MENTAL HEALTH ISSUES WITHIN THE GENERAL HEALTH CARE SYSTEM: IMPLICATIONS FOR THE NURSING PROFESSION

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ABSTRACT

Aim:

The aim of this paper is to briefly describe the prevalence of mental illness within the general health care population and the implications for the nursing profession.

Primary argument:

The nursing profession espouses holism as its philosophy of care. This philosophy embraces the essential interaction between the biological, psychological and social aspects of each individual. The mainstreaming of mental health services within the general health care system has increased the level of contact nurses have with people experiencing mental health problems, yet the research evidence suggests they are not confident or competent in meeting the associated needs.

Conclusion:

There is an urgent need for education of the current and future nursing workforce if the challenges presented by mental health issues are to be addressed.

INTRODUCTION

Nurses constitute the largest professional health care group, comprising 45% of full time public hospital staff and 60% of private hospital staff (Australian Bureau of Statistics 2001). By virtue of their numbers and their specific expertise: 'Nurses are in a unique position to assist their clients in achieving and maintaining optimal levels of health. Nurses understand the challenges of today's health care system and embrace the opportunity to use, wellness activities to promote health and prevent illness' (McMurray 2001).

The World Health Organisation (WHO) defined health as 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (1974, p.1). Health is clearly a complex concept that includes biological, social, psychological and spiritual factors, and cannot be considered in isolation from the individual and environmental factors that influence each person's life (McMurray 2001).

The fundamental role of nursing in relation to health led to the development of the concept of holism as the central philosophy for nursing. Holistic nursing care dates back to Florence Nightingale who identified the importance of the psychological and spiritual aspects of the individual when caring for their physical needs (Dossey and Dossey 1998). The provision of holistic nursing care therefore depends on the willingness and ability to address all aspects of the person within the health care system, in order to achieve the best possible health outcome.

The mental health needs of patients must therefore be seen as crucial to the provision of high quality nursing care. In this paper the prevalence of mental health issues within the general health care system and the implications for contemporary nursing practice is discussed.

IMPLICATIONS OF MENTAL HEALTH ISSUES FOR NURSING

The integration of mental health care into primary health care has become an area of priority both locally and internationally. This process, known as 'mainstreaming' is now completed in the state of Victoria, Australia, in response to the launch of the Mental Health Policy (Australian Health Ministers 1992). Mainstreaming is characterised by a fundamental shift of psychiatric services from psychiatric institutions to general health settings. Mainstreaming was intended to increase consumers' access to a quality, comprehensive health care service and to reduce the stigmatisation of and discrimination against people experiencing a mental illness (Whiteford 1998).

As a direct result of mainstreaming, nurses now have more frequent contact with people experiencing mental health problems (Sharrock and Happell 2000). However, nurses tend not to have a comprehensive understanding of the problems and needs of people experiencing mental health problems (Bailey 1998; Muirhead and Tilley 1995; Sharrock and Happell 2000). Furthermore, general nurses expressed a lack of enjoyment in caring for patients with eating disorders, schizophrenia and those who committed deliberate self-harm as the result of a mental health problem (Fleming and Szmukler 1992). A study of emergency nurses suggests they were not clear whether their role should include care for patients with mental health problems (Gillette et al 1996). Consequently, nurses have come to avoid patients experiencing mental health problems because of feelings of fear and powerlessness and the acknowledgement that attending to these patients is more time consuming (Gillette et al 1996).

Nurses in general hospitals tend to place a higher priority on physical care than on psychosocial care (Gillette et al 1996; Swan and McVicar 1990; Whitehead and Mayou 1989). It has been claimed 'basic human skills are seriously lacking in the nursing workforce today, at least in many acute settings' (Armstrong 2000, p.27). This is largely attributed to insufficient psychiatric and mental health content in undergraduate courses to prepare nurses for mental health care (Wynaden et al 2000; Happell 1998).

The prevalence of mental illness is found to be higher in hospital and other health care settings than in the general population, signifying the already substantial discrepancy between what mental health care is needed and the availability of services. Australian researchers have highlighted a great need for better mental health care services across local health care settings, including general hospitals (Sharrock and Happell 2000), parentcraft hospitals (McMahon et al 2001), nursing homes (Arie 2001; Snowdon 2001), for children and adolescents (Birleson et al 2000), and health care in general (Mott and Kingsley 1999). Similar claims have been made in Britain (Mavundla 2000). Common health care issues that drive these claims will now be reviewed.

COMMON MENTAL HEALTH RELATED PROBLEMS IN HEALTH CARE SETTINGS

A significant barrier to high quality care for people experiencing a mental illness, in all contexts, is stigma and discrimination. Negative labelling is more likely to occur in hospital settings, as patients with mental illness often exhibit behaviour inconsistent with the traditional 'sick role' (Sharrock and Happell 2000). Implications of negative labelling include the continuation of problem behaviours and occasional extreme efforts by staff to control them (Trexler 1996). So called difficult patients run the risk of being neglected or abused (Mott and Kingsley 1999; Bridges-Parlet et al 1994). In light of this, common myths and misconceptions must be dispelled and positive attitudes fostered, particularly among health professionals and workers (World Health Organisation 2001).

The psychosocial needs of people with mental illness are far less likely to be addressed if these patients are not recognised as having a mental illness. Symptoms of mental illness are commonly construed as 'normal' given the adverse situations a patient may be experiencing, such as reactive anxiety. Furthermore, it is consistently found that many people with a mental disorder present to primary care, but their condition is not detected (Roy-Byrne et al 2000; Rost et al 1998; Ronalds et al 1997; Saravay 1996; Fifer et al 1994; Kirmayar et al 1993; Ormel et al 1991). This is also the case in general hospital settings (Hansen et al 2001; Gater et al 1998; Mayou and Hawton 1986; Ammon 1983), including critical care units (Rincon et al 2001).

It has been acknowledged in North America that critical care unit nurses and physicians do not possess the skills and expertise to make diagnoses of anxiety, depression and delirium (Rincon et al 2001). Overall, it appears that for a variety of reasons, mental illness is not recognised or identified. This may be partly overcome through the application of brief screening instruments by nursing staff during patient admission (Booth et al 1998).

Even if it is recognised that a patient has a mental illness, there is no evidence that this recognition translates to acknowledgement of a greater need for care than patients without a mental health problem (Armstrong 2000). This may be partly due to a lack of understanding of the extent to which mental illness contributes to precipitating, aggravating and prolonging physical disability and illness.

Meeting the psychological and psychiatric needs of patients

Nursing constitutes the largest professional health care group, comprising 45% of full time public hospital staff and 60% of private hospital staff (Australian Bureau of Statistics 2001). Therefore, nurses are the group most in direct and indirect contact with people experiencing a mental illness and potentially play an important role in the detection of mental health problems and subsequent care (Sharrock and Happell 2000). Furthermore, as nurses

aspire to a holistic model of care, they may help to balance the scales between biomedical and psychosocial support, in a complementary fashion, towards the provision of optimal quality care.

Currently, psychiatric consultation-liaison nursing (PCLN) is the primary formal avenue to increased on-the-job nurse expertise in caring for people experiencing a mental illness (Sharrock and Happell 2000). American data suggest that consultation rates are less than one tenth of reported prevalence rates of psychiatric morbidity in hospitals. European data also suggests that consultation liaison psychiatry service delivery falls significantly short of reported rates of psychiatric comorbidity (Huyse et al 2001). These findings indicate that consultation liaison nursing alone is insufficient. Improving psychological and psychiatric care for patients on a large scale will require increased training in mental health education as part of comprehensive nursing education (Clinton and Hazelton 2000; Prebble 2001). These sentiments reflect recommendations of the World Health Organisation (2001) that general health personnel be trained in mental health care skills, with mental health content included in the training curricula, as well as refresher courses.

Increased skills in attending to the mental health needs of patients would also relieve strain on the nurses themselves, including the stress of dealing with challenging behaviour such as non-adherence to prescribed medication (Hallberg and Norberg 1993) and lack of confidence (due to lack of training). Mental health care skills were noted to diminish distress for nurses caring for patients with dementia following an attitude change intervention (Hallberg and Norberg 1993).

Prevalence of mental illness in the general community

The National Survey of Mental Health and Wellbeing of Adults (Australian Bureau of Statistics 1997) found that 18% of Australians had a mental illness at some point during the 12-month period prior to survey completion. Mental illness was diagnosed with a computerised version of the Composite International Diagnostic Interview (CIDI). The National Survey of Mental Health and Wellbeing of Adults (Andrews et al 1999) estimated that at some time during a year 1,300,000 adults over 18 years of age have an anxiety disorder, 1,042,000 a substance abuse disorder and 779,000 an affective disorder. It is important to note that 62% of those with a mental disorder do not access mental health services (Australian Bureau of Statistics 1997). Therefore, general health care settings provide an opportunity for detection and intervention for clients with a mental illness, who would not otherwise receive treatment.

