

Reducing health inequalities for people with serious mental illness

Hallett, Nutmeg; Rees, Helen

DOI:

[10.7748/ns.2017.e10787](https://doi.org/10.7748/ns.2017.e10787)

Document Version
Peer reviewed version

Citation for published version (Harvard):

Hallett, N & Rees, H 2017, 'Reducing health inequalities for people with serious mental illness', *Nursing Standard*, vol. 31, no. 38, pp. 60-70. <https://doi.org/10.7748/ns.2017.e10787>

[Link to publication on Research at Birmingham portal](#)

Publisher Rights Statement:

Checked for eligibility: 16/06/2017

This is not the version of record.

<http://journals.rcni.com/doi/10.7748/ns.2017.e10787>

General rights

Unless a licence is specified above, all rights (including copyright and moral rights) in this document are retained by the authors and/or the copyright holders. The express permission of the copyright holder must be obtained for any use of this material other than for purposes permitted by law.

- Users may freely distribute the URL that is used to identify this publication.
- Users may download and/or print one copy of the publication from the University of Birmingham research portal for the purpose of private study or non-commercial research.
- User may use extracts from the document in line with the concept of 'fair dealing' under the Copyright, Designs and Patents Act 1988 (?)
- Users may not further distribute the material nor use it for the purposes of commercial gain.

Where a licence is displayed above, please note the terms and conditions of the licence govern your use of this document.

When citing, please reference the published version.

Take down policy

While the University of Birmingham exercises care and attention in making items available there are rare occasions when an item has been uploaded in error or has been deemed to be commercially or otherwise sensitive.

If you believe that this is the case for this document, please contact UBIRA@lists.bham.ac.uk providing details and we will remove access to the work immediately and investigate.

Nursing Standard

evidence & practice / CPD / mental health

HEALTH PROMOTION

Reducing health inequalities for people with serious mental illness

NS894 Hallett N, Rees H (2017) Reducing health inequalities for people with serious mental illness. Nursing Standard.

Date of submission: 5 December 2016; date of acceptance: 14 March 2017. doi: 10.7748/ns.2017.e10787

Nutmeg Hallett

Lecturer, School of Nursing, College of Medical and Dental Sciences, University of Birmingham, Edgbaston, Birmingham

[Q1: Are these details correct as written?]

Helen Rees

Teaching fellow in mental health nursing, Birmingham City University, Birmingham

Correspondence

n.n.hallett@bham.ac.uk

@dr_nutmeg

Conflict of interest

None declared

Peer review

This article has been subject to external double-blind peer review and checked for plagiarism using automated software

Revalidation

Prepare for revalidation: read this CPD article, answer the questionnaire and write a reflective account:

rcni.com/revalidation

Online

For related articles visit the archive and search using the keywords

To write a CPD article

Please email tanya.fernandes@rcni.com. Guidelines on writing for publication are available at: journals.rcni.com/r/author-guidelines

Abstract

People with serious mental illness (SMI) are at risk of dying many years earlier than the general population. Providing an effective, cost-efficient healthcare service requires a holistic approach, and improving the physical health of people with SMI

should be integral to all healthcare roles. It is important for nurses to identify and understand the barriers that people with SMI may experience when accessing physical healthcare. A range of factors contribute to reduced life expectancy, including lifestyle factors, symptoms of mental illness and the side effects of medications. This article discusses four areas of health that commonly affect people with SMI: metabolic syndrome, smoking, oral health and sexual health. Metabolic syndrome is a cluster of risk factors that increase an individual's risk of cardiovascular disease, stroke and type 2 diabetes mellitus. Smoking is increasingly prevalent in people with SMI, with rates remaining steady despite a decline in smoking rates nationally. Oral health and sexual health can negatively affect the physical health and well-being of people with SMI; however, these aspects of health are often neglected. This article identifies ways that nurses in all practice settings can use health promotion, assessment and treatment to improve the physical health of people with SMI in relation to these four areas.

health inequalities, health promotion, mental health, mental illness, metabolic syndrome, oral health, sexual health, smoking

Aims and intended learning outcomes

The aim of this article is to discuss the main issues relating to the physical health of people with serious mental illness (SMI) and how nurses in all practice settings can improve the health of these individuals. It considers the barriers to accessing physical healthcare for people with SMI, as well as metabolic syndrome, smoking, oral health and sexual health, including potential ways to address these issues. After reading this article and completing the time out activities you should be able to:

- Identify the factors leading to a reduced life expectancy for people with SMI.
- Outline potential barriers to accessing physical healthcare for people with SMI.
- Describe metabolic syndrome and outline the steps that can be taken to reduce the risk of people with SMI developing this syndrome.
- Identify the risks of changes to smoking frequency in people with SMI and plan appropriate care for this.
- Provide assessment, health advice and information about management that may support smoking cessation, oral health and sexual health for people with SMI.

Relevance to The Code

Nurses are encouraged to apply the four themes of The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives to their professional practice (Nursing and Midwifery Council (NMC) 2015). The themes are: Prioritise people, Practise effectively, Preserve safety, and Promote professionalism and trust. This article relates to The Code in the following ways:

- It discusses the importance of identifying and treating the physical health needs of people with SMI. The Code states that nurses must make sure that people's physical, social and psychological needs are assessed and responded to.
- The Code states that nurses must pay particular attention to promoting wellbeing and preventing ill health. This article emphasises the importance of health promotion for people with SMI.
- It describes the stigma that people with SMI may experience when accessing healthcare. The Code requires that nurses challenge discriminatory attitudes and behaviour relating to care.

