EDITORIALS

Medical Care for Patients with Severe and Persistent Mental Illness

From the moment of detection, schizophrenia confers an increased risk of death. The diagnosis of schizophrenia peaks in the third decade of life; subsequently individuals with this disorder become casualties of suicide, violence and other injuries. Risk of death by injury wanes by middle age, but is supplanted by a mounting toll of chronic medical illnesses. Schizophrenia reduces life expectancy by approximately 15 years.[1]

With increasing emphasis on the primary care provider's role in promoting preventive care, lifestyle changes, and patient self-management, the separation of chronically mentally ill patients from the mainstream has become more pronounced. Obesity, poor nutrition, tobacco and substance abuse, and sedentary lifestyle are pervasive among patients with severe and persistent mental illnesses such as schizophrenia. The population of older patients with schizophrenia is growing. In 2000, there were an estimated 350,000 people with schizophrenia over the age of 65 in the United States and this number is expected to increase 50% by 2020.[2] Though study of medical illnesses in the chronically mentally ill has lagged, the pharmaceutical industry, which has promoted second generation "atypical" antipsychotics, is now financing efforts to educate psychiatrists about medical morbidity due to accumulating evidence of increased risk of metabolic syndrome and frank diabetes mellitus with this class of medications.[3] Psychiatric physicians are being drawn back to their medical roots by the need to monitor patients for hyperglycemia, hyperlipidemia and obesity, and to collaborate more closely with primary care physicians.

Reasons for poor health among patients with schizophrenia are almost certainly multifactorial; patients, clinicians and the health care system all play a role. Most patients with schizophrenia receive psychiatric services in community mental health systems which offer medication, social and rehabilitative services, but are isolated from delivery of medical care. For patients with schizophrenia, negotiating a separate, complex, medical health care system can be challenging. Integrated services offering both mental and medical care at the same location, sometimes even by the same clinician, can overcome systems-based barriers. For example, Krien et al.[4] recently demonstrated that patients with serious mental illness in the integrated Veterans Affairs medical care system received diabetes care that was comparable to patients without mental illness.

Clinicians may struggle to understand the nature and importance of physical symptoms in patients with schizophrenia. Sources of poor communication include somatic delusions, disorganized speech, affect that is incongruent with the nature of the physical complaints, or difficulties in developing a participatory relationship. Symptoms of paranoia, hallucinations and delusions may be perceived by clinicians to be main barriers to care for patients with schizophrenia. However, the neurocognitive impairments and negative symptoms associated with schizophrenia such as apathy, avolition, lack of insight, poor judgment and difficulty with long-term planning, are more powerful culprits, impeding patients' abilities to comprehend health care information, integrate change, and transition into a healthier lifestyle. Yet both psychiatric physicians and primary care practitioners at times underestimate these patients' interest in involvement in health care decisions. Rettenbacher and colleagues measured the attitudes of patients with schizophrenia toward mental and medical diseases. One quarter of patients rated diabetes mellitus, one third rated epilepsy and almost three quarters rated cancer as more serious illnesses than schizophrenia.[5] Admittedly some patients with schizophrenia are profoundly resistive to care, and unable to tolerate interventions or adhere to treatments. Efforts to prioritize the most effective and least invasive preventive measures may help clinicians overcome any sense of futility that impedes attempts to improve these patients' health.

The study by Carney et al.[6] in this issue of *JGIM* has several notable findings. The study places into context the somewhat myopic focus on diabetes mellitus in patients with schizophrenia that has predominated in the psychiatric literature. The authors report that patients with schizophrenia have elevated odds of a variety of common, potentially preventable, but life-threatening, cardiovascular, neurological, pulmonary, renal, gastrointestinal, hematological and other endocrine diseases. Although this study is the first to report an increase in some types of diseases, this may be an artifact of including patients with schizoaffective disorder. Many of these patients are exposed to lithium preparations, increasing odds of hypothyroidism, renal disease and electrolyte disorders. The use of lithium, however, illustrates another example of a commonly used psychiatric medication with potential medical adverse events which requires close monitoring by psychiatrists and primary care clinicians.

As much as there is interest in diseases in which schizophrenia increases risk, there are theories that schizophrenia protects against some illnesses and experiences. The prevalence of rheumatoid arthritis in patients with schizophrenia is reported as one fifth of comparable nonmentally ill populations.[1] Many studies suggest that patients with schizophrenia are less likely to report painful conditions, a perception that is fueled by memorable cases in which these patients come to emergency departments with fractured limbs or ruptured internal organs, but no pain complaints. Carney's data challenge this lore by demonstrating elevated rates of painful conditions such as headache and arthritis, and no apparent decreased risk of rheumatoid arthritis.

Finally, Carney's data likely represent a best case scenario. Patients over age 65 years were not included, which may

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account for the failure to show increased rates of some tobacco-related illnesses such as cancer. Few ethnic minorities were included, limiting comparison with national samples. Only 0.2% of the sample was diagnosed with schizophrenia, whereas the prevalence of this disorder is between 3 and 5 times higher in the community.[7] Schizophrenia is a disorder of great heterogeneity and varying severity. Patients who are able to maintain private insurance coverage, in this case Blue Cross/Blue Shield, must be less severely affected if they are able to maintain employment or family/spousal relationships that would facilitate private insurance.

Currently there are efforts across medical systems to improve the health of populations, with the specter of financial incentives for clinicians who meet measurable heath care quality goals. These efforts may improve the health of patients with chronic mental illness by pushing clinicians to overcome barriers to care. Conversely, some physicians will perceive mentally ill patients as economic liabilities, further disenfranchising and stigmatizing them. The best methods of integrating care for this population remains uncertain, but financial remuneration is likely to be key to success.—**Sahana Misra, MD,[1,2] Linda Ganzini, MD, MPH,[2,3]** *[1]Portland VAMC (PVAMC), Portland, OR, USA; [2]Oregon Health & Science University (OHSU), Portland, OR, USA; [3]Center for the Study of Chronic, Comorbid Mental and Physical Disorders, PVAMC, Portland, OR, USA.*

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