Prevalence of mental illness in the general health care population

General hospitals

It is not uncommon for physical and psychological problems to co-occur in general hospital patients. They may: 1) occur simultaneously, either taking place by chance or sharing a common cause (eg major life event); 2) be a complication of a physical problem; or, 3) be the cause of a physical problem (Mayou and Sharpe 1991). Maladaptive coping from experiences such as hospitalisation presumably would increase the risk of developing mental illness.

Estimating the prevalence of mental illness within the general health care population has proven problematic as the result of significant variations in methodological approach such as the use of measurement tools (Mayou and Sharpe 1991). Prevalence rates have frequently been estimated based on mental illness symptoms (self-reported or observed), rather than formal diagnoses. Symptoms of depression may be confounded with physical illness symptoms (Parker et al 2001). Selection bias effects may also lead to an underestimation of the prevalence of psychiatric co-morbidity. Estimates based on discharge diagnoses or consultation files are particularly susceptible, because: a) the psychiatric disorders are not recognised by non-psychiatric staff; b) some physicians avoid a psychiatric diagnosis for fear of patient stigmatisation; and, c) often only the most serious cases are attended to (Wancata et al 2001). Overall, these methodological shortcomings are likely to lead to an underestimation of true prevalence rates.

Prevalence rates: International

The prevalence rates of psychiatric disorders is higher in the general hospital setting (outside psychiatric wards), than in the general community (Clarke 1998; Gelder et al 1996; Patten and Fick 1993; Van Hemert et al 1993). Clarke (1998, p.410), in a brief review of psychiatric co-morbidity, reports that 'major depression is two to four times more common in medical inpatients than in the general population. Somatization disorder, panic disorder, alcohol abuse and cognitive impairment are all about ten times more common in hospitalised patients.' For medical inpatients Gomez (1987) estimates prevalence of psychiatric morbidity to be between 30-65%. Overseas studies of psychological morbidity in cancer patients report estimates ranging from 23% (Greer et al 1992) to 47% (Derogatis et al 1983).

Prevalence rates are likely to vary according to the type of physical illness and patient demographics. In critical care settings, given that patient admission is based on severe medical or surgical disorders, it is more likely that these disorders will co-occur with a psychiatric condition. Rincon et al (2001) assessed 96 patients from three critical care units in California. Based on the Hospital Anxiety Depression Scale, 13.7% experienced depression and 24% experienced anxiety. Using the Confusional Assessment Method, 7.3% experienced delirium. In addition, 29.2% of patients were classified as possible problem drinkers. Prevalence rates also vary according to the type and severity of the disease. Yovtcheva et al (2001) assessed 306 randomly selected hepatitis C patient records using DSM-IV diagnosis

criteria. Thirty-eight per cent of the veteran patients had mood disorders, 30% personality disorders, 19% Post Traumatic Stress Disorder and 17% psychotic disorders, 86% alcohol abuse disorders and 28% intravenous drug use disorders. Prevalence rates for personality disorders among primary care patients with chronic pain range from 24-47% (Sansone et al 2001). Depression and suicidal ideation is common in acutely medically ill older patients, with prevalence rates of depression as high as 45% (Ramsey et al 1991; Koenig et al 1988).

Prevalence rates: Australia

There is less literature pertaining to physical and psychiatric co-morbidity in Australia than in Britain or the US, therefore this research will be reviewed in more detail. In an examination of medical and surgical admissions to a major metropolitan teaching hospital in Melbourne, Clark et al (1991) estimated that 30% of the sample had 'significant psychiatric morbidity' mostly characterised by depression and anxiety. Pascoe et al (2000) examined the prevalence of depression and anxiety among cancer patients in a cross-section of health services in Sydney, Australia. On the basis of the Hospital and Anxiety Depression Scale (HADS), 11.5% suffered from anxiety and 7.1% from depression. The majority of these patients did not receive any psychological treatment. According to Pascoe et al (2000, p.790), these rates suggest that for a typical metropolitan hospital, where about 110 patients attend for consultation or treatment per day, 17 significant cases of depression and anxiety (and 33 cases in total, if borderline cases are included) would be identified each day. Pascoe et al (2000) suggested that the results might not be generalisable to hospital populations as the sample consisted of people of relatively high socioeconomic status. The low prevalence rates found may also be attributed to the use of the HADS, which has been found to have low sensitivity at identifying psychological morbidity, in some cases (Hall et al 1999).

