Supporting patients with serious mental illness during physical health treatment

Lauren Chuttoo and Vijay Chuttoo

Abstract
People with serious mental illness (SMI) are more likely to experience severe health conditions, such as cardiovascular disease, respiratory disease and stroke, and are likely to die earlier, than the general population. This article explores the reasons for such disparities, using a case study approach to outline the ways that general nurses can support people with SMI when they access general healthcare services. It identifies five areas of learning from the case study: diagnostic overshadowing and stigma; developing the therapeutic relationship; the ward environment; inclusion of family members and carers; and integration of physical and mental health services.

Citation

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In the UK in 2006, the Disability Rights Commission (DRC) published a report that explored the disparity in healthcare provision for people with serious mental illness (SMI) and learning disabilities, compared with the general population (DRC 2006). The report identified that people with SMI (those with psychosis spectrum conditions, bipolar disorder and major depressive disorders) were significantly more likely to experience serious health conditions, such as cardiovascular disease, respiratory disease and stroke, than the general population. Extensive evidence has since accumulated for the disparity in health outcomes for people with SMI (De Hert et al 2011, Walker et al 2015, Jayatilleke et al 2017), and bridging this gap is seen as a priority in the UK. In 2016, multiple healthcare organisations collaboratively produced a report, Improving the Physical Health of Adults with Severe Mental Illness: Essential Actions (Working Group for Improving the Physical Health of People with SMI 2016).

This report detailed how organisational structures, particularly mental health services, and nurses, needed to adapt and incorporate high-quality physical health promotion into the care they provide. However, there is a lack of research and recommendations regarding what general nurses can do to support people with SMI, and to reduce the barriers these individuals may experience when accessing and receiving treatment from general healthcare services.

The reasons why people with SMI have worse physical health and worse illness courses compared with the general population are complex and interrelated. SMI has been identified as an independent risk factor for some physical health conditions because of underlying genetic abnormalities (Viron and Stern 2010). Psychiatric medicines often only have partial efficacy and can cause serious side effects, for example sexual dysfunction and metabolic disorders with associated weight

Why you should read this article:
● To recognise the disparity in health outcomes for people with serious mental illness (SMI) compared with the general population
● To understand how you can effectively support people with SMI and reduce potential barriers for these individuals when accessing and receiving treatment from general healthcare services
● To remain aware of the reciprocal relationship between physical health and mental health, and the relevance of both when treating an individual

Keywords
bipolar disorder, comorbidity, management, mental health, mental health therapies, nursing care, patient experience, patients, stigma, therapeutic relationships, ward environment, ward organisation
gain (Rummel-Kluge et al 2010). These side effects, in turn, can affect a person's self-esteem, leading to self-neglect. People with SMI may find it challenging to work because of their symptoms and therefore may experience social disadvantages, often with sedentary lifestyles and low-fibre, high-fat diets, which are direct risk factors for coronary heart disease (Osborn et al 2007). Some of these issues may also be features of the mental health conditions themselves, with other possible symptoms, such as disorganised thinking, meaning that it may be challenging for them to prioritise their physical health, and cognitive impairments impeding their ability to plan, attend appointments and communicate their physical health needs adequately (Mitchell and Selmes 2007). Furthermore, these symptoms may come and go over time, and may increase during periods of stress.

Accessing general healthcare services can present challenges for people with SMI. They may experience discriminatory attitudes based on stigma, for example the idea that patients with mental health conditions are challenging or time-consuming (Lawrence and Kisely 2010); diagnostic overshadowing with symptoms being misattributed to the patient's mental health condition rather than underlying physical causes (Noblett et al 2017); and they may find it challenging to tolerate waiting rooms and noisy environments in general (Lester et al 2005). The DRC (2006) identified several organisational and local-level recommendations to support people with SMI in accessing general healthcare services. These included: health inequalities programmes to address diagnostic overshadowing; identifying groups in need of outreach services; tracking morbidity and survival rates; and making adjustments to meet the needs of people with SMI. Such adjustments included offering telephone appointments, sending appointment reminders and documenting access needs for individuals.

