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Med Clin (Barc). (2022);158(1):24–26

MEDICINA CLINICA

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Editorial article

COVID-19 and physical health of women with severe mental illness☆

La COVID-19 en los resultados de salud en mujeres con trastorno mental grave

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The study and intervention of physical health problems in women with severe mental disorders (SMD) has been the subject of increasing interest in recent decades.[1] Numerous studies indicate that women with SMD experience a higher incidence of gynaecological health issues[2] and higher cancer-related mortality rates than healthy women.[3] One of the main factors influencing physical and gynaecological health in women is adherence to drug therapy, outpatient follow-up, early detection programmes and the presence of substance use.[4] Recently, during the COVID-19 pandemic, several authors have reported a worsening of physical and mental health in the general population, especially in the case of women.[5] However, there is little information regarding the impact of the COVID-19 pandemic on physical health in women with SMD, and what interventions can be recommended to improve health outcomes.

The aim of this editorial is to understand what factors influence the physical and gynaecological health of women with SMD, what interventions can be made to reduce the risk of physical health problems in women with SMD, and how the COVID-19 pandemic has influenced the general health of women with SMD. Likewise, we will make specific proposals to provide differential care according to gender, with special emphasis on community care models and partial hospitalization programs, understood as intermediate resources between conventional hospitalization and outpatient follow-up. All of this in the context of women with SMD during the COVID-19 pandemic.

There are multiple factors that influence the physical health of women with SMD: psychosocial, patient-related, healthcare-related and those related to the provision of services.

Women with SMD continue to act as caregivers for their relatives and are often forced to abandon their jobs or reduce their working hours.[6] This fact determines social and economic consequences that can have an impact on their mental and physical health. Reduced working hours or absenteeism decrease income and increase stress levels for these women, in addition to the stress of mental illness, their biological vulnerability and the stigma they experience as a result of having a mental disorder.[6]

Psychosocial risk factors not only hinder mental health care, but also influence the general health of these women, including gynaecological health.[7] Some studies suggest that women seek help more often than men and adhere more frequently to treatments prescribed by professionals. However, numerous obstacles hinder the optimal follow-up and monitoring of these patients,[8,9] e.g., early diagnosis and correct follow-up of diseases such as cancer.[7] In the context of the COVID-19 pandemic, distance between care facilities, travel affordability and mobility constraints may influence these outcomes, as accessibility to resources influences health outcomes.[10] The economic difficulties resulting from the COVID-19 pandemic and the lack of resources in some sectors of the population have undoubtedly had an impact on the health of these women. Strengthening care networks in social services and identifying potential psychosocial risk factors in women with SMD can therefore also help improve their health outcomes.

A recent review highlights that SMD patients do not have a higher risk of cancer compared to the general population, but a significantly higher risk of mortality from breast, lung and colon cancer, compared to the general population.[3] These differences in cancer mortality have been traditionally attributed to an increase in potentially modifiable risk factors in SMD, such as lifestyle and health behaviours: smoking, high-fat diet, sedentary lifestyle, etc.[10] If we focus on the intervention of these risk factors in women with SMD, various studies reveal that, in addition to poverty and lack of financial resources, some clinical symptoms such as cognitive impairment (memory, alertness, executive function problems, etc.) influence adherence to cancer therapies, correct follow-up and adherence to early detection programs.[11] In the context of the COVID-19 pandemic, many women have been forced to telework, increase their role as family caregivers and restrict their mobility, thus making it difficult to comply with medical visits and early cancer detection programs.[11,12] Health behaviour interventions that have been shown to be effective in reducing cancer risk could also decrease cancer mortality, especially in women with SMD. Some interventions are listed below: (1) pharmacological and non-pharmacological strategies for smoking cessation (directly

☆ Please cite this article as: González-Rodríguez A, Monreal Ortiz JA. La COVID-19 en los resultados de salud en mujeres con trastorno mental grave. Med Clin (Barc). 2022;158:24–26.

