

basic medical tasks. Moreover, knowledge about specific medication effects and greater attention to the possible impact of psychotropic medications on the physical health of people with SMI can aid psychiatrists in selecting appropriate treatment<sup>3,10</sup>.

The same is true for primary care providers. Some primary care professionals hold negative attitudes toward this vulnerable group, or wrongly attribute physical illness signs and symptoms to concurrent mental disorders, leading to underdiagnosis and mistreatment of the physical conditions. It seems that there still is a lack of awareness among these providers that people with SMI face a greater risk of developing physical illnesses, such as heart disease, obesity and diabetes<sup>3</sup>. Primary care providers may also not be knowledgeable about the health risks associated with psychotropic medications and the resulting health monitoring that

is indicated for persons with SMI. They therefore should specifically be trained to identify and treat physical health problems in people with SMI<sup>3</sup>.

It is clear that deficiencies in the care of those with SMI, due to cultural and educational factors and unclear roles and responsibilities of their providers, continue to leave many service users with SMI vulnerable to serious physical health issues, which may limit their recovery. We can change these aspects through educational innovations. Only then we can leave the road of Cheshire cat and will multi-level interventions or strategies, as those proposed by Liu et al<sup>4</sup>, result in improved outcomes for people with SMI.

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## Perspectives from resource poor settings

Over the last decade, concern has been mounting over the excess mortality in persons and populations with mental, neurological and substance use disorders, and the health and economic burden they represent<sup>1,2</sup>. It has been stated that excess mortality in persons with severe mental disorders (SMD) is a “right to health” issue and that the lack of access to effective physical health care is a form of “structural discrimination”<sup>3</sup>. Liu et al<sup>4</sup> propose and describe a multilevel model for understanding the relationships among risk factors and correlates of excess mortality in persons with SMD, and a framework for interventions at the individual, health system and socio-environmental levels. They also outline priorities for clinical practice, policy and research to enable a move towards health equity for those with SMD. I will critique the otherwise robust paper from the perspective of its relevance for resource poor settings.

Liu et al quote sophisticated evidence which shows that persons with SMD – i.e., schizophrenia and other psychotic disorders, bipolar disorder, and moderate-to-

severe depression – die 10 to 20 years earlier than the general population; and that the majority of deaths in persons with SMD are due to preventable physical diseases, especially cardiovascular disease, respiratory disease, infections, diabetes mellitus and cancers. However, they overstate the case when they claim that this is also true regarding low- and middle-income countries (LMICs). Systematic reviews of population-based epidemiological studies conducted to inform the Global Burden of Disease estimates showed that nationally representative data for mortality in persons with SMD were virtually non-existent across LMICs. Such data were available from just five LMICs for schizophrenia and one LMIC for major depression<sup>5</sup>.

Quantifying mortality presents several challenges in LMICs, because many deaths are not medically certified, and different data sources and diagnostic approaches are used to derive cause-of-death estimates<sup>6</sup>. The need to improve and expand sources of national mortality estimates should be emphasized. It is hoped that

documents presenting evidence of relevance to LMICs carefully parcel out the actual evidence from those countries themselves rather than making generalizations mostly based on high-income country estimates.

Infections may be a particularly important factor related to premature mortality among persons with SMD in LMICs, accounting for half or more of the excess mortality in these settings<sup>7,8</sup>. This should be covered in greater detail in a framework for interventions, beyond the HIV risk management implied under “sexual and other behavioural risks”, because tuberculosis and other infections relevant to “local settings” account for at least as much mortality as HIV in people with SMD.

Based largely on data derived from management of schizophrenia, Liu et al state that appropriate administration of medications can reduce excess mortality in persons with SMD. This is a problematic statement in a situation where moderate-to-severe depression, a condition that explains a greater proportion of population attributable risk than schizophrenia

and bipolar disorder<sup>1,2</sup>, is included in SMD, as guidelines on its management are less medication-centric<sup>9</sup>. An overemphasis on pharmacological solutions has been a regrettable trend in response to mental health problems in LMICs<sup>10</sup>.

Almost missing in the discussion is the fact that health care delivery in LMICs is dominated by primary health centres, with the bulk being provided by general physicians, nurses and ancillary health workers. Many recommendations based around coordination between mental and physical health care divisions sit uneasily against the reality of primary health centre based care in LMICs, where coordination may be required more in terms of referral between sub-primary, primary and specialist care rather than between specialists of different disciplines.

The proposed framework is not configured to assess whether more holistic and sustainable culturally appropriate interventions for LMICs could be useful. Instead, it mostly focuses on health strategies successfully used in North America and Europe, with emphasis on active engagement in surveillance, education and care. These strategies may or may not translate well to LMIC settings. The authors describe facilitators and barriers to application of recommendations and

provide advice on how the recommendations can be put into practice, but do not assess resource implications for application of recommendations and monitoring in under-resourced settings.

Another issue relates to the responsibility and capacity of the state to provide adequate care for its citizens<sup>11</sup>. Persons with SMD tend to live in less safe neighbourhoods, have less access to healthy foods, and have less opportunities to be involved in healthy activities, which may contribute to poor lifestyle behaviours. The proposed framework for intervention largely shies away from comments on structural economic, political and social determinants of mortality in SMD. Rates of inequality and inequity within countries affect the distribution of health and welfare resources, so advances in medical science and health and social welfare sector responses by themselves cannot reduce mortality and morbidity. Moreover, the emphasis on chronic disease self-management and parity in service access, in the absence of structural correctives, may facilitate the erosion of traditional state-centred mechanisms of care and the will to care<sup>11</sup>.

Finally, the proposed framework for intervention assumes that improved care for comorbid physical disorders would

strengthen the overall response to SMD. However, it is possible that the focus on mortality rather than disability, in the resource strapped settings of LMICs, may draw attention away from the mental disorders in general and towards risk factors that are supposed to underlie both physical and mental illnesses.

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## A policy implementer's perspective

We live in a time when we have a fair knowledge about what works for mental health, how best to deliver it, where best to fit the intervention and who should be doing it. Yet we are still far from achieving what we are committing ourselves to in the World Health Organization's Mental Health Action Plan 2013-2020<sup>1</sup>.

When it comes to the framework proposed by Liu et al<sup>2</sup> to address the excess mortality in persons with severe mental disorders, it is clear that the authors are tackling all relevant levels with the aim of building up a holistic evidence-based approach to address the issue. Let me list, however, some crucial points.

The first point is an operational one, that can be summarized by the following

questions: How does this framework link with local health systems at country level? What would be the cost and what is the best order of implementation of the different proposed interventions? Are there any best buys for countries that cannot fully implement? How does the framework rank in terms of priority with respect to other mental health interventions at country and global levels? Should some proposed interventions – especially policy level ones – be a prerequisite for other clinical ones? For example, should we consider launching tobacco cessation programmes for persons with severe mental disorders even if a country does not have policy regulations in line with the Framework Convention on Tobacco Control?

These are the kind of over-arching questions that arise when considering the implementation of this framework.

The second point focuses more on the content of the framework and more explicitly on the groupings used for severe mental disorders and the integration of mental health into primary care.

The inclusion of moderate-to-severe depression within the “severe mental disorders” grouping might be problematic, as the course of that condition, the help-seeking behavior of the person, and the stigma around it are different from those related to schizophrenia. The inclusion of moderate-to-severe depression within the same framework as schizophrenia might be counter-productive for both