Commentary: Reducing the Mortality Gap for the Mentally Ill – Rethinking How and Where We Provide Care

Commentaire : Réduire l'écart de mortalité chez les personnes atteintes de maladie mentale – repenser la façon et le lieu où nous fournissons des soins

NICK KATES, MBBS, FRCPC, MCFP (HON)
Professor
Department of Psychiatry and Behavioural Neurosciences
McMaster University
Hamilton, ON

Abstract

The mortality gap faced by Canadians living with a severe and persistent mental illness is a national scandal. If we are to change this and take advantage of the possibilities that *reverse integration* presents, we need to rethink the ways our systems of care function and remove barriers to accessing care while tapping the full potential of collaborative partnerships, moving to earlier interventions with this population and integrating poverty reduction into all our work. Above all, we need to be much more effective in bringing these issues into the public discourse.

Abstract

L'écart de mortalité auquel font face les Canadiens atteints d'une maladie mentale grave et persistante est un scandale d'ordre national. Si nous voulons changer cela et tirer parti des possibilités que présente « l'intégration inverse », il faut repenser la façon dont les systèmes de soins fonctionnent et éliminer les obstacles à l'accès aux soins, tout en tirant pleinement profit du potentiel des partenariats collaboratifs. Il faut aussi commencer à intervenir plus tôt auprès de cette population et à intégrer la réduction de la pauvreté dans tous les aspects de notre travail. Nous devons surtout être beaucoup plus efficaces pour faire entrer ces enjeux dans le débat public.

Introduction

Evans et al. (2024) issue a timely call to action about the shameful situation of the premature mortality of individuals living with a severe and persistent mental illness (SPMI) (Fiorillo and Sartorius 2021; Thornicroft 2011). While we have long been aware of this, we have been unable to correct the situation despite many previous windows of opportunity, and if we are to have more success this time, we need to better understand why that has been the case.

Evans et al.'s (2024) proposals – reverse integration (Ward and Druss 2017) and the buildings of collaboratives to advocate for this approach (Scharf et al. 2013) – are laudable and achievable, as is the emphasis on building programs based on key underlying principles, within a common framework.

But if we are to achieve this, however, we have to recognize that many of these problems arise from system failures and take a deeper dive into their root causes. That will allow us to identify the specific factors that need to be addressed and the ways in which our systems of care need to be redesigned (Kates 2017) so that we can take full advantage of the possibilities that these approaches offer and introduce new standards for care.

These system issues can be divided into two broad groups: barriers to accessing care and the ways our systems of care are organized and connected.

Barriers to Accessing Care

Obvious issues include lengthy waiting lists, restrictive intake processes, decreased availability of family physicians, limited outreach activity and costs associated with accessing treatment or getting to appointment (Mental Health Commission of Canada 2021).

But many of the SPMIs, especially those with concurrent substance use problems, have also been abandoned by services because their behaviours may not always conform to expected norms – such as not always showing up for appointments – or because of stigma or bias on the part of providers (Ronaldson et al. 2020). Service delivery models need to be more inclusive, flexible and user friendly, tailoring services around the needs of individuals who face multiple challenges and who may already feel traumatized by contacts with the mental healthcare system (WHO 2018).

The Ways Our Systems of Care Are Organized and Connected

Fragmentation of services and over-specialization create problems with communication between providers and with transitions between services while reducing the likelihood of a single service or provider taking primary responsibility for an individual's ongoing care (Ayerbe et al. 2018) or people being *lost to care* when moving between services or sectors. We also need to rethink our approaches to health teaching and support for self-management and lifestyle interventions (De Rosa et al. 2017; Fiorillo et al. 2019), as we may be failing to provide individuals with the tools to better manage their own conditions, especially at times when they have no contact with any (mental) health service. Inadequate monitoring of medications and their metabolic side effects is also a contributing factor.

There are, however, two additional and potentially significant factors that the authors have not included in their analysis. These are: (1) a need to focus on prevention and earlier identification rather than just treating more advanced conditions and (2) a broader view of the potential of collaborative partnerships.

A focus on prevention and early detection

Simply focusing on treating well-established and possibly already life-threatening conditions is not enough. To make a lasting difference to the trajectory of these problems, we must find ways to intervene sooner. These problems usually develop over a lengthy period of time, with many opportunities to identify and treat emerging medical issues, often before other factors complicate the picture (Firth et al. 2020). In addition to promoting lifestyle changes, reversed integration teams can assist by regularly reviewing the medical histories of everyone with a SPMI being seen in a mental health service and adding a periodic health check-up. Services must also monitor people proactively rather than waiting for individuals to come to them when a problem becomes more severe.

