Disability and health behaviours

Health behaviours joint strategic needs assessment literature review

Donna Gadsby, JSNA research officer
Puala Jones, South Lancashire Physical Disability Partnership

September 2014

www.lancashire.gov.uk

Lancashire County Council

Contents

Introduction 3
Disability 3
Healthy eating 3
Physical activity 5
Stress and disability 7
Smoking 8
Alcohol, drug and substance misuse 9
Conclusion 11
References 11

Introduction

This short report on disability completes a suite of literature review documents around the seven health behaviours incorporated in the joint strategic needs assessment (JSNA).

It complements the secondary data analysis report which can be found on the JSNA publications page with final health behaviours report.

For further information please visit our website: www.lancashire.gov.uk/lancashire-insight or email jsna@lancashire.gov.uk

Disability

The World Health Organization (WHO) describes disability as "a multidimensional and complex concept which includes impairments, activity limitations and participation restrictions". People with disabilities face many challenges in everyday life and in particular with their health-related needs and health inequalities. People with physical, sensory and learning disabilities can face difficulties in using health services. For example, people with sensory disabilities may need support with communication (such as lip reading or using sign language) when dealing with health professionals.

Health inequalities are also linked to the wider determinants of health such as poor housing, poor employment, poverty, and the existence of other health conditions. These are often disproportionately experienced by people with a disability, and people with learning disabilities have greater health inequalities than those without a disability.[1]

There is evidence to show that unemployment or inadequate employment exacerbates depression or depressive symptoms, worsens health status and can lead to the development of chronic physical conditions, whilst increasing the impact of existing disabilities. Therefore, people with disabilities and long-term conditions are more likely to experience unemployment.

Promoting the benefits of a healthy lifestyle to people with a disability, their carers and families can provide great improvements to a person's health. There is a responsibility on service providers, commissioners and other decision makers to consider the individual needs of people with a disability.

Healthy eating

There are many health behaviours conducive to good health. Healthy eating is consuming the right quantities of foods from all food groups in order to ensure an individual's body is appropriately nourished and capable of functioning, dependent on lifestyle and activity levels. The current government guidelines for healthy eating

include eating five portions of fruit and vegetables per day, reducing levels of salt and sugar, and ensuring alcohol consumption is limited.[2]

Poor nutrition can lead to being overweight/underweight, obesity or malnutrition and contribute to other health problems and there is evidence that shows obesity is more prevalent in the disabled population when compared to the general population. There are many factors that can impact on whether an individual will engage in healthy eating such as knowledge, time, cost, competing needs, personal motivation and health position. These barriers are relevant for disabled and non-disabled populations, but disabled people may face additional obstacles such as reliance on others (carers) to prepare healthy food and a lack of facilities for their needs.

Although a disabled person is more likely to have poorer general health and experience a range of obesity-related conditions in conjunction with their disability, it is acknowledged that wellness can co-exist with a disability. Nutrition can often be a lower priority than other needs, but this does not always reflect a lack of motivation to eat well for a person with a disability.[3]

Being underweight is also significantly associated with having a disability, compared to the general population. Again this may be due to the lowered priority attached to nutrition for the reasons noted above, along with unintentional weight loss from frailty, other medical and psychological conditions (such as depression), and difficulty in buying, storing and preparing healthy food.[4]

There are many barriers and facilitators to eating healthily and the ones below are particularly pertinent for people with physical disabilities and/or learning disabilities.

Table 1: Barriers and facilitators to healthy eating

Barriers	Facilitators
Transport difficulties to get to supermarkets	Online food shopping
Issues with daily living tasks	Adequate and appropriate storage/cooking facilities
Access to food within the supermarket/store	Cooking skills programmes
Reliance on other people (including lack of cooking/nutrition skills of carers)	Social inclusion
Social exclusion	Support from family/friends/care workers
Lack of opportunities/facilities for cooking	Higher levels of self-efficacy
Lack of confidence in skills	Supermarkets with increased awareness of the needs of their disabled customers
GPs not referring to dietician/nutritionist	

Interventions which can increase levels of healthy eating may not always be inclusive for disabled people, for example access to community gardens or allotments may be difficult to someone who uses a wheelchair. Therefore, it is imperative that consideration is given to the needs of people with disabilities.

