



Duty to Care

Physical illness in people
with mental illness

Consumer Summary

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Duty to Care

**Physical illness in people with mental
illness**

Consumer Summary

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Introduction

People with mental illness are among the most marginalised people in our community. The consequences of mental illness often extend beyond the direct symptoms of the illness to affect people's social and economic well being and all aspects of their lives. The aim of this study was to examine the physical health of people with mental illness.

People with mental illness are often isolated from family and friends. Mental illness can also affect people's job prospects and make it difficult to secure and retain full-time employment. They face a continual stigma based on fear of mental illness. The separation of medical care for physical illness from psychiatric care often fragments the total care offered to this group. These factors often lead to people with mental illness not receiving adequate health care in relation to their health needs.

This study determined the extent to which users of mental health services (who comprise 8% of the population of WA) have different rates of physical illness compared to the general population for the period 1980–98. The study compared deaths, the total number of cancers that were diagnosed and hospital admission rates in people with mental illness with the general population.

This consumer summary describes the main findings of the study. More detailed reports from the study are also available and can be downloaded from www.dph.uwa.edu.au.

Background

The nature and delivery of psychiatric services has changed dramatically in the 20th century. This has resulted in a large reduction in the number of people with mental illness in hospitals and other mental health care facilities. More effective treatment for mental disorders, particularly the introduction of newer and more effective medicines has been the main reason for this trend. It has allowed many people with mental illness to be treated outside of institutions and helped them on the path to more normal lives.

After heart disease, mental illness is the most common cause of premature death. Also, about 30% of the non-fatal disease burden on the community is due to mental illness. Depression is the most common cause of non-fatal disease burden. A range of effective treatments exist for most mental disorders. However, a powerful stigma, based on fear of mental illness,

remains a significant barrier to effective treatment and rehabilitation. Premature death is more common among people with mental illness. This is due to their higher rates of physical illness and the fact that they tend to acquire much more serious physical illnesses. Higher rates of physical illness in people with mental illness add to the difficulties of living with a mental illness.

Physical illness may also be the result of treatment of mental illness (*eg* side effects of some medications). Physical illness may not be diagnosed or properly treated and people with mental illness may have their physical illness diagnosed at a later stage.

Mental illness is associated with behaviours that carry high health risks, such as smoking, alcohol and other substance abuse, obesity, poor diet and lack of exercise. Mental illness can create difficulty in communicating symptoms of physical illness which can complicate diagnosis. People with mental illness are also less likely to be in contact with general health services and more likely to not have their illnesses identified and treated.

Cigarette smoking is a major risk factor for many commonly occurring physical illnesses. Smoking is common among people with mental illness. The highest rates and heaviest consumption are among those with the most serious disorders. In WA, 43% of people with diagnosable mental illnesses smoke compared with 24% of the overall population. Despite the adverse effects smoking can have on people with mental illness, they are rarely encouraged to quit.

Alcohol abuse and use of illicit drugs are also common problems among people with mental illness. Around half of people with psychotic disorders report illicit drug use. People with mental illness also have high rates of obesity and poor nutrition.

If a mentally ill person has a physical illness when being treated for a mental illness, there is a strong possibility that the physical illness will not be diagnosed. This can occur even when the physical illness is either causing or exacerbating the mental disorder. Proper treatment of physical and mental conditions at the same time improves the overall well being of the consumer. Barriers to effectively treating people with mental illness in general practice have been identified. Also, some psychiatrists tend to regard themselves as specialists who shouldn't be called upon to diagnose physical illnesses. The separation of mental health services has led to fragmented care for people with mental illness.

In WA, as the world over, there has been a major shift from inpatient-based to community based treatment for mental illness. In WA this commenced in the 1960s, and has continued up to the present time. Over time, inpatient services for people with mental illness have been reduced or decommissioned, and outpatient and community based treatment have developed. The number of inpatient psychiatric beds has almost halved since 1970. Models of community based psychiatric services have evolved over time.

Adequate funding of mental health services has always been a difficult problem. A general run down of mental health services in the 1980s and early 1990s lead to a government taskforce being established. As a result, several major changes have been made in mental health services. Inadequate resources and low staff numbers have stretched services to their limit. Despite the best of intentions, there have been areas of unmet need. In 1996, the Mental Health Division was established with a separate budget within the Health Department of WA. Government injected an additional \$40 million into mental health services over three years, which has resulted in the commissioning of new facilities and the expansion of others.

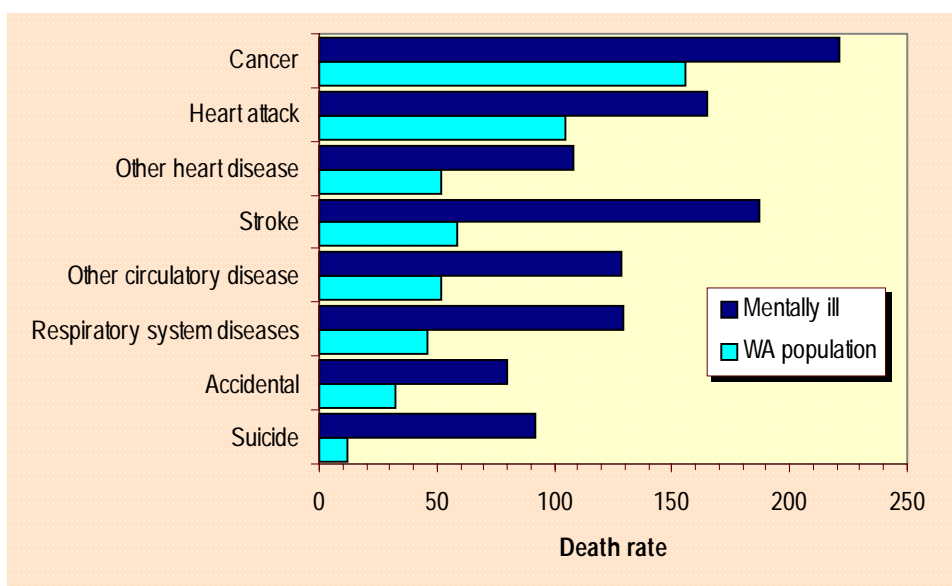
There has been a marked change in recent years in the philosophy of community mental health services, away from the traditional outpatient clinic and towards integrated, community facilities and intensive case management. Even so, with resources stretched, home visits are rare.

The study used the WA Linked Database to examine serious physical illness in people with mental illness. It is based on hospital records and death records and is restricted to illnesses serious enough to require treatment in hospital. The study covers the period 1980–98, and includes approximately 240,000 people who were recorded on the Mental Health Information System during this time. The system includes public and private hospital admissions for mental illness, community psychiatric services and outpatient clinics as well as residents of licensed psychiatric hostels. The system does not cover people seeking treatment for their mental illness from general practitioners or who see private psychiatrists in their consulting rooms.

Death

Despite the major changes in treatment of mental illness the death rates from all main causes of death, both natural and unnatural, remain considerably higher in people with mental illness than the general population. **Figure 1** shows death rates (per 100,000 people per year) from the main causes of death in WA for people with mental illness and the WA population. Overall the death rate of people with mental illness was two and a half times higher than the general population of WA.

Figure 1: Death rates in people with mental illness compared to the WA population

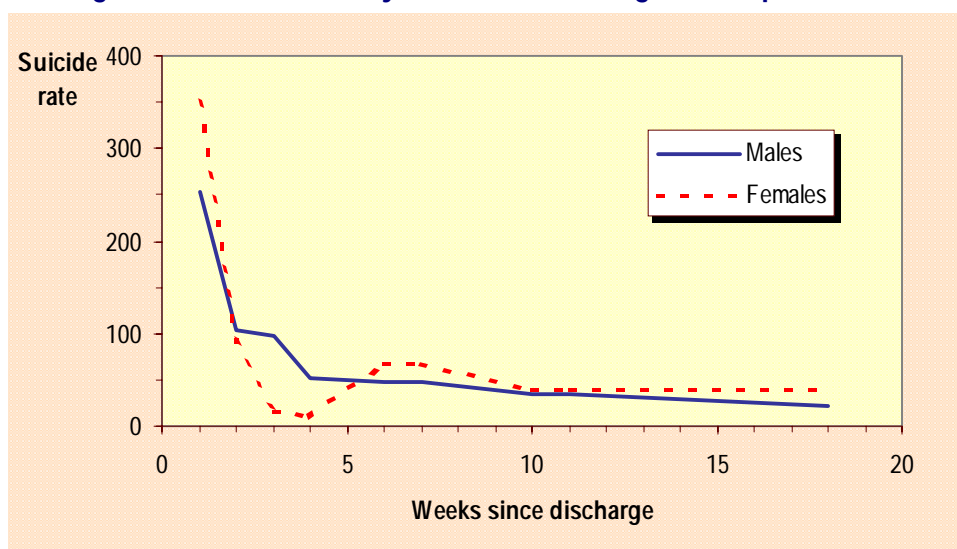


While suicide is a significant cause of death in people with mental illness physical health problems, particularly heart disease contribute strongly to death rates. The greatest number of excess deaths in people with mental illness was due to heart disease (at 16% of excess deaths) and was double the number of excess deaths due to suicide (at 8%). The expected number of deaths in people with mental illness from any given cause can be worked out by applying the general population death rate to the population of people with mental illness. Deaths above this number are called excess deaths. Smoking appears to be a contributing factor to the higher death rate in people with mental illness from heart disease, respiratory disease and a number of other conditions.

Suicide

About 45% of suicides in WA in 1980–98 occurred in people who had contact with mental health services. The contribution of mental illness would be even greater, because a proportion of the other suicides would be people with mental illness who weren't in contact with mental health services. In people with mental illness suicide rates were seven times higher than the overall suicide rate for the WA population. At highest risk were people with schizophrenia, affective psychoses, and depressive disorder.

Figure 2: Suicide rates by time since discharge from inpatient care



Except for people with schizophrenia, the greatest risk of unexpected death is in the period following first contact with mental health services, particularly for suicide. **Figure 2** shows how the suicide rate changes with time after discharge from inpatient care. The highest risk was in the first seven days after discharge from care with the risk reducing over time. Even so, the suicide rate for those discharged from care remained above the general population rate even 5-10 years after discharge. The suicide rate was lowest during inpatient care, and comparable to the suicide rate in the general population. The first two weeks after discharge are the period of highest risk when people with mental illness must make the transition from the hospital setting to independent living.

The current approach is to treat people with mental illness at home during the acute phase of the illness as much as possible. Even those people admitted to

hospital are only kept in for short periods before discharge to home care. Research suggests that community care outside hospitals and other mental health care facilities may place people at greater risk of suicide.

Figure 3: Relative risk of suicide by year of first contact with mental health services

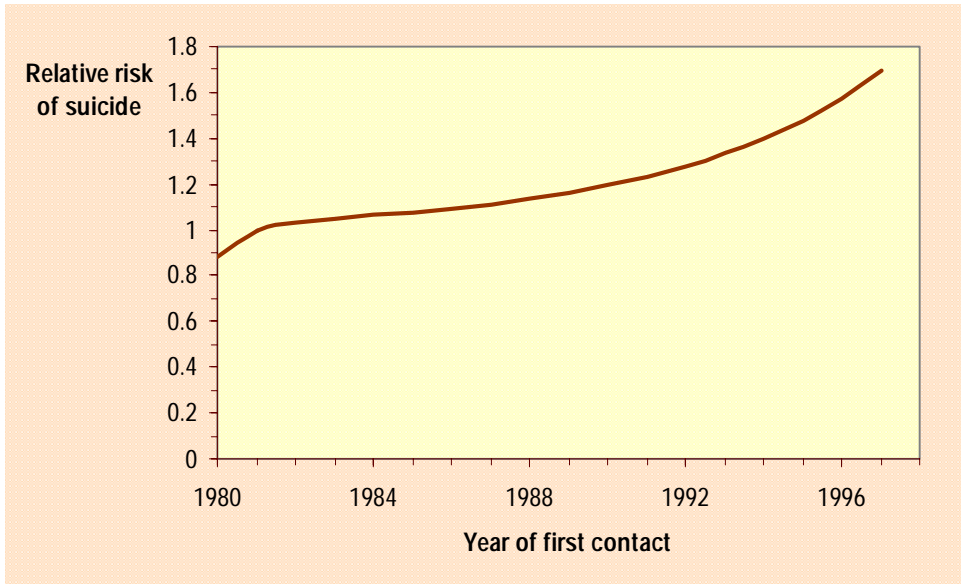


Figure 3 shows how the risk of suicide in the first year after first contact with mental health services has changed over time. The rate of increase was greatest in the early 1980s and again in the late 1990s. The average rate of increase in the suicide rate was 3.5% per year. By contrast, the suicide rate in the WA population has increased by only 1.2% per year over the same period. While a variety of factors are likely to contribute to the high suicide rates in people with mental illness, the changes in mental health care delivery may have relaxed some of the protective barriers that existed in the hospital treatment of people with mental illness.

HIV

Nineteen percent of people with HIV have had contact with mental health services prior to being hospitalised for HIV. This was more than three times the expected number, based on the HIV rate in the general population. Most at risk were people with psychoses, alcohol and drug disorders and personality

disorder. The seriously mentally ill are at greatly increased risk of HIV infection due to intravenous drug use and high risk sexual behaviours.

Viral Hepatitis

There are three main types of hepatitis infection: hepatitis A, B and C. The best protection from hepatitis A is good sanitation and personal hygiene. Hepatitis B and C are both transmitted by contact with blood and other bodily fluids of someone who has the virus. The main modes of transmission are unprotected sex, sharing needles and syringes and from infected mother to baby. Hepatitis C is mainly linked to injecting drug use.

People with mental illness were hospitalised for viral hepatitis about twice as frequently for hepatitis A, three times as frequently for hepatitis B, and more than five times as frequently for hepatitis C compared to the WA population. Hepatitis was particularly common in people with alcohol or drug disorders, personality disorders and psychoses. In fact, 44% of Hepatitis C cases in WA occurred in users of mental health services.

Sexually Transmissible Diseases

Only a small number of people were hospitalised for sexually transmissible diseases (STDs). STDs are usually treated in outpatient settings, and only the most serious cases result in hospitalisation. Rates of hospitalisation for STDs in people with mental illness were about twice as high as expected. The STDs considered were syphilis, gonorrhoea, genital herpes and genital warts. People with alcohol and drug disorders were at very high risk. Research examining high risk behaviours for HIV infection has shown that injecting drug users also have high risk sexual behaviour which naturally exposes this group to risks for STDs.

High use of intravenous drugs and high risk sexual behaviours among people with mental illness have been identified. Actions to reduce exposure to high risk behaviours among people with mental illness may have the greatest potential to reduce their high rates of infectious disease.

Cancer

Figure 4: Cancer incidence and death rates in people with mental illness compared to the WA population

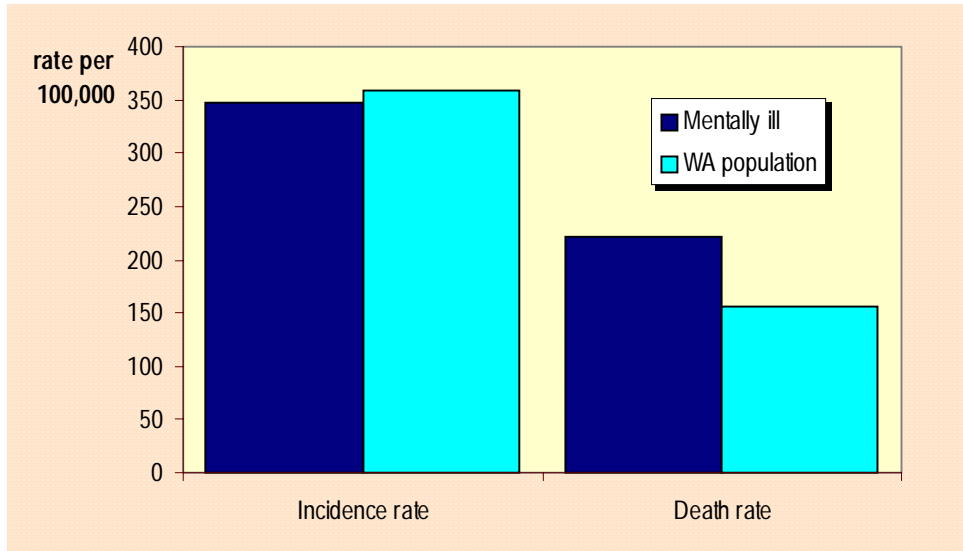


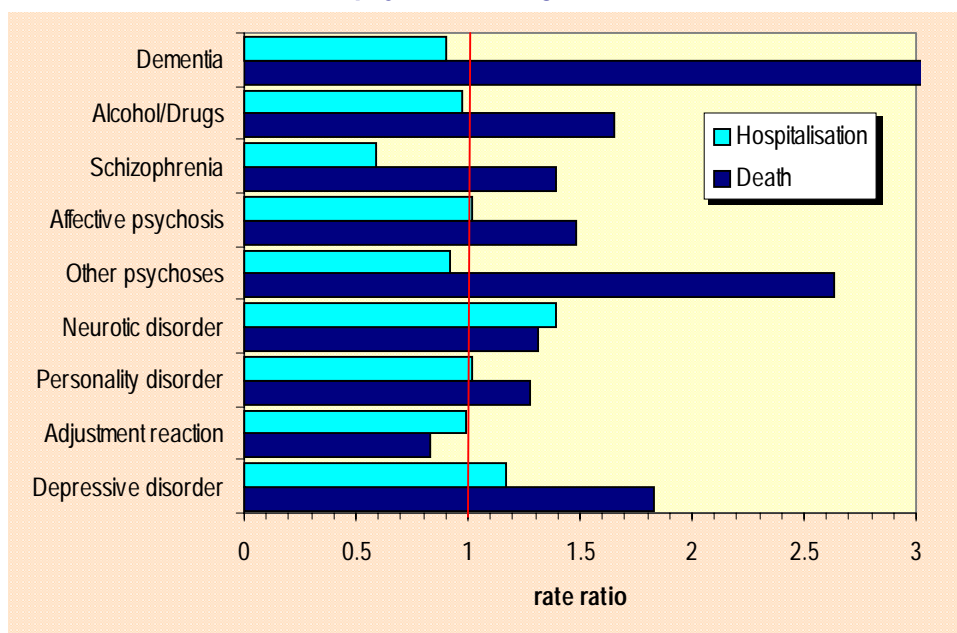
Figure 4 compares cancer incidence rates in people with mental illness with the WA population, as well as cancer death rates. The study found that there was no difference in the rate that cancer occurred in people with mental illness than in the general population. However, people with mental illness were more than 30% more likely to die from cancer. People with alcohol and drug related disorders had the worst cancer survival. There are many reasons why this is so. People with mental illness may have difficulty accessing health care, including cancer screening programmes. As a result their cancers may be missed or diagnosed later, resulting in a worse prognosis. Also they may have difficulty in effectively communicating their physical symptoms, and they may find that their cancer treatment is complicated by their mental illness. Overall people with mental illness don't get cancer any more than anyone else, but they are more likely to die of it, and sooner.

Heart disease

Heart disease is the leading cause of death in WA and accounts for 16% of excess deaths among people with mental illness. People with mental illness are at increased risk of death from heart disease compared to the general community. Deaths are higher for all circulatory conditions in both men and women, particularly for stroke. People with dementia were at particularly high risk of death from stroke. People with alcohol and drug disorders showed consistently higher risk of death from heart disease and other circulatory diseases.

Figure 5 shows comparative rates of hospitalisation and death for heart disease in people with mental illness relative to the general population. A value of one indicates the same rate in the two groups. Values higher than one reflect higher rates in people with mental illness, and values less than one show lower rates in people with mental illness. For most psychiatric diagnoses hospitalisation rates are about what is expected. However, the death rate from heart disease in people with mental illness far exceeds the number of admissions to hospital. This suggests that heart disease is not detected and treated as frequently in people with mental illness as in those without mental illness.

Figure 5: Heart disease hospitalisation and death rates, by principal psychiatric diagnosis



In WA there has been a steady decline in deaths from heart disease, due to the success of health promotion efforts, and improved treatment methods. However, death rates from heart disease have not declined at all in people with mental illness, and in women have actually increased substantially. Health promotion campaigns do not seem to have benefited people with mental illness.

Heart bypass operations were performed much less frequently in people with mental illness, particularly in people with schizophrenia who almost never received them. These results raise questions as to whether people with mental illness receive appropriate care, if they have established heart disease, at a level that is equitable to that in the general population.

Injuries

Injuries are a major cause of hospitalisation in WA. People with mental illness were at high risk for all types of injuries particularly injuries inflicted by others, accidental poisonings and adverse drug reactions. People with mental illness were more than three times more likely to be victims of injuries inflicted by others, and almost three times as likely to be hospitalised for accidental poisoning, particularly poisoning by therapeutic drugs. Adverse drug reactions were most commonly caused by cardiovascular agents, analgesics and antibiotics. Hospitalisation rates for adverse drug reactions were two and half times higher for people with mental illness than the general population. People with mental illness were 50% more likely to be hospitalised following a road injury, despite being less likely to own a car.

People with mental illness undergoing surgery were more likely to have complications leading to hospital readmission, even though they were less likely to receive certain types of surgical procedures.

Women with mental illness were at greater relative risk than men of injuries inflicted by others. One in every four women hospitalised due to injuries inflicted by others were users of mental health services. People with mental illness are at risk of violent victimisation. Substance abuse and homelessness make criminal victimisation more likely.

Conclusions and Recommendations

These results paint a picture of a vulnerable population suffering high rates of each major physical illness and dying at higher than expected rates. This leads to significantly reduced life expectancy, and a greater burden of ill health. Physical illness is more likely not to be diagnosed leading to a lower hospital admission rate. Problems of substance abuse and other lifestyle factors contribute to the overall burden of poor health in people with mental illness.

Excess deaths from physical illness is a major issue in people with mental illness, raising questions as to whether people with mental illness receive an appropriate level of care for their physical health problems based on need. Do people with mental illness receive appropriate primary health care? Do mental health services diagnose and treat physical health problems?

More integrated and cooperative approaches to health care are required to effectively meet all of the health needs of people with mental illness. Currently the fragmented approach to health care for the mentally ill sees too many people falling through the cracks too often resulting in illness not being diagnosed or treated.

Substance abuse and addiction are major problems for the mentally ill. Services to deal with addictions need to be incorporated into the every day care of people with mental illness. Programmes to reduce smoking and other substance abuse in people with mental illness could lead to significant reductions in physical illness in this group.

People with mental illness have not benefited from public health campaigns aimed at reducing major health risk factors. Specially targeted programmes would be welcome. More outreach services and more proactive health care is needed for people with mental illness otherwise they risk missing out on vital health care.

Health services must adapt to the needs of people with mental illness, otherwise this vulnerable group will continue to have an unacceptably high death rate and reduced life expectancy. There are several steps that could be taken to address these issues, including programmes to reduce smoking and other substance abuse, promote healthier lifestyles, and developing integrated health services that make diagnosing, treating and managing physical health problems a priority in the overall health care of people with mental illness.