- The Code states that nurses must support those receiving care to access relevant health and social care, information and support. This article outlines the barriers to accessing healthcare that people with SMI may experience, and how nurses can reduce these.
- It provides information about verbal and non-verbal communication skills for nurses. The Code states that nurses must communicate clearly and effectively.

Introduction

There is no universally agreed definition of SMI; however, the NHS Outcomes Framework (Health and Social Care Information Centre 2014) defined adults with SMI as 'anyone aged 18 or over who has been in contact with secondary mental health services in a defined time period'. People with SMI are at risk of experiencing barriers to accessing healthcare and a fragmented approach to care, which may contribute to the health inequalities experienced by these individuals (Mental Health Taskforce 2016, Naylor et al 2016). Research has indicated that these health inequalities contribute to reductions in life expectancy for people with SMI of between seven and 24 years (Chesney et al 2014). This is an effect similar to that of smoking, and is a serious public health concern.

It is evident that effective, cost-efficient and safe healthcare cannot be provided without a holistic approach to health. This is reflected in the World Health Organization (WHO) (1948) definition of health as 'a state of complete physical, mental and social well-being'. Integrated services that have the potential to meet physical and mental health needs present the opportunity for a range of societal benefits, with Naylor et al (2016) indicating healthcare savings of up to £11 billion by reducing health inequalities, as well as improved quality of life and better mental and physical health outcomes.

Healthcare professionals regularly come into contact with people who are affected by SMI. Nurses are well-placed to reduce the disparity in life expectancy and improve the overall health of people experiencing SMI. Nurses also have a professional duty to provide this care, outlined in The Code (NMC 2015), which states that nurses must 'make sure that people's physical, social and psychological needs are assessed and responded to'. This article discusses how nurses in all practice settings can enhance the physical health of people with SMI.

Barriers to accessing physical healthcare

People with SMI may experience barriers to accessing physical healthcare, and as a result are considerably less likely than the general population to have their physical health needs identified, assessed or treated (Happell et al 2012). Happell et al (2012) identified four areas in which these individuals may experience barriers to accessing healthcare, including:

- Identifying the health concern and **reaching** healthcare services [Q2: **should this be making contact with healthcare services?**].
- Arriving at the healthcare service.
- Consulting with healthcare services.
- Following-up the identified health concern.

The first stage of accessing physical healthcare is recognising that there may be a health concern. There is evidence to suggest that some people with SMI may be unaware of physical symptoms, or only recognise them at a late stage, and reasons for this include: cognitive impairment associated with their mental illness; increased pain thresholds; social isolation; and suspicion of healthcare services (Phelan et al 2001, Samele 2004). People with SMI frequently have lower expectations of healthcare services and correlating higher thresholds for seeking support because of perceived stigma (Department of Health 2006); almost one in five people (17%) with SMI experience stigma when accessing physical healthcare (Lasalvia et al 2013, Harangozo et al 2014).

There are many symptoms of mental illness that can make the process of accessing healthcare challenging. Lack of motivation is common in people with depression and schizophrenia, and similarly tiredness, which can make engaging in activity increasingly challenging, is a common side effect of many psychiatric medications (Barch 2005, Fava et al 2006). Social isolation and socioeconomic status can make travelling to healthcare appointments challenging (Phelan et al 2001).

People with SMI have reported finding it challenging to cope with crowded and noisy waiting rooms and long waiting times (Lester et al 2005). These individuals are sometimes viewed as 'difficult' by staff in primary care, and conversely, people with SMI have found staff to be unhelpful and disrespectful (Happell et al 2012). These experiences, together with negative attitudes towards primary care, mean that people with SMI may be increasingly likely to seek assistance from emergency services, even when primary care is more appropriate (Happell et al 2012).

TIME OUT 1

List the barriers that someone with SMI might experience when accessing your healthcare service. What could you do to minimise the effects of one or more of these barriers?

At an individual level, the greatest effect healthcare professionals can have on these barriers is during consultations. The interaction between a healthcare professional and a person with SMI can have a significant effect on that person's attitudes towards accessing healthcare. Uncaring or uncompassionate behaviours [Q3: by healthcare professionals?] can be particularly challenging for people with SMI to manage, because they may lack confidence or assertiveness (Chadwick et al 2012). For some people with SMI, uncaring and dismissive attitudes can reinforce the belief that healthcare professionals do not believe them and that they are 'faking' their physical illness, while others may not disclose their mental illness for fear of not being believed about their physical health symptoms (Chadwick et al 2012). This is known as diagnostic overshadowing; when physical symptoms that should lead to further investigation are instead attributed to the individual's mental illness (Nash 2013). This can be harmful because many physical health issues may present with psychological symptoms that are more commonly associated with mental illness, as shown in Table 1 (Wilber 2006, Schildkrout 2011).

[Q4: can we list the physical causes for each psychological symptom in alphabetical order, i.e. Cushing's syndrome, Giant cell arteritis, Hyperthyroidism etc... or is there a particular reason for the order?]