Kissane et al (1998) found that for women recently diagnosed with primary -stage breast cancer, 42% were diagnosed with a psychiatric disorder, most commonly depression and anxiety. This was a particularly substantial proportion given the low pain and disability and relatively good prognosis. Selection bias may explain the high prevalence, as patients were informed of the possibility of group psychological intervention for taking part, and 38% of the patients initially approached declined to participate in the study.

Intentional self-harm accounted for 25,260 separations in public hospitals and 1,477 separations in private hospitals (Australian Hospital Statistics 1999-2000). Dhossche, Ulusarac and Syed (2001) found retrospectively that suicide rates for general hospital patients were close to three times more common in general hospitals than in the general population. Cases of deliberate self-poisoning constitute about 10% of medical admissions in Australia (Henderson et al 1993). Also, patients who attempted suicide make up 3-5% of major intensive care admissions in Melbourne (Bailey 1998). Overall, from the limited data available, Australia does not appear to differ from other countries in the level of prevalence of mental illness in hospital settings.

Specific health care settings

Prevalence of mental illness higher than that expected within the general population has been identified in a variety of health care settings. Prevalence of depression for mothers admitted to residential parentcraft units ranged from 39% (Barnett et al 1993) to as high as 86% (Armstrong et al 2000). Nursing homes have particularly high rates of psychiatric illness, due in part to the closure of long-term care services in hospitals, the consequent relocation of people diagnosed with dementia to nursing homes, and the rise in typical severity of physical impairment experienced by nursing home residents (Snowdon 2001). Prevalence of dementia has been reported to be higher than 80%, with 25-50% of those with dementia exhibiting psychotic symptoms (Rovner and Katz 1993). Australian reports indicate similar prevalence rates. A study of nursing home residents from a Sydney district indicated 80% had cognitive impairment (Snowdon et al 1996), 30.4% had depression (Snowdon et al 1996), and 11.2% had a generalised anxiety disorder (Cheok et al 1996).

Many individuals with mental illness use general medical services in place of mental health care. Cross-cultural studies by the World Health Organisation (2001) examined the prevalence of mental disorders in primary care settings, using screening instruments and clinical and psychiatric diagnoses. It was found that almost one in four patients that attended primary care had a mental disorder. Depression, anxiety and substance abuse were the most commonly recognised disorders.

Overall, the literature provides extensive evidence that the prevalence of mental illness is high in the general community, but even higher in general health care settings, especially hospitals and nursing homes. While numerous methodological problems common to epidemiological research were encountered in these studies, those studies with a stronger design (eg Booth et al 1998), including random sampling of patients, use of diagnostic criteria and large sample size, were generally consistent with the wider literature when accounting for lifetime episodes of mental illness.

Mental illness and disease burden

Globally, mental illness accounts for almost 11% of the total disease burden (Murray and Lopez 1998, cited in National Action Plan 2000). In Australia, mental disorders caused 13% of the total disease burden in 1996, and accounted for about 30% of the non-fatal burden (Australian Institute of Health and Welfare 1999). Based on Years of Life lost due to Disability (YDL), mental disorders are the leading cause of non-fatal health outcomes, followed by nervous system and sense organ

disorders (Mathers et al 1999). Furthermore, mental disorders account for 55% of the total disease burden for young adults (Mathers et al 1999).

In 1996, depression was the second leading cause of disease burden, second only to ischaemic heart disease for adults aged between 25-64 years, and the leading cause among females (Mathers et al 1999). Among older Australians, senile dementia is the leading cause of burden of disease after ischaemic heart disease and stroke. In terms of the burden of mental illness, substance use disorders are the major cause among men (33%), while for females almost the entire mental health DALYs (Disability-adjusted life years) may be attributed to depression (87%) (Mathers et al 1999). Mental illness is responsible for 0.8% of all deaths, 1.4% of years of life lost, and 27.2% of YDLs - signifying that mental illness is not a direct cause of death but a substantial cause of chronic disability (Mathers et al 1999). Home-based individuals with a chronic disease are more likely to have a psychiatric disorder than individuals without chronic disease (Wells et al 1991; Wells et al 1989a; Wells et al 1989b).

Mental illness and mortality

Mortality rates, a key indicator of population health (Davidson et al 2000) strongly suggest that mental illness is associated with significantly poorer health, even after controlling for death through unnatural causes (Ruschena et al 1998; Brown 1997). Cardiovascular and respiratory diseases are more likely to lead to mortality among the mentally ill (Davidson et al 2000). Frasure-Smith et al (1995) found that for patients with myocardial infarction, depression is a significant predictor of mortality at six, 12 and 18-month follow-ups.

