MEETING THE NEEDS OF PEOPLE EXPERIENCING A MENTAL ILLNESS IN GENERAL HEALTH CARE SETTINGS: AN URGENT IMPERATIVE

By

Brenda Happell, Professor of Contemporary Nursing, Department of Health Innovation, Coordinator, Mental and Psychosocial Health, CQU Healthy Communities, Centre for Social Science Research, Faculty of Science, Engineering and Health, Central Queensland University, Bruce Highway, Rockhampton, 4702, Queensland, Australia, Email: b.happell@cqu.edu.au

Abstract:

Rapid changes to the structure and delivery of mental health services in Australia, has increased the prevalence of mental health issues within the general health care system. In response to this, nurses now have more contact with people experiencing mental illness and mental health issues. Unfortunately these broad changes were not accompanied by education and training, and the available evidence suggests that nurses do not view caring for these people in a positive light, largely because they lack the necessary knowledge and skills to do so with confidence. This paper provides an overview of the prevalence of mental illness within the general health care system, with particular emphasis on the relationship between physical health and mental health. The need for nurses to respond to the complex needs of people experiencing mental illness is emphasised.

Keywords: Nursing, General Health Care, Mental illness, Knowledge and skills

Introduction

Mental health services in Victoria, Australia have become integrated within the broader health care system as part of the ‘mainstreaming’ process. Mainstreaming is characterised by a fundamental shift of psychiatric services from psychiatric institutions to general health settings. As a result of mainstreaming it was intended that consumers have increased access to a quality, comprehensive health care service and to reduce the stigmatisation of and discrimination against people experiencing a mental illness (Australian Health Ministers, 1992).

While the philosophy underpinning mainstreaming is widely accepted, concerns have been raised about the extent to which the health system was ready for such a radical change. This new approach to service delivery has brought nurses into contact with people experiencing mental health problems more often than previously (Sharrock & Happell, 2000). It is therefore of concern to note that nurses tend to lack knowledge and expertise when it comes to providing care for these people (Bailey, 1998; Gillette & Bucknell, 1996; Muirhead & Tilley, 1995; Sharrock & Happell, 2000).
It has been argued that physical needs take priority over psychosocial needs within the general hospital system (Gillette & Bucknell, 1996; Swan & McVicar, 1990; Whitehead & Mayou, 1989) as reflected in the following statement: “basic human skills are seriously lacking in the nursing workforce today, at least in many acute settings” (Armstrong, 2000, p. 27). While the reasons for this lack of skill are undoubtedly complex, inadequate psychiatric nursing content in comprehensive undergraduate courses has been identified as a causative factor (Happell, 1998; Wynaden et al., 2000).

Community awareness of the high prevalence of mental illness is increasing become known. However, the prevalence increases substantially within the general health care system. Consequently the Australian literature has identified an urgent need for services to be more responsive to mental health related issues within general hospitals (Mott & Kingsley, 1999; Sharrock & Happell, 2000), parentcraft hospitals (McMahon, et al., 2001), nursing homes (Arie, 2001; Snowdon, 2001), for children and adolescents (Birleson, Sawyer & Storm, 2000).

Those people diagnosed with a mental illness are likely to receive a lesser standard of care within the general health care system. They are likely to be subjected to stigma and discrimination (Sharrock & Happell, 2000). Often labelled as “difficult”, patients diagnosed with mental illness are more likely to be neglected or abused (Bridges-Parlet, Knoeman & Thompson, 1994; Mott & Kingsley, 1999). The development of more positive attitudes amongst health professionals, including nurses, is therefore a priority (World Health Organisation, 2001).


A study by Gater et al. (1998) found that “only 40 per cent of the definite [psychiatric] cases has been noted by the medical staff before the screening procedure”. Overall, it appears that for a variety of reasons, mental illness is not recognised or identified. This may be partly overcome through the application of brief screening instruments by nursing staff during patient admission (Booth et al., 1998).

Improving recognition rates would therefore be helpful, however there is no evidence that increased recognition results in a more responsive service. This is partly due to the under acknowledgement, both among lay people and health care staff, of the great extent to which mental illness contributes to precipitating, aggravating and prolonging physical disability and illness (Armstrong, 2000).
As the largest professional group in the health care workforce (Australian Institute of Health and Welfare, 2004), nurses are well positioned to take an active role in improving the standard of care for people experiencing mental illness (Sharrock & Happell, 2000). The development of psychiatric consultation-liaison nursing has proved a valuable resource for both nurses and patients in relation to mental health care (Sharrock & Happell, 2000). However, international data suggests that only a small proportion of people in need (both staff and patients) are recipients of this service (Huyse, et al., 2001).

Mental Illness in the General Population

It is now widely acknowledged in Australia that mental illness affects approximately 20% of the population (Andrews, Hall, Teeson, & Henderson, 1999). When translated to numbers of people, the impact of mental illness becomes more clearly established. A national survey of mental health and well being conducted in the late 1990s estimated that during a 12 month period approximately 1,300,000 adults over 18 years of age have anxiety disorder, 1,042,000 a substance abuse disorder and 779,000 an affective disorder.

These figures become particularly alarming in light of the knowledge that approximately 62 per cent of people with a mental disorder do not access health services as a direct result of their mental health needs (Andrews, Hall, Teeson, & Henderson, 1999). However, they may access services for other reasons meaning that general health care settings provide an opportunity for detection and intervention for clients with a mental illness, who would not otherwise receive treatment. In light of this it is important to explore the relationship between physical illness and mental illness.

Physical illness as an antecedent to mental illness

Major physical disease is one of many factors associated with the incidence, onset and course of mental disorders (World Health Organisation, 2001). Mental illness may arise from maladjustment to adverse experiences of having a physical condition. Diseases of a severely debilitating and life-threatening nature, such as cancer, are understandably traumatic. In the case of AIDS, stigma and discrimination towards the individual affected and his or her family plays a significant role in creating psychological distress (World Health Organisation, 2001).

Most people with AIDS will experience mental illness following the onset of the syndrome (Buhrich & Judd, 1977, as cited in Maude, 1998). One preliminary Australian study (Kelly et al., 1998) of mental illness following HIV diagnosis for a sample of homosexual/bisexual men (n=61) found that 30% presented with a syndrome of posttraumatic stress disorder, which was also associated with initial episodes of major depression.
AIDS patients are at increased risk of disorders range from depression or anxiety and adjustment disorder (Maj, et al., 1994) to cognitive deficits (Starace, et al., 1998). As many as 70 per cent of HIV infected people will be diagnosed with an organic mental disorder such as delirium or dementia; and 25 per cent with major depression (Maude, 1998, p.92). Those diagnosed with HIV are vulnerable to attaining mental illness if maladjustment occurs.

**Mental illness as antecedent to physical illness: risk behaviour as mediator**

Mental illness predisposes individuals to engage in health risk behaviours (Davidson, et al., 2000; Glassman, 1993) such as unsafe sex, physically inactive lifestyle, smoking and bad diet. People experiencing a mental illness are more likely to engage in unprotected sex, have multiple partners and engage in illicit drug use, making them a high risk group for HIV (Stefan & Catalan, 1997). North American data suggests that those with mental illness have increased risk of HIV infection (Maude, 1998), and there is some evidence that this trend is true to Australia's population (Thompson, et al., 1997). For instance, at community mental health clinics in the North-Western Health Care network in Melbourne, those with chronic mental illness were identified as a high risk group for HIV/AIDS and Hepatitis C (Davidson, et al., 2001).

Individuals may engage in health-risk behaviours because they perceive them as a means to cope with or actually treat their mental illness. Patton et al. (1996) report evidence that teenagers with depressive and anxiety symptoms were more likely to smoke, and inferred that smokers, especially female regular smokers saw the behaviour as effective psychological self-treatment.

Recent reviews concur that there is strong evidence of depression and anxiety as risk factors for cardiovascular disease. Hemingway and Marmot (1999), in their review of prospective studies on the aetiology of coronary heart disease, report that four out of the four studies with anxiety as a predictor had positive results. Depression was a significant predictor in all eleven studies reviewed. Notwithstanding publication bias, these overall results are a strong indication that depression and anxiety play an aetiological role in coronary heart disease (Hemingway & Marmot, 1999). Rozanski, Blumenthal & Kaplan (1999) review a number of large scale studies that have established a prospective role of depression and evidence that the severity of cardiovascular disease, according to frequency of cardiac events increases linearly with severity of depression.

**The health consequences of mental illness**

The burden of disease associated with mental illness in Australia is significant, accounting for approximately 13 per cent of the total burden in and approximately 30 per cent of the non-fatal burden (Andrews et al, 1999). Furthermore, mental illness is identified as the leading cause of non-fatal health outcomes (Mathers, et al., 1999). Individuals with a chronic disease are more likely to have a psychiatric disorder than individuals without chronic disease (Wells, Golding & Burman, 1989a; Wells, Golding and Burman, 1989b; Wells, et al., 1991).
Mental Illness and Mortality

A review of mortality rates demonstrates a link between mental illness and poor physical health (Brown, 1997; Davidson et al., 2000; Ruschena, et al., 1998). Physical illness, particularly cardiovascular and respiratory are more likely to cause mortality in people experiencing mental illness (Davidson et al., 2000). Frasure-Smith et al. (1995) identified depression as a predictor of mortality. Among elderly medical inpatients that are acutely ill, depression has been associated with increase mortality in many studies, but for other studies an association was not demonstrated (Shah et al., 2000). Evidence is also mixed where minor depression is used as a predictor, though studies that do show a relationship have been more thorough in sample size and follow-up (Cavanaugh et al., 2001).

It is becoming well established that patients with medical illness have higher rates of mortality when the illness is coupled with major depression, particularly for patients with cardiovascular disease and stroke (Cavanaugh et al., 2001). Recent studies have questioned whether depression is merely an indicator of medical illness severity. Controlling for medical illness severity and age, depression was still a significant predictor of mortality (Cavanaugh et al., 2001; Wulsin, Vaillant & Wells, 1999). In the Cavanaugh et al. (2001) study, controlling for disease severity, even a past history of depression alone was associated with greater odds of death (odds ratio=4.4), and these odds were greater with a current diagnosis of major depressive disorder (odds ratio=7.4).

In response to the question of whether depression increases the likelihood of earlier death, Wulsin et al. (1999) conducted a review of over 50 studies linking depression to early death. Cognisant that the majority of studies demonstrated poor control, depression was associated with substantially increased risk of early death, especially via unnatural causes and cardiovascular disease. As the studies varied considerably in terms of design, sample type and other features, it was difficult for the researchers to specify whether the effect was the direct result of pathophysiology or the more distal consequence of inadequate self-care.

Large community studies involving males, including one sample of around 34,000 men, found a significant association between death though cardiovascular disease and anxiety disorder, with sudden death as the most common occurrence (Rozanski, Blumenthal and Kaplan (1999). More research into anxiety as a risk factor for cardiovascular disease in women is clearly needed.

The relationship between mental illness and mortality is generally under acknowledged because the link between the two is not as obvious as with physical illness. Nevertheless, mental illness may contribute indirectly because of its exacerbation of chronic disability, associated poor health habits such as bad diet, alcohol abuse, smoking and sedentary lifestyle and self harming or at risk behaviours (Davidson, et al., 2000; Glassman, 1993). While it is important to analyse mortality figures, to rely on them solely will lead to a significant underestimation of the non-fatal disease burden, occurring as a direct result of mental illness (Goldney et al., 2000).
Mental Illness and Additional Burden

It is not surprising to find that medical illness and hospitalization are accompanied with a lower level of health and functional status; what is more significant is the additional burden of having a mental illness. In a rare study of additional effects, Booth, et al. (1998) accessed a random sample of 1007 male medical and surgical patients, who were administered a computer version of the psychiatric diagnostic interview. All three psychiatric disorder groups—mood, anxiety and substance abuse—reported lower functioning than patients without a psychiatric disorder. Booth et al. (1998) concluded “it is clear...that apparent co-occurring psychiatric disorders, particularly mood and anxiety disorders, are associated with excess impairment and lower health-related functional status over and above what is contributed by the medical illness itself.” (p.1558).

Nonclinical mental illness

Mental ill health (eg. high stress) not severe enough to be classified as a disorder is enough to influence physical health progress and outcomes. It is generally established in the literature that there is a link between psychosocial factors (eg. low perceived emotional support, denial/repression coping) and the development and progression of severe chronic diseases (eg. coronary heart disease, HIV/AIDS and cancer) (Baum & Poslusny, 1999). The underlying mechanisms common to immunological functioning and psychosocial stress that impact on physical health, are in the process of being unravelled (Kiecolt-Glaser & Glaser, 1995; Rozanski, Blumenthal & Kaplan, 1999). At the same time, a number of psychosocial interventions have shown to be efficacious towards improving patients’ physical health (Schneiderman et al., 2001; Sobel, 1995). For instance, in the case of breast cancer, cognitive-behavioral stress management can modulate neuroendocrine levels (eg. cortisol) and immune system functions (Schedlowski et al., 1994). However, according to their meta-analysis of 59 studies on psychological intervention effects on immune functioning, Miller and Cohen (2001) report the overall results are inconclusive, and modest at best.

Stress has been implicated in increased illness behaviour, and may play a role in increasing risk of infection and reactivation of infectious disease (Baum & Poslusny, 1999; Cohen & Williamson, 1991; Rozanski, Blumenthal & Kaplan, 1999). The social environment may impact negatively or positively on neuroendocrine regulation, contributing to the risk for hypertension or cardiovascular disease (Seeman & McEwen, 1996). Evidence for the role of stress in the onset of cancer is poor (Edelman & Kidman, 1997), while psychosocial intervention success for people with cancer is mixed (Fawzy, 1999).
The theoretical link between mental and physical illness has been a multidisciplinary research effort, uniting fields such as behavioural medicine, health psychology, and psycho-immunology. The high incidence of co-morbidity between physical and mental disorders suggests the two are causally related. The paths between mental illness and physical illness are multiple and bi-directional, and their details are beyond the scope of this paper. Suffice to say, that biopsychosocial models of health and illness are rising in acceptance among health carers and researchers (Milgrom & Burrows, 2001). Theoretical considerations aside, it is clear that having a co-occurring mental illness compounds the physical problems faced by patients. The prevention of development of mental disorders and their treatment in general care settings may be critical to the progress of recovery from physical impairment and disease.

**Nurses and mental health issues**

In a survey of undergraduate students’ perceptions towards mental health nursing, Wynaden et al. (2000) found that the students generally considered themselves insufficiently prepared to work with people experiencing a mental illness, despite some exposure to the theory and practice of mental health nursing. Interestingly, this particular nursing educational program allocated greater content to mental health nursing than many similar programs in Australia.

General nurses have expressed a lack of enjoyment in caring for patients with eating disorders, schizophrenia and those who committed deliberate self-harm as the result of a mental health problem (Fleming & Szmukler, 1992). Emergency nurses are not clear whether their role should include care for patients with mental health problems (Gillette, et al., 1996). Nurses have come to avoid patients experiencing mental health problems because of feelings of fear and powerlessness and the acknowledgement that attending to these patients is more time consuming (Gillette, et al., 1996).

There is no doubt that many nurses, qualified or otherwise, have provided the highest quality mental health care for many patients, and that these efforts are not recognised and acknowledged. However, these studies strongly suggest that there are often cases where nurses take a reactive approach rather than a proactive one, and that their negative attitudes are a substance of fear and appraisals of lack of mental health care skills and less enjoyment. The greatest opportunity to change this situation is by fostering an understanding of mental illness before nurses enter the health workforce.

**The potential mental health care role of nurses.**

By virtue of their numbers and the closer and more frequent contact they have with patients, nurses can have an important role in detecting (or at least suspecting) the presence of mental illness. Nurses may implement brief screening instruments for newly admitted patients. Such instruments are available, particularly for major depression and alcohol problems (Booth, et al., 1998). Empirically based assessment tools for identifying patients with a mental illness or patients who are vulnerable to a mental illness would contribute greatly to attending to patient needs and establishing a more accurate picture of true prevalence rates of psychiatric co-morbidity.
Such tools are being developed by Huyse et al. (2001) to detect patients with complex care needs. Research conducted by Silverstone (1996) suggests that nurses were more competent than medical staff at identifying patients who had received a DSM-IV diagnosis. Nurses recognised 61 per cent of cases as compared to 41 per cent by medical staff.

As stated above, detection alone is not sufficient (Gray, et al., 1999; Nisenson, et al., 1998; Rost et al., 1998). With adequate training, nurses may also contribute to the assessment and treatment of social health and emotional functioning (Mann, et al., 1998), as part of an interdisciplinary team, and especially in cases where consultation-liaison services are in short supply (Booth et al., 1998) or require support (Huyse et al., 2001).

The development of nurses in mental health care should unfold in close collaboration with other health care staff. To create greater syncronicity between mental and physical health care is a general goal in the global effort to provide a more responsive health care system for people experiencing a mental illness (World Health Organisation, 2001).

Nurses, because they have most contact with patients, are also the main source of encouragement for proper self care and physical activity. Emphasis on physical activity is of particular importance, given evidence that physical activity appears to lower levels of depression and anxiety (Paluska & Schwenk, 2000).

Nurses can play a pivotal role in implementing psycho-social interventions which can significantly improve health outcomes. Interventions targeted at empowering individuals to proactively and flexibly adapt to disease have the promise of improving overall health perceptions and health outcomes (Sobel, 1995). Sobel (1995) argues that patients should be encouraged and educated to be proactive in managing their health and that psychosocial interventions are efficacious in meeting this goal. Sobel (1995) cites a behavioural medicine intervention study at the Harvard Community Health Plan (Hellman et al., 1990) where education and practice at mental self-care was found to reduce reported physical symptoms and psychological distress, as well as health care use. In contrast the control group, which only received information on stress management, did not report improved outcomes.

With adequate training, generalist nurses can provide effective treatment for some psychiatric disorders such as postnatal depression (Gerrard et al., 1993). Brief psychiatric services have not been found to be consistently effective, probably as a result of the very short duration of the intervention (Booth et al., 1998). Nevertheless, patients with a chronic medical illness have had better outcomes following psychosocial interventions (Levenson, 1992). Guthrie (1996) reviewed trials of psychological therapies in helping patients with chronic somatic illness. Guthrie (1996) concluded that the current therapies were not effective for all physical illnesses, but the majority of patients with somatic illness did respond well to brief psychotherapy.
Mental health treatment for medical outpatients appears to offset medical costs, according to a meta-analysis of 58 controlled studies performed by Mumford et al. (1984). These findings provide support for the utility of mental health treatment for helping individuals deal with the stress of suffering a physical disease and maintaining adherence to treatment, particularly among older people, who are in greater need of these supports.

Linden, Stossel and Maurice (1996) conducted a meta-analysis utilising randomised control studies on the additional value of psychosocial treatment for patients in rehabilitation from coronary artery disease. Compared with patients who did not receive psychosocial treatment, the treatment patients showed lower mortality, morbidity and psychological distress. The effects were most pronounced during the first two years and decreased over extended periods.

Psychological and psychiatric interventions are difficult to conduct methodologically and large samples are needed to adequately assess mortality outcomes (Clarke, 1998). Nevertheless, there is growing evidence that psychosocial and psychiatric interventions are effective.

**Conclusions**

Contemporary society has a responsibility to provide a high standard of health care to all individuals regardless of their diagnosis. Indeed given the facts and figures discussed in this paper, people with mental illness have a right to thorough assessment, and access to more appropriate treatments, including both medical and psychosocial interventions (Booth et al., 1998).

Attending to patients’ mental health needs is not just a matter of duty of care and promoting wellbeing; the research reviewed herein provides substantial evidence that mental illness has a significant adverse influence on the course and outcomes of physical illness, including increased mortality. Higher rates of mental illness in hospital patients may be largely explained by biopsychosocial perspectives. However, regardless of whether one endorses biopsychosocial models of illness, the strong association between mental illness and physical illness has practical implications. Lowering mental illness rates is likely to translate into better physical health outcomes.

As mental illness is common within general health care, psychological intervention is a key priority for improvement (Wynaden et al., 2000), particularly as it is likely that co-morbid physical and mental illness is likely to increase in response to the ageing population. Nurses in all areas of the health care system need adequate mental health knowledge and skills in order to respond to the needs of these clients.

It is not within the scope of this paper to argue whether this should happen through increasing the psychiatric nursing component of undergraduate courses, or the introduction of training for the existing nursing workforce. The impact of both options needs to be explored in detail. However, nurses have an important role within mental health by broadening the scope of care, contributing to consumers’ empowerment, reducing the levels of stigma and discrimination in the hospital setting and engaging in simultaneous assessment to increase detection rates.
References