Table 1. Psychological symptoms and possible physical causes

Psychological symptom	Possible physical causes
Anxiety	<ul style="list-style-type: none">• Hyperthyroidism or hypothyroidism• Lupus erythematosus• Liver failure• Giant cell arteritis• Cushing's syndrome• Insulinoma
Cognitive changes	<ul style="list-style-type: none">• Multiple sclerosis• Parkinson's disease• Dementia• Brain injury or infection• Liver disease

	<ul style="list-style-type: none"> • Mercury or lead poisoning
Delirium	<ul style="list-style-type: none"> • Urinary tract infection or dehydration, particularly in older adults • Non-convulsive status epilepticus
Emotional disturbance, such as anger, irritability, panic, depression, euphoria	<ul style="list-style-type: none"> • Drug or alcohol intoxication or withdrawal • Head injury • Endocrine gland disorders, for example diabetes and thyroid, parathyroid, adrenal, pituitary or ovarian disorders • Liver or kidney disease • Sleep disorders • Seizure disorders, for example epilepsy
Hallucinations	<ul style="list-style-type: none"> • Charles Bonnet syndrome • Migraine • Narcolepsy • Poisoning, for example involving lead, manganese, mercury or thallium • Drug or alcohol withdrawal, for example delirium tremens • Brain injury • Brain tumour or infection
(Wilber 2006, Schildkrout 2011)	

TIME OUT 2

Access the National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summaries at <https://cks.nice.org.uk/#?char=A>. Identify the symptoms of one of the physical conditions listed in Table 1. Discuss with a colleague why this might be mistaken for a mental illness.

It is important to remember that a person with SMI may have had to overcome one or more of the previously mentioned barriers to attend healthcare appointments. The person's SMI may also affect their ability to communicate their physical health concerns clearly and effectively (Cole and Padmanabhan 2012). In such situations, the nurse's communication skills are particularly important. The communication skills listed in Table 2 are integral to nursing; taking the time to reflect on these is a quick and simple way to improve nursing practice.

Table 2. Essential communication skills for nurses

Skill	Explanation
Listening	<ul style="list-style-type: none"> • Provide the person with time and space to talk • Listen for the underlying message in what the person is saying • Focus on what the person is saying by giving them your full attention • Tune out internal distractions, for example thinking about what to say next • Use verbal prompts such as 'go on', 'yes' and 'tell me more'
Silence	<ul style="list-style-type: none"> • Give the person time to communicate without feeling rushed • Practice to develop the ability to be still and silent • Wait for five seconds before asking a question, to give the person time and encourage them to talk

Reflecting	<ul style="list-style-type: none"> • Demonstrate understanding of the core message by providing feedback • Repeat verbatim what the person has just said • Paraphrase by repeating the meaning but using different words – this communicates that the message has been understood • Summarise, by providing a synopsis of what has been said • Reflect to enable misunderstandings to be identified
Questioning	<ul style="list-style-type: none"> • Use open-ended questions to invite a full response from the person, for example questions beginning with who, what, where, when and how? • Use cognitive questions, which focus on thoughts or beliefs, for example asking the person ‘what do you think?’ • Use affective questions, which focus on feelings, for example asking the person ‘how did you feel?’ • Use behavioural questions, which focus on behaviour or actions, for example asking the person ‘what did you do?’ • Use time-orientated questions, which focus on time – past, present and future – for example by asking the person ‘what did you do that helped in the past? What are you doing now that helps? What could you do in the future to help?’ • Avoid asking the person unhelpful questions, including: closed questions that require a yes or no response; multiple questions; asking more than one question at a time; and why questions, which can appear interrogative
Non-verbal communication	<ul style="list-style-type: none"> • Be aware of your non-verbal communication, and observe what the other person is communicating non-verbally • Use the SOLER acronym (Egan 2010) to remember the non-verbal skills that can assist communication: <ul style="list-style-type: none"> - S: face the other person squarely, but at a slight angle - O: adopt an open posture, for example do not cross your arms - L: lean slightly towards the person - E: maintain appropriate eye contact, without staring - R: relax posture

(Adapted from Morrissey and Callaghan 2011)

TIME OUT 3

During the next consultation you have with a patient who you want to encourage to talk, practise waiting for five seconds before you speak. This may feel like a lot longer to begin with. Reflect on whether you think this was beneficial to the consultation.

Metabolic syndrome

Metabolic syndrome can be defined as a cluster of risk factors, including obesity, hypertension, hyperglycaemia and dyslipidaemia, that increase an individual's risk of cardiovascular disease, stroke and type 2 diabetes mellitus (Kassi et al 2011). It has been described as one of the challenges that mental health practitioners currently

experience, and it is thought to contribute significantly to the disparity in life expectancy between people with SMI and the general population (Ho et al 2014).

Since many antipsychotic medications, in particular 'atypical' antipsychotic medications, are associated with an increased risk of metabolic syndrome, it is essential that healthcare professionals caring for those with SMI are aware of the potential for iatrogenic harm (De Hert et al 2012). Antipsychotic medications may increase cardiovascular risk by: elevating triglycerides; increasing low density lipoproteins, also known as 'bad cholesterol'; and lowering high density lipoproteins, also known as 'good cholesterol' (British Heart Foundation 2017). These metabolic changes are collectively referred to as dyslipidaemia. Although the exact mechanisms of these changes remain unclear, they can be identified using routine blood tests and are associated with a hardening of the arteries (atherosclerosis) and the development of ischaemic heart disease (NICE 2014). Therefore, it is essential for healthcare professionals to encourage people with SMI to access physical health screening as part of holistic care.

Obesity is another reason why people with SMI are more likely to develop metabolic syndrome than the general population (De Hert et al 2012). The Mental Health Foundation (2006) indicated that people experiencing mental illness are increasingly likely to consume diets higher in saturated fats and less likely to consume daily portions of fresh fruit and vegetables. Weight gain is also a commonly reported side effect of most antipsychotic medications, for example clozapine and olanzapine. This is thought to be partly related to the action of these medications on H1 (histamine) receptors, resulting in significant increases in appetite (He et al 2013, British National Formulary (BNF) 2016). Such changes are compounded by the association between atypical antipsychotic medications and hyperglycaemia, which is an independent risk factor for the development of type 2 diabetes (NICE 2014). Therefore, evidence-based nutritional advice, in combination with body mass index monitoring, should be offered to everyone who experiences SMI, particularly those commencing antipsychotic medication (NICE 2014).

