

## JOINT POSITION STATEMENT

# ADDRESSING THE PHYSICAL HEALTH OF PEOPLE WITH MENTAL ILLNESS

Mental health and physical health are fundamentally connected. A proportion of individuals experiencing mental illness will also experience poor physical health, and poor physical health can in turn be associated with poor mental health. Given the well-known relationship between physical and mental health, an increased focus on holistic multidisciplinary treatment can enhance quality of life, and improve the physical and mental health outcomes for individuals living with a mental health disorder.

The high rates of physical illness including diabetes, respiratory illness, cardiovascular disease and cancer among people with serious mental illness are well documented. For example, people with serious mental illness are two to three times more likely to suffer from diabetes and the rate of cardiovascular disease is almost four times that of the general population<sup>[1,2]</sup>. Depression is considered an independent risk factor for coronary heart disease, but can also affect the recovery of people with coronary heart disease and increase their risk of further heart problems<sup>[3]</sup>. Thus, people with chronic health conditions are themselves more likely to experience a mental illness<sup>[4]</sup>.

The high level of comorbidity with chronic disease contributes to poor quality of life and is acknowledged as one of the major reasons for the high mortality and morbidity rates among people with serious mental illness. For example, the relative risk of death is estimated to be 2.2 times higher in people with mental disorders compared to the general population<sup>[5]</sup>, and this is primarily due to chronic physical rather than mental illness<sup>[6]</sup>.

The poor physical health of many people living with mental illness is due, in part, to the side effects of medication, a range of lifestyle factors, and inadequate management of chronic disease. Importantly, lifestyle factors such as poor diet, low levels of physical activity, smoking, and substance misuse are modifiable and offer a way for health professionals to assist people living with mental illness. The provision of multi-disciplinary care to address modifiable lifestyle factors is therefore an important component of holistic care for many people with mental illness and can improve both their physical and mental health outcomes.

## POSITION STATEMENT

Healthy eating behaviours, regular physical activity, moderate alcohol consumption, and smoking cessation can help decrease the burden of chronic disease<sup>[7]</sup>. When incorporated with evidence-based psychological and medical treatment, dietary and exercise interventions can provide a range of physical, social and mental health benefits for people living with a mental illness.

The Dietitians Association of Australia, Exercise & Sports Science Australia and the Australian Psychological Society endorse:

- Increased access to dietary and exercise interventions in addition to evidence-based psychological and medical treatment for individuals experiencing mental illness.
- Regular screening and ongoing monitoring of both physical and mental health for people experiencing mental illness.
- Where indicated, referral to appropriately qualified allied health professionals to address lifestyle issues and physical health needs.
- Strengthening referral networks and collaboration between core professionals in the mental health treatment team.

# THE MANAGEMENT OF MENTAL ILLNESS:

## THE ROLE OF DIETITIANS, EXERCISE PHYSIOLOGISTS AND PSYCHOLOGISTS



### ACCREDITED PRACTISING DIETITIANS

Poor dietary habits are well documented among people living with mental illness. When compared to the general population, people with schizophrenia consume more energy (kilojoules) and saturated fat and eat less fruit, vegetables and dietary fibre<sup>[8]</sup>. A significant association has also been found between depressive symptoms and a reduced likelihood of eating a healthy diet<sup>[9]</sup>. Poor dietary patterns account for, in part, the higher rates of obesity, diabetes and cardiovascular disease within this population.

Accredited Practising Dietitians are experts in food and medical nutrition therapy with skills to translate scientific nutrition information into personalised, practical dietary advice. They are skilled in coaching strategies to improve diet quality through lifestyle change, so as to:

- Improve concurrent and comorbid conditions (e.g. diabetes, cardiovascular disease, obesity, metabolic syndrome) and reduce all-cause mortality risk<sup>[10-13]</sup>.
- Mitigate weight gain commonly seen in patients taking psychotropic medications<sup>[13-15]</sup>.
- Reduce the risk and progression of common mental disorders (e.g. depression and anxiety)<sup>[9, 16-20]</sup>.
- Identify and improve disordered eating patterns and eating behaviours<sup>[21]</sup>.
- Enhance food security (i.e. food access, supply and utilisation) through improved meal planning, budgeting, shopping, food preparation and cooking skills<sup>[22]</sup>.