It is more than a decade since the DRC (2006) report and the NHS Five Year Forward View (NHS England 2014) prioritised the need to break down barriers between physical health and mental health. Despite this, research continues to demonstrate reduced life expectancy of at least 11 years for people with SMI (Laursen et al 2018). People with SMI are presenting to general healthcare services with a wide range of physical health conditions, including urinary and digestive symptoms (Jayatilleke et al 2018), and mortality rates continue to be higher compared with the general population, notably for cardiovascular disease (Correll et al 2017) and cancer (Manderbacka et al 2017).

Meeting the significant physical health needs of people with SMI is a primary objective for the NHS, and should be addressed at both the organisational level (how health services are structured) and the individual level (nurse and patient interactions). This article considers both levels, focusing on how general nurses can support people with SMI when they are accessing and receiving treatment from general healthcare services. It uses a case study to illustrate the opportunities for additional support. All names and identifying features have been altered to maintain anonymity.

Case study
Patricia is a 50-year-old, white British woman with bipolar disorder and comorbid rheumatoid arthritis, who lives and works in a city environment. She has managed both her conditions well for more than 15 years, attending appointments regularly. She is highly knowledgeable of her triggers, such as disruption to sleep pattern.

Patricia experienced a deterioration in her mental health, and booked an appointment with her community mental health team (CMHT). One of her psychiatric medicines, lamotrigine, was increased from 200mg to 400mg to assist her in managing her symptoms – the maximum recommended dose is 500mg daily (British National Formulary 2018).

A few days later, Patricia became physically unwell at home; she was seeing vertical moving stripes in her field of vision, which led to her being unable to stand. Her sister Jane had come to visit her, and she managed to get Patricia into a taxi to the local hospital. On the way to hospital, Patricia explained that she had been confused that morning and could not remember how many of her tablets she had taken. Within minutes at the emergency department, Patricia collapsed and became non-responsive. Jane relayed to the nurse in charge that Patricia had said she could not remember what medicines she had taken that morning and could have double-dosed. Patricia was treated with intravenous fluids while standard diagnostic tests such as blood samples and a computed tomography (CT) scan were undertaken; however, no physiological cause for her collapse could be identified. Her blood medication levels were not checked.

The treating team understood from Patricia’s health records that she was under the local CMHT and was prescribed various medicines for her two long-term conditions.

After four hours, Patricia regained consciousness. She was assessed by a psychiatric liaison nurse and a liaison psychiatrist, to whom she explained she had no idea what had happened. She was diagnosed with conversion disorder, which was explained to her as a severe stress reaction. The liaison psychiatrist spoke to Patricia about the possibility of psychodynamic therapy as a treatment. Patricia’s view of the diagnosis was that she had been feeling happy that morning, since her sister was visiting, and Patricia was feeling hopeful that the recent increase in her lamotrigine dose would assist her in managing her mental health. Therefore, she felt confused that the treating team felt she was experiencing a response to stress.

Patricia was admitted to a general ward overnight, where she continued to recover. Jane brought Patricia’s medicines from home, which were dispensed as prescribed. Patricia thought that only half her dose of lamotrigine was being given to her, but she did...
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General nurses can effectively support people with SMI by: adopting a positive, supportive attitude towards them; avoiding misattributing physical health symptoms to their mental health; developing a therapeutic relationship with them; considering the ward environment; and ensuring family members, carers and mental health services are included in treatment plans and decision-making processes. They suggested it tended to occur when patients had complex presentations, displayed challenging behaviour, when the emergency department was particularly busy, or when staff had stigmatising attitudes towards people with SMI.