Promoting regular exercise is an important way in which healthcare professionals can attempt to prevent people with SMI from developing metabolic syndrome (Pitsavos et al 2006). Low mood, medication-related drowsiness and challenges accessing leisure facilities may be barriers for people with SMI who want to take part in exercise (Glover et al 2013, McNamee et al 2013). A sedentary lifestyle is linked to obesity, type 2 diabetes and hypertension (Tremblay et al 2010). It is important to note that despite the widely held belief that people with SMI are not responsive to advice about lifestyle changes (Wright et al 2006), there is increasing evidence to show that people with SMI positively engage with weight management programmes (Vreeland et al 2003, Khazaal et al 2007).

TIME OUT 4

Select one antipsychotic medication. Identify what health screening is recommended for that medication, by reading the NICE (2014) guideline on *Psychosis and Schizophrenia in Adults: Prevention and Management* or accessing the BNF Online at www.bnfonline.org/, which has a section on monitoring requirements for each medication. How could you use this information in your consultations with patients to discuss the importance of health screening?

Smoking and mental health

A report by the Royal College of Physicians and the Royal College of Psychiatrists (2013) on the relationship between smoking and mental health disorders, demonstrated a strong correlation between people with SMI and the likelihood of smoking, indicating that people with SMI are twice as likely to smoke as the general population. While smoking rates have decreased among the general population, this has not been reflected in people with SMI, despite no differences in their motivation to stop smoking (Gilbody et al 2015).

This is a substantial health inequality that contributes significantly to the reduced life expectancy of those with SMI. To reduce this disparity by improving the physical health of people with SMI, many trusts in the UK have become 'smoke free', and the Mental Health Taskforce (2016) recommends that all mental health trusts become smoke free by 2018.

It is important to remember that the positive benefits associated with smoking cessation, including reductions in depression, anxiety and stress, and improved positive mood, are as great for people with SMI as for the general population (Taylor et al 2014).

Smoking and psychiatric medication

P450 enzymes are the group of enzymes in the liver that are responsible for metabolising many medications. One of these enzymes is increased by the hydrocarbons from cigarette smoking (not found in nicotine replacement products), meaning that some medications are metabolised and excreted more quickly in smokers than in non-smokers, resulting in less medication in the bloodstream. This means that an individual who smokes requires a higher dose of medication than if they did not smoke. Any reduction in smoking can lead to a potential increase in side effects because this causes reduced metabolism and greater availability of medication in the bloodstream (Royal College of Physicians and Royal College of Psychiatrists 2013). Therefore, changes in smoking frequency should be monitored carefully. The Maudsley Prescribing Guidelines (Taylor et al 2015) recommend reducing doses of certain psychiatric medications by up to 25% during the first week after stopping smoking, and monitoring blood plasma levels at weekly intervals after stopping smoking until these levels have stabilised.

TIME OUT 5

Develop a care plan for someone with SMI who is planning to stop smoking. What factors would you consider important, and what support would you provide?

Smoking reduction

NICE (2013) guidelines suggest working with people to develop smoking reduction plans that include increasing the amount of time between cigarettes smoked to gradually reduce the frequency, choosing certain periods of the day to go without smoking, and delaying the first cigarette of the day for as long as possible then gradually increasing this delay. A brief opportunistic intervention that can be used for smoking cessation in primary care is the 'four As': ask, advise, assist and arrange (West et al 2000). All people with SMI should be asked about their smoking status, and follow-up assessment questions can be used to assess their smoking habits and motivation to stop smoking, such as (Nash 2014) [Q5: The text below has been reworked to reflect that these are questions. Is this okay?]:

- How do you smoke? For example, do you smoke cigarettes, electronic cigarettes, shishas, unfiltered cigarettes or pipes?
- How much **they have** per day [Q6: meaning unclear, please rewrite], including the cost and amount smoked per day.
- What are your smoking habits? For example, do you smoke more or less in certain environments, or at particular times of day?
- Do you want to stop smoking for good?
- Are you interested in attempting to stop smoking in the near future?
- Would you like support to assist you in attempting to stop smoking?

Patients who smoke should be given advice on the benefits of smoking cessation and the potential health risks of continuing to smoke (Raw et al 1998). Practical assistance can be given to those who wish to stop smoking, and may include (Raw et al 1998):

- Setting a date to stop smoking completely.
- Reviewing previous attempts to stop smoking, for example what helped and hindered the attempt.
- Identifying potential issues and planning for them, including alcohol use.
- **Advising the person to tell their family and friends [Q7: that they are planning to stop smoking?].**
- Considering nicotine replacement therapy.

It can be beneficial to arrange a follow-up appointment, or for those who have had several unsuccessful attempts to stop smoking, referral to a specialist smoking cessation service (Raw et al 1998).

It is important to ensure the person is given information about the types of support for smoking cessation and what is available in their local area; even if they are not ready to change their smoking behaviour, it is important they are aware of the potential support available if they do become motivated to do so. People who are considering reducing their frequency of smoking should have access to nicotine replacement therapy, since research has suggested that people are twice as likely to be successful in smoking cessation using such therapy (Moore et al 2009).

For people with SMI, it is important to notify their care coordinator, GP and any other specialist mental health services they attend about potential changes to their smoking frequency, to enable them to increase mental health monitoring and review the individual's medication if necessary.

TIME OUT 6

Think about your attitude towards smoking cessation and mental health, and consider what effects this may have on the motivation of a person with SMI to reduce the frequency they smoke. Start a conversation with a person with SMI that explores their motivation to change their smoking behaviours. Reflect on this health promotion interaction, while taking into account that changing health behaviour is often not a linear process.