Physical activity

The growing rate of obesity in the UK is a major public health concern and it is accepted that the causes of overweight and obesity are complex. Individuals with a disability tend to have lower levels of activity, lower muscle mass and reduced energy expenditures. For those who have a disability or other health condition there may be many reasons for reduced activity levels, including a low outcome expectation from undertaking exercise, a lack of time, and a fear of falling or other injuries (depending on the disability); specific barriers which would require sympathetic and tailored interventions to encourage exercise or activity.[5] For those who are carers, there are extra time burdens placed upon them, further restricting their ability to exercise and take care of themselves as well as the person they are looking after.

Physical disabilities often co-exist with secondary conditions such as coronary heart disease, diabetes and obesity. These can all be reduced or prevented with physical activity, so promoting physical activity for disabled people is of paramount importance.[6] Each individual will have their own personal and contextual factors which will affect their motivation, and taking into account these differences will make any intervention more successful.

The Disabled People's Lifestyle Survey 2013 suggests that increasing awareness of opportunities and ensuring information and communication reaches the relevant people will help to maximise participation. It further recommends increasing the opportunities available in an area and ensuring clubs are inclusive. The terminology used is also important; the terms 'sport', 'exercise', 'physical activity', 'fitness' and 'recreation' can mean different things to different people. For example the word 'sport' may imply competition and can put some people off. When opportunities/interventions have been identified they should be developed to be more attractive to disabled people and promoted effectively to have maximum impact.[7]

The table below outlines some of the reasons why disabled people may or may not take part in exercise and activity.

Table 2: Barriers and facilitators to physical activity and exercise for disabled people

Barriers	Facilitators
Insufficient knowledge about their health/disability	Accessible exercise facilities (including equipment)
Fear of injury/developing injuries or complications	Knowledgeable instructors with experience of working with adapted equipment
Immobility from health condition	Support from family and friends and positive role models
Lack of time	Activities which support a sense of belonging
Low perceived or real outcomes, for example not enough 'benefit' from the activity	Previous physical activity
Having to travel to suitable facilities	Understanding the positive effects of exercise
Reluctance of GP to refer to gym/activities	Improving health, fitness and wellbeing
Lack of opportunities for fitness/sport/ exercise	Funding for activities
Lack of accessible and convenient exercise facilities locally	Exercising with others with a disability
No support to undertake exercise/physical activities	Range of activities/exercise
Health problems	Perception of fun and enjoyment
Unsafe environment	For weight management
Lack of motivation	Awareness of opportunities
Lack of energy	Promotion of activities
Costs/financial issues	Readily available up to date information on exercise/health/fitness
Lack of suitable equipment	

For individuals with a learning disability activity levels can be low and their weight may be problematic (for example, people with Down's syndrome). In these circumstances additional support may be needed to make healthy diet and lifestyle choices. The outcomes of structured exercise programmes for adults with a learning disability include physical and social benefits, such as weight management, meeting new people, and gaining confidence and knowledge.[8]

The Inclusive Fitness Initiative is a scheme to make the sport and leisure industry more inclusive for all disabled people by addressing four key areas:

- accessible facilities;
- inclusive fitness equipment;
- staff training; and
- inclusive marketing strategies.

Promoting initiatives such as inclusive fitness allows disabled people the opportunity to socialise and mix with other fitness-minded people, potentially promoting the development of other facilities (by showing there is a need) and tackling discrimination and stereotypes, which may be held by providers and users of sporting/exercise facilities. However, it is important to ensure people with a disability have a choice in whether they take part in activities with others who have a disability, or alongside able-bodied people, and help should be given to promote a mix of opportunities.

Interventions which address the wider determinants of health such as improving people's financial situation, increasing social participation and decreasing discrimination can have a massive impact on the health of people with a disability.[9] The physical benefits of exercise are not limited to those without a disability. Physical activity can produce better mental wellbeing, improve health generally and can assist weight control. For people with a physical disability, there may be the added bonus of increased strength, reduced hypertonia (muscle tone, stiffness and poor elasticity), increased flexibility and pain relief.

Increasing access to services, facilities and resources whilst promoting physical activity and improving health care and service delivery for people with a learning and/or physical disability will help to narrow health inequalities.

Stress and disability

Stress is a physiological and psychological response to negative events, traumas, emotional and mental pressures. Stress occurs when external events are perceived as a threat or danger. This leads to an increase in cortisol and adrenaline levels, preparing the body for a 'fight or flight' situation. In itself this is a valuable survival mechanism, however when this is continuous or accumulative it can exceed the adaptive capacity of an individual. Pre-existing or ongoing medical conditions – including disabilities – are both a source of and a risk factor for stress.

Research on stress and health identifies how negative events are more strongly associated with poor physical and mental health, whilst prolonged or extreme stress can lead to anxiety, depression or more serious mental health conditions.[10] Stress can be an inherent part of life for people with disabilities, with the demands on daily living (energy, effort, time and care required to fulfil daily responsibilities) and associated issues such as employment, exclusion, physical accessibility and economic marginalisation. Individuals with a disability are often exposed to a wider range of stressors, which can be further exacerbated by the disability.[11]

Table 3: Potential sources of stress for people with a disability

Individual	Environmental
Disability	Employment accessibility
Health	Exclusionary social systems and structures
Interpersonal relationships	Physical accessibility – to services, public
Inability to meet expectations	realm etc.
Ageing	Economic marginality
Medications and/or side effects	Transportation
Caregivers	Poor facilities
Lack of independence	Unequal treatment

Evidence suggests coping with and adaptation to disability can be difficult for people and multiple factors can influence the coping process. Perceived social support (from caregivers, friends and family) is important for coping, with family and friends often being the primary source of social support.

When dealing with a disability and associated issues, adaptive strategies which incorporate problem solving, seeking support and a high level of self-efficacy (the strength of an individual's belief in their control over life and their ability to complete tasks and reach goals) are associated with lower anxiety levels, better psychosocial adaptation, functioning and quality of life. Maladaptive coping strategies are strongly associated with increased psychological distress and poorer adaptation. The use of disengagement coping strategies (e.g. wishful thinking, using alcohol or drugs, self or external blame) is associated with increased levels of psychological distress. Avoidance coping strategies have also been associated with people with financial difficulties, those who are less educated and of a lower socio-economic status and those with lower self-efficacy (with or without a disability).[12-13]

As more men and women with learning disabilities are supported to live in a variety of accommodations in the community and given more freedom, they may be exposed to greater social stressors. This exposure may lead to greater use of alcohol and illicit drugs as a coping mechanism/stress reliever.[14]

Smoking

Comparing smoking rates among people with specific disabilities to those without shows individuals with psychological or emotional disabilities tend to have higher rates of smoking and a current smoking status. However, there is no clear pattern among those with other disabilities and other studies have shown that smoking rates vary with the type of disability, whilst individuals who have chronic conditions are more likely to be former smokers.[15]

The reasons for the differences in smoking rates between people with a disability and those without are not clear, but there are associations with stress, depression and disability. Smoking is incorrectly perceived as a stress reliever and coping with and adapting to disability may result in an individual using smoking as a maladaptive coping strategy. In many instances smoking will have led to the disability (and other health conditions) rather than the disability resulting in the uptake of smoking behaviours. Other demographic factors (such as income and education levels) may contribute to the differences in smoking behaviour.

The health implications for disabled smokers are serious: smoking is the major contributor to many life-threatening conditions such as cancer, respiratory disease, cardiovascular disease and strokes. However, smoking cessation may be more problematic for smokers in this population. There is evidence that people with disabilities are less likely to be questioned about tobacco use and smoking by their doctor or health provider. Secondly smoking cessation services may not always be easily available and/or accessible (including financial costs) and there may be pharmacological contra-indications between nicotine replacement therapies and prescribed medications for health conditions. Any interventions should be sensitive and individually targeted to gain the most positive outcomes. Environments which facilitate healthy lifestyles overall for disabled people may also encourage individuals to stop smoking.

Alcohol, drug and substance misuse

There are no clear estimations of alcohol and/or substance misuse amongst people with a disability, but alcohol misuse is more likely than drug or other substance misuse. For people with a learning disability the prevalence rates may vary due to methodological problems, specifically around definitions of use and misuse and the label of learning disability. Difficulties may arise in identifying individuals with alcohol or drug issues, as they may be a hidden population. There may also be conflict between a duty of care and a person's freedom of choice in lifestyle behaviour. Due to the small number who may have substance misuse problems it may not be an area where a service user is questioned. In addition there may be issues with access to and appropriateness of treatment services which do not take into account a person's disability.[16]

There is limited to no integration between addiction services and learning disability services, which can mean people fall through the gaps. Specifically for learning disabilities there are a number of risk factors (outlined below), which can make someone more vulnerable to misusing drugs or alcohol.

Table 4: identified risk factors for substance misuse

Individual factors	External factors
Having a borderline to mild learning disability Being young and male Having a specific genetic condition Conduct disorder, ADHD or anti-social personality disorders Compromised tolerance to drugs Coming from an ethnic minority group Co-existence of a mental health problem Low self-esteem Disempowerment Inadequate self-control/regulatory behaviour Impulsivity Cognitive limitations (e.g. illiteracy, short attention span, memory deficits, poor problem-solving skills, over-compliant dispositions)	Living in the community with low levels of supervision Poverty Parental alcohol-related neuropsychiatric disorders Presence of negative role models with punitive child management practices Family dysfunction Negative life events (neglect, abuse, bereavement) Unemployment Limited educational and recreational opportunities Excessive amounts of free time Deviant peer group pressure Limited relationships/friends Lack of meaning in life Lack of routine Loneliness Desire for social acceptance or 'fitting in'

Source: Taggart et al (2008)

There are risks involved for people with both physical and learning disabilities who may misuse substances. Those with a learning disability may be more vulnerable to exploitation and risk-taking behaviour around substances (sharing or non-safe use of equipment for example). This will be compounded by the degree of the learning disability. Physical disabilities and substance use can lead to risks whilst using mobility or other aids and can worsen existing physical conditions or lead to alcohol-related disability. There is also an increased risk of falls, incorrect taking of prescribed medication whilst under the influence, and risks of overdose or contraindication when mixed with other substances.

From a services perspective, the practitioner may be unable to offer appropriate services to their client group due to a lack of experience or training in working with people with a disability. Prioritisation of other issues over alcohol or drug use may further compound addiction or problematic substance use, as can the incorrect assumption that people with a disability do not have issues with substance use and therefore do not need tailored services.[17]

Conclusion

There is evidence that having a disability may result in fewer preventative health care services such as screening and health promotion messages. This may be due to physical barriers, such as the ability to access health services, misconceptions from health care staff and ineffective communication between medical professions and individuals.[18]

Poor lifestyle behaviours can further compound long-term chronic conditions, mental health disabilities, and complications associated with physical and learning disabilities. Alongside the wider determinants of health, negative health behaviours can present a potentially bleak outlook for people with a disability. There is clear evidence that people with disabilities can benefit from adopting healthier lifestyle behaviours and having access to clear, relevant and applicable health care messages. To achieve the best possible outcomes there is a responsibility on commissioners of services, planners, policy makers, health professionals, and disability groups and disabled people to promote the needs of the disabled population, therefore reducing the impact of negative health behaviours and make positive health choices the norm rather than the exception.

