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Providing leadership on a hidden issue: Where are the mental health nurses?

The general population is aware of the reduced life expectancy of Indigenous populations and the need for sustained programs to improve Indigenous health and wellbeing. For example, the Australian Government has agreed on targets to “close the gap” in life expectancy between Indigenous and non-Indigenous Australians within a generation (by 2031) (Council of Australian Governments, 2008). However, the reduced life expectancy of another vulnerable population remains largely hidden from public awareness and health professionals continue to debate where the responsibility lies for this now global public health issue (Maj, 2009).

The reduced life expectancy for people with a severe mental illness is approximately 16 years when compared to the general population (D. Lawrence, Hafekost, Hull, Mitrou, & Zubrick, 2013; Scott & Happell, 2011). However, some estimates propose the gap to be much higher with men and women with schizophrenia at greatest risk (Bradshaw & Pedley, 2012; El-Mallakh, Howard, & Evans, 2010). People with a severe mental illness are now dying at a younger age than comparable groups 30 years ago (Aschbrenner, Mueser, Bartels, & Pratt, 2013; Bradshaw & Pedley, 2012; Champion, Checinski, Nurse, & McNeill, 2008; Galon & Graor, 2012), and while some mortality is associated with suicide and trauma, the majority is related to chronic illnesses such as diabetes, cancer, stroke and cardiovascular disease (Hardy, Hinks, & Gray, 2013).

Most people with a severe mental illness have at least one chronic physical health condition, and while mental health recovery principles are firmly embedded in mental health policy, people with comorbid physical health problems face many challenges and obstacles to their recovery journey (Viron & Stern, 2010). The deinstitutionalisation of services under modern mental health policy (Australian Health Ministers, 2009), has led to a fragmented approach to health care delivery (De Hert et al., 2009; D. M. Lawrence & Kisely, 2010), leading to consumers’ physical health needs often being overlooked during mental health admissions (Henderson & Battams, 2011). Furthermore, people with a severe mental illness are reluctant to access primary care services even though they have the same concerns about their health as other members of the general population (Chadwick, Street, McAndrew, & Deacon, 2012). People with a severe mental illness also experience difficulty establishing engaging relationships with health professionals, often lack knowledge of health care and psychiatric disability, have difficulties making and adhering to appointments and follow up care and as a result, are often excluded from primary care practices (Bradshaw & Pedley, 2012).

The difficulty this marginalised group experience in accessing health care is evidenced in three ways. Firstly, they overuse emergency departments when they are ill (Chadwick et al., 2012), and a lack of follow up care on discharge from emergency care leads to increased morbidity and mortality as well as system costs. Secondly, the negative and stigmatising attitudes often displayed by health professionals is a major reason why consumers underuse

preventative health services (Chou, Tsai, Su, & Lee, 2011). Xiong et al, 2008 reported that 50% of mental health consumers over 50 years had not received colorectal cancer screening and 31% of women had no cervical cancer screening performed in the past three years. Lord et al's (2010) systematic review of 61 comparisons of preventive care and screening between people with a mental illness and the general population identified 27 comparisons of inferior preventative care offered to people with a mental illness, and inferior preventive care was most apparent in those with schizophrenia (Lord, et al, 2010). Lastly, the misuse of services occurs when people with severe mental illness get caught between the physical health/mental health divide (Chou et al., 2011) which arises from the inability of health professionals to take responsibility for this consumer group's physical health issues. Many reasons for this have been postulated, for example, diagnostic overshadowing where health professionals only focus on the person's mental illness and pay little relevance to presenting physical health issues (Cunningham, Peters, & Mannix, 2013). In one study, health professionals reported that they believed mental health consumers were faking their illness and they were turned away from primary care services (Chadwick et al., 2012). Stigma or the discriminatory attitudes of health professionals (Nash, 2011), along with therapeutic fatalism (where health professionals see no value in trying to instigate change that they believe will not be maintained by the consumer) are also factors that impact on a misuse of services to this consumer group (Ehrlich et al., 2014). For example, metabolic screening and monitoring is now recommended best practice for mental health consumers. It is the responsibility of mental health professionals as it is estimated that metabolic syndrome is present in up to 50% of mental health consumers (John, Koloth, Dragovic, & Lim, 2009) particularly those receiving antipsychotic medication (Bresee, Majumdar, Patten, & Johnson, 2010; Galon & Graor, 2012; Lam, Lam, Lam, & Ku, 2013; Lord, Malone, & Mitchell, 2010; Pallava, Chadda, Sood, & Lakshmy, 2012), or with a diagnosis of schizophrenia (Chacón, Mora, Alicia, & Inmaculada, 2011). However, current Australian research revealed only a small percentage of consumers in the research groups received appropriate screening (McKenna et al., 2014; Ward, 2015), and a recent study identified that community mental health nurses only allocated 1% of their workload to the physical health care needs of consumers in their care (Heslop, 2013).

Mental health nurses must determine what level of accountability and ethical responsibility they have to address the increasing poor physical health outcomes of consumers in their care. Can nurses continue to "close their eyes" to the accumulative health issues occurring in people they provide care to some of which are linked to the use of antipsychotic medications they administer each day? Will mental health nurses continue to view the consumer's weight gain as an inevitable consequence of antipsychotic drug treatment or as a risk factor for the development of chronic disease and implement strategies to reduce the risk? Will they continue to only see and treat the "mental illness" even when the consumer prioritises their physical health outcomes as the most distressing impact on their overall wellbeing? None of the procedures to achieve 100% compliance rates for metabolic screening and monitoring or annual health checks are beyond the scope of practice of a registered nurse. Similarly, providing health promotion and prevention is a key area of nursing practice focussed on recovery.

Mental health consumers are vulnerable to the negative consequences of mismanaged physical health problems (Siantz & Aranda, 2014) and mental health nurses can play a vital role in bridging the gap between primary and secondary care services and stop the fragmentation of care to these consumers. Improved rates of monitoring and screening could identify issues for follow up by the consumer's general practitioner (GP), and mental health nursing GP liaison roles can assist improved engagement of consumers with primary care services. Increased education and training about metabolic syndrome, what constitutes metabolic screening and the causes of the reduced life expectancy in this group may facilitate an attitudinal change for mental health nurses.

Physical health is an important dimension of quality of life and is intrinsically linked to mental health recovery. As a profession we need to provide leadership at the clinical level to address the current failures in our delivery of care. Small clinician led changes to lower modifiable risk factors are possible for most consumers (Bergqvist, Karlsson, Foldemo, Wårdig, & Hultsjö, 2013), and are within the mental health nursing scope of practice. Nurses need to show leadership and advocate for mental health consumers to increase community awareness that mental illness is a risk factor for physical illness and reduced life expectancy. While this phenomenon remains "hidden" little will be done to change the lives of people living with serious mental illness.

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