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associated with the risk of lung cancer); (2) intervention on the consumption of alcohol or other substances; (3) physical exercise. On the other hand, adherence to gynaecological cancer screening (such as mammography) in women with SMD may also improve early cancer detection in these women. Previous studies suggest that women with SMD attend cancer screening programmes and gynaecological consultations less frequently,[13] which increases the risk of late diagnosis and therefore disease-related mortality. Once women who undergo screening and diagnostic procedures are diagnosed, there are also difficulties or barriers to receive the correct treatment. Stigma is one of them and it occurs at all levels. Some clinical trials in medical oncology include a diagnosis of SMD as an exclusion criterion, even though this group has the highest mortality rates. This fact makes it difficult to know if these users present specificities or differences in response to medications, compared to the rest of the population.[3]

Comorbid substance use has been associated with poorer adherence to medication and outpatient visits in mental health and in the context of other medical specialties. In addition, its presence has been correlated with an increased risk of various types of cancer, as mentioned above.[3] During the COVID-19 pandemic, women affected by SMD have also presented an increase in the consumption of substances (tobacco, alcohol, etc.), which, together with the application of social distancing measures, has made access to mental health services difficult.[8] Throughout this period, these women have also suffered an increase in situations of gender-based violence, and health professionals have had to modify their protocols and intensify their care efforts.[14]

Another factor influencing the physical health of these women with SMD is the fact that they have difficulty expressing pain or some of the symptoms. It has even been claimed that some people with SMD may have a higher pain threshold than healthy women and therefore tolerate pain better, which may delay medical or gynaecological diagnosis.[15] Knowing the different pattern of symptom expression in women with SMD could help to improve early detection in some medical conditions, including cancer.[16] It is even more important to know these specificities during the COVID-19 pandemic in order to better plan services and early detection tools.

As we have discussed above, women with SMD have more medical complications and a higher risk of late diagnosis, which further increases when they reach menopause. During this period of the life cycle in women, changes in female sex hormones occur, mainly a drastic reduction in oestradiol levels, leading to a loss of the neuroprotection conferred by oestrogens during the childbearing years.[17] Oestrogen loss is not only associated with worse clinical outcomes and antipsychotic response in women with SMD,[17] but also increases the risk of cardiovascular disease. Special attention should also be paid to autoimmune diseases, which are more common in patients with SMD, particularly women.[18] Overall, it is therefore reasonable to think that women with SMD, having greater medical comorbidity, deserve more specialised care focused on physical and gynaecological health, independently of the mental health care they might be receiving.

To improve the overall health of women with SDM during the COVID-19 pandemic and post-pandemic, we propose a number of interventions. All of them are based on principles of collaboration, cooperation and coordination between levels of care. In the first place, the creation of specialized teams is proposed, made up of medical professionals, internists, psychiatrists, psychologists, nursing personnel and social workers, and coordinated with primary health care. Primary care support programmes should be strengthened, as well as screening for other physical health problems in these women. Women with SMD need support so that they attend primary care consultations and comply with breast cancer and other screening programmes. Nurses can be active players for change in this area,[19] from outpatient settings or partial hospitalisation programmes such as Day Hospital.[19] Nursing teams, with their comprehensive care functions, can be involved in encouraging attendance at outpatient mental health visits, other medical specialties and even gynaecology visits. During the COVID-19 pandemic, the creation and consolidation of home hospitalisation teams has been encouraged and can be a useful resource for women with SMD who are limited in their ability to travel, either due to mobility problems, family burdens or because of the chronic stress associated to the COVID-19 pandemic. Multidisciplinary outpatient and home-based teams should be specially trained in the detection of substance use, and the appropriate referral and intervention for women with SMD. Greater efficiency and effectiveness in referral circuits from primary care to specialised care, with an increase in consultation facilities and an improvement in the information systems to be shared could also facilitate collaboration between primary care and addiction services for women,[20] especially in times of the COVID-19 pandemic.

Clinical and social work teams should identify situations of risk of gender-based violence, especially in this period,[14] since several authors report an increase in risk, which is exacerbated by an increase in substance use. Better coordination should be encouraged between sexual and reproductive health care centres focusing on women's care and mental health and addiction centres. In summary, intervention is needed to address the overall health risk factors for women with SMD during the COVID-19 pandemic, and strategies should be implemented that focus on early detection, increased adherence to health care services and better coordination between primary care, specialised care (mental health and addictions) and women's health care teams (clinical and social).

Funding

No funding has been received.

Conflictof interests

Dr. González-Rodríguez has received honoraria and/or conference registrations from Janssen-Cilag, Lundbeck-Otsuka and Angelini. Dr Monreal has been a consultant for or received honoraria from Sanofi, Pfizer, Servier, Janssen and Lundbeck-Otsuka.

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