The potential of collaborative partnerships

Co-location is an important step in the right direction, but that should be the start, not the endpoint of collaborative partnerships. Once working side by side, primary care and mental health personnel can interact in new ways to fully realize its benefits (Kates et al. 2023). Regular two-way communication facilitates the integration of care and the coordination of plans as well as the sharing of information on community resources. Co-location can also help to increase the skills and comfort of mental health providers in identifying and monitoring physical health problems – it is probably the most effective and lasting way of doing so – and to build integrated teams to assist with care that goes beyond just medical treatment, including effective health teaching.

And while the authors excluded socio-economic factors from their analysis, it is impossible to overstate the impact of poverty and its contribution to the development or worsening of physical health problems (Topor et al. 2016), whether through inadequate diet and food insecurity, climate inequity, inadequate or unhealthy housing and living environments or an inability to purchase healthcare aids or medication that are not covered (Luciano et al. 2021). Poverty reduction needs to be part of every individual care plan, and one critical policy change may be a minimum guaranteed income (Rizvi et al. 2024).

How to move forward

As the authors point out, building "Collaborations" between various stakeholders – based on the Equally Well approach (Te Pou 2014) – requires careful consideration. Who is best positioned to take the lead, can different groups come together around a single issue or will differing agendas fracture these coalitions, is there an optimum size and what can facilitate these arrangements, bearing in mind that every community's solution will likely differ from every other?

But to make real headway, there are three other steps we can take, in addition to a guaranteed minimum income:

1. We must increase the awareness of this crisis, and its possible solutions, among both the medical and the wider community. This issue needs to be front and centre in our public discourse until we reach a *tipping point*, where decision makers and funders can no longer ignore this national disgrace.
2. All mental health services should include an annual screening and physical exam of everyone living with a SPMI as an expected standard of care, as is now the case in the UK (NHS England n.d.) with Core20PLUS5.
3. As Ontario moves to guarantee access to a primary care provider for every citizen, could this guarantee extend beyond traditional clinics and practice to include individuals who will only receive the medical care they need if primary care services come to where they are living or receiving mental healthcare (Government of Ontario 2024)?

In raising this issue and linking it to a specific and potentially effective solution, Evans et al. (2024) have taken a helpful step in that direction.

Correspondence may be directed to Nick Kates by e-mail at nkates@mcmaster.ca.

References

Ayerbe, L., I. Forgnone, Q. Foguet-Boreu, E. González, J. Addo and S. Ayis. 2018. Disparities in the Management of Cardiovascular Risk Factors in Patients With Psychiatric Disorders: A Systematic Review and Meta-Analysis. *Psychological Medicine* 48(16): 2693–701. doi:10.1017/S0033291718000302.

De Rosa, C., G. Sampogna, M. Luciano, V. Del Vecchio, B. Pocai, G. Borriello et al. 2017. Improving Physical Health of Patients With Severe Mental Disorders: A Critical Review of Lifestyle Psychosocial Interventions. *Expert Review of Neurotherapeutics* 17: 667–81. doi:10.1080/14737175.2017.1325321.

Evans, C., C. Canning, M. Ambreen, B. Lo, M.R. Van Kesteren, C.M.E. Walker et al. 2024. A Canadian Call for Addressing Physical Health in Specialized Mental Health Settings. *Healthcare Policy* 20(1): 19–28. doi:10.12927/hcpol.2024.27475.

Fiorillo, A., M. Luciano, M. Pompili and N. Sartorius. 2019. Editorial: Reducing the Mortality Gap in People With Severe Mental Disorders: The Role of Lifestyle Psychosocial Interventions. *Frontiers in Psychiatry* 20: 434. doi:10.3389/fpsyt.2019.00434.

Fiorillo, A. and N. Sartorius. 2021. Mortality Gap and Physical Comorbidity of People With Severe Mental Disorders: The Public Health Scandal. *Annals of General Psychiatry* 20(1): 52. doi:10.1186/s12991-021-00374-y.