Oral health

People with SMI are at an increased risk of untreated dental caries, tooth loss and edentulousness (missing teeth), missing or ill-fitting dentures, gingivitis, periodontitis and mucosal disease (Lewis et al 2001, Ramon et al 2003, Kumar et al 2006, Kisely et al 2015). Suboptimal oral health, some symptoms of mental illness and side effects of medication can result in dental complications (Shaw and Smith 1999).

Low mood and a lack of motivation can lead to a reduction in personal care activities including oral healthcare, which increases the risk of oral infections (Okoro et al 2012). Overzealous use of oral healthcare aids, such as toothbrushes or dental floss, can cause cervical abrasion and mucosal or gingival lacerations (Clark 2003). This can be associated with mania and **obsessive compulsions [Q8: okay to change to obsessive-compulsive behaviours?]**. Vomiting and malnutrition associated with some eating disorders can also significantly increase the risk of dental decay (Frydrych et al 2005). Side effects of medications can affect dental health. For example, one potential side effect of some antipsychotic and antidepressant medications is xerostomia (dry mouth), which can adversely affect oral health. Another potential side effect of some antipsychotic medications is tardive dyskinesia (involuntary face or body movements), and when this affects the mouth and facial muscles it can cause several dental complications, including difficulties receiving dental treatment, and ill-fitting dentures (Stanfield 2004).

TIME OUT 7

Access the electronic Medicines Compendium website at www.medicines.org.uk/emc or the BNF (2016) to identify which antipsychotic and antidepressant medications list xerostomia as a side effect. For each medication identify whether xerostomia is very common, common, uncommon, rare or very rare. How could you use this information to improve oral health promotion in people with SMI?

While SMI can lead to suboptimal oral health, the opposite can also be the case, with suboptimal oral health being linked to depression. One large oral health survey in the UK found that 70% of people with suboptimal oral health reported that it negatively affected their lives, with 39% hiding their smile and 31% saying their teeth made them feel less confident in public (Dentistry.co.uk 2012).

To improve the oral health of people with SMI, healthcare professionals should:

- Support people to access local dental practices.
- Use a harm minimisation strategy for those who frequently induce vomiting, encouraging them to use a mouthwash rather than brushing their teeth after vomiting to reduce acid exposure.
- Be aware of xerostomia and its potential effects on oral health. Consider recommending oral lubricating gels or artificial saliva, which can support symptom relief, as can chewing sugarless gum to stimulate the flow of saliva.
- Ensure individuals are aware of the recommended guidance regarding fluoride content in toothpaste. Recommend a 'spit don't rinse' strategy after brushing teeth, which can support the remineralisation of teeth, thus reducing the risk of cavities (Daly 2016).
- Provide advice on basic oral health, including brushing teeth twice a day, using floss or interdental brushes, reducing sugar and alcohol intake, and having regular dental check-ups.

Information on basic oral healthcare is available from NHS Choices (2015).

Sexual health

Based on the WHO (1948) definition of health, sexual health would be defined as a state of physical, mental and social well-being relating to sexuality. It is important to remember that sexuality not only refers to sexual acts, but encompasses the person's behaviours, desires, and attitudes related to sex and physical intimacy with others (National Cancer Institute 2016). Sexuality can be influenced by biological, psychological, social and cultural factors. Sexual dysfunction is defined by the WHO (1992) as 'the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish... Sexual response is a psychosomatic process and both psychological and somatic processes are usually involved'.

Sexual health is an area that many healthcare professionals are reluctant to discuss with patients. Sexual issues are often seen as complex and sensitive, and healthcare staff may feel that they are restricted by a lack of time and their limited expertise (Gott et al 2004). Nurses might feel uncomfortable initiating discussions about sexual health, and worry that patients may also become anxious or embarrassed (Kong et al 2009). However, neglecting this area of health means that holistic care is not provided, and sexual health issues may be particularly important for people with SMI. Studies have shown that people with schizophrenia have higher levels of sexual dysfunction than the general population, and it is estimated to affect 30%-80% of women and 45%-80% of men (De Hert et al 2011). This is likely to be a side effect of antipsychotic medication; some medications have a greater effect on sexual function than others (Baggaley 2008).

Sexual dysfunction is more likely with medications that raise prolactin levels, such as amisulpride, paliperidone and risperidone, than those that do not, such as aripiprazole, olanzapine and quetiapine (Basson et al 2010).

Similarly, some antidepressant medications induce or exacerbate sexual dysfunction in approximately half of patients (De Hert et al 2011). Despite this, patients rarely initiate discussions about these issues; therefore, it is crucial for healthcare professionals to actively identify the presence and extent of the person's sexual dysfunction (Dossenbach et al 2005).

A lower proportion of people with SMI are sexually active than the general population; however, those who are sexually active are increasingly likely to engage in risky sexual behaviours, such as unprotected sex (Cournos et al 2005). This may be because of a lack of knowledge about sexually transmitted diseases (STDs), unwanted sexual activity as a result of an increased susceptibility to coercion, and comorbid alcohol and substance misuse. These risky behaviours increase the risk of human immunodeficiency virus (HIV) and other STDs (Robson and Gray 2007), and the prevalence of people who are HIV-positive among those with SMI is higher than in the general population (De Hert et al 2011).

