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Editorial

Physical illness in those with mental illness: psychiatric services need to change focus

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Summary
Those with mental illness die prematurely. One reason may be that psychiatrists are overly concerned with risk, focusing too much on this aspect of practice and neglecting the physical health needs of our patients. We need to reconsider how we approach our patients and their needs.

Declaration of interest
I am a sessional consultant psychiatrist with the Regulation and Quality Improvement Authority (RQIA), the independent health and social care regulatory body for Northern Ireland. Although RQIA has an interest in the subject matter of this editorial the views contained within are mine and do not necessarily reflect those of RQIA.

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Background

The independent Mental Health Taskforce to the National Health Service (NHS) in England recently called the fact that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people one of the greatest health inequalities in England.[1] Neither this inequality nor the knowledge of it is new. Phillips, writing in 1937, noted 'an abnormally high incidence of physical disorder in mental admissions'.[2] Phelan and colleagues noted how research has consistently confirmed that psychiatric patients have high rates of physical illness, much of which goes undetected, with those attending psychiatric out-patients nearly twice as likely to die as the general population.[3] This is not a problem unique to the British Isles with Walker and colleagues estimating that 14.3% of deaths worldwide, or approximately 8 million deaths each year, are attributable to mental disorders, with suicide accounting for one in six and natural causes leading to over two in three.[4]

Why should our patients experience more physical illness, and die so much younger, than the general population? Why have we been unable to address this problem nearly 80 years after Phillips published his paper? Significant progress has been made in the development of physical, psychological and social treatments in the intervening years (not as much as we would like, however) but not in this critical (literally) area. It is the most vulnerable and deprived in our communities who tend to suffer most from multiple morbidity and our patients are among the most vulnerable and deprived. We know that, for many of our patients, their physical health problems are the result of a combination of poor diet, lack of exercise, smoking, high rates of substance misuse and the side-effects of psychotropic medication.[3] We also know that our patients with schizophrenia are less likely to spontaneously report physical symptoms, engage properly with services and receive appropriate assessment, monitoring or good care.[3] Despite this, as doctors we are poor at undertaking physical examinations and carrying out investigations, with the occurrence of diagnostic overshadowing when reports of physical ill health are erroneously viewed as part of the mental health problem and so are not investigated properly.[5]

Re-evaluation of priorities

A number of interventions have now been shown to reduce mortality, such as encouraging patients to adhere to their anti-psychotic[6] and antidepressant[7] medication. Smoking cessation interventions that combine behavioural support with cessation pharmacotherapy, and are effective in the general population, are also likely to be effective in people with mental disorders[8] but treatment may need to be prolonged.[9] Yet, despite this increasing body of evidence about effective interventions, the inequality remains. Why are we still failing to address this neglect of the most fundamental aspects of our patients' care? It is correct to say that stigma must be tackled, that our patients need to be treated equally to those who do not have mental illness, that we need more resource. However, that is not a sufficient response. There is much that can be done irrespective of stigma and discrimination and it is we in psychiatry who must take the necessary steps.

In the most recent Government mandate to NHS England the Health Secretary, Jeremy Hunt, tasked the NHS with reducing the number of avoidable deaths in England and Wales.[10] Using data from the Health Survey for England, the Mental Health Minimum Data Set and a previously published analysis,[11] Rethink calculated that 1 in 3 of the 100 000 people who die avoidably each year have a mental illness,[12] equating to over 33 000 avoidable deaths per annum in our patients, most of which deaths are because of comorbid physical illnesses although not all because of our patients' lifestyles and structural discrimination. Between April 2000 and December 2004 there were approximately 1300 patient suicides per year reported to the National Confidential Inquiry into Suicide and Homicide.[13] Of these 18%, or 233 per year, were identified as a group of most preventable suicides. In a similar period 52 patient homicides per year were reported with 14% of these, or 7 per year, being identified as most preventable. The Inquiry, therefore, identified 240 potentially avoidable deaths per annum. The difference between preventable deaths due to physical illness and preventable deaths due to suicide/homicide is of a magnitude well in excess of 100-fold.

Problems presented by a risk-adverse culture

It appears that we may have been focusing too many of our efforts, and finite resources, on areas of least gain. Rather than leading by informing the public, commissioners and our political masters about the difficulties in predicting violence, suicide and homicide, instead we collude by pretending that we can indeed mostly prevent suicide or homicide in those with mental illness.[14] We are allowing psychiatry to be driven by unrealistic public expectations and by the political need to 'be seen to be doing something'. We seem to have forgotten the fundamentals of psychiatric care, doing what is best for the patient. We are so risk averse that we have allowed a risk management culture to overshadow everything else in our practice including, inter alia, addressing the physical health needs of our patients. As psychiatrists we should be more forceful in advocating for our patients and for what is best for them, influencing commissioners about how we might address these problems together. We need to lead in the further development of biopsychosocial models of care, integrated with primary care, and informed by public health goals, to ensure that our patients' physical illnesses are identified and treated in a timely manner. Psychiatrists and primary care colleagues must work together to prioritise the physical health needs of our patients, irrespective of who takes the lead. It is our responsibility to educate our patients about their physical health needs to empower them to take ownership of their own health issues.

Conclusions

The time has now long passed for us all – politicians, commissioners, psychiatrists, general practitioners and all others with the interests of the mentally ill – to reconsider our approach to our patients and help them to address their basic needs, focusing less on the stigmatising risk aspects of the illnesses (without neglecting them). As psychiatrists we need to be at the forefront, leading, developing services that are holistic and properly addressing our patients' needs, rather than colluding with a risk averse culture.

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