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Mind and body: physical health needs of individuals with mental illness in the 21st century

It is well recognized that individuals with severe mental illness show high rates of suicide and also various physical illnesses which contribute to reduced longevity[1]. This is a major public health challenge in the 21st century. Drugs and alcohol consumption and tobacco use further add to the increased rates of morbidity and mortality. The delays in help-seeking, whether it is for physical illness or psychiatric illness, and the underdiagnosis due to stigma and other factors contribute further to this disparity. Liu et al[2] provide a model based on a multi-level approach at individual, health care systems and social determinant levels to cope with the excess mortality among mentally ill people. We believe that it is a relevant proposal in the framework of modern medicine.

At the individual level, although early recognition of physical comorbidity and early interventions are effective strategies to reduce mortality, it is also relevant to explore what people seek help for and where they seek it from. In fact, culture and explanatory models will guide people to the sources of help, especially those which are easily available and accessible[3]. Explanations of distress and symptoms (explanatory models) will vary across cultures and communities and also be related to educational and socio-economic status.

Health care systems need to be geographically and emotionally available and accessible for people affected by mental illness, so that they can seek help early. Some of the physical comorbidity may not be recognized by clinicians and on occasion the responsibility for managing physical illness may be left to primary care physicians or specialists who in turn may not recognize mental illness or due to stigma may not intervene early enough. This might be due, in the West at least, to a somewhat rigid division between mental health and physical health services. For centuries, the mind-body dualism attributable to Descartes' dogma has affected clinical practice and has increased the dichotomy between psychiatric and physical health care services. This dualism may well have contributed to stigma against mental illness, the mentally ill and the psychiatric services[4]. Furthermore, if physicians are not very good at identifying psychiatric disorders or carrying out mental state examinations, psychiatrists are often not very good at identifying and managing physical illnesses either. When interventions have taken place in partnerships between services, physical health of patients with severe mental illness has been shown to improve[1].

At a social level, explanatory models of disease do not only vary across cultures and communities. They may also differ between the patients, their families and their carers, who may interpret these experiences on the basis of physical or psychosocial factors. More industrialized societies are likely to have psychological, medical or social causative factors as explanations, whereas more traditional societies may hold supra-natural and natural explanations[3]. In many cultures, mind and body are seen as in connection with each other, and patients may link their symptoms to both body and mind, thus making sense of their experiences in a holistic manner. Among Punjabi women in India and Pakistan, for example, the distress may be expressed in different parts of the body feeling hot and cold at the same time[3]. So, when they seek help from physicians who are not aware of these cultural differences, the clinician may miss the distress and underlying psychiatric disorders completely.

In 2013, in a report for the UK Mental Health Foundation[5], we recommended an integration at multiple levels similar to Liu et al's model. One of the potential solutions might be to develop units based on medical liaison, such as consultation-liaison psychiatry, where physicians work with psychiatrists to help early diagnosis and management[6]. Also, we believe that the multi-level model proposed by Liu et al has major implications for training. Training health professionals is a critical first step to make them aware of various components of patient's health. Moreover, education on cultural factors that may influence physical and mental health is relevant. One option may well be teaching social sciences and medical humanities at early stages of training[7], so that clinicians are aware of the impact of cultures on presentation and the interaction between mind and body.

Psycho-educational programmes about physical health among mentally ill patients need to be widely explained and utilized, as they are known to be effective[1]. In addition to the general information about various risk factors, specific programmes must be developed for vulnerable groups and individuals. Also, screening at early stages of treatment may help to reduce physical complications, improving psychiatric outcomes[1,6]. Integration with social care may help individuals with chronic mental illness so that all their needs are met in a single port of call.

Integrated care across primary and secondary care, across physical and mental health, and across social and health care means that training, recruitment and re-

tention of workforce needs to be at the top of the political agenda, so that patients with severe mental illness get the best services they need, deserve and will utilize[8]. It is imperative that psychiatrists take the lead in identifying the physical health needs of persons with severe mental illness as well as in orienting the public mental health agenda to ensure that cultural norms and values are taken into account when developing and delivering integrated care at all levels. They must work with stakeholders, including service users and their families groups, to ensure that integrated care and services are sensitive to patients' needs.

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Excess mortality in severe mental disorder: the need for an integrated approach

Liu et al's paper[1] comes at a crucial and relevant time, because it coincides with a period of increased global efforts to raise interest and awareness in mental health issues so that appropriate treatments are made available to narrow the mental health gap. We need to ensure that up to date medical interventions are available to people with severe mental disorder in the same way that they are available to everybody else and, as a family doctor, I particularly welcome this.

Although we know that people with severe mental disorder such as schizophrenia and bipolar disorder die 10 to 20 years earlier than the general population, there has been little progress in addressing this health disparity over time and there is an urgent need to narrow this gap.

People often try to find linear answers to complex issues, but Liu et al's paper highlights that excess mortality is not due to a single factor. This means that we require novel approaches to this complex problem. Doing nothing is not an option. We can no longer continue to treat the statistics about poor outcomes in mental disorder as if it is all that can be expected. Every life matters and that of course includes lives affected by mental ill health.

There has always been controversy about which elements of mental health promotion and lifestyle choices contribute to an improvement in mental health outcomes, including excess mortality. The research evidence provided in Liu et al's paper lends support for some health promotion activities, including smoking cessation and weight management. Furthermore, it is traditionally believed that substance use disorder has a significant impact on long-term physical and mental health outcomes in people with a diagnosis of mental disorder. Many interventions to address this particular comorbidity have been put forward and the paper notes the limited evidence base about the effectiveness of our current strategies. This is consistent with a recent review[2], highlighting the need to direct resources at continuing research into the effective treatment of substance abuse in people with severe mental illness in order to reduce morbidity and mortality.

The proposed framework supports current thinking about the need to deliver interventions for such complex problems through an integrated care pathway, recognizing that each component of that pathway is a care package. Some care packages will need to be delivered by the individual affected by ill health, some through social care interventions, some through primary care, and some through secondary care.

Policy change is often seen as a tool to deliver care packages, but this should not be the case. Policies should be regarded as a care package in their own right. This new way of thinking needs to be recognized by those who purchase and commission services, so that they can change their own ways of working, especially as current commissioning practice has not made a significant impact on rates of excess mortality in people with severe mental disorder.

The proposed multilevel intervention also highlights the need to have combined mental and physical health guidelines to address both screening and treatment, because for too long there has been an over-reliance on specialism and so called "silo working", which has not delivered the desired health outcomes for people with severe mental disorder. It also reinforces the need for services to have an integrated approach to care which delivers health promotion and emphasizes the role of the individual and self-care, and the need for research that is aligned with practice so that we can continue to apply those interventions that we know will work.

Innovative working and task shifting such as developing workforce roles for the management of long-term physical and mental health conditions is needed, because mental and physical health comorbidity significantly increases costs of care and use of health care resources[3,4].

As a family doctor, mental health advocate and somebody who has previously been involved in commissioning health and mental health services, I find Liu et al's paper useful because it brings together much of the relevant evidence