The PLISSIT model (Annon 1976) was developed to assist [Q9: healthcare professionals?] to broach the subject of sexual health with patients, and later this model was further developed by [Davis and Taylor (2006)] into the Extended PLISSIT (Ex-PLISSIT) model. There are four levels of intervention in the PLISSIT model: permission-giving, limited information, specific suggestions and intensive therapy (Box 1). While the PLISSIT model (Annon 1976) is linear, the Ex-PLISSIT model [Davis and Taylor 2006] suggests that the permission-giving level should be revisited at the start of each intervention. The Ex-PLISSIT model [Taylor and Davis 2006] [Q10: which is the correct reference for the Ex-PLISSIT model? Could one reference be used for consistency?] incorporates reflection and review at each level, enabling the nurse to develop their practice. This includes reviewing the consultation with the patient, by asking questions such as 'how does that sound to you?', 'how might your partner feel about that?' and 'is there anything we haven't covered?' It is necessary for nurses to be able to reflect on their own attitudes towards sexuality, since the provision of effective care will not be possible if patients perceive judgement or disapproval from nurses. Barriers related to attitudes include: gender, with same-sex consultations being preferred; ethnicity – the belief being that people from some ethnic backgrounds would be more reluctant to discuss sexuality; and patients who are not heterosexual, where the nurse's personal views may be challenging to reconcile with effective clinical practice (Gott et al 2004).

Box 1. Levels of intervention in the PLISSIT model

Permission-giving

This level is aimed at unambiguously opening the discussion about sexual health. The nurse may think they have given the patient the opportunity to talk about this by asking questions such as 'do you have any further questions?' However, if it is not explicitly stated, the patient will not know that the nurse is asking about sexual health. This explicit permission-giving is necessary, because patients may be too embarrassed or reticent to initiate the discussion themselves. The type of questions to ask the patient at this level are:

- Some people with this condition experience a loss of sexual desire or enjoyment. Is this something that you have experienced?
- Sometimes people are concerned about how this condition or treatment will affect sexual functioning. Is this something that you are concerned about or have experienced?

Limited information

In most non-specialist settings, this level would directly follow on from the permission-giving level. This is an opportunity for the nurse, even with limited knowledge, to give the patient some basic information in relation to sexual health. This could include information about how a particular condition or treatment can affect sexual function. During this level, the nurse has the opportunity to correct any misinformation, dispel myths and normalise the patient's experience, particularly in relation to the side effects associated with medications. The information given may be consolidated with written information in the form of leaflets or discussing useful websites.

Specific suggestions

In this level, the nurse requires additional skills and knowledge to take a detailed patient history and identify specific sexual health issues. It may be necessary to refer the patient to another healthcare professional at this level.

Intensive therapy

This level requires specialist knowledge and is usually beyond the remit of healthcare staff in non-specialist services. Nurses should know what specialist services are available for patient referral. This may include sexual dysfunction clinics and psychosexual counselling.

(Adapted from Davis and Taylor 2006, Taylor and Davis 2006)

TIME OUT 8

Reflect on your attitudes and beliefs regarding sex and sexuality. Use the following questions as a guide:

- Do you find it challenging to talk to patients about their sexual health? If so, why?
- Have you made assumptions about your patients' sexuality, for example that they are heterosexual, or that because they have a long-term health condition they would not be interested in sexual relationships?
- Do you currently consider your patients' sexuality and sexual health? If not, why do you think this is? If so, in what way do you do this?

Conclusion

There are many ways in which healthcare professionals in all practice settings can promote the physical health of people with SMI. Nurses should be aware of the barriers that people with SMI may experience when accessing physical healthcare. By considering that the person may have overcome several issues and challenges in making and getting to appointments, and understanding that they may not be able to communicate their concerns effectively, nurses are better able to provide care that is compassionate and appropriate.

It may be more important for people with SMI to seek physical healthcare than the general population, since suboptimal physical, oral and sexual health, obesity, diabetes and smoking are increasingly common in these individuals. They may have a range of physical health needs that are beyond those discussed in this article; there are many more needs that will be relevant for different areas of practice. To reduce health inequalities, it is necessary for healthcare professionals to examine their areas of specialty and consider how they can integrate the health promotion, assessment and treatment of people with SMI.

TIME OUT 9

Nurses are encouraged to apply the four themes of The Code (NMC 2015) to their professional practice. Consider how reducing health inequalities for people with SMI relates to the themes of The Code.

TIME OUT 10

Now that you have completed the article you might like to write a reflective account as part of your revalidation.