To find an Accredited Practising Dietitian go to: [www.daa.asn.au/find-an-apdl](http://www.daa.asn.au/find-an-apdl)



### ACCREDITED EXERCISE PHYSIOLOGISTS

Exercise is an efficacious adjunct intervention for improving both physical and mental health outcomes<sup>[23]</sup>. However, it can be more difficult for people experiencing mental illness to initiate and maintain exercise programs because of the complex nature of mental illness.

Accredited Exercise Physiologists are trained to provide evidence-based exercise interventions to individuals at high risk of developing, or with existing, chronic and complex medical conditions and injuries. In populations with mental illness regular physical activity prescribed by an Accredited Exercise Physiologist has been shown to:

- Improve cardiorespiratory fitness and reduce all-cause mortality risk<sup>[24, 25]</sup>.
- Improve psychosocial functioning (i.e. activities of daily living, social and occupational functioning)<sup>[23]</sup>.
- Mitigate weight gain induced by psychotropic medications<sup>[26]</sup>.
- Improve chronic disease outcomes (especially type 2 diabetes and cardiovascular disease)<sup>[27]</sup>.
- Decrease symptoms of depression and anxiety<sup>[28-30]</sup>.
- Improve sleep quality<sup>[31]</sup> and increase self-esteem<sup>[32]</sup>.

To find an Accredited Exercise Physiologist go to: [www.essa.org.au/find-aep/](http://www.essa.org.au/find-aep/)



## PSYCHOLOGISTS

Psychologists are trained to provide evidence-based psychological treatment for mental health problems. These treatments are effective for a large number of mental health difficulties including anxiety<sup>[33]</sup>, depression<sup>[34]</sup>, and eating disorders<sup>[35]</sup>, as well as sleep problems<sup>[36]</sup> and drug and alcohol difficulties<sup>[37]</sup>. Psychologists play a major role in the provision of interventions for mental illness but they also have a key role in addressing the lifestyle factors associated with poor physical health in people living with mental illness. For example, Psychologists can deliver:

- Motivational interviewing to facilitate lifestyle behaviour change<sup>[38]</sup> (e.g. smoking, substance use, weight loss).
- Behavioural strategies to support lifestyle change (e.g. eating habits<sup>[39]</sup>, sleep<sup>[36]</sup>).
- Cognitive approaches to overcome barriers to improving quality of life<sup>[40]</sup>.
- Strategies to assist individuals to adjust to new lifestyles and maintain the changes<sup>[40]</sup>.

To find a psychologist go to: [www.psychology.org.au/FindAPsychologist/](http://www.psychology.org.au/FindAPsychologist/)

## EXISTING REFERRAL AND FUNDING PATHWAYS

In addition to traditional fee-for-service and the Medicare Better Access items for the delivery of psychological services for diagnosed mental illness, there are a number of existing referral and funding pathways to support access to Accredited Practising Dietitians, Accredited Exercise Physiologists and Psychologists:

- **MEDICARE BENEFITS SCHEDULE**  
Individuals with chronic medical conditions (likely to be present for 6 months or longer), can be managed by their general practitioner (GP) under a GP Management Plan (item 721) and Team Care Arrangement (item 723) that facilitates Medicare rebates for allied health services on referral from the GP.
- **DEPARTMENT OF VETERANS' AFFAIRS**  
The Department of Veterans' Affairs (DVA) funds all health services necessary to meet a clinical need for Gold Card holders. For White Card holders, the DVA will fund those services required because of their accepted war-caused or service-related condition(s).
- **PERSONAL INJURY SCHEMES**  
Allied health services make a significant contribution to improving health and return to work outcomes for injured workers, including those with mental illness. Personal Injury Schemes can pay the reasonable costs of healthcare services up to a maximum amount as detailed in the relevant fee schedule.
- **PRIVATE HEALTH INSURANCE**  
Some individuals with mental illness may be eligible for private health insurance rebates for services delivered by Accredited Practising Dietitians, Accredited Exercise Physiologists and Psychologists.
- **PRIMARY HEALTH NETWORKS (PHNS)**  
PHNs commission primary mental health services across Australia. In addition to Psychologists, PHNs may provide access to a range of allied health services for individuals with mental illness. Contact your local PHN to ascertain if they provide access to Accredited Exercise Physiologists and Accredited Practising Dietitians for this cohort.

