World Mental Health Day 2014

LIVING WITH SCHIZOPHRENIA

SECTION V
TIME TO ACT

LIVING A HEALTHY LIFE WITH SCHIZOPHRENIA: PAVING THE ROAD TO RECOVERY

M.T. Yasamy, A. Cross, E. McDaniell, S. Saxena

Background

People with schizophrenia can recover[1,2]. The service users, their families, communities and the health and social care providers need to recognize such a possibility and maintain realistic hope during treatment[1, 3]. However, for most of the affected population in the real world, especially those with poor psychosocial support, this would be a lengthy and strenuous journey. One extreme for people living with schizophrenia is immediate and complete recovery; the other is enduring disability. The gray zone in between embraces the majority of affected people.

We briefly review the different requirements for a better outcome among people with schizophrenia, as well as how certain changes and interventions can contribute to the healthy life that is attainable for people living with schizophrenia. A "healthy life" here refers to the WHO definition of health which comprises physical, mental and social health. Respecting the human rights of people with schizophrenia is an overarching principle that needs to be recognized across all these interrelated aspects of health.

Physical Health

Premature mortality

An important phenomenon observed among people with schizophrenia and other severe mental disorders is poor physical health and premature death. Such physical health disparities have rightfully been stated as contravening international conventions for the 'right to health'[4, 5]. The physical health of people with severe mental illness is commonly ignored not only by the service users themselves but also by people around them and even by health systems.

People with severe mental disorders, including schizophrenia, experience disproportionately higher rates of mortality[6, 7], often due to physical illnesses such as cardiovascular diseases, metabolic diseases, and respiratory diseases[8]. The mortality gap results in a 10-25 year life expectancy reduction in these patients[4,5,9-11]. For people with schizophrenia, mortality rates are 2 to 2.5 times higher than the general population (9, 12).

Physical health conditions

There is evidence to suggest that people with schizophrenia have higher prevalence rates of cardiovascular problems and obstetric complications (in women). There is also good evidence that they are more likely to become overweight, develop diabetes, hyperlipidaemia, dental problems, impaired lung function, osteoporosis, altered pain sensitivity, sexual dysfunction and polydipsia or be affected by some infectious diