Running head: APPLYING THE VPCM TO MENTAL ILLNESS

Applying the Vulnerable Populations Conceptual Model to Mental Illness

University of Alabama

NUR 735-902: Population Health in Advanced Practice Nursing

Submitted To: Dr. Susan Gaskins, DSN, ACRN

Submitted By: Beatrice Cabrera, MSN, APRN-BC, FPMHNP

Introduction – Vulnerable Populations

A vulnerable population group is part of a larger population that has an increased likelihood of developing health problems as a result of exposure to risk or to have a health problem that presents with worse outcomes than the rest of the population. People who are poor and homeless, pregnant adolescents, migrant workers and immigrants, people with mental illnesses, people with substance use problems, people who are victims of abuse, and people with communicable diseases are all examples of vulnerable populations (Stanhope & Lancaster, 2012).

Vulnerable Populations Conceptual Model

The Vulnerable Populations Conceptual Model (VPCM) was developed as a methodology of evaluating a population’s risk of health problems. The model proposes that the concepts of resource availability, relative risk, and health status are inter-related (Nyamathi, Koniak-Griffin, & Greengold, 2007).

Resource availability includes the availability of human capital, social status and connection, and environmental resources. Human capital can be measured by observing income, jobs, education, and housing. Prestige, power, integration into society, and social networks all describe social status and connection. A major component is access to health care systems. (Nyamathi, Koniak-Griffin, & Greengold, 2007).

Relative risk indicates that certain populations are more prone to poor health, compared to the rest of the population, following negative or stressful life events. Risk factors may be behavioral or biologic. In other words, lifestyle choices, the choice to participate in health screening and promotion services, and exposure to dangerous life events are all examples of behavioral risk factors. Unfortunately, some people are simply genetically predisposed to certain health problems (Nyamathi, Koniak-Griffin, & Greengold, 2007).

Disease incidence, prevalence, morbidity rates, and mortality rates are measures of health status of a population. Thus, the VPCM involves numerous aspects that must be evaluated to determine the level of risk of health problems of a population (Nyamathi, Koniak-Griffin, & Greengold, 2007).

Mental Illness

The American Psychiatric Association (2000), also called the APA, has published the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision* (DSM-IV-TR); it is the ultimate resource for mental health disorders. This manual includes the criteria for over 300 mental health disorders which include illnesses such as mood disorders, namely depression and bipolar; anxiety disorders; personality disorders; mental retardation disorders; dementia disorders; attention deficit disorder; and psychotic disorders. These disorders may cause significant behavioral and/or psychological impairment. Mental disorders affect people’s ability to think and how they behave according to the World Health Organization, also known as the WHO, (2003). Furthermore, when unstable, people with these disorders cannot function independently (Varcolis & Halter, 2010). As already mentioned earlier, people with mental illnesses represent an example of a population that is vulnerable (Stanhope & Lancaster, 2012). By applying the VPCM, the reasons why they are at risk and level of risk for health problems will become apparent.

Application of VPCM – Resource Availability

In regards to human capital, people with mental illnesses often have a difficult time obtaining a job; moreover, they have a harder time maintaining a job. One study found that employment agencies would put forward individuals with mental illnesses, but employers had too many concerns about these individuals to hire them (Biggs, Hover, Tyson, & Macdonald, 2010). For those who do work, they tend to make less than people without mental illnesses. They have been found to make an average of 1/3 less money in a year compared to people without a mental illness. This comes from a survey of people who live in 19 different countries including the United States (Levison, et al., 2010). Because of stigma and discrimination, this population often cannot obtain an education, cannot hold a job, and cannot appreciate the benefits of public facilities (WHO, 2003). Many people with mental illnesses end up in public housing, group homes, shelters, long-term care facilities, and jails or prisons; live with loved ones due to inability to live independently; or simply remain homeless.

People with mental illnesses tend to lack in social connectedness (APA, 2000). Their own families often have many ups and downs as they try to support their loved ones with mental illnesses. One articles notes that the families of people with mental illnesses having difficulty establishing a balance in their own lives as they constantly balance multiple concerns in dealing with the mental illness (Weimand, Hall-Lord, Sallstrom, & Hedelin, 2013). People with mental illnesses routinely battle segregation; they have low likelihood of being perceived as prestigious or powerful. The main reason for the segregation is mostly fear of and social stigma associated with mental illnesses (Riley, 2011).

A major downfall for people with mental illnesses is lack of mental health specialists including counselors, psychiatric nurses, psychiatric nurse practitioners, and psychiatrists. There are few community resources such as outpatient clinics or hospitals, so these people often end up in emergency rooms in crisis. One article describes the need for a more “concerted effort” to increase psychiatric capacity for inpatient treatment (Bloom, 2010). Another source reports the need for more access to mental health services in the community (Mojitabai, 2011). The National Alliance on Mental Illness (NAMI) reports that less than 1/3 of adults and ½ of children with a diagnosable mental illness receive services in a given year.

Application of VPCM – Relative Risk

As already stated above, inadequate health care resources increase the risk of poor quality of care for people with mental illnesses. Mental health illnesses already affect a person’s sleep pattern, eating pattern, energy level, and motivation level; therefore, the lifestyle choices pertaining to these things suffer more (APA, 2000). Then it becomes a cycle. For example, depression may present with poor appetite, lack of energy and motivation, and poor sleep. People with mental illnesses already have illnesses that by definition necessarily impair their lifestyle habits; even when they are stable or better, they are highly prone to make poor lifestyle choices (APA, 2000).

As already discussed, this population tends to make less due to lower education; it is not uncommon that their physical needs, such as food, go unmet. This creates a cycle as well because food insufficiency can be detrimental to the mental health of a person (Heflin & Ziliak, 2008).

Due to the social stigma facing people with mental illnesses, it is difficult for many of them to seek treatment for their mental illness, much less to keep current with such things as physicals, eye exams, dental exams, and immunizations. For example, people with psychosis have difficulty trusting others (APA, 2000). For some, it is simply too difficult to remember all the necessary providers they should see regularly. For others, they cannot afford it. Others cannot drive; they lack transportation for their appointments. Many of these people fear being ridiculed by others or struggle with waiting or being in crowds and cannot handle sitting too long at a clinic (APA, 2000). For example, people with anxiety often have this problem. The symptoms of mental illnesses predispose people with these disorders to be less likely to engage in health-promoting behaviors. Furthermore, some mental illnesses by definition include the tendency for a person to engage in high-risk behaviors (APA, 2000). People with bipolar disorder are an example; they may have multiple sexual partners.

When obtaining the social history of people with mental illnesses, it is common to find that many of them are victims of abuse or were exposed in some way to a traumatic event. Also, bearing in mind that people with mental illnesses generally have poor coping skills and poor resilience; any change in their life can be deemed as stressful. People with dementia may have behavioral aggression. Those who have psychosis may become violent (Varcarolis & Halter, 2010). Thus, some mental illnesses increase the likelihood that the person be involved in violent or traumatic situations.

Application of VPCM – Health Status

It is very common for people with mental illnesses to have co-morbidities. Many of them present to a psychiatric clinic only after receiving a referral from their primary care provider (PCP) who is already treating them for a medical problem. Many of them meet the criteria for more than one mental illness according to the National Institute of Mental Health, also known as NIMH.

Social stigma and sometimes cultural barriers prevent many people from seeking psychiatric help, so they delay diagnosis and treatment. Sometimes they only present to a psychiatric clinic after having been in a crisis, going to the emergency room, being sent to a psychiatric institution, and being referred to an outpatient clinic. In other words, many people with mental illnesses fear seeking treatment or simply deny the need for diagnosis and treatment until they end up in a crisis (Varcarolis & Halter, 2010).

Depending on the mental illness they have, some people are at high risk of death. A depressed patient may become suicidal. A psychotic person may be involved in violence towards others or themselves. A bipolar manic person may engage in high-risk behavior that exposes them to accidents or communicable diseases (APA, 2000). Research has shown, for more than 60 years, that people with mental illnesses are twice as likely to die from physical illness compared to people without a mental illness (Younger, 2011).

