

Responding to the Challenge of Multimorbidity in People with Serious Mental Illness

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A consequence of the ageing population and the ever expanding range of life-prolonging medical advances is the increase in the number of people with 2 or more co-occurring disorders, commonly referred to as multimorbidity which is an emerging public health challenge.¹ The increase in the number of chronic disorders within an individual is associated with an exponential increase in health care costs:² approximately 65% of total healthcare expenditure in the United States (US) is consumed by the 25% of population with multiple chronic conditions; at an individual level, it often means more out-of-pocket healthcare spending.³ For patients being shunted from one clinic to another for different chronic conditions is an inconvenient and confusing experience with the potential of duplicative investigations and conflicting medical advice.⁴ Multimorbidity is also associated with unnecessary hospitalisations, adverse events, poor functional status and even death.⁵⁻⁸

Much of the current practice of medicine and research seems ill-suited to deal with the complexity of multimorbidity with its single disorder approach ranging from disease-specific treatment guidelines⁹ to new interventions that are trialed in highly selected patients without multimorbidity.¹⁰ This has created a “silo mentality” — further reinforced by medical specialty bodies, advocacy groups, disease management organisations, and government agencies.¹¹

A recent study involving more than a million patients registered with medical practices in Scotland, found that 16% of patients had multimorbidity, and the presence of mental disorders increased the likelihood of other physical illnesses and worsened the quality of life.¹² The Singapore Mental Health Study found that 42.6% of mentally ill people had a comorbid chronic physical disorder which was also associated with poorer health related quality of life.¹³ What was alarming too was that 84% of them had not sought any form of treatment for their mental illness.

Findings from various studies have been consistent in their revelation of the poorer clinical outcomes for this subpopulation of people with serious mental illness (SMI) — with significantly higher rate of morbidity and mortality that are largely due to modifiable risk factors.¹⁴ This is typified by the finding that people with schizophrenia have an average health profile that is 10 to 15 years older than their counterparts in the general population¹⁵ and have a much higher rate of mortality especially from cardiovascular diseases.¹⁶ Compared to persons in the general population, individuals with SMI, on average die 25 years younger and mostly from preventable health conditions.¹⁷

There are multiple reasons for these poor outcomes. People with SMI are less likely to avail themselves of public health screening programmes; moreover, they have greater difficulties in interpreting and understanding physical signs and symptoms, as well as solving their health problems and caring for themselves.¹⁸ But more decidedly, they are victims of failed systems of care.^{11,19} They are far less likely to have health insurance and have poorer access to healthcare.²⁰ Additional obstacles include the stigmatisation by primary care physicians who often perceive their physical complaints as psychosomatic in nature,^{21,22} and the complexity of coordinating medical and psychiatric medications for the same patient by different prescribers.²³

The default situation is that the mental health sector has become the “healthcare home” for the majority of people with SMI i.e. the first, and often the only, point of contact with the healthcare system.²⁴ Unfortunately, the mental healthcare providers often fail to provide the standard of medical care needed for general health problems.²⁵ Despite numerous consensus statements and treatment guidelines advocating and recommending the need for routine physical health screening of all individuals receiving treatment with antipsychotic drugs,²⁶⁻³² survey after survey has shown huge disparity between the awareness of the need for,

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and the actual performance of adequate screening and monitoring.³³⁻³⁵

There is, therefore, a clinical, moral and public health imperative to address these unmet needs of people with SMI.

To start with, there must be a change in the attitude of the mental healthcare providers particularly the psychiatrists who must be prepared to abandon that somewhat blinkered perception of their role as being confined to treating only the psychiatric symptoms. Psychiatrists do not necessarily assume the task of treating these medical conditions but they should play a pivotal role ensuring that the tasks of detection and management are clearly defined, delegated, and carried out.³⁶

There must be a better integration of medical and mental healthcare services. Coordinated and integrated physical care offers the greatest potential of improving the physical healthcare outcomes of patients with SMI.³⁷ Such a model of integrated care might encompass co-locating an integrated primary healthcare team within the mental health setting. There is compelling evidence of the beneficial effects of such an integrated service: a randomised trial of integrated, medical care for patients with SMI led to a greater utilisation of preventive services, and greater improvement in health measures than for patients in a control group.³⁸

Needed too are what Horvitz-Lennon et al¹¹ called “linking mechanisms” which are the organisational and financial means to bridge the mental/medical health divide. These include formal agreements with primary healthcare providers, integrated clinical information systems for the effective communication and sharing of information, and the financial support for these to happen.³⁹⁻⁴¹

Involvement of the clinical and administrative leadership is crucial in putting up a coherent policy agenda, allocating adequate resources, and enforcing the set standards through evaluation with cycles of audits and surveys of stakeholders, and making modifications as and when necessary to ensure that these standards are met.

Currently, the knowledge base for multimorbidity is still paltry. Research is obviously needed to fill these gaps ranging from the need to better understand the basic pathophysiology of these co-existing conditions and how they relate to each other, to evaluating the feasibility and effectiveness of interventions, and how best to organise the services to meet the needs of these patients, and at what costs.

In the meantime, doing better with what we already know about screening, diagnosis, and treatment is the best immediate strategy for enhancing outcomes. This transformation requires integration with its prerequisites of communication, collaboration, clarity of roles, comprehensiveness and continuity of care,¹¹ and skills for teamwork and interdisciplinary work.⁴² It also requires

the willingness and commitment to measure performance and clinical outcomes, and achieving good outcomes as efficiently as possible.

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