LETTER TO EDITOR

Parity of Esteem for Mental Health: Improving the Physical Health of People with Mental Illness

*Lessons from Bintulu and Around the World*

Panirselvam RR

Department of Psychiatry and Mental Health, Hospital Bintulu, Sarawak, Malaysia

Abstract

The parity of esteem remains as a global mental health challenge. The divide is greater in the developing world where physical health of individuals with mental health conditions often takes a backseat. This article explores the extent of the problem and feasible solutions both in global and regional perspectives of Bintulu; a low resource centre in Sarawak, Malaysia. Starting from the self which focuses on empowering mental health providers in becoming cognizant of monitoring physical health in service users. The discussion then delves on the overarching role of mental health teams in supporting allied services including primary health care teams and caregivers. Finally the need to improve healthcare systems in becoming more comprehensive and inclusive to service users is analysed. In conclusion practical evidence based solutions necessitate in achieving parity of esteem.

Keywords: Low And Middle Income Countries, Primary Care, Global Mental Health, Physical Health

Introduction

All human beings are born free and equal in dignity and rights (Article 1, Universal Declaration of Human Rights, 1948). This document among many of its kind were written in the years post the Second World War in hope that the countless lives lost would not be forgotten and the lessons learned at that unprecedented cost would be remembered. Article 25 of the aforementioned document enshrines the right to health. The preamble of the Constitution of the World Health Organisation two years prior provides an aspirational and holistic definition of health. Yet nearly seventy years down the road, paradoxically the quality of physical health of people with mental illness has not improved with the rest of the world. People with severe mental illness die at least a decade earlier, live a life ridden with the wealth of ill-health and have been left behind in the wave of progress in physical health. The parity of esteem or lack of it as highlighted in the advocacy volume of the
Mental health service providers are at crossroads in this challenge. At one end we face the trials of any health service especially resource limitations with increasing demands and at the other end we fight almost daily battles delivering mental healthcare in face of stigma. We can easily become discouraged when confronted with service users who are also physically unwell or at risk to the point that we become therapeutically nihilistic and stomach this as a necessary evil. Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966) recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. We can choose to heed this clarion call by being catalysts for change rather than opting helplessness. I work in a middle income country at a low resource centre covering a population across 30 000 km$^2$. Being neither here or there, it is vital that our modus operandi is efficient, cost-conscious and situationally appropriate. In this essay, three viewpoints of improving physical health in mental illness are discussed: self, support and system.

**Self**

Mental health professionals are the cornerstone for care of individuals with surgical interventions, such as stenting and coronary artery bypass grafting. Conversely treating mental illnesses is not without physical consequences. Obesity and subsequently metabolic syndrome due to second generation dopamine antagonists are common feature in most mental health clinics. The length of treatment in most cases that span across entire lifespans compounds this further. Incarceration and prolonged institutionalisation which occur in some parts of the world prevent access to proper screening and healthcare.

The burden of physical health in mental illness is a revolving door conundrum. Mental illness on its own predisposes to physical conditions either in cause or effect. A person with mental illness often comes from an impoverished background with socioeconomic challenges which prevent access to healthcare. Poor housing, sanitation, nutrition, employment opportunities and high risk behaviours summon a gamut of diseases mainly infectious in origin. The effect of having a mental illness itself increases the likelihood of having physical illnesses and vice versa. For example, persistent depression despite treatment increases cardiovascular risk (Nicholson, 2006) and nearly a third of individuals with coronary heart disease have depression (Ramamurthy et al., 2013). An individual’s mental state could further deter them from seeking the help they need. An illustration of these groups would be individuals who could not care for themselves, leave their dwellings or refuse life-saving interventions. This spirals into possibly poorer service provider attitudes towards individuals with mental illness. Hert 2011 aggregates these findings and one noteworthy finding from many: mental health service users have low rates of

Annual Report of the Chief Medical Officer 2013 and the Royal College of Psychiatrists report Whole-person care: from rhetoric to reality. Achieving parity between mental and physical health from the UK summarise the evidence for the grim situation. At this point one does wonder about the developing world. A world where the sun goes down in gunshots, economies are trying to lift themselves up and statistics are merely smokescreens. Where do people with mental illness figure in this numberless abyss? Furthermore regardless of location how are the priorities in physical health for individuals with mental illness upheld?