# REFERENCES

1. Australian Health Policy Collaboration, The Costs and Impacts of a Deadly Combination: Serious Mental Illness with Concurrent Chronic Disease. A Policy Issues Paper for: The Royal Australian and New Zealand College of Psychiatrists. 2016.
2. Morgan, V, et al., National survey of people living with psychotic illness 2010., in Commonwealth of Australia 2011: Canberra.
3. Beyond Blue and National Heart Foundation. Fact sheet: Coronary heart disease, anxiety and depression. 2011 [cited 2016 13 July]; Available from: [https://www.heartfoundation.org.au/images/uploads/publications/Beyondblue\\_depression\\_CHD.pdf](https://www.heartfoundation.org.au/images/uploads/publications/Beyondblue_depression_CHD.pdf)
4. World Health Organisation, Risks to mental health: An overview of vulnerabilities and risk factors. 2012.
5. Walker, E., R. McGee, and B. Druss, Mortality in mental disorders and global burden of disease implications. A systematic review and meta-analysis. *JAMA Psychiatry*, 2015. 72(4): p. 334-41.
6. Lawrence, D., K. Hancock, and S. Kisely, The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. *British Medical Journal* 2013. 346.
7. World Health Organisation, Global action plan for the prevention and control of noncommunicable diseases 2013-2020. 2013, WHO: Geneva, Switzerland.
8. Dipasquale, S., et al., The dietary pattern of patients with schizophrenia: a systematic review. *J Psychiatr RES*, 2013. 47: p. 197-207.
9. Quirk, S., et al., The association between diet quality, dietary patterns and depression in adults: a systematic review. *BMC Psychiatry* 2013. 13(175).
10. Teasdale, S., S. Harris, and S. Rosenbam, Individual dietetic consultations in first episode psychosis: a novel intervention to reduce cardiometabolic risk. *Community Mental Health Journal* 2014. 51: p. 211-14.
11. Teasdale, S., et al., A nutrition intervention is effective in improving dietary components linked to cardiometabolic risk in youth with first-episode psychosis. *Br J Nutr*, 2016. 115(11): p. 1987-93.
12. Reedy, J., et al., Higher diet quality is associated with decreased risk of all-cause, cardiovascular disease and cancer mortality among older adults. *J Nutr*, 2014. 144(6): p. 881-889.
13. Teasdale, S., et al., Solving a weighty problem: systematic review and meta-analysis of nutrition interventions in severe mental illness. *The British Journal of Psychiatry*, 2016. November 2016.
14. Álvarez-Jiménez, M., et al., Antipsychotic-induced weight gain in chronic and first-episode psychotic disorders. *CNS drugs*, 2008. 22(7): p. 547-562.
15. Curtis, J., et al., Evaluating an individualized lifestyle and lifeskills intervention to prevent antipsychotic-induced weight gain in first-episode psychosis. *Early Interv Psychiatry* 2016. 10(3): p. 267-76.
16. Akbaraly, T., et al., Dietary patterns and depressive symptoms in middle age. *Br J Psych*, 2009. 195: p. 408-413.
17. Forsyth, A., F. Deane, and P. Williams, A lifestyle intervention for primary care patients with depression and anxiety: A randomised controlled trial. *Psychiatry Res*, 2015. 230(2): p. 537-44.
18. Sanhueza, C., L. Ryan, and D. Foxcroft, Diet and the risk of unipolar depression in adults: systematic review of cohort studies. *Journal of Human Nutrition and Dietetics*, 2013. 26(1): p. 56-70.
19. Sanchez-Villegas, A. and M. Martínez-González, Diet, a new target to prevent depression? *BMC medicine*, 2013. 11(1).
20. Lai, J., et al., A systematic review and meta-analysis of dietary patterns and depression in community-dwelling adults. *The American Journal of Clinical Nutrition*, 2014. 99(1): p. 181-97.
