Improving the life expectancy of people with serious mental illness

People with diagnoses of serious mental illness (including schizophrenia, schizoaffective disorder, bipolar disorder and sometimes depressive psychosis) have higher risks of premature mortality from various causes, not just as a result of suicide but also from physical illnesses commonly found in the general population (Robson and Gray, 2007). They face remarkably elevated all-cause mortality in all age groups and thus a shorter longevity (Laursen et al, 2007; Chang et al, 2010, 2011; Piatt et al, 2010).

Specifically, recent reports on the general mortality of people with serious mental illness in south-east London revealed standardized mortality ratios ranging from two to three and around 12 years shorter life expectancy than the general population in the UK (Chang et al, 2010, 2011). Reduced life expectancy for people with serious mental illness has been attributed to socioeconomic dysfunction, stigma and direct consequences of psychopathology, as well as to deleterious physical consequences of long-term exposure to antipsychotics and adverse lifestyle choices (e.g. smoking, drinking, poor diet, obesity, illicit drug use and physical inactivity), mainly increasing mortality from cardiovascular and respiratory causes and cancer (Robson and Gray, 2007; Wildgust et al, 2010).

In most developed and some advanced developing countries, since the 1980s mental health services have been transformed from institution-centred to integrated community-based services. Physical and mental health inequality among people with serious mental illness has been recognized as the next critical global issue (Robson and Gray, 2007; Wildgust et al, 2010; Westman et al, 2011). Although the health-care service system has been generally improved in recent decades, little effort has been made to reduce inequalities in general mortality and life expectancy between people with serious mental illness and the general population (Laursen et al, 2007; Piatt et al, 2010; Wildgust et al, 2010; Hoang et al, 2011; Westman et al, 2011).

Socioeconomic disadvantages and difficulties in integrating different health-care sectors remain substantial challenges for people with serious mental illness effectively using physical health services in both primary and secondary care (Robson and Gray, 2007). The challenge for people living with serious mental illness is how to manage their mental disorders properly and avoid physical consequences of the treatments at the same time. Further understanding of the major risk factors which affect mortality within the broader context of health-care delivery systems will help to unravel the riddle of people with serious mental illness.

Effect of physical conditions on the health of people with serious mental illness

The importance of physical health among people with severe mental disorders has been underestimated in research and clinical practice. The UK National Institute for Health and Clinical Excellence updated the guidelines for the treatment of schizophrenia in both primary and secondary care providers, and emphasized the importance of developing and using practice case registers to monitor the physical and mental health of people with schizophrenia in primary care (National Collaborating Centre for Mental Health, 2009). It recommended that GPs and other primary health-care professionals monitor the physical health of people with schizophrenia at least once a year and that health-care professionals in secondary care should check that this is being done (Robson and Gray, 2007; National Collaborating Centre for Mental Health, 2009; Hardy and Gray, 2010).

Without appropriate clinical assessment, monitoring and recording physical health status for people with serious mental illness, there are limited opportunities for early intervention to treat physical illness (Hardy and Gray, 2010; Piatt et al, 2010; Wildgust et al, 2010). The leading causes of mortality for people with serious mental illness are not very different to those in the general population (especially for older age groups), but the specific pattern of deaths varies by gender, across age groups and between psychiatric diagnoses (Laursen et al, 2007; Chang et al, 2010; Piatt et al, 2010). However, studies comparing people with serious mental illness to the general populations will help clarify particular research requirements in serious mental illness and help to address the issue of excess mortality (Piatt et al, 2010; Chang et al, 2011).

In the USA, decedents with serious and persistent mental illness being cared for in the community demonstrated 14.5 years of potential life lost. Heart disease was identified as the leading cause of death both in this group (30.5% of total deaths) and general population (27.2%) (Piatt et al, 2010). Long-term cumulative exposure to any antipsychotic was suggested to be associated with lower mortality compared to patients with schizophrenia who were not taking antipsychotics, but the role of typical or atypical antipsychotic use and polypharmacy in mortality among people with serious mental illness remains controversial (Tiihonen et al, 2009; Wildgust et al, 2010). Given the physical health disparities associated with serious mental illness, research into the particular patterns of major physical illnesses leading to death is needed to inform strategies to prevent premature mortality.

Importance of community-based intervention and integrated medical care systems

Guidelines for physical health promotion to people with serious mental illness are mostly generated by extrapolating evidence from studies in the general population. This is not necessarily appropriate for

these people as their outcomes might arise from particular causal processes such as metabolic abnormalities associated with the mental disorder in question (Wildgust et al, 2010).

However, community-based physical health promotion programmes for people with serious mental illness have been conducted in primary and secondary health-care settings to generate specific evidence for this group (Smith et al, 2007; Hardy and Gray, 2010). A trial of wellbeing support in south-east London provided evidence that cardiovascular risk factors could be efficiently reduced by using the intervention with people with serious mental illness (Smith et al, 2007). Another project in Northampton using 'Health Improvement Profile for Primary Care' as a tool contributed further evidence on the effect of support for self-care to people with serious mental illness on reducing their cardiovascular risk. This involved a physical health risk assessment given by health-care professionals in the practice and community mental health nurses linked with the practice. Active responses such as referrals to appropriate services could be accordingly made (Hardy et al, 2010). Nonetheless, a lack of clarity about whose role it is to promote general health, detect preclinical physical disorders and manage physical problems in people with serious mental illness is still an important obstruction to effective health-care services (Robson and Gray, 2007) and leads to concerns about the quality of physical care (Wildgust et al, 2010).

Conclusions

In the UK and elsewhere, individuals receive medical care from multiple providers or switch from one to another for their own good. To some extent, this makes problems with information going missing between health-care services inevitable. Establishing a comprehensive health-care service system by enforcing the role of 'key-worker' or 'care coordinator' in primary or secondary mental health care to compensate for sub-optimal physical care in general practice is a challenge but might be efficient for premature death prevention among people with serious mental illness. Ensuring that tools which are validated with good evidence are used for community based interventions is a good starting point (Smith et al, 2007; Hardy and Gray, 2010).

In future, studies could focus on specific adverse outcomes and underlying disorders, or subgroups within people with serious mental illness which are at higher risk of premature deaths. To make the most impact, investigators in this field will need to collaborate with health-care providers, e.g. by data linkage, to fully characterize this vulnerable population. BJHM

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KEY POINTS

- People with serious mental illness experience a significantly higher general mortality and consequently a shortened life expectancy.
- Leading causes of mortality for people with serious mental illness do not differ from those in the general population, especially for older age groups, but the pattern of deaths dramatically changes by gender, age groups and psychiatric diagnoses.
- Guidelines for physical health promotion to people with serious mental illness are generally based on extrapolation of evidence from studies in the general population, which are not necessarily representative of this particularly vulnerable group of people.
- Physical health promotion programmes for people with serious mental illness have been proposed and preliminary outcomes are promising.
- In the UK and elsewhere in the world, achieving well-integrated services from primary and secondary care is still an important challenge for reducing the risk of premature death among people with serious mental illness.