References

[1] Improving Health and Lives: Learning Disabilities Observatory, 2011. *Health inequalities and people with learning disabilities in the UK: 2011* Department of Health [pdf].

[2] NHS website, 2014. *Food and diet* [online].

[3] Mudge, S., 2013. Living well with disability: needs, values and competing factors. *International Journal of Behavioural Nutrition and Physical Activity*, [online].

[4]Kim, D.H., Sagar, U.N., Adams, S., and Whellan, D.J., 2009. Lifestyle Risk Factors and Utilization of Preventive Services in Disabled Elderly Adults in the Community. *Journal of Community Health 34.5: 440-8.*

[5] Ellis, T., Boudreau, J.K., DeAngelis, T.R., Brown, L.E., Cavanaugh, J.T. Earhart, Gammon M., Ford, M.P., Foreman, K., Dibble, B., and Leland, E., 2013. Barriers to exercise in people with Parkinson disease. *Physical Therapy*, vol. 93, issue 5 (628-636).

[6] Junker, L., and Brogen Carlberg, E., 2011. Factors that affect exercise participation among people with physical disabilities. *Advances in Physiotherapy*, 13: 18-25 [online].

[7] English Federation of Disability Sports website, 2014. *Disabled People's Lifestyle Survey 2013* [online].

[8] Lante, K. A.,Walkley, J.W., Gamble, M., and Vassos, M.V., 2011. An initial evaluation of a long-term, sustainable, integrated community-based physical activity program for adults with intellectual disability. *Journal of Intellectual and Developmental Disability*, Vol. 36, issue: 3 (197-206) [online].

[9] Junker, L., and Brogen Carlberg, E., 2011. Factors that affect exercise participation among people with physical disabilities. *Advances in Physiotherapy*, 13: 18-25 [online].

[10] Mind website, 2013. *Information and support* [online].

[11] Iwasaki, Y., and Mactavish, J.B., 2005. Ubiquitous yet unique: Perspectives of people with disabilities on stress. *Rehabilitation Counselling Bulletin*, 48:4, 194-208 [online].

[12] Belguzar, K., and Cengiz, H.A., 2011. Predictors of coping in a group of Turkish patients with physical disability. *Journal of Clinical Nursing*, 21, 983-993 [online].

[13] Livneh, H., Lott, S.M., and Antonak, R.F., 2004. Patterns of psychosocial adaptation to chronic illness and disability: a cluster analytic approach. *Psychology, Health & Medicine,* vol 9, no.4 (411-430).

[14] Taggart, L., Huxley, A., and Baker, G., 2008. Alcohol and illicit drug misuse in people with learning disabilities: implications for research and service development. *Advances in mental health and learning disabilities* Vol. 2, issue 1.

[15] Brawarsky, P., Brooks, D.R., Wilber, N., Gertz, R.E., Klein Walker, D., 2002. Tobacco use among adults with disabilities in Massachusetts. *Tobacco Control 2002; 11 (Suppl II):ii29–ii33*.

[16] Taggart, L., Huxley, A., and Baker, G., 2008. Alcohol and illicit drug misuse in people with learning disabilities: implications for research and service development. *Advances in mental health and learning disabilities* Vol. 2, issue 1.

[17] Dance, C., Allnock, D., Galvani, S., and Hutchinson, A., 2013. Social care practice with older people, people with learning disabilities, and physically disabled people who use alcohol and other drugs. *SCIE Social Care Online January 2013*.

[18] Kim, D.H., Sagar, U.N., Adams, S., and Whellan, D.J., (2009). Lifestyle Risk Factors and Utilization of Preventive Services in Disabled Elderly Adults in the Community. *Journal of Community Health 34.5: 440-8.*