The burden of physical health in mental illness is a revolving door conundrum. Mental illness on its own predisposes to physical conditions either in cause or effect. A person with mental illness often comes from an impoverished background with socioeconomic challenges which prevent access to healthcare. Poor housing, sanitation, nutrition, employment opportunities and high risk behaviours summon a gamut of diseases mainly infectious in origin. The effect of having a mental illness itself increases the likelihood of having physical illnesses and vice versa. For example, persistent depression despite treatment increases cardiovascular risk (Nicholson, 2006) and nearly a third of individuals with coronary heart disease have depression (Ramamurthy et al., 2013). An individual’s mental state could further deter them from seeking the help they need. An illustration of these groups would be individuals who could not care for themselves, leave their dwellings or refuse life-saving interventions. This spirals into possibly poorer service provider attitudes towards individuals with mental illness. Hert 2011 aggregates these findings and one noteworthy finding from many: mental health service users have low rates of
mental illness. By virtue or in due process, the service user comes in contact with mental health-workers regularly leading to greater therapeutic rapport. A typical follow-up in a general adult medical clinic at our set-up is 10 minutes while a mental health follow-up could last from twenty minutes to an hour. This scenario may not translate in minutes across the world but generally we have longer consultations due to the nature of work than our colleagues elsewhere and should use that window of opportunity.

Most mental health professionals started training in general health before pursuing mental health. The basics should not be allowed to rust. The stethoscope and tendon hammer should never be hung up! Medical education in physical health needs to be continued and constantly updated. Vital signs or systems like the Early Warning Score should be a norm of day-to-day practice to detect a deteriorating patient. Follow-up appointments need to consider weight trends and progress in other co-morbidities. Learning to listen to beyond our usual field of work may do justice as mental health service users may not articulate physical health symptoms in the same manner as others. The common aspects of health that require an extra antenna on our part with mental health service users would include oral health, metabolic syndrome, smoking, high risk behaviour and infectious diseases.

Investigations and physical examinations are frequently forgotten after the first few months. Prompt sheets serve as good reminders as demonstrated by Pasha et al, 2015 and Ramanuj, 2013. This idea can be applied electronically in centres with information technology support or by a simple highly visual card on the service user’s follow-up book. A nifty small book with temporal records of vital signs, investigations and medications costs very little to initiate and maintain. It will not only offer service providers a tap to perform examinations or order investigations, a prod to review them but also an overview to the service user and increase their awareness of their own health.

Advocacy thereby becomes paramount on this front to ensure that service users are able to communicate their needs to other healthcare professionals. This should not be misconstrued as paternalism or over-reaching ones limits but viewed as ongoing support. The power of a good therapeutic relationship is often underestimated. It will not be enough at times to just give a referral letter! A telephone ring to see if the service user has the means to get there or even accompanying a service user with his caregiver to assist in the referral should not seem outlandish. These may take time but make strides in outcomes. When we work together we are able to advice each other on our specialities and prevent unnecessary mishaps; for example drug interactions. Communications happen and liaison relationships foster.

Service heads should lead by being role models in putting physical health in the forefront of training and practice. Audit cycles can be mooted and pitfalls to best practice can be identified. Personal development needs to be inventive because situations change but service has to go on.

**Support**

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO 1946). Health requires cohesive effort of various specialities for best outcomes. Mental health service users have different and often challenging needs. Behaviours
which are socially unacceptable or even silence are common place. Most physical health providers have little training or expertise in understanding or even managing such clinical features. Left perplexed and unsupported, this can become a deterrent to provide optimum care. The need to be supported is therefore overwhelming.

Goldberg and Huxley’s filter model recognises the pathways to care in mental illness. Most service users come into contact with services through primary care. In countries like Malaysia, sparsely populated rural areas are managed by health clinics which are only manned by community health attendants and nurses. Such areas are remote, have minimal amenities and often lack proper access. Basic training to integrate mental and physical health is important to prevent diagnostic overshadowing. Periodic specialist visits to these clinics can ensure regular expert input (Figure 1). This can be supplemented with the aid of telecommunications by means of secure wireless satellite internet services to update progress of service users. While sending an ECG as an image record no longer seems alien in most places, prudence must be exercised with new technology. It must be discussed with service users and caregivers regarding access and protection of information that is shared electronically. Similarly general practitioners can be supported through a local mental health network. Dual directional care streams can be established rendering better physical and mental health outcomes (Figure 1). Care can be delivered closer to the service user’s home and regular monitoring of physical health becomes easier to prioritise. This is also significant in terms of understanding local cultural beliefs and acceptable practice standards where the primary healthcare team would be able to lead and deliver better care.
Community mental health teams can form smart partnerships with primary health teams to overcome barriers of accessibility for service users who are not able to attend health facilities. Mental health teams could utilise their rapport as previously discussed to provide access to primary healthcare providers. Therefore home based monitoring and investigations are made possible through mobile units. This provides an excellent middle ground in situations of socioeconomic constraints, distance or conflict to ensure continuity of care.

Mentorship and support within the mental health team and allied health teams should not be forgotten in this process. Junior staff should be trained alongside seniors to ask difficult questions, to touch and examine patients. Staff should be familiarised and comfortable with the service framework. Regular meetings with liaison services like physiotherapy, occupational therapy and
other teams should be a norm to co-manage and support the needs of both service users and providers. Maintaining dialogue is crucial for access and continuity of services. Simple and inexpensive multidisciplinary team meetings can be easily implemented in low-to-middle resource set-ups. Video conferencing can be used to bridge distances where specialty services are scarce. The only trouble everywhere seems to be getting everyone to spare some minutes to talk about a common topic!

At this point it is due that we remember that the pulse of healthcare services are the users and caregivers. A quarter of the homeless in the US suffer from some form of severe mental illness as opposed to the prevalence of severe mental illness which is only 6% (National Institute of Mental Health, 2009). Identification of social difficulties and physical health issues should take precedence. From the point of a healthcare provider, simple measures that reduce red-tape, educate stakeholders regarding health conditions and facilitate could improve access to care. Open walk-in policies, NGO involvement and fees exemptions in certain mental healthcare facilities in Malaysia have enhanced service user interphase. Reducing appointments to a minimal number of visits for physical comorbidities reduces default. Instead of blood taking one day, CT scan another day and different doctors’ appointments in the following weeks, services need to endeavour to make themselves efficient to the user. Rephrasing this scenario would be getting the blood work done at a primary care centre, arranging the CT scan in the morning of the appointment with scheduling of various appointments on the same day while awaiting the report. This flexibility is an example on how adaptability will make a great difference to service users who in some parts of the world would have to travel hundreds of kilometres for a specialist appointment.

Caregivers for mental health service users form the safety net of the therapeutic relationship. At times, the expectations are overwhelming as highlighted by the On Pins and Needles: Caregivers of Adults with Mental Illness report (2016) with almost two-thirds of adult service users in the US being financially dependent on their caregivers. Respite care needs to be given attention and adequate information must be provided especially when capacity of the service users are compromised. Peer and family support groups which traditionally function on the crucible of mental health conditions could increase value by discussing and supporting physical health conditions. Creative ways can be used to improve physical health of service users through these groups; for instance a trip to get a routine mammogram or a healthy kitchen camp. NGO participation can buffer costs and involve public at places where resources are limited. When individuals are supported, valued and informed they become motivated in their care.

**Systems**

Echoing that thought, systems need to be empowered to improve physical health in mental health service users. Global and national commitments translate campaigns into guidelines and implementations. Different nations have different healthcare priorities but apical goals conform to the standards of health as per the World Health Organisation.

The way health is viewed requires a paradigm shift. The organelle perspective of specialisation is not without its consequences especially inward thinking and compartmentalisation of services. A
healthcare service user has to carry many individual labels i.e. mental health service user, surgical service user etc. leading to loss of continuity due to complexity. The latter is major reason for unintentional non-adherence to therapy (Hugtenberg 2013). Simplifying and integrating systems with supporting services can aid both service users and providers. Short messaging alerts, one stop information hubs and error minimisations have become a reality now with the growth of information technology. This sadly is mostly confined to middle to high income infrastructures. However a bigger part of the change would encompass dissemination of knowledge. In that sense, technology transfer and international collaborations on health information systems would enable such services to be made available and cheaper in low income countries.

