor physical healthcare
• Better involvement of primary care through different levels of support
• Better education and awareness of staff and consumers
• Medication optimization
• Life style optimization
• Smoking cessations
• Alcohol and Drug services
What can we do about this problem?

Primary care services

• Awareness
• Reduced stigma and prejudice
• Joint working with MH services – shared care agreements
• Medication optimization
• Life style optimization
• Smoking cessations
• Alcohol and Drug services
• Funding structure and service delivery paradigm changes
Goal - MHC life expectancy (→)