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Editorial

Physical morbidity and mortality in people with mental illness

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Evidence has consistently shown that patients with mental illness have greater physical health morbidity and mortality compared to the general population.[1] Many factors have been implicated and include a generally unhealthy lifestyle, side effects of medication, and inadequate physical healthcare.[2, 3] Higher rates of suicide and accidents are other known risks. Psychiatric patients are more likely to smoke, have less inclination to exercise, and are prone to poor dietary habits and obesity, the latter through general inertia, the result of the adverse effects of neuroleptic medication, or increased alcohol use. Psychotropic medication is associated with impaired glucose tolerance and diabetes, metabolic syndrome, dyslipidemia, cardiovascular complications, extrapyramidal side effects and sexual dysfunction. A broad range of clinician and organisational factors prevent access to adequate physical healthcare that in turn compounds the above problems.

Scale of physical morbidity and mortality in mental illness

Patients suffering from depression are twice as likely to develop type 2 diabetes mellitus, and the prevalence of stroke and myocardial infarction is three- and five-fold respectively higher than people without depression.[4] A mortality rate ratio (MRR) of 2 to 3 in patients with schizophrenia or bipolar disorder is a general finding.[5] Schizophrenia is associated with higher rates of diabetes mellitus (side effects of medication partly to blame), osteoporosis (lifestyle risk factors play a role), obesity, and cardiovascular problems.[2, 6, 7, 8] It has been estimated that life expectancy is reduced by at least ten years.[9, 10] People with learning disabilities, particularly those with concurrent epilepsy, dementia and polypharmacy, are at greater risk of developing added complications.[11] Eating disorders are associated with a high mortality because of physical disorders caused by anorexia/bulimia nervosa affecting other organ systems.[12] Mental illness in general is associated with an increased risk of hepatitis, human immunodeficiency virus (HIV), tuberculosis, and poor dental health.[9, 10]

Causes of raised physical health morbidity and mortality in psychiatric patients

Explanations for the higher morbidity and mortality in mental illness include cardiovascular and respiratory problems in addition to the increased suicide risk. Aetiological factors include adverse effects of medication (weight gain, diabetes, and dyslipidemia), lifestyle (smoking and the cost of smoking, poor diet and nutrition, lack of exercise, and obesity) and inability to access physical healthcare. Obesity, smoking and physical inactivity contribute to hypertension. Poor physical healthcare outcomes in mental illness are related to a combination of factors generally considered under the headings of patient/illness, psychiatrist/physician, and service provider/system issues.

De Hert and colleagues[9, 10] have outlined the factors that account for the raised physical health problems. For instance the patient/illness factors comprised difficulty in understanding health care advice combined with the motivation required to adopt new changes in lifestyle, poor compliance with treatment, cognitive deficits, reduced pain sensitivity (induced by antipsychotic medication), poor communication and deficient social skills (seen in many cases of schizophrenia, for example) which all accounted for the shortened life-span of patients with severe mental illness (SMI).

An additional patient/illness factor is that psychiatric symptoms may render patients less inclined to discuss physical problems. Some doctors are uncomfortable dealing with psychiatric patients because the latter may be cognitively compromised which may impair or impede a doctor's clinical assessment. The stigma of mental illness, often the result of disparaging media coverage and negative stereotypes surrounding psychiatric patients, are other hurdles that prevent people from seeking treatment. Furthermore, psychiatric patients are less likely to see a primary care physician and therefore to receive other interventions such as screening for cancer.

Psychiatrist-related factors are characterised by an overemphasis on mental health to the exclusion of physical health, infrequent screening rates for metabolic abnormalities, omission of medical examination of patients because physical complaints frequently are part of the psychiatric presentation, poor communication with the patient and the primary care teams, a lack of awareness and perhaps adherence to treatment guidelines, insufficient medical knowledge, and erroneous, sometimes misguided beliefs about patients' capability to change their lifestyle.[9, 10] Even when risk factors are documented in the patient's

clinical file, very little is done by way of further investigations or prevention.

Factors common to the psychiatrist and other physicians include a tendency to dismiss or interpret physical symptoms as psychosomatic, lack of good quality care, unequipped teams, insufficient assessment, and difficulties providing consistent monitoring and continuity of care. Other physician-related factors relate to problems coordinating psychiatric and medical care.[9, 10]

Service-provision factors included a lack of clarity and consensus as to where the responsibility of physical health lies.[9, 10] Should general practitioners (GPs) supervise the majority of patients who do not suffer from severe, enduring mental illness? Should patients with acute alcohol withdrawal symptoms be managed at home by the GP, treated in a general hospital, or admitted to a psychiatric unit? The fragmentation of medical and mental health care systems, lack of integration of services (poor or absent liaison links) and insufficient funds to resource the mental health service, limit the ability of most psychiatrists to focus beyond their own speciality.

Service and system changes are prevalent in industrialised countries because reforms in mental health have led to reduced inpatient resources leading to shorter and infrequent hospital admissions with less time available to focus or investigate physical health problems. In the United Kingdom (UK) there is intense emphasis on community care and talking therapies, yet the management of physical health issues by community mental health teams may be poor because of inadequate training and learning.