21. Ozier, A. and B. Henry, Position of the American Dietetic Association: Nutrition Intervention in the Treatment of Eating Disorders. *J Am Diet Assoc*, 2011. 111(8): p. 1236-1241.
22. Holben, D., Position of the American Dietetic Association: Food Insecurity in the United States. *J Am Diet Assoc*, 2011. 110(9): p. 1368-1377.
23. Lederman, O., et al., Consensus statement on the role of Accredited Exercise Physiologists within the treatment of mental disorders: a guide for mental health professionals. *Australasian Psychiatry*, 2016.
24. Stubbs, B., et al., Exercise improves cardiorespiratory fitness in people with depression: A meta-analysis of randomized control trials. *Journal of Affective Disorders*, 2016. 190: p. 249-253.
25. Vancampfort, D., et al., Exercise improves cardiorespiratory fitness in people with schizophrenia: a systematic review and meta-analysis. *Schizophrenia Research*, 2015.
26. Curtis, J., A. Watkins, and S. Rosenbaum, Keeping the body in mind: an individualised lifestyle and life skills intervention to prevent antipsychotic-induced weigh gain in first episode psychosis. *Early Interv Psychiatry* 2015.
27. Exercise & Sports Science Australia, ESSA position statement: Exercise prescription for patients with type 2 diabetes and pre-diabetes. *Journal of Science and Medicine in Sport*, 2010. 15: p. 25-31.
28. Rebar, A., et al., A meta-analysis of the effect of physical activity on depression and anxiety in non-clinical adult populations. *Health Psychol Rev*, 2015. 9(3): p. 366-378.
29. Rosenbaum, S., A. Tiedemann, and C. Sherington, Physical activity interventions for people with mental illness: a systematic review and meta-analysis. *Journal of Clinical Psychiatry*, 2014. 75: p. 964-974.
30. Stanton, R. and P. Reaburn, Exercise and the treatment of depression: a review of the exercise program variables. *Journal of Science and Medicine in Sport*, 2014. 17(2): p. 177-182.
31. Rethorst, C., P. Sunderajan, and T. Greer, Does exercise improve self-reported sleep quality in non-remitted major depressive disorder? *Psychol Med*, 2013. 43: p. 699-709.
32. Krogh, J., et al., The effect of exercise in clinically depressed adults: systematic review and meta-analysis of randomized controlled trials. *J Clin Psychiatry*, 2011. 72(4): p. 529-538.
33. Linden, M., et al., Efficacy of cognitive behaviour therapy in generalized anxiety disorders. Results of a controlled clinical trial (Berlin CBT-GAD Study). *Psychotherapy and psychosomatics*, 2005. 74: p. 36-42.
34. Serfaty, M., D. Haworth, and M. Buszewicz, Clinical Effectiveness of Individual Cognitive Behavioral Therapy for Depressed Older People in Primary Care. *Archives of General Psychiatry*, 2009. 66: p. 1332-1340.
35. Wilson, T., C. Grilo, and K. Vitousek, Psychological Treatment of Eating Disorders. *American Psychologist*, 2007. 62(199-216).
36. Morin, C., et al., Psychological and behavioural treatment of insomnia: Update of the recent evidence (1998-2004). *Sleep* 2006. 29: p. 1398 - 1414.
37. Baker, A., et al., Brief cognitive behavioural interventions for regular amphetamine users: a step in the right direction. *Addiction* 2005. 100: p. 367-378.
38. Miller, W. and S. Rollnick, *Motivational interviewing: Helping people change*. 2013, Guilford Press: New York, NY.
39. Pimenta, F., et al., Brief cognitive-behavioural therapy for weight loss in midlife women: a controlled study with follow up. *International Journal of Women's Health*, 2012. 4: p. 559 - 567.
40. Beck, A., The current state of cognitive therapy: A 40 year retrospective. *Archives of General Psychiatry*, 2005. 62: p. 953 - 959.