Mental illness is not generally recognised as a high risk factor for mortality, because its link to mortality is not as clear as that of physical disease. However, mental illness is frequently an indirect cause of death, because it heightens chronic disability, is associated with bad health habits including inadequate diet, alcohol abuse, smoking and sedentary lifestyle (Davidson et al 2000; Glassman 1993) and therefore contributes to disease onset and severity. Therefore, while mortality rates are a handy measure of health burden, recognition only of mortality leads to a serious underestimation of the amount of non-death related burden contributed to mental illness (Goldney et al 2000).

Most research linking mental illness and physical illness has focused on the influence of depression (Booth et al 1998). Depression is the fourth leading cause of disease and disability in the world (World Health Organisation 2001). In Australia, there is substantial evidence that major depression is associated with a high level of morbidity (Henderson et al 2000; Andrews et al 2000; Mathers et al 1999). A representative study in South Australia found those with depression reported a diminished level of physical functioning, including physical illness and difficulties with independent living (Goldney et al 2000). In Australia, disability (as assessed by the number of days spent out of role) is higher for people with co-morbid mental and physical illness, than for people with any one illness alone (Andrews et al 1999).

IMPLICATIONS FOR NURSING

As nurses have more contact with patients than any other health care provider, they could potentially play a central role in the detection of problem behaviours and concurrent mental illness. The issue however is far more complex than merely one of numbers. Research conducted by Silverstone (1996) found that nurses were more proficient than medical staff at identifying patients who had received a DSM-IV diagnosis, recognising 61% of cases compared with 41% for medical staff. These findings further support the potential value nurses may contribute to general health care, provided they receive adequate training for this role.

Detection alone may not translate into improved outcomes for those patients affected without appropriate management of the illness (Nisenson et al 1998; Rost et al 1998). Due to the close relationship nurses have with patients, they are the main source of encouragement for proper self-care and physical activity. Emphasis on physical activity is of particular importance, given evidence that physical activity appears to lower levels of depression and anxiety (Paluska and Schwenk 2000).

Koch (1999) describes nursing practice as undergoing rapid change, with mental health care issues emerging as a crucial challenge for nursing education. To create greater synchronicity between mental and physical health care is a general goal in the global effort to provide a more responsive health care system for people experiencing a mental illness (World Health Organisation 2001).

The important role of nursing in addressing the mental health needs of patients across all health care settings is clearly crucial to its holistic philosophy. Indeed, if the nursing profession is to uphold this philosophy as more than just rhetoric, the meeting of mental health care needs must be embraced enthusiastically.

The literature discussed in this paper suggests that the nursing profession is not currently positioned to perform this important role. Strategies are required to address the knowledge, skill and attitudinal deficits that currently impede a comprehensive approach to mental health issues. The education of both current and future nurses must be viewed as an important step to rectifying the current problem.

CONCLUSIONS

Mental illness is clearly recognised as a major health problem for the Australian community. The content of this paper demonstrates that the prevalence of mental illness and related mental health problems is significantly

higher within the general health care system than it is within the broader community.

Attending to patients' mental health needs is not just a matter of duty of care and promoting well-being; the research reviewed provides substantial evidence that mental illness has a significant adverse influence on the course and outcomes of physical illness, including increased mortality. Higher rates of mental illness in hospital patients may be largely explained by bio-psychosocial perspectives. However, regardless of whether one endorses bio-psychosocial models of illness, the strong association between mental illness and physical illness has practical implications. Lowering mental illness rates is likely to translate into better physical health outcomes.

As mental illness is common in the general health care system, psychological intervention is a key priority for improvement (Wynaden et al 2000). This is more so, given that medical and psychiatric co-morbidity is expected to rise rapidly with the ageing population, over the coming decades. Adequate mental health education for all nurses is a feasible strategy towards the improvement of general mental health services and promoting the importance and value of mental health nursing as a specialised career. An adequate compulsory component is founded on the inevitability that all nurses will be caring for patients with a mental illness, no matter what type of health care setting they find themselves in. Upon entering the work setting, nurses may further build on attitudinal and educational benefits already established at the undergraduate level.

Nurses can play a central role in lowering prevalence and burden of mental disorders by broadening the scope of care, contributing to consumers' empowerment, reducing the levels of stigma and discrimination in the hospital setting and engaging in simultaneous assessment to increase detection rates. That they do so is crucial for the best possible standard of nursing care.

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