Addressing mental health inequalities

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Welcome to the first mental health section of *Journal of Diabetes Nursing*. Within this section, we will be discussing the many struggles faced by people with mental health conditions. There is a wealth of information available regarding the problems that these people face; however, healthcare professionals still face challenges when trying to address them. When the NHS was created in 1948, it was formed to support the improvement in the health of all people living in this country. Sadly, we now know that people who have a diagnosis of severe mental illness (SMI) are at greater risk of comorbid health problems than the general population. This is perhaps most aptly emphasised by the quote from the *British Journal of Psychiatry* (Wahlbeck et al, 2011):

> *"The fact is that when you are diagnosed with schizophrenia in the UK you have a lower life expectancy than children born in many third world countries."*

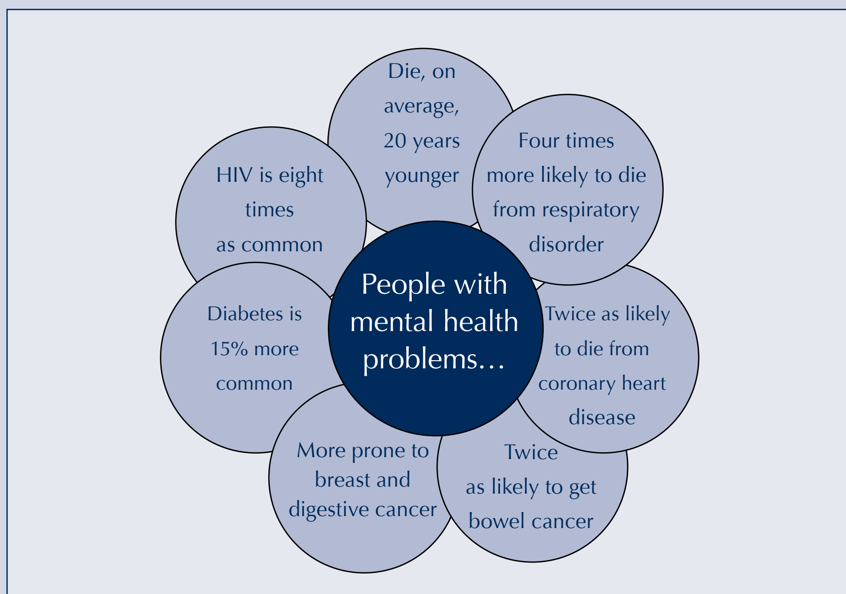

Figure 1. The scale of the problem (Cohen et al, 2004; Disability Rights Commission, 2006; Department of Health, 2010)

Evidence now suggests the problem is more significant than previously recognised and this has been highlighted in research and data from many different sources. It is well documented that people with mental health problems die on average 20 years earlier than the general population. This was apparent in the Department of Health (DH) publication *No health without mental health: Delivering better mental health outcome for people of all ages* (DH, 2011a), which provided some very sobering statistics.

Costs

Within these times of austerity, there is a need to review the financial case for improving the quality in mental health. In 2007, the financial cost of depression was said to be £7.5 billion and schizophrenia was £6.7 billion (DH, 2011b); however, these figures have increased dramatically. Furthermore, obesity-related conditions cost £4.2 billion and this cost is rising (Sainsbury Centre for Mental Health, 2010). It has also been reported that mental health conditions cost approximately £105 billion each year in England alone. This includes £21 billion in health and social care costs and £29 billion in losses to business from reduced productivity, sickness absence and unemployment (Sainsbury Centre for Mental Health, 2010).

It should be recognised that if there was a collaborative approach to care in mental health and its physical comorbidities, there would be great financial benefits. The DH (2011b) suggested that, with appropriate co-management of depression and type 2 diabetes, approximately £1.9 billion could be saved in efficiency gains. This is worth considering in these difficult economic times.

Health inequality

So, why do people with mental health problems have worse health outcomes than the general population? There are many potential reasons. General inequalities are worked out by one or a combination of multifaceted risk factors (see *Table 1*). Additionally,

evidence suggests there is a link between schizophrenia and diabetes generally. Defects in insulin function could directly contribute to psychiatric disorders such as schizophrenia. Vanderbilt University Medical Centre investigators have discovered a molecular link between impaired insulin signalling in the brain and schizophrenia-like behaviours (Siuta et al, 2010). Early findings in mice studies offer a new perspective on the psychiatric and cognitive disorders that affect people with diabetes and could suggest new strategies for treating these co-existing conditions (Siuta et al, 2010).

There have also been suggestions that there is a relationship between long-term stresses and the cardiovascular, immune and central nervous systems. If the physiological stress responses are frequently activated, it increases an individual's susceptibility to diabetes, hypertension, high cholesterol, infection, myocardial infarction and stroke. When combined, these multifaceted risk factors significantly increase morbidity rates in adults with SMI (Yardley, 2011).

Health policies

Since 2000, the NHS has been introducing policies to readdress the promotion of physical health improvement in people with SMI. These policies have all highlighted comorbidity concerns and the risk of premature death. Despite this, the physical health needs of people with mental health problems have remained a fairly low priority. By 2006, the DH accepted that there were very few resources which openly addressed this issue and stated that there was a need to bring the physical and mental health needs of people to the forefront of service provision (DH, 2006). Now, the "No health without mental health" strategy states that the only way to address these issues is with a significant shift to collaboration and a joint-care planning approach (DH, 2011a). To achieve appropriate outcomes there needs to be detection and holistic action planning by all practitioners involved in the care of people with SMI.

While diabetes is only one of the many problems faced by people with mental health problems, it is important for us, as diabetes practitioners, to provide individualised treatments strategies for this group of people by understanding the day-to-day issues they can be facing. We then should be working in co-operation with other specialists and utilise appropriate resources to aid a better outcome. Often, it is very difficult to reach optimal diabetes targets, which can be very frustrating; however, if we are mindful of all the issues that need to be addressed, we can move forward in providing a higher standard of diabetes care. The desired outcome would be a reduction in diabetes-related complications, improved communication between healthcare professionals and finally, a reduction in health service costs. ■

Table 1. Risk factors for poor physical health in people with mental illness.

Demographics	E.g., age, gender, culture, ethnicity, social class, religious beliefs, poor professional attitudes and limited professional skills and knowledge.
Lifestyle	E.g., smoking, alcohol and substance misuse, poor diet, poor fluid intake, high cholesterol, lack of exercise, anxiety and stress.
Social	E.g., poor financial income, poor housing, poor relationships, unemployment, lack of education, risk of crime, stigma and public attitude.
Medical	E.g., medical history, medication regimen, adverse medicine side effects, lack of screening or immunisation, no self-examination, lack of contraception, lack of health education and limited health policies.

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