

Development and policy

Health inequalities

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It's frightening. Dying 9 years younger because you have schizophrenia? That's what they found in the USA,^{1,2} but could the same be the case here? We know that, if you have a serious mental health problem, you are twice as likely to die early.³ Even when deaths from unnatural causes such as suicide are taken into account, the mortality rate for people with serious mental health problems still remains significantly higher.

Some of this is related to the greater prevalence of smoking-related fatal disease among people with schizophrenia, including an increased risk of arteriosclerosis and sudden cardiac death.^{4,5} Diabetes, too, is more common among people with schizophrenia.⁶ And the links between depression and physical illness are becoming increasingly well known: having depression as well as a physical illness worsens the prognosis of both.⁷⁻¹⁰

The seriousness of the problems prompted the Disability Rights Commission to launch an investigation into the health inequalities experienced by both people with mental health problems and people with learning disabilities. The focus of the investigation is on primary healthcare services in England and Wales. It is very much a collaborative exercise which involves people with mental health problems themselves, MIND, Rethink, the Royal College of General Practitioners, British Medical Association, Royal College of Nursing, Department of Health and many others. The aim is to understand the causes of the inequalities, the extent to which recent initiatives have or have not helped to address the problems, what remains to be done, and how measures can be effectively implemented to prevent unnecessary ill-health or death. The evidence-gathering phases have now been completed and a final report will be produced in the autumn.

The evidence confirms and adds to what is already known. New analysis of the records of 1.7 million primary care patients from 242 practices in England

and Wales shows that, among people with schizophrenia or bipolar disorder:

- diabetes is 2.4 times more common, stroke 1.8 times, heart disease 1.6 times, and hypertension 1.3 times
- obesity is also more common: 33% of people with schizophrenia and 30% of people with bipolar disorder are obese, compared with 21% of the remaining population.¹¹

There are many potential causes of poor health among people with mental health problems. Firstly, there is a link with poverty. Mental health problems are more common among people who are unemployed or have a low standard of living.¹² The White Paper *Saving Lives: our healthier nation* recognised that being worse off financially is associated with higher rates of mental health problems.¹³ And we know that poor people generally experience poor health.¹⁴

Lifestyle, poor diet and lack of exercise contribute to ill-health, and potentially lead to avoidable death: they are particularly related to higher rates of diabetes and cardiovascular disease.¹⁵⁻¹⁸ Our own analysis found that 61% of people with schizophrenia and 46% of people with bipolar disorder smoke, compared with 33% of the remaining population.¹¹

Accessing health care can be a major problem. Some people don't have a general practitioner (GP).¹⁹ They may have been struck off and have experienced problems finding another GP.²⁰⁻²² One person told us:²³

'I have been removed from GPs' lists as "too demanding" and told off the record my needs are too expensive.'

Another said:

'I was removed from the panel because I made a complaint about inaccurate records and neglect.'

Permanent registration is particularly difficult for refugees, asylum seekers and homeless people.²⁴

Experiences of primary health care are very variable. Many people speak highly of the services they have received, but others have referred to inappropriate stereotypes, negative attitudes and detrimental assumptions about a person's quality of life.^{16,19,25,26} While these attitudes may not always be associated with poorer outcomes, they do affect the extent to which expressed concerns are treated seriously or dismissed, symptoms are explored, and opportunities to carry out screening or medicine reviews are taken up or missed. We were told:

'Discriminatory and intimidatory language like "nutter", "weirdo" and sneering can put you off. What type of healthcare will you get from someone who does not like the mentally ill?'

The problems start when people first make contact with a surgery: rude, hostile or discriminatory treatment, receptionists preventing access to GPs, a lack of understanding and awareness of their mental health problem, and inflexible arrangements with appointments.

'Complete lack of understanding from most of the GP's receptionists.'

'Receptionists often say that you need to call back and be persistent to get an appointment to see your GP of choice. This is very difficult to do if you are depressed.'

Once in the consulting room, further problems arise. One of the most common is diagnostic overshadowing, whereby physical health problems are wrongly attributed to the mental health condition:

'The doctor just assumes that everything is psychological. If he can't find a reason for it with just talking to me, then it can't be a real illness.'

'My GP seems to think that everything I go to him for is related to my mental health impairment, so much so that he first told me a lump I found was not there until I pushed for a second opinion, whereby a tumour the size of an orange was found.'

'A few years ago I vomited daily for 10 months and this wasn't investigated as it was put down to anxiety.'

Negative attitudes and a lack of serious attention to problems mean that people may well be put off from contacting a doctor when they need to:

'She makes me feel I am doing wrong by not being well enough to work, and from many of her comments to me she does not believe I am telling the truth. Because of this undermining attitude I

very rarely feel able to go to my GP even if I am very unwell.'

'It has got to the stage where I avoid the doctor when I am ill as there seems no point.'

This is compounded for people who have been sectioned and for whom any contact with a GP can evoke the fear of this happening again.

It has to be stressed that in our investigation we also found many instances of people being highly complimentary of the support and understanding of healthcare staff. But the wide existence of poor experiences indicates that there are still many problems to be overcome.

The types of health problems that people experience mean there is a key role for health promotion. Earlier research has indicated that such support, in the form of smoking cessation, blood pressure checks or prescriptions for leisure, is often lacking.^{16,27-29} In our work, we have found some signs that practice may be improving. More people with serious mental health problems who smoked, for instance, had been recorded as receiving smoking advice (65%), and more had been prescribed smoking cessation medication (9.6%) compared to smokers in the remaining population (5.9% and 7.6% respectively).¹¹ It may be that GPs are taking advantage of higher consultation rates to mention smoking cessation, but the quality of advice and support may be limited. Also, low incomes mean that many people with mental health problems will receive free prescriptions, rather than having to pay for medication at a pharmacy. At first sight, though, the results are encouraging,

Encouraging, too, are the findings that people with serious mental health problems have a higher rate of blood pressure recording over the past five years, compared with the remaining population; and a larger proportion of people with schizophrenia had a normal blood pressure reading.

