Having a severe mental illness often means dying before your time

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People with severe mental illness have at least a two-and-a-half times higher risk of dying than the general population. In essence, people with severe mental illness are dying for the same sorts of reasons as the rest of

the us – but there are more of them and they are dying younger. We examined the causes of deaths of almost 400,000 people over ten years to try and find out why.

We have known for a long time that people with illnesses such as schizophrenia and bipolar disorder die earlier than the rest of us by 10 to 15 years. This means that while men in the UK are expected to live to about 78 and women 82 – if you have a severe mental illness and are known to mental health services, those ages drop to 68 and 72 years respectively. It's called premature mortality.

This issue remains one of the major health injustices of modern life, comparable to premature mortality in those who are socio-economically deprived. But many of these early deaths are preventable.

Tripling the risk

In our study of almost 4m people, we compared deaths in the general population to those with severe mental illness who are seen in general practice and hospitals. Such a detailed examination of different causes of death has not been done before. Most studies have focused on just one type of healthcare setting. We found that not only did people with severe mental illness have at least a two-and-a-half times higher risk of dying than the general population, but that this rose to almost three times higher in those with a hospital admission.

Nearly two thirds of all the deaths in those with severe mental illness were from cardiovascular disease (heart attacks or strokes), respiratory disease (particularly pneumonia) and cancer (most commonly lung and bowel). For these common causes of death, even a small increase in risk of death above everyone else will have a huge impact in terms of numbers. It's in these areas we can potentially save the most lives. We found a tripling of risk from respiratory disease and a doubling for

cardiovascular disease (there was little difference for cancers) in those with severe mental illness.

Other deaths from so-called natural causes were also particularly high when compared to the general population. These included those with severe mental illness who also had Alzheimer's, Parkinson's or dementia. It may be that we are better at diagnosing these illnesses in those already being seen in services or it may be that the age-related decline in cognition of those with severe mental illness is mislabelled. Understanding this will have implications for addressing it.

Credit: AI-generated image (disclaimer)

We found that the single biggest difference in mortality for those with severe mental illness compared to the general population was for those

who died from ill-defined or unknown causes (13 times higher), followed by suicide (12 times higher) and substance misuse (eight times higher). These types of deaths were relatively uncommon compared to heart attacks and strokes but the risk compared to the general population was greater.

Studies have shown that deaths labelled "ill-defined" or "unknown" are often from suicide and heart disease. So although we know the risk of suicide in the severely mentally ill is disturbingly high compared to the general population (12 times higher for all those with a severe mental illness, 16 times if they had a hospital admission and 21 times if female) the problem may well be worse than we currently think.

The current national policy focus on suicide prevention is important but it should also be looking at hospital and community settings for supporting those with severe mental illness.

So what can we do?

From a public health perspective, patients with severe mental illness should be considered a high risk population for physical illness. There needs to be improved access to care across the board. The onus is on developing services that people can engage with and addressing the causes of the causes (housing, deprivation, social connection).

For those with these long-term conditions getting to appointments and follow-up care can be challenging. Some of the differences we found relating to infections may be because those with severe mental illness present later than the rest of us, and so do worse.

Lifestyle factors also play a huge role. The significant emphasis on improving physical health care for people with severe mental illness through screening and management for cardiovascular and metabolic

disorders, such as diabetes, is important. Families and friends should encourage them to engage in programmes to stop smoking and recreational drug use, increase activity and healthy eating, keep a healthy body weight and control high blood pressure and high cholesterol.

There are no easy answers. Long-term studies are also needed to look at links between between anti-psychotic treatment, lifestyle choices, social deprivation, metabolic indicators, age and genetics. There is also a need for intervention studies to assess if more novel prescribing, such as gardening or walking groups, may work better. But there is no doubt we need to find ways tackle this health injustice.

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