People with mental illnesses commonly claim disability because they simply cannot hold a job or find a way to support themselves due to their illness. In the United States and Canada, mental disorders are the leading cause of disability (NIMH).

The Centers for Disease Control and Prevention notes that the cost of mental illness in the United States “is substantial,” about $300 billion in 2002. NAMI reports that one in four adults experience a type of mental illness in a given year. The 12-month prevalence of mental illnesses in adults is about 26.2% of the United States Population (NIMH).

Conclusion

By applying the VPCM model to the population of people with mental illnesses, it is clear that there are multiple concerns in every aspect of the model including resource availability, relative risk, and health status. Health care providers have need for great concern when dealing with this population. Mental illnesses transcend all races, genders, and ages. Healthcare providers will probably be exposed to a patient with a mental illness at least once in their career. All need to realize how vulnerable people with mental illnesses are for numerous health problems.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders*

(4th ed., text revision.). Washington, DC

Biggs, D., Hovey, N., Tyson, P., Macdonald, S. (2010). Employer and employment agency

attitudes towards employing individuals with mental health needs. *Journal of Mental Health, 19*(6), 509-516. doi:10.3109/09638327.2010.507683

Bloom, J. (2010). “The incarceration revolution”: the abandonment of the seriously mentally ill

to our jails and prisons. *Journal of Law, Medicine & Ethics*, 727-734.

Center for Disease Control and Prevention. U.S. Adult Mental Illness Surveillance Report.

Retrieved on 4/15/13 from http://www.cdc.gov/Features/MentalHealthSurveillance/

Heflin, C. & Ziliak, J. (2008). Food insufficiency, food stamp participation, and mental health.

*Social Science Quarterly, 89*(3), 706-727.

Levinson, D., et. al. (2010). Associations of serious mental illness with earnings: results from

the WHO World mental health surveys. *The British Journal of Psychiatry*, 197: 114-121.

doi: 10.1192/bjp/bp.109.073635

Mojitabai, R. (2011). National trends in mental health disability, 1997-2009. *American Journal*

*of Public Health, 101*(11), 2156-2163. doi:10.2105/AJPH.2011.300258

National Association on Mental Illness. Mental Illness: Facts and Numbers. Retrieved on 4/15/13

from http://www.nami.org/Template.cfm?Section=About\_Mental\_Illness&Templates=/contentManagement/ContentDisplay.cfm&contentID=53155

National Institute of Mental Health. Mental Disorders in America. Retrieved on 4/15/13 from

http://www.nimh.gov/

Nyamathi, A., Koniak-Griffin, D. & Greengold, B. (2007). Development of nursing theory and

science in vulnerable populations research. *Annual Review of Nursing Research, 25*, 3-25.

Riley, G. (2011). The pursuit of integrated living in Fair housing Act as a sword for mentally

disabled adults residing in group homes. *Columbia Journal of Law and Social Problems*,

45(2), 177-224.

Stanhope, M. & Lancaster, J. (2012). *Public Health Nursing: Population-Centered Health Care*

*in the Community.* 8th ed. Maryland Heights, MO: Elsevier.

Varcarolis, E. & Halter, M. (2010). *Foundations of Psychiatric Mental Health Nursing: A*

*Clinical Approach.* 6th ed. St. Louis, MO: Saunders Elsevier

Weimand, B., Hall-Lord, M., Sallstrom, C., & Hedelin, B. (2013). Life-sharing experiences of

relatives with severe mental illness – a phenomenographic study. *Scandinavian Journal of Caring Sciences, 27*, 99-107. doi:10.1111/j.1471-6712.2012.01007.x

World Health Organization. (2003). Mental Health Legislation and Human Rights. Retrieved

on 4/15/13 from http://www.who.int/mental\_health/policy/services/7\_legislation%20HR\_WEB\_07.pdf

Younger, C. (2011). The relationship between physical wellbeing and mental health care. *Mental*

*Health Practice, 15*(1), 34-36.