Recommendations to improve physical health care in psychiatric patients

Health care professionals need to be more aware of these findings in order to improve medical screening and treatment of psychiatric patients. Currently there is no evidence this is happening, with increasing concerns regarding inequalities between those with and without mental illnesses.[13]

We propose the following recommendations to promote integration between mental and physical health care:

1. A greater effort to increase awareness of the problem among primary care and mental health care providers. The Royal College of Psychiatrists has launched a campaign called Fair Deal to highlight the importance of physical health of people with mental illness.[1] Patients still feel stigmatised and therefore psychiatrists need to boost their efforts to reduce this discrimination. The excess mortality associated with this discrimination needs to be recognised as a human rights issue.[13]

2. Primary care providers need to change the culture of undertreating physical health in mental health patients. The National Institute for Health and Clinical Excellence (NICE) guidelines for schizophrenia and bipolar disorder highlight the importance of monitoring antipsychotics and mood stabilizers.[14] The Royal College of Psychiatrists should lead by implementing the NICE guidelines for mental and behavioural conditions.

3. Education and training of doctors who pursue a career in psychiatry needs to be improved with mandatory trainee placements in acute medicine or neurology, regular personal development plan (PDP) courses, and training to update knowledge of recognising physical illness and the performance of basic medical tasks. The Royal College of Psychiatrists should develop a diploma in clinical psychiatry for GPs and clinicians with a specialist interest in psychiatry. The curriculum needs to be widened to include electrocardiogram (ECG) interpretation, basic endocrinology, and neurological investigations (magnetic resonance imaging and so forth). This would allow psychiatrists to develop better liaison with their fellow professionals and share responsibility with them, which undoubtedly would encourage good medical practice.

4. The Royal College Scoping Group's report[15] sets key standards for the physical healthcare of patients in a range of psychiatric services. It outlines the responsibilities of psychiatrists monitoring the physical health of patients, such as problems associated with adverse effects of medication. The report recommends that psychiatrists are trained and kept up to date in relevant physical health matters. These recommendations need to be followed.

5. Mental health professionals should encourage patients to monitor simple measures such as weight, dietary plans, and exercise programs, with the involvement of the voluntary sector (MIND, Mental Health Foundation) where possible. Patients and carers need to be educated about the health risks associated with unhealthy lifestyles: for example, smoking and alcohol misuse may interfere with the metabolism of neuroleptic medications. Smoking cessation clinics and alcohol treatment programmes may help. Advice from dieticians about patients' nutritional requirements to offset changes in metabolism caused by neuroleptics is important.

6. Because of the large-scale reduction of inpatient psychiatric beds and service redesign the majority of psychiatric care provision now exists in the community. Therefore community mental health teams and psychiatric outpatient clinics need to be appropriately designed and equipped to enable proper assessment of physical health monitoring. Annual health checks from the GP would benefit patients who require long-term monitoring in the community. Screening for deleterious effects of medication for example, hypothyroidism and renal dysfunction caused by lithium, at regular intervals would be appropriate.[16] It should also be made clear to psychiatrists that they should resist working in clinical settings that compromise patient care and inhibit good medical practice.

7. Financial initiatives such as Commissioning for Quality and Innovation (CQUIN)[17] may be used by commissioners to improve physical health monitoring. As part of this process, primary care commissioners could mutually agree with mental health providers to fulfil measured targets related to such monitoring.

8. In order to better understand the interplay between psychiatric conditions and medical complications contributing to the high physical morbidity and mortality, further studies are essential. To cite one example, we now know that psychotropic medications contribute to many physical problems (abnormal ECGs, weight gain, changes in plasma glucose) and lead to higher morbidity rates. The 'newer' generations of antidepressants and neuroleptics have not lived up to expectations and have as many untoward effects as the older drugs. Developments of newer drugs with different mechanisms of action are required, though this will take time.

9. The discrimination faced by people with mental illness and learning disabilities, with the accompanying excess mortality, represents a human rights issue[13] that requires legislative changes. The Disability Right's Commission[18] has already recommended appropriate physical health care screening, for example, annual physical health checks. The government's health inequality agenda should incorporate these conditions into its indicators of disadvantage and include mental illnesses and learning disability in the framework.

Conclusion

Traditionally the field of psychiatry involves a holistic approach in the management of patients. Unfortunately, over the decades psychiatry appears to have lost its way and therefore it is important to re-establish a more comprehensive system of treating mental illness that encompasses regular physical health monitoring. Physical morbidity and mortality in patients with mental illness is on the rise and is associated with a complex interplay of factors outlined above. The overall health care of psychiatric patients can be improved through the changes in education and training of clinicians, close liaison between primary and secondary care, implementation of recommendations by NICE and the Royal College of Psychiatrists, improved research through better funding, public health education of patients and carers, and legislative changes.

Competing Interests
None declared.
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