References

- Annon JS (1976) The PLISSIT model: a proposed conceptual scheme for the behavioral treatment of sexual problems. *Journal of Sex Education and Therapy*. 2, 1, 1-15.
- Baggaley M (2008) Sexual dysfunction in schizophrenia: focus on recent evidence. *Human Psychopharmacology: Clinical and Experimental*. 23, 3, 201-209.
- Barch DM (2005) The relationships among cognition, motivation, and emotion in schizophrenia: how much and how little we know. *Schizophrenia Bulletin*. 31, 4, 875-881.
- Basson R, Rees P, Wang R et al (2010) Sexual function in chronic illness. *Journal of Sexual Medicine*. 7, 1 pt 2, 374-388.
- British Heart Foundation (2017) High Cholesterol. www.bhf.org.uk/heart-health/risk-factors/high-cholesterol (Last accessed: 22 April 2017.)
- British National Formulary (2016) British National Formulary. No. 71. BMJ Group and the Royal Pharmaceutical Society of Great Britain, London
- Chadwick A, Street C, McAndrew S et al (2012) Minding our own bodies: reviewing the literature regarding the perceptions of service users diagnosed with serious mental illness on barriers to accessing physical health care. *International Journal of Mental Health Nursing*. 21, 3, 211-219.
- Chesney E, Goodwin GM, Fazel S (2014) Risks of all-cause and suicide mortality in mental disorders: a meta-review. *World Psychiatry*. 13, 2, 153-160.
- Clark DB (2003) Dental care for the patient with bipolar disorder. *Journal of the Canadian Dental Association*. 69, 1, 20-24.
- Cole M, Padmanabhan A (2012) Breast cancer treatment of women with schizophrenia and bipolar disorder from Philadelphia, PA: lessons learned and suggestions for improvement. *Journal of Cancer Education*. 27, 4, 774-779.
- Cournos F, McKinnon K, Sullivan G (2005) Schizophrenia and comorbid human immunodeficiency virus or hepatitis C virus. *Journal of Clinical Psychiatry*. 66, Suppl 6, 27-33.
- Daly C (2016) Dental note: oral and dental effects of antidepressants. *Australian Prescriber*. 39, 3, 84.
- Davis S, Taylor B (2006) From PLISSIT to EX-PLISSIT. In Davis S (Ed) *Rehabilitation: The Use of Theories and Models in Practice*. Elsevier, Edinburgh, 101-130.
- De Hert M, Correll CU, Bobes J et al (2011) Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*. 10, 1, 52-77.
- De Hert M, Detraux J, van Winkel R et al (2012) Metabolic and cardiovascular adverse effects associated with antipsychotic drugs. *Nature Reviews Endocrinology*. 8, 2, 114-126.
- Dentistry.co.uk (2012) Bad Teeth can have Mental Impact. www.dentistry.co.uk/2012/06/25/bad-teeth-can-have-mental-impact (Last accessed: 25 April 2017.)
- Department of Health (2006) Choosing Health: Supporting the Physical Health Needs of People with Severe Mental Illness. Commissioning Framework. www2.rcn.org.uk/_data/assets/pdf_file/0009/524979/choosing-healthpdf.pdf (Last accessed: 25 April 2017.)
- Dossenbach M, Hodge A, Anders M et al (2005) Prevalence of sexual dysfunction in patients with schizophrenia: international variation and underestimation. *International Journal of Neuropsychopharmacology*. 8, 2, 195-201.

- Egan G (2010) *The Skilled Helper: A Problem-Management and Opportunity-Development Approach to Helping*. Ninth edition. Brooks/Cole Cengage Learning, Belmont CA.
- Fava M, Graves LM, Benazzi F et al (2006) A cross-sectional study of the prevalence of cognitive and physical symptoms during long-term antidepressant treatment. *Journal of Clinical Psychiatry*. 67, 11, 1754-1759.
- Frydrych AM, Davies GR, McDermott BM (2005) Eating disorders and oral health: a review of the literature. *Australian Dental Journal*. 50, 1, 6-15.
- Gilbody S, Peckham E, Man MS et al (2015) Bespoke smoking cessation for people with severe mental ill health (SCIMITAR): a pilot randomised controlled trial. *The Lancet Psychiatry*. 2, 5, 395-402.
- Glover CM, Ferron JC, Whitley R (2013) Barriers to exercise among people with severe mental illnesses. *Psychiatric Rehabilitation Journal*. 36, 1, 45-47.
- Gott M, Galena E, Hinchliff S et al (2004) 'Opening a can of worms': GP and practice nurse barriers to talking about sexual health in primary care. *Family Practice*. 21, 5, 528-536.
- Happell B, Scott D, Platania-Phung C (2012) Perceptions of barriers to physical health care for people with serious mental illness: a review of the international literature. *Issues in Mental Health Nursing*. 33, 11, 752-761.
- Harangozo J, Reneses B, Brohan E et al (2014) Stigma and discrimination against people with schizophrenia related to medical services. *International Journal of Social Psychiatry*. 60, 4, 359-366.
- He M, Deng C, Huang XF (2013) The role of hypothalamic H1 receptor antagonism in antipsychotic-induced weight gain. *CNS Drugs*. 27, 6, 423-434.
- Health and Social Care Information Centre (2014) NHS Outcomes Framework: November 2014 Publication. content.digital.nhs.uk/catalogue/PUB15930/nhs-out-fram-ind-nov-14-comm.pdf (Last accessed: 25 April 2017.)
- Ho CSH, Zhang MW, Mak A et al (2014) Metabolic syndrome in psychiatry: advances in understanding and management. *Advances in Psychiatric Treatment*. 20, 2, 101-112.
- Kassi E, Pervanidou P, Kaltsas G et al (2011) Metabolic syndrome: definitions and controversies. *BMC Medicine*. 9, 48, 1-13.
- Khazaal Y, Fresard E, Rabia S et al (2007) Cognitive behavioural therapy for weight gain associated with antipsychotic drugs. *Schizophrenia Research*. 91, 1-3, 169-177.
- Kisely S, Baghaie H, Laloo R et al (2015) A systematic review and meta-analysis of the association between poor oral health and severe mental illness. *Psychosomatic Medicine*. 77, 1, 83-92.
- Kong SK, Wu LH, Loke AY (2009) Nursing students' knowledge, attitude and readiness to work for clients with sexual health concerns. *Journal of Clinical Nursing*. 18, 16, 2372-2382.
- Kumar M, Chandu GN, Shafiulla MD (2006) Oral health status and treatment needs in institutionalized psychiatric patients: one year descriptive cross sectional study. *Indian Journal of Dental Research*. 17, 4, 171-177.
- Lasalvia A, Zoppei S, Van Bortel T et al (2013) Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey. *The Lancet*. 381, 9860, 55-62.
- Lester H, Tritter JQ, Sorohan H (2005) Patients' and health professionals' views on primary care for people with serious mental illness: focus group study. *British Medical Journal*. 330, 7500, 1122.
- Lewis S, Jagger RG, Treasure ET (2001) The oral health of psychiatric in-patients in South Wales. *Special Care in Dentistry*. 21, 5, 182-186.
- McNamee L, Mead G, MacGillivray S et al (2013) Schizophrenia, poor physical health and physical activity: evidence-based interventions are required to reduce major health inequalities. *British Journal of Psychiatry*. 203, 4, 239-241.
- Mental Health Foundation (2006) *Feeding Minds. The Impact of Food on Mental Health*. Mental Helth Foundation, London.
- Mental Health Taskforce (2016) *The Five Year Forward View for Mental Health: A Report from the Independent Mental Health Taskforce to the NHS in England*. Mental Health Taskforce, London.

- Moore D, Aveyard P, Connock M et al (2009) Effectiveness and safety of nicotine replacement therapy assisted reduction to stop smoking: systematic review and meta-analysis. *British Medical Journal*. 338, b1024.
- Morrissey J, Callaghan P (2011) *Communication Skills for Mental Health Nurses*. Open University Press, Maidenhead.
- Nash M (2013) Diagnostic overshadowing: a potential barrier to physical health care for mental health service users. *Mental Health Practice*. 17, 4, 22-26.
- Nash M (2014) *Physical Health and Well-being in Mental Health Nursing: Clinical Skills for Practice*. Second edition. Open University Press, Maidenhead.
- National Cancer Institute (2016) NCI Dictionary of Cancer Terms. www.cancer.gov/publications/dictionaries/cancer-terms?expand=S (Last accessed: 25 April 2017.)
- National Institute for Health and Care Excellence (2013) *Smoking: Supporting People to Stop*. NICE, London. [Q11: Is this quality standard No.43?]
- National Institute for Health and Care Excellence (2014) *Psychosis and Schizophrenia in Adults: Prevention and Management*. NICE, London. [Q12: Is this clinical guideline no.178?]
- Naylor C, Das P, Ross S et al (2016) *Bringing Together Physical and Mental Health: A New Frontier for Integrated Care*. The King's Fund, London.
- NHS Choices (2015) *Take Care of your Teeth and Gums*. www.nhs.uk/Livewell/dentalhealth/Pages/Dentalhealthintroduction.aspx (Last accessed: 25 April 2017.)
- Nursing and Midwifery Council (2015) *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives*. NMC, London.
- Okoro CA, Strine TW, Eke PI et al (2012) The association between depression and anxiety and use of oral health services and tooth loss. *Community Dentistry and Oral Epidemiology*. 40, 2, 134-144.
- Phelan M, Stradins L, Morrison S (2001) Physical health of people with severe mental illness: can be improved if primary care and mental health professionals pay attention to it. *British Medical Journal*. 322, 7284, 443-444.
- Pitsavos C, Panagiotakos D, Weinem M et al (2006) Diet, exercise and the metabolic syndrome. *Review of Diabetic Studies*. 3, 3, 118-126.
- Ramon T, Grinshpoon A, Zusman SP et al (2003) Oral health and treatment needs of institutionalized chronic psychiatric patients in Israel. *European Psychiatry*. 18, 3, 101-105.
- Raw M, McNeill A, West R (1998) *Smoking Cessation Guidelines for Health Professionals: a guide to effective smoking cessation interventions for the health care system*. Thorax. 53, Suppl 5, S1-S18.
- Robson D, Gray R (2007) Serious mental illness and physical health problems: a discussion paper. *International Journal of Nursing Studies*. 44, 3, 457-466.
- Royal College of Physicians, Royal College Psychiatrists (2013) *Smoking and Mental Health*. RCP, London.
- Samele C (2004) Factors leading to poor physical health in people with psychosis. *Epidemiologia e Psichiatria Sociale*. 13, 3, 141-145.
- Schildkrout B (2011) *Unmasking Psychological Symptoms: How Therapists can Learn to Recognize the Psychological Presentation of Medical Disorders*. John Wiley & Sons, Hoboken NJ.
- Shaw L, Smith AJ (1999) Dental erosion: the problem and some practical solutions. *British Dental Journal*. 186, 3, 115-118.
- Stanfield M (2004) Schizophrenia and oral healthcare. *Dental Update*. 31, 9, 510-515.
- Taylor B, Davis S (2006) Using the extended PLISSIT model to address sexual healthcare needs. *Nursing Standard*. 21, 11, 35-40.

- Taylor D, Paton C, Kapur S (2015) The Maudsley Prescribing Guidelines in Psychiatry. 12th edition. Wiley Blackwell, Oxford.
- Taylor G, McNeill A, Girling A et al (2014) Change in mental health after smoking cessation: systematic review and meta-analysis. British Medical Journal. 348, g1151.
- Tremblay MS, Colley RC, Saunders TJ et al (2010) Physiological and health implications of a sedentary lifestyle. Applied Physiology, Nutrition, and Metabolism. 35, 6, 725-740.
- Vreeland B, Minsky S, Menza M et al (2003) A program for managing weight gain associated with atypical antipsychotics. Psychiatric Services. 54, 8, 1155-1157.
- West R, McNeill A, Raw M (2000) Smoking cessation guidelines for health professionals: an update. Thorax. 55, 12, 987-999.
- Wilber ST (2006) Altered mental status in older emergency department patients. Emergency Medicine Clinics of North America. 24, 2, 299-316.
- World Health Organization (1948) Constitution of the World Health Organization.
www.who.int/governance/eb/who_constitution_en.pdf (Last accessed: 25 April 2017.)
- World Health Organization (1992) The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. WHO, Geneva.
- Wright CA, Osborn DP, Nazareth I et al (2006) Prevention of coronary heart disease in people with severe mental illnesses: a qualitative study of patient and professionals' preferences for care. BMC Psychiatry. 6, 16, 1-12.