

Schizophrenia: No Health Without Physical Health

Jimmy Lee,^{1,2,3} MBBS, MMed, MCI, Tih-Shih Lee,⁴ MD, PhD, FRCPC, Gary Remington,^{3,5} MD, PhD, FRCPC

Introduction

Schizophrenia is a severe and chronic mental disorder, with onset routinely occurring in late adolescence. It is associated with the poorest outcomes among all described psychotic conditions, and there is currently no cure. However, effective treatments are available to mitigate some of the psychiatric symptoms, and more recent studies have suggested that outcome in schizophrenia may not be as pessimistic as once thought. For example, we now know from longer-term follow-up studies that about one-third of individuals with schizophrenia can achieve recovery at some point over a 10-year interval.¹

It remains, though, that schizophrenia is for many a debilitating illness. The recently completed Global Burden of Disease Study (2010) ranked schizophrenia as one of the 5 leading causes of disability among all mental and substance use disorders. Notably, schizophrenia appeared to make a larger contribution to years lived with disability (YLD) than years of life lost (YLL) because mental disorders are rarely fatal. However, what is not considered in the computation of burden is the increased risk of physical illnesses and consequent reduced life expectancy frequently observed in individuals with schizophrenia. The unfortunate reality is that individuals with schizophrenia are at greater risk for medical illnesses and chronic medical conditions.² All these exact significant burden with a consequent impact on morbidity and mortality.

Schizophrenia and Mortality

The life expectancy for individuals with schizophrenia has been estimated to be 20% shorter, which translates to about 15 years less than the general population.³ Deaths from natural causes account for up to 63% of the excess mortality.⁴ Reflecting this, mortality from digestive, infectious and respiratory diseases has been reported to range from 4- to 5-fold higher than the general population. Paradoxically, mortality rates for schizophrenia have increased in recent decades, contrary to what is observed

in the general population.⁵

These statistics are sobering, and while one can argue that they were not obtained from Singapore there is no reason to believe that Singapore bucks the global trend. In fact, data gathered locally in recent years point to increased rates of obesity, metabolic disorders and higher cardiovascular risk in individuals with schizophrenia.⁶⁻⁸ In short, these results suggest that the local population would not be any different from other countries.

Possible Reasons for Increased Mortality

When we examine the possible reasons for the mortality gap, several uncomfortable findings emerge. Mortality from cardiovascular causes account for the greatest majority, and schizophrenia has been linked to increased cardiovascular risks. Reasons for this increased risk included lifestyle and dietary factors, inherent genetic vulnerability and psychotropic medications. However, these reasons might be insufficient to explain the non-cardiovascular mortality causes.

Schizophrenia is a highly stigmatised mental disorder that has often been misunderstood by the public as well as healthcare workers not practising in the mental health field. Could this misunderstanding and stigma act as an invisible barrier when individuals with schizophrenia attempt to access care? This does not diminish the fact that access to care is a 2-way street. From the patients' perspective, their ability to be aware that something warrants medical attention and/or to communicate their concerns clearly to the healthcare provider highlights possible opportunities where this might go awry. Conversely, from the clinicians' perspective, one has to be mindful of diagnostic overshadowing, whereby physical symptoms are misattributed to mental illnesses.⁹ This is an understudied area, deserving greater attention, as cognitive biases of this sort can be addressed.

There is, in fact, evidence that individuals with schizophrenia receive suboptimal medical care. A recent meta-analysis concluded that such individuals (which

¹Department of General Psychiatry 1, Institute of Mental Health, Singapore

²Office of Clinical Sciences, Duke-NUS Graduate Medical School, Singapore

³Schizophrenia Division, Centre for Addiction and Mental Health, Canada

⁴Neuroscience & Behavioral Disorders, Duke-NUS Graduate Medical School, Singapore

⁵Department of Psychiatry, University of Toronto, Canada

Address for Correspondence: Dr Jimmy Lee, Department of General Psychiatry, Institute of Mental Health, 10 Buangkok View, Singapore 539747.

Email: jimmy_lee@imh.com.sg

includes those with other severe mental illnesses) are prescribed significantly lower quantities of several common medications, especially cardiovascular medications.¹⁰ Along similar lines, another study found that individuals with mental illnesses fared poorer in all measured parameters of quality of diabetes care received.¹¹ When we look at preventive medical care, the evidence once again points to individuals with mental illnesses receiving lower rates of preventive services.¹²

The above highlights not only a treatment gap in physical healthcare for schizophrenia, but a glaring disparity in most aspects of medical care provided to this vulnerable group. As psychiatrists, it behooves us to look for ways to close this gap by highlighting these pertinent issues and acting as patient advocates. Particularly with the severely mentally ill, it is all too easy to focus only on the psychiatric symptoms when, in fact, they warrant the same attention to medical risks as their non-psychiatric counterparts. We expect no less from medical practitioners and have gone to considerable lengths to ensure that they screen for psychiatric symptoms.

As noted, many of the highlighted studies relate not just to schizophrenia, but to most mental illnesses. The mind and body are not separate—mental and medical health care are bi-directional and should be seen as such across all levels of training. While gains have been made, it remains that too often the different disciplines work in parallel when closer collaboration between psychiatrists, family physician and medical specialist would ensure better and more timely care in both directions.

To this end, alternative models of care delivery need to be considered and evaluated. One such alternative is collocation of medical clinics with mental health services, a strategy that reduces the physical barrier to care access and can allow for training a dedicated team with tailored preventive care algorithms. Evidence is already in place to support such a strategy, indicating improved quality of preventive medical care and, more importantly, outcomes of medical care.¹³

Conclusion

It may well be the case that psychiatry has contributed to the present situation, divesting itself of attention to medical care but, at the same time, not ensuring alliances that would address this gap are in place. In an environment that fosters subspecialisation, it is not even so surprising that care would be partitioned. Now clearly recognised, though, it is time to address this service gap and disparity, advocating and working collaboratively with our medical counterparts to provide equitable care for this vulnerable group.

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