To the Senate Select Committee on Mental Health

Sent: Wednesday, 27 April 2005 6:52 PM

To: Committee, Mental Health (SEN)

Subject: Physical Health of the Mentally Ill

To the Senate Select Committee on Mental Health

Topic

The General Physical Health of people suffering from a mental Illness.

The two aspects of this topic which I would like to address are

1.The Smoking Habit

2.The Iatrogenic General Health Factors

1. At a time when great emphasis is being given to the deleterious effects of smoking in society in general it seems a great and tragic anomaly that so many sufferers from mental illnesses take up smoking in, of all places, the hospital to which they are admitted.

Many justifications are given for this factor such as

a.. smoking seems to provide some relief for those who are distressed
b.. smoking provides a socialising experience for those who are afflicted
c.. there are already many programmes in the psychiatric scene that seek to encourage people to stop smoking.

It would seem a simple solution to at least part of this problem to segregate the smokers from the non- smokers at the first admission. There must surely be many sufferers (as well as members of my own family) who did not smoke before they were first admitted to a psychiatric hospital.

If this affect were noticed in any other health department there would be an immediate and strong outcry. The people afflicted with a mental illness are at their most vulnerable and indeed are not well enough to resist the invitation to smoke when hospitalise which is usually at a time of crisis . Those who are ill are unable to find a way out of this addiction which seriously affects their general health and further isolates them from mainstream society.

The cost of cigarettes would seem prohibitive to those who exist on a Disability Support Pension but they seem nevertheless to be so addicted that they are unable to quit. Surely anti-smoking programmes should be given a higher priority.

2.Iatrogenic Illnessess

While Sufferers must receive some relief from the many and varied medications that are used to relieve the symptom of these illnesses the medications are still just used to control symptoms. A cure for Schizophrenia for example, has not been found so the side effects from these medications need to be addressed more rigorously.

For Example -at a time when there is a strong awareness to tackle the obesity problem in the general community it is ironic that many mentally ill people are powerless to keep their weight in check because of the effect of the medications.

As a step toward ameliorating the condition could patients be rigorously monitored by additional medical staff especially trained to check their physical health ?There is a great need for additional staff to be provided for this purpose.

Also Psychiatric staff should be encouraged to confront the horrendous side effects of the medications and to understand that people are sometimes extremely disabled and may even die as a result of the treatments. (I have personal experience here)

Medically trained people are usually associated with promoting health but in the case of the mentally ill the treatments actually cause physical disease.

If the general health of the mentally ill were improved some of these people would be able to contribute to a greater degree to society in general, particularly those who already have qualifications. A cessation of smoking and better health would provide a community resource which is at present being wasted.

I would like to refer to some articles that address these concerns.

1.The Physical Health Check: A tool for mental health workers.

Journal of Mental Health, June 2004:13(3):277-284

This article begins with the statement –"The strong relationship between severe mental illness and poor physical health is well established" This is followed with a description of measures which may be taken to check physical health of the mentally ill.The Physical Health Check described would be a start in improving the poor health of those who are medicated".

2. "Lambert TJR. Velakoulis D. Pantelis C. Medical comorbidity in schizophrenia. MJA 2003; 178: S67-S70. 8Copyright 2003. The Medical Journal of Australia - reproduced with permission".

"Abstract

§ Schizophrenia has been described as a "life-shortening disease", and physical comorbidity accounts for 60% of premature deaths not related to suicide.

§ People with schizophrenia and other mental illnesses have a higher rate of preventable risk factors such as smoking, high alcohol consumption, poor diet, and lack of exercise.

§ Recognition and management of morbidity in people with mental illness are made more difficult by barriers related to the patient, the illness, the attitudes of medical practitioners, and the structure of healthcare delivery services.

§ Improved detection and treatment of medical illness in people with schizophrenia will have significant benefits for their psychosocial functioning and overall quality of life."

"3: What should be done?

Collection of a standard checklist and core information data concerning physical health should be routine.39

Psychiatric services should be adequately equipped to carry out basic physical medicine tasks.40

Refresher training should be regularly provided for psychiatrists and key members of multidisciplinary community psychiatric teams. This could encompass elements of detection, management and preventive counselling.

Specific interdisciplinary teams with broad medical and psychiatric expertise and training should be created. These could serve in enhanced models of shared care.

Formalised programs to address training and other issues should be set up at a state or regional level. These could be modelled on, for example, the MH-OAT program in New South Wales,41 or the educational tools being developed by the Alliance of NSW Divisions of General Practice in collaboration with NSW Health."

