Equally Well

Take action to improve physical health outcomes for New Zealanders who experience mental illness and/or addiction

A consensus position paper

This consensus position paper is based on the findings of an evidence review undertaken by Te Pou (2014)[1] and has been written in consultation with representatives from the following organisations:

Matua Raki Consumer Leadership Group
New Zealand Medical Association
New Zealand Nurses Organisation
Nga Hau e Wha National Service User Group
Platform Trust
Royal Australian and New Zealand College of Psychiatrists
Te Ao Māramatanga New Zealand College of Mental Health Nurses Inc
Te Pou

[1]Te Pou o Te Whakaaro Nui. 2014. *The physical health of people with a serious mental illness* and/or *addiction: An evidence review.* Auckland: Te Pou.

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Introduction

People experiencing challenges with mental health and/or drug and alcohol use also often experience physical health problems. The associations between mental illness and/or addiction and relatively poor physical health outcomes have been well-established over many decades. However, these issues and the people who experience them have not yet been formally acknowledged as a priority.

Platform[1] and Te Pou[2] have been working together over the past year to develop **Equally Well**, an informed, collaborative response to this challenge. **Equally Well** aims to draw on expertise and knowledge across the health and related sectors to translate the available evidence into action.

The first phase of **Equally Well** was a call for New Zealand evidence and a review of published research from here and overseas to understand the physical health issues, contributing factors to poor health, and effective interventions. This review has brought together overseas and national data on the extent of the issue here, and what local services are doing to address it.

Equally Well now calls for a concerted and sustained effort by all those who can effect change including policy makers, academics, and the whole health workforce particularly primary care and mental health and addiction treatment services in partnership with the people who experience these challenges. Together we seek to make the necessary changes at policy, service delivery and individual levels[3].

This consensus position paper is supported by organisations and representative bodies committed to working together to influence change in order to support better physical health outcomes for people affected. The signatories to this paper recognise there is an urgent need for coordinated action that will contribute to improved life expectancy and physical health. The driving principles of the **Equally Well** collaboration are that people who experience mental illness and/or addiction need:

- To be identified as a priority group at a national policy level based on significant health risks and relatively poor physical health outcomes
- To have access to the same quality of care and treatment for physical illnesses as everybody else, and in particular to have a right to assessment, screening and monitoring for physical illnesses
- To be offered support to make the connection to how they are affected physically and guidance on personal goals and changes to enhance their physical wellbeing.

We acknowledge Te Tiriti o Waitangi as the founding document of Aotearoa/New Zealand, and the rights of all New Zealanders to reach their full health potential.[4]

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[1] (www.platform.org.nz) The peak body for mental health and addictions non-government organisations

[2] (www.tepou.co.nz) A national mental health workforce development centre which incorporates Matua Raki, national addictions workforce development centre

[3] The definition used in the evidence review of 'people who experience serious mental illness and/or addiction' includes those who have been diagnosed with schizophrenia, major depressive disorder, bipolar disorder, schizoaffective disorder and/or addiction with the primary focus on alcohol, cannabis and methamphetamine addiction. However, it is likely that many people with other mental health conditions and/or addiction face similar challenges.

[4] In accordance with Te Tiriti o Waitangi principles, Aotearoa and New Zealand are used interchangeably in this document.

Evidence review findings: mortality and morbidity

The situation in New Zealand is very similar to other relatively wealthy countries. People who experience serious mental illness and/or addiction die much earlier than their counterparts in the general population, with a two to three times greater risk of premature death.[5] [6] Two-thirds of this premature mortality is due to cardiovascular disease, cancer, and other physical illnesses.

Māori who experience mental illness and/or addiction have a higher mortality rate than Māori in the general population (one-third greater) [1].

This group also have significantly higher rates of physical illnesses including metabolic syndrome[7], viral and oral health diseases, respiratory diseases, diabetes and cardiovascular disease [2,3,4,10]. A significant association has been found between anti-psychotic use and risk of diabetes [5]. The evidence is mixed regarding the prevalence of cancer; what is clear is that the outcomes for this group are much worse, indicating that timely access to diagnosis and effective treatment is problematic [1,5].

Alcohol use is causally related to more than 60 different medical conditions including gastrointestinal and liver diseases, central nervous system effects, a range of cancers, coronary heart disease and sexually transmitted diseases [23]. It is estimated that a quarter of alcohol-related deaths in New Zealand are due to cancer and a further quarter to other chronic diseases. Alcohol-related deaths for Māori are over four times the rate of non-Māori [22].

The physical health effects of illicit substance use vary according to the specific substance, method, frequency and level of use. For example, intravenous drug use has a number of health risks including transmission of blood-borne viruses [23]; methamphetamine addiction is linked to oral health disease, heart disease, and cerebrovascular complications [25,26]. The most probable effects of chronic cannabis use are bronchitis and impaired respiratory function, respiratory cancers and cardiovascular disease [23,28]. High rates of hepatitis C have been found among people who inject substances including those in opioid treatment [29].

There are notable gaps in research relating to, for example, Māori and Pacific populations as well as people with a dual diagnosis of mental illness and intellectual disability, and people with a dual diagnosis of substance use and mental illness.[8]

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[5] Premature death is defined as dying before the age of 65.

[6] These data include people with a primary diagnosis of substance use who had premature mortality rates over two and a half times that of the population as a whole

[7] **Metabolic syndrome** is a disorder of energy utilization and storage, diagnosed by a co-occurrence of three out of five of the following medical conditions: abdominal (central) obesity, elevated blood pressure, elevated fasting plasma glucose, high serum triglycerides, and low high-density cholesterol (HDL) levels.