It is easier to make commitments than to fulfil them. Universal healthcare remains as one of the final frontiers of the human race. Leadership should recognise that healthcare access should be similar to all but the progress is not seen in people with mental illness. Good governance and monitoring of services through consistent national synergistic systems is a start. Service accountability in the form of key performance indicators is a method to implement this ideal. Manual or computerised systems with independent assessors could identify pitfalls in physical health markers (for example weight). The shortfall in quality would then be investigated and interventions would be put into place. If a service user has gained weight excessively, his case record would be flagged as a shortfall in quality. The information is looped as feedback to the service and planners (medical directorate, nursing directorate, pharmaceutical services and policy makers). Service providers can act on the information i.e. change of medications, institute a more rigorous lifestyle modification while planners analyse service trends. The latter can act on policy changes and later extrapolate to regional and global standards of care. The Healthy Active Lives (HeAL) is one such international initiative of 11 countries which aims to reverse the trend of premature death in individuals with severe mental illness by tackling future physical illnesses.

Improving physical health in the long run would depend on inclusivity and breaking down stigma. People with mental illness are fringe populations in isolation who miss out on development. Institutions do no better by segregating people with severe mental illness from routine health services. Deinstitutionalisation, community reintegration and forming mental health units within general healthcare facilities go far in removing obstacles to care. Mental health units need adequate facilities for physical health monitoring including resuscitation equipment and an accessible laboratory with the recommended security precautions in place. This would enable early intervention to prevent further deterioration in the physical state of service users.

A particular point on community integration would be supported employment and social enterprise. When an individual gains independence through livelihood; his standards of living would increase, so will self-esteem, self-care and overall health. Corporations offering comprehensive supported employment for individuals with severe mental illness should be encouraged along with supporting individuals with mental illness for employment. Moreover if comprehensive health plans are included in employment packages, incentives like tax rebates and recognition can be offered.
Legislations and mental health policies therefore need to be in place and regularly updated to curb discrimination and reduce inequalities. When opportunities are unlocked, progress follows.

**Conclusions**

Translating ideas into action require prudence and planning. Novelty and enthusiasm can fizzle out quickly. Expensive and complex ideas become cumbersome on stretched resources. Whenever possible, expenditure should be weighed by its cost-benefits-risks ratio. Building values and reusing existing resources should be prioritised. Health education and screening pamphlets can be digitalised to reduce paper use, medical items can be collected as donations from local medical associations for purposes of mobile health teams and hospital resources can be shared wherever permissible. Crowdfunding and collaborations can be expedited where money is low. Action plans must be devised in-lieu of executing them at the simplest health-care set-up. Involvement and feedback of all stakeholders particularly service users should resonate in policy development and implementation. Co-production along with ownership nurture and sustain new ideas.

It is possible that someday the playing field will be levelled. That one fine day when an individual living with mental illness would have the same lifespan and physical health status with any other person of his age group with other factors adjusted. A day in which parity of esteem is achieved. The 3 Ss are no spell or sermon. They are human resource intensive but economically viable and sustainable options for the world. They offer us an opportunity to introspect and remember our values so that mental health service users are not forgotten in the global prosperity of health. We are realising now more than ever before that we need more people from all walks of life in mental health. Campaigns like Anti-BASH promote better understanding of the uncomfortable word. The dearth of research should prompt us to think from the tip of the iceberg into the deep blue sea. Numbers jolt policy makers and stakeholders. Numbers wake people up. Numbers help us remember the forgotten. After all, psychiatry does not need sophisticated machines but more so sophisticated people.

**References**


[16] Clinical Performance Surveillance Unit, Medical Care Quality Section, Medical Development Division, Ministry of Health Malaysia. Technical Specifications Key Performance Indicators (KPIs) Clinical Services Medical Programme Version 4.0. Ministry of Health Malaysia; 2016 p. 145-149.
**Corresponding Author**
Ravivarma Rao Panirselvam
Department of Psychiatry and Mental Health, Hospital Bintulu, Sarawak, Malaysia

**Email:** ravivarmarao@gmail.com