Firth, J., M. Solmi, R.E. Wootton, D. Vancampfort, F.B. Schuch, E. Hoare et al. 2020. A Meta-Review of "Lifestyle Psychiatry": The Role of Exercise, Smoking, Diet and Sleep in the Prevention and Treatment of Mental Disorders. *World Psychiatry* 19: 360–80. doi:10.1002/wps.20773.

Government of Ontario. 2024, October 21. Province Appoints Dr. Jane Philpott as Chair of New Primary Care Action Team [News release]. Retrieved November 16, 2024. <https://news.ontario.ca/en/release/1005209/province-appoints-dr-jane-philpott-as-chair-of-new-primary-care-action-team>.

Kates, N. 2017. Mental Health and Primary Care: Contributing to Mental Health System Transformation in Canada. *Canadian Journal of Community Mental Health* 36(4): 33–67. doi:10.7870/cjcmh-2017-033.

Kates, N., N. Sunderji, V. Ng, M.J. Patriquin, J. Alloo, P. Mirwaldt et al. 2023. Collaborative Mental Health Care in Canada: Challenges, Opportunities and New Directions. *The Canadian Journal of Psychiatry* 68(5): 372–98. doi:10.1177/07067437221102201.

Luciano, M., G. Sampogna, V. Del Vecchio, V. Giallonardo, C. Palummo, I. Andriola et al. 2021. The Impact of Clinical and Social Factors on the Physical Health of People With Severe Mental Illness: Results From an Italian Multicentre Study. *Psychiatry Research* 303: 114073. doi:10.1016/j.psychres.2021.114073.

Mental Health Commission of Canada. 2021. *Towards Better Mental and Physical Health: Preventing and Managing Concurrent Mental and Physical Conditions: A Scoping and Rapid Realist Review*. Retrieved October 31, 2024. <https://mentalhealthcommission.ca/wp-content/uploads/2021/11/MHCC-CPAC-Chronic-Disease-Report-EN-Final-1.pdf>.

NHS England. n.d. Core20PLUS5 (Adults) – An Approach to Reducing Healthcare Inequalities. Retrieved November 16, 2024. <https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/>.

Rizvi, A., M. Kearns, M. Dignam, A. Coates, M.K. Sharp, O. Magwood et al. 2024. Effects of Guaranteed Basic Income Interventions on Poverty-Related Outcomes in High-Income Countries: A Systematic Review and Meta-Analysis. *Campbell Systematic Reviews* 20(2): e1414. doi:10.1002/cl2.1414.

Ronaldson, A., L. Elton, S. Jayakumar, A. Jieman, K. Halvorsrud and K. Bhui. 2020. Severe Mental Illness and Health Service Utilisation for Nonpsychiatric Medical Disorders: A Systematic Review and Meta-Analysis. *PLoS Medicine* 17(9): e1003284. doi:10.1371/journal.pmed.1003284.

Scharf, D.M., N.K. Eberhart, N.S. Hackbarth, M. Horvitz-Lennon, R. Beckman, B. Han et al. 2013, November 13. *Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Grant Program: Final Report*. RAND Corporation. Retrieved November 5, 2024. <https://aspe.hhs.gov/reports/evaluation-samhsa-primary-behavioral-health-care-integration-pbhci-grant-program-final-report>.

Te Pou. 2014. *Equally Well: Take Action to Improve Physical Health Outcomes for New Zealanders Who Experience Mental Illness and/or Addiction: A Consensus Position Paper*. Retrieved November 8, 2024. <https://www.equallywell.co.nz/wp-content/uploads/2022/10/EQW-A-consensus-position-paper.pdf>.

Thornicroft, G. 2011. Physical Health Disparities and Mental Illness: The Scandal of Premature Mortality. *The British Journal of Psychiatry* 199: 441–42. doi:10.1192/bjp.bp.111.092718.

Topor, A., I. Ljungqvist and E.L. Strandberg. 2016. Living in Poverty With Severe Mental Illness Coping With Double Trouble. *Nordic Social Work Research* 6(3): 201–10. doi:10.1080/2156857X.2015.1134629.

Ward, M.C. and B.G. Druss. 2017. Reverse Integration Initiatives for Individuals With Serious Mental Illness. *Focus* 15(3): 271–78. doi:10.1176/appi.focus.20170011.

World Health Organization (WHO). 2018, January 1. *Management of Physical Health Conditions in Adults With Severe Mental Disorders: WHO Guidelines*. Retrieved November 7, 2024. <https://www.who.int/publications/i/item/978-92-4-155038-3>.