Stigma against people with SMI is common in the general population, in healthcare services, and among people with SMI themselves (Corrigan and Watson 2002). Common stereotypical beliefs that people with SMI are dangerous, unpredictable or violent, and that a person’s mental health symptoms are within their control, for example that their symptoms occur because the person is lazy or lacks discipline, can lead to a blame culture and stigmatisation of people with SMI (Ross and Goldner 2009). Much research has explored the harmful effects of stigma (Thornicroft et al 2016) and how to bring about cultural changes, for example via anti-stigma campaigns.

In Patricia’s case, the details of the treating team’s decision-making process are unknown. It is possible that the treatment rationale may have been justified based on the information at the time, rather than an instance of diagnostic overshadowing. However, in the absence of staff talking to Patricia about what was happening for her, she did not feel that her viewpoint was valued. She therefore felt belittled and concluded that she was being stigmatised against. The perception of being stigmatised against is likely to lead to feelings of shame and embarrassment for the patient, regardless of whether diagnostic overshadowing was occurring or not. One solution would be to include patients with SMI in decision-making as much as possible so that they feel an equal partner in their treatment, something which is being increasingly promoted in mental health services (Slade 2017).

In cases where diagnostic overshadowing occurs and a person’s physical health symptoms are misattributed to their mental health condition, this can have a significant effect on the self-esteem of the individual, as well as being a missed opportunity for thorough exploration of the person’s physical presentation. Shefer et al (2014) consulted liaison psychiatry professionals for their views of when diagnostic overshadowing occurs. They suggested it tended to occur when patients had complex presentations, displayed challenging behaviour, when the emergency department was particularly busy, or when staff had stigmatising attitudes towards people with SMI.

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Diagnosis overshadowing and stigma
At discharge, Patricia believed that the treating team had failed to vigorously investigate her physical symptoms because of her mental health condition; a belief that has been reported elsewhere by people with SMI when accessing general healthcare (Nash 2014). In one study, a patient described having SMI as a ‘red flag on your file’ that invalidated their physical health concern (Happell et al 2016). Ross and Goldner (2009) conducted a literature review into the stigmatisation of people with SMI in healthcare, reporting that the physical health concerns of patients with SMI were frequently given little credibility, with assumptions made by staff that the physical health concerns reported by this group were symptoms of their mental health conditions. This is known as diagnostic overshadowing (Ross and Goldner 2009).

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Key points
- The Disability Rights Commission (DRC) published a report that explored the disparity in healthcare provision for people with serious mental illness (SMI) and learning disabilities, compared with the general population (DRC 2006). People with SMI (those with psychosis spectrum conditions, bipolar disorder and major depressive disorders) were significantly more likely to experience serious health conditions, such as cardiovascular disease, respiratory disease and stroke, than the general population.
- Research has identified the separation of physical health and mental health services as contributing to the challenges that people with SMI experience in accessing general healthcare services (Horvitz-Lennon et al 2006).
- General nurses can effectively support people with SMI by: adopting a positive, supportive attitude towards them; avoiding misattributing physical health symptoms to their mental health; developing a therapeutic relationship with them; considering the ward environment; and ensuring family members, carers and mental health services are included in treatment plans and decision-making processes.
such as Time to Change (Henderson and Thornicroft 2009). On an individual basis, every healthcare professional has a responsibility to challenge stereotypical beliefs and to view each patient as an individual, considering them holistically as a person, beyond their diagnosis (Giddings 2013).

Developing the therapeutic relationship

The importance of the therapeutic relationship should not be underestimated, and is perhaps the cornerstone of all nursing practice. This relationship can be an agent for change, and has been shown to enhance an individual’s adherence to treatment and improve treatment outcomes (Dearing 2004). The development of the therapeutic relationship requires the healthcare professional to connect with the patient by carefully talking and listening to them, with the aim that this will establish trust and the patient will become increasingly invested in their treatment. Some people with SMI will have experienced compulsory, traumatic admissions to hospital and received treatment against their will, meaning that patients may feel a strong mistrust of healthcare services (Viron and Stern 2010). This can make developing a therapeutic relationship with some people with SMI challenging, but perhaps increasingly important to establish.

