Health inequalities

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The association between mental illness and poor physical health has been known for decades (Philips, 1934). This is not a trivial relationship between mental ill health and minor physical problems but an association with such poor physical health that it results in premature death. For example, a study in the USA showed that the life expectancy of those with schizophrenia or other serious mental illness was 9 years shorter than for the general population (Dembling *et al*, 1999). Similarly, those with learning disabilities have an increased risk of early death, and this increase is greater in those with severe disability.

A number of factors may account for a higher than average mortality rate among people who are mentally ill. For example, the nature of their mental illness and their lifestyle may increase the risk of suicide and accidental death. Psychotropic drugs used in the treatment of major illnesses can have serious physical side-effects; for instance, atypical antipsychotic drugs may cause or exacerbate diabetes, some psychotropic drugs are cardiotoxic and lithium can cause renal impairment. Furthermore, mental illness and psychological stress may affect behaviour in a way that adversely affects physical health. In particular, people with a mental illness may not take much care with their diet, and may drink and smoke excessively and take little exercise (Brown *et al*, 2000); also, they may fail to take essential prescribed medication for pre-existing physical illness.

Superimposed on all this are the consequences of the stigma and social isolation that are still associated with mental illness and that all too often lead to unemployment, poverty and poor housing – all of which are known to be associated with poorer physical health. Those with learning disabilities may suffer in similar ways and old age presents additional risk factors if declining physical health is combined with depression, anxiety or dementia.

Although the reasons for a high incidence of physical illness in people with a mental illness are predictable and well understood, physical illness often goes undetected. In part this is because the patients themselves may not bother to seek help for their symptoms. Indeed, they may not be registered with a general practitioner at all. If they do seek help, their underlying mental illness may make it hard for them to explain what is wrong.

This makes it all the more important that the healthcare professionals with whom they come into contact take a holistic approach to their care and actively seek to compensate for the problems outlined above, whenever they can. They should always take account of the physical health needs of their patients as well as their mental health problems. Sadly, there is evidence that this is not the case and that those with a mental illness or a learning disability, in addition to the physical problems inextricably linked to their mental state, also suffer significant inequalities in terms of their access to high-quality healthcare. For example, the proportion of women with a learning disability who receive cervical and breast screening is lower than in the general population (Stein & Allan, 1999; Davies & Duff, 2001) and levels of immunisation are also lower (NHS Health Scotland, 2004). Similarly, although people with a mental illness consult doctors more frequently than do the general population, they are less likely to be offered health promotion services (Cohen & Hove, 2001). All this adds up to serious health inequalities for some of the most vulnerable people in our society.

It is important to understand why this is happening and there are probably multiple, interlinking contributory factors. For example, in the UK, as in many other countries, there has been a move away from the institutional care of individuals with mental illness and learning disability in favour of treatment in the community, with outreach by specialist community mental health teams (CMHTs). It would be facile to pretend that long-term inmates of large hospitals used to receive high-quality care for physical ill health, but it is also important to acknowledge that it is difficult for the CMHTs, even in a well organised healthcare system, to provide such care in the community.

The treatment of multiple pathology of any kind is always more difficult than the treatment of a single, discrete condition, and requires particularly knowledgeable and experienced physicians. The management of multiple pathologies seems to have become even more difficult in recent years owing to increasing specialisation and sub-specialisation, which lead to a greater reluctance on the part of professionals to venture outside their own area of (often narrow) expertise. Many mental health doctors are now unwilling to carry out anything more than a basic physical examination, and tend to refer patients to another specialist for what used to be considered routine investigations such as electrocardiography.

In this context, the role of the general practitioner and the primary care team in the holistic care of those with a mental illness or learning disability is of prime importance for the increasing number of patients now being cared for in a community setting. However, their

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responses may be hampered by negative attitudes and stereotyping and by unacknowledged prejudices. They may make unarticulated assumptions about the value of interventions for these groups of patients, so that they are less often referred for specialist advice. Such feelings may be reinforced by the fact that, because of difficulties in communication, it may take much longer than usual (and longer than scheduled appointment times) to deal with these patients – and this may be problematic in a busy general practice. Finally, even the best primary care physician, when faced with a patient with known mental health problems or learning disability, may assume that new symptoms and signs of physical disease are attributable to the underlying condition and fail to carry out investigations that would be routine for other patients.

The major role of the primary care team in relation to the physical health of patients with mental illness has been acknowledged in some countries. However, much more is needed globally to make the provision of health services sensitive to the needs of these patients. Specifically, more attention must be paid to methods of communication with such patients so that, like the rest of the population, they are better informed and better able to participate in the healthcare decisions that affect them. Special approaches will need to be developed, in both primary and secondary care, to tailor preventive medicine programmes to meet the particular needs of patients with mental illness and learning disability.

In a few countries, concern about the health inequalities experienced by people with mental illness and learning disability has produced a response. In the UK, for example, the Disability Rights Commission has set up a formal investigation into these issues. Its aim is to 'shine a light on both health inequalities and potential solutions', and its focus is on practical approaches to reducing inequality within primary care. The emerging solutions include training for a number of different groups, such as general practitioners, practice nurses and receptionists, to promote positive attitudes towards these patients and to improve their knowledge of medical and social issues linked to mental ill health and disability (Disability Rights Commission, 2005). It also suggests that practitioners should be trained by people with such disabilities and that disability issues should be integrated within the medical undergraduate curriculum.

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Although the Disability Rights Commission's investigation focuses on primary care, there is much that is relevant to secondary care too, and this enquiry should act as a prompt to all who are involved in the care of patients with a mental illness or learning disability to reconsider the standard of care that they provide. The World Health Organization (2005) estimates that, worldwide, there are more than 450 million people with mental, neurological or behavioural problems. Psychiatrists in all countries – indeed, all mental health workers and their professional associations – have a responsibility to make sure that the physical needs of their patients are not only recognised but also responded to within their health service. Wherever and whenever psychiatrists are involved, they should be vigilant to ensure that these patients, who are often among the most vulnerable and the least legally protected, are not further disadvantaged by having their physical health needs overlooked or ignored.

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THEMATIC PAPERS – INTRODUCTION

Alcohol misuse among young people

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Recently, the UK government expressed concern about the rising tide of antisocial behaviour among young people who, in certain areas of the country, were habitually engaging in acts of minor delinquency – often fuelled by drink. On the other hand, legislation was introduced to make it legal for premises that sell alcohol to remain open longer, up to 24 hours a day. This latter arrangement has courted considerable controversy. For example, the British Medical Association commented that any

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