3. "Castle DJ. Pantelis C. Comprehensive care for people with schizophrenia living in the community. MJA2003;178: S45 –S46& Copyright 2003

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" In Australia there continue to be significant barriers to care and gaps in service provision for people with schizophrenia. The extent of these shortcomings is echoed in the National Survey of Mental Health and Wellbeing study on low-prevalence (psychotic) disorders.1 Of the 998 people with psychotic disorders surveyed, 84% were single, separated, divorced or widowed; 85% were reliant on welfare benefits; 72% did not have a regular occupation; and 45% were living in some form of hostel or supported accommodation, or were homeless. These unacceptable psychosocial outcomes were evident despite the fact that 91% of the people surveyed were currently receiving psychotropic medication. Furthermore, only 19% of patients had used any form of rehabilitation service over the previous year. It was not that they did not want to access such services; indeed, 47% of the survey cohort perceived the need for a particular type of service that was not accessible to them, either because it was unavailable or they could not afford it.

The service provider with whom the majority of survey respondents did have regular contact was their general practitioner: 81% had seen their GP in the previous year, and the average number of visits was 12 per year.1 Clearly, not all of these contacts were for mental health reasons, but the extent and regularity of

contact with GPs by people with schizophrenia highlights the potentially crucial role GPs can play in their overall health. GPs are likely to have increasing involvement with managing medical comorbidity in patients with schizophrenia, especially now that newer "atypical" antipsychotic drugs are available. Thus, this Supplement, highlighting the latest developments in managing schizophrenia and delivering comprehensive care, is particularly relevant for GPs.

Hocking (page 47)2 underlines the place of the community in schizophrenia management — highly pertinent in these "post-institutionalisation" days, when the vast majority of people with schizophrenia are resident in the community. It is important that GPs understand the functioning of the modern mental healthcare system, know what resources are available to assist in managing patients with schizophrenia, and have the information required to negotiate potential barriers to accessing support services. These issues are detailed by Harvey and Fielding (page 49).3 A model for GP participation in managing people with schizophrenia is outlined by Meadows (page 53),4 in the hope that the principles can be adapted more broadly.

There have been substantial recent developments in pharmacological treatments for schizophrenia. No longer are treatments for psychosis inevitably associated with unpleasant and potentially debilitating extrapyramidal side effects such as parkinsonism, akathisia and tardive dyskinesia. The newer "atypical" antipsychotics are much less likely to have these disabling side effects, and are now first-line treatment for schizophrenia. However, the atypicals have been associated with other medical problems, including weight gain,5 diabetes6 and hyperlipidaemia.7 The decision about which drug to use for any individual patient requires a careful weighing of the side effects against potential therapeutic effects. An overview of the atypical antipsychotics is provided by Lambert and Castle (page 57).8 Despite pharmacological advances, some patients remain "resistant" to conventional treatments. However, we are increasingly able to offer such patients newer treatments that more effectively reduce psychotic symptoms and enhance quality of life. Indeed, the newer agents can have benefits in a number of domains, including those of behaviour, depressive and suicidal thoughts, and cognitive functioning, as well as improving social and vocational outcomes. The management of "treatment resistance" in schizophrenia is reviewed by Pantelis and Lambert (page 62).9

The physical health of people with schizophrenia is often suboptimal, and general medical conditions may either be missed, through inadequate screening, or treated suboptimally. The GP has a crucial role to play here. Lambert et al (page 67)10 outline the main medical problems encountered in people with schizophrenia and the barriers to detection and treatment. Many of the interventions

for general medical conditions such as obesity and hypertension require educating the patient about "healthy living", including regular exercise, attention to diet, and stopping smoking.

A common problem among people with schizophrenia is the misuse of alcohol and illicit substances. Substance misuse impairs the overall health of the individual, resulting in more severe symptoms, greater chance of relapse and re-hospitalisation and, in some instances, increased risk of crime and violence. Again, the GP has an important role to play in detection and management of comorbid substance misuse. Lubman and Sundram (page 71)11 provide practical guidance for GPs in dealing with this complex issue.

Finally, Crosse (page 76)12 suggests ways in which people with schizophrenia can be helped to participate fully in society so that each day is full and meaningful. This should be the aim of all of us involved in the care of people with schizophrenia.

References

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I am able to outline in more detail and in private, family experiences which corroborate these points.

Yours, Faithfully,