[8] Although there is a growing evidence base for responding to co-existing mental illness and addiction, much of the research tends to focus on either one or the other. We acknowledge the work going on at a service delivery level to better meet the treatment needs of people with co-existing problems [31].

Evidence review findings: factors contributing to the disparity

The links between socio-economic status and mental health have been widely reported both in terms of the effects of socio-economic status on mental health and vice-versa. **Mental illness and/or addiction can further compound the disadvantages associated with low socio-economic status**, for example, through increased exposure to risk factors [24].

The socio-economic consequences associated with mental illness and/or addiction can have a serious impact on the physical health of people affected. Consequences include restricted access to employment, social stigma and isolation, poverty and poor housing [7]. However socio-economic status does not fully explain the disparities in health status or outcomes [6].

People who experience mental illness and/or addiction have a greater exposure to risk factors associated with physical illnesses such as tobacco smoking, poor nutrition, reduced physical activity, and higher levels of alcohol use [3].

'Within group' variations have also been identified such as high levels of alcohol abstinence as well as alcohol dependence. Therefore, there is a need to avoid generalisations and stereotyping [3,4].

Smoking prevalence for people who experience mental illness has been estimated at 40-50 per cent, three times the general population rate [2,3] with many people also being heavy smokers [8,9,10]. There is also evidence that many are trying to quit and/or would like help to quit and can be effectively supported with no detrimental impact to their mental health [10,11,12].

Recent systematic reviews have identified a **negative impact of psychotropic medications on physical health** due to their contribution to obesity, cardiovascular disease, poor oral health, and type II diabetes [8].

Access to healthcare can be problematic for people with serious mental illness and/or addiction, due to stigma and discrimination, financial constraints, and practical issues such as lack of transport [14]. Stigma and discrimination by health professionals has been identified as a key barrier in accessing adequate healthcare for people who have an addiction to an illicit substance [29]. Systemic issues such as the physical separation of physical and mental health and addiction services are also barriers to access.

There is a lack of clarity over health professional roles and responsibilities for the physical health needs of people who experience mental illness and/or addiction. This appears to be contributing to the disparity [15] as well as to inconsistent assessment, monitoring and documentation of physical health status.

There is a growing body of research examining the quality of health care received by people who experience mental illness and/or addiction with stigma and discrimination being a key factor along with diagnostic overshadowing. The quality of medical care received can be compromised, particularly in relation to general medicine and cardiovascular care, but also for cancer and diabetes care [6,13,16].

Evidence review findings: promising interventions

There is an emerging body of literature on effective strategies and interventions for improving the physical health of this group. Interventions need to occur at the level of the individual and at a systemic level, with a core aim to reduce exposure to known risk factors as well as the impact of psychotropic medications.

Systems level changes

It is clear that people who experience mental illness and/or addiction should be **identified at a national policy level as a 'priority' health group** across the whole health system, who require specialised and properly-resourced interventions in relation to their physical health [16].

Policies that can reduce health inequalities amongst groups most affected by social exclusion, vulnerability, and disadvantage should be drawn on to improve physical health outcomes for this group. These include addressing the *'causes of the causes, i.e. the conditions in which people are born, grow, live, work and age and inequities in power, money and resources that give rise to them'* [17]. Universal approaches to public health need to be tailored to people at a level and intensity proportionate to need. It is important to avoid focusing on the individual attributes and behaviours of people who are socially excluded [17].

Changes are needed in the way health care services are structured and funded to improve integration between mental health, addiction and physical health care services, particularly in developing shared care arrangements between primary and secondary care. Methods of integration should be adapted to local needs and capacities [18] and can include:

- all relevant parties endorsing the need for linked services at a senior level, and supporting this at all levels of the service
- planning and accountability at both local and regional levels e.g. through PHOs and DHBs
- ensuring people who experience mental illness and/or addiction are at the centre of care, around which services collaborate
- promoting models of clinical collaboration such as practice nurse or GP liaison with psychiatric services, or vice-versa with psychiatry liaison into primary care
- identifying and responding to the training needs of all health professionals regarding the physical health care of people who experience mental illness and/or addiction [19].

Clinical guidelines are needed to clearly identify roles and responsibilities of all health professionals in relation to the monitoring and ongoing management of the physical health care of people who experience mental health problems and/or addiction.

Reducing exposure to risk factors

Personal interventions

Identifying and making changes can be supported by combinations of personalised support for smoking cessation, increasing physical activity, nutrition, and general wellbeing. Those based on good evidence, which are service-user directed and work towards achieving long-term sustainable lifestyle changes, have been shown to be successful at a personal and small group level [20,21]. However no simple or single approach has demonstrated long-term effectiveness. Findings from evaluations of diet and exercise programmes indicate that the following characteristics are likely to facilitate greater success:

- Build on existing therapeutic alliance
- Incorporate both cognitive and behavioural strategies
- Combine exercise, dietary counselling and health promotion
- Specific, realistic and measurable goals identified by the person seeking change and supported by the therapeutic alliance
- Are flexible in accommodating individual needs and differences and are culturally appropriate
- Are long-term and provide ongoing support beyond the initial intervention
- Include support through participation in a group and/or social component
- Acknowledge and address wherever possible the barriers faced by people participating in such programmes
- Have an active peer support component alongside health professional support [20, 21].

Conclusion

Addressing the inequalities that lead to and arise from mental illnesses and addiction is a key part of a sustainable health strategy; it is also a key part of the work of healthcare professionals in primary and secondary care, and of colleagues in other professions such as public health and government [24].

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