In Patricia’s case, there were several potential barriers to effective communication and the development of a trusting therapeutic relationship, for example time-pressured nurses and nurses lacking in confidence to talk to someone with mental health issues. Gilburt et al (2008) identified positive patient experiences associated with the need to feel cared for and safe, being communicated with as an equal, being treated with honesty, dignity and respect, and feeling in control. In Patricia’s case, the nurses could have paid greater attention to what Patricia was communicating to them and adopted an increasingly empathic approach. This would have enabled them to develop a relationship with Patricia, where she would have been increasingly likely to voice her concerns and share further details about herself, such as the dose of lamotrigine she usually takes at home.

Professional codes of practice for registered healthcare staff, such as The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (Nursing and Midwifery Council (NMC) 2018), outline the standard of professional conduct that nurses must adhere to and which all patients can expect to receive. For the NMC (2018), this includes developing trust through effective communication, honesty and respect, treating people with kindness and compassion, and working in partnership with people to ensure that care is delivered effectively. While most general nurses would say they follow these requirements in their practice, patients with SMI might require increased input from general nurses to feel respected and able to trust healthcare professionals.

Ward environment

In this case study, the noisy and bright ward environment appeared to have a negative effect on Patricia’s experience. Patients with SMI may be sensitive to medical environments for several reasons. For example, they may have previously experienced compulsory admissions and/or compulsory treatment. Research has shown that experiences such as these may connect to memories of trauma and violation (Bonner et al 2002). Busy, noisy settings can also be unsettling for people with SMI. Therefore, it is important for general nurses to enable patients to feel safe and acknowledge the sensitivity that some people with SMI may display in medical environments.

Dijkstra et al (2006) conducted a systematic review of physical features that constitute a ‘healing’ ward environment for people with SMI, identifying various environmental factors that improved patient outcomes. For example, patients with bipolar disorder had shorter hospital stays when in sunny rooms compared with dull rooms. Modern mental health wards typically include features such as plants (Dijkstra et al 2008a), mood colours (Dijkstra et al 2008b), natural light (van der Schaaf et al 2013) and quiet rooms. While it may not be possible to incorporate all these features in general healthcare wards, some elements could be introduced, for example asking the patient if there is anything in the environment that is disturbing them and making adjustments if possible.

Patricia had found that she could not sleep on the medical ward because of other patients making noise, and because she was placed in a bay close to the nursing station. Patricia knew that sleep was important to her well-being, so she agreed to be discharged even though she felt that her diagnosis was inaccurate and that she had not received sufficient treatment. She preferred to go home to get some sleep, which is in keeping with the knowledge that many people with SMI will prioritise their mental health over their physical health (Buhagiar et al 2011). In this case, a general nurse with the understanding that people with SMI can find hospital environments stressful could have suggested moving Patricia to a quieter area of the ward.

Inclusion of family members and carers

Family members and carers have a vital role in supporting people with SMI, both practically, for example assisting them to access appointments, and emotionally, for example supporting them to tolerate the stress of appointments. Firth et al (2016) described how a lack of social support is a significant barrier for people in accessing general healthcare services. Therefore, it is essential that both mental health and general healthcare services acknowledge and involve family members as a way of enhancing engagement of people with SMI. While caring can be rewarding, it can also be a demanding role and healthcare professionals should also offer support to carers where appropriate.
This admission was highly emotional for Patricia’s sister, Jane, who saw her sister collapse. Jane was put in the challenging position of wanting to believe her sister, who disagreed with the diagnosis, while at the same time trusting the healthcare professionals’ expertise. No one spoke to Jane about the situation or listened to her point of view. Her comment that Patricia may have double-dosed also seemed to be disregarded by the nurse in charge because Patricia’s blood medication levels were not checked during her admission. At discharge, Jane had to support Patricia since she felt disregarded by the treating team, and Jane felt angry on behalf of her sister who could have experienced physiological harm as a result of her experience. Effective nursing practice would have involved a nurse speaking to Jane privately, to elicit her account of the situation, to empathise with her that it was a challenging situation, and to signpost her to further carer support if necessary.