Other findings, though, are of more concern:

- fewer people with schizophrenia and ischaemic heart disease (IHD) had had a blood pressure reading in the last 15 months, compared with the remaining population with IHD
- fewer patients with schizophrenia and IHD had had a recent cholesterol test, compared with the remaining population
- fewer stroke patients with schizophrenia had had a cholesterol test in the last 15 months
- fewer stroke patients with schizophrenia were on aspirin (whether prescribed or over the counter), compared with other stroke patients
- only 63% of eligible women with schizophrenia had had a cervical smear in the previous five

years, compared to 73% in the remaining population.

People have repeatedly told us about the side-effects of psychotropic medication. Adverse interactions between general medical and psychotropic drugs have already been recorded.³⁰ So too has the association between psychotropic drugs and higher mortality. A number of psychotropic drugs, for instance, have a well demonstrated risk of cardiotoxicity.^{5,31,32} Combined with co-existent mild heart disease, the effects can be serious.³³ The use of neuroleptic drugs has been linked to premature death.³⁴ Patients on antidepressant treatment are at risk of drug interactions and adverse effects, and antidepressant treatment is a statistically significant predictor for increased mortality in older people.^{35,36}

But there is a danger in focusing only on mortality. Many other side-effects have a detrimental effect on people's health: weight gain is well established and much researched, but others include: cardiovascular disease; hypotension; impaired glucose tolerance; and increased prolactin levels (associated with decreased bone mineral density, infertility and amenorrhea).³⁷ National Institute for Clinical Excellence (NICE) guidance on schizophrenia states that GPs should discuss the benefits and side-effects of medication before it is prescribed.³⁸ PRIMHE (Primary Care Mental Health and Education) endorses the practice of monitoring side-effects such as weight gain and the provision of advice to combat them. Where the side-effects are unacceptable, some GPs consider a change in the type or quantity of medication or the times at which it is taken. Patients may wish to strike a balance between the impacts on their mental and physical health. Information leaflets are available advising that they speak to their doctor, community psychiatric nurse (CPN) or pharmacist, or seek support from an advocacy or user group. Medication review is particularly important for older people, who are more likely to be taking more medicines and be more sensitive to their effects.

In practice, however, side-effects and their management can leave a lot to be desired:

'My GP is very good in the way of listening, but like most GPs does not warn patients of side-effects if put onto new drugs, has lots of literature on diabetes, stroke, heart problems but nothing in relation to mental health or neurological problems like epilepsy, which I feel are all very closely linked.'

'I am dismayed and surprised that my consultant psychiatrist has advised me to remain permanently on antidepressants. I have been taking this drug for six years (with unpleasant physical side-effects). He has never suggested that an

alternative antidepressant may be a better option. It is my experience that some psychiatrists are oblivious to the negative response in the elderly to certain drugs. I feel I am living in a permanent fog – simply existing and not living.'

Little evidence is currently available about the physical healthcare needs of people from black and minority ethnic (BME) communities who have mental health problems, though work is being initiated in some parts of the country to recognise and address their needs. However, the reluctance of some people from some BME communities to contact primary care services in relation to mental health problems, resulting from their experiences of mental health services, and recent data showing they are more likely to be referred to specialist mental health services via the criminal justice system rather than primary care, both give cause for concern and highlight the importance of paying particular attention to their physical health needs.^{39,40}

The delivery of adequate primary health care to people in institutional settings poses further challenges. The needs of people with mental health problems in prison are now beginning to be recognised but, given the fact that many prisoners have not been registered with GPs prior to admission, the extent of those needs is likely to be considerable.⁴¹ Those in inpatient psychiatric settings rarely have any contact with primary care. In one instance where a primary care service was provided, demand outstripped supply, and access to the service had to be curtailed.⁴²

The need to address physical health is recognised within the Care Programme Approach, though the extent to which this happens remains highly variable. Both the English and Welsh National Service Frameworks for Mental Health make specific recommendations about physical health, including the need for primary care services to ensure that people with mental health problems receive effective services to meet their physical health needs.^{43,44} Including mental health indicators within the new general medical services (GMS) contract may have played a part in increasing the extent to which physical health checks are provided to people with serious mental health problems. Results from the first year of the contract show that, over the preceding 15 months, 76% of practices carried out reviews for at least 90% of registered patients with severe long-term mental health problems, and 40% reviewed all the patients on the register. Although reviews should include 'a check on the accuracy of prescribed medication [and] a review of physical health',⁴⁵ questions remain about the precise nature of these reviews. In addition, reviews are only

offered to people who are willing to have their details recorded on a mental health register: fears around labelling and stigmatisation mean that some of those with the greatest physical healthcare needs may not have given consent to their details being included. Further attention is being given to physical health issues as part of the 'Healthy Body and Mind' programme being carried out by 'mentality' for the National Institute for Mental Health Education (NIMHE), and Rethink's project 'Running on Empty'.^{46,47}

Our investigation includes further research into local needs and service provision. We have been paying particular attention to ways of addressing the problems, and a review of the effectiveness of interventions has been commissioned. An inquiry panel has been taking evidence from key national organisations and government departments, again with a focus on solutions to the problems and how those solutions can be effectively implemented. Our final report will present a comprehensive set of recommendations to ensure that health inequalities for people with mental health problems become a thing of the past. Experiencing worse health and dying younger if you have a mental health problem are not acceptable.

Further information about the DRC's investigation can be found at www.drc.org.uk/.

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