Integration of physical and mental health services

Research has identified the separation of physical health and mental health services as contributing to the challenges that people with SMI experience in accessing general healthcare services (Horvitz-Lennon et al 2006). It is likely that people with SMI feel overloaded with appointments if they are regularly attending both mental health and physical health check-ups at different times and in different locations. Research has shown that people with SMI tend not to prioritise their physical health (Buhagiar et al 2011), which can lead to missed physical health appointments. There have been some proposed models of care that would integrate services, but these have not been fully implemented in the UK (Naylor et al 2016). Until healthcare services are increasingly structurally integrated, improving communication between healthcare professionals would enhance continuity of care, both as people with SMI pass between the different services, and by bringing specialist knowledge into patient consultations.

One way to bridge the gap between services is for there to be channels enabling effective flow of information. For example, mental health nurses should: provide basic physical health monitoring during consultations, such as taking readings for blood pressure, heart rate and oxygen saturation levels; refer patients to appropriate services if there are physical health concerns; and ensure patients then attend physical health appointments (Bradshaw and Pedley 2012). However, when people with SMI are seen in general healthcare services, it is important that general nurses relay findings and missed appointments back to the referring mental health team, where possible. This enables all parties to work in partnership to optimise support for people with SMI.

Whichever treatment the person with SMI is receiving, it is also best practice to integrate specialist knowledge into consultations. For example, a patient with a comorbid physical health condition being seen in a community mental health setting might benefit from a mental health nurse contacting a general nurse for advice, and vice versa. In Patricia’s case, she would have consented for a general nurse to contact her community mental health nurse for additional information, which might have shaped the understanding of what was happening to Patricia – that she was not prone to psychosomatic symptoms or extreme stress reactions. In cases where people with SMI have effective relationships with their CMHT, they may feel reassured that the general healthcare team are consulting with the CMHT about them, and doing so can provide general nurses with a holistic overview of the patient.

The separation of healthcare services may also lead to general nurses and mental health nurses feeling that the other domain is not necessarily an important aspect of their role, for example supporting someone psychologically or undertaking physical health monitoring respectively (Happell et al 2012, Robson et al 2013). However, it is likely that physical health and mental health have a reciprocal relationship (Teychenne et al 2008), so both are relevant when treating an individual. Therefore, it is important that education and training programmes for nurses encourage proactive attitudes towards the other domain, and that nurses can feel confident to use their skills in these areas (Howard and Gamble 2010).

Discussion

This case study has been used to explore areas of learning for general nurses when supporting people with SMI who are receiving physical health treatment. As a case study, its applications to the wider population are limited; however, the themes identified are linked to extensive research on various areas relevant to nurses’ clinical practice. Improving the physical health of people with SMI is an NHS priority in the UK and several large-scale interventions are being developed to address this issue, including computerised health risk screening tools (Dale et al 2016), peer-supported physical health programmes (Stubbs et al 2016) and health passports (Kirby 2016). Health passports are patient-held health records documenting physical and mental health assessments, which can improve patients’ understanding of their current health status and provide individualised guidance regarding healthy lifestyle changes.

Conclusion

When people with SMI access and receive treatment from general healthcare services, there are various interventions that general nurses can undertake to improve their experience. General nurses can effectively support people with SMI by: adopting a positive, supportive attitude towards them; avoiding misattributing physical health symptoms to their mental health; developing a therapeutic relationship with them; considering the ward environment; and ensuring family members, carers and mental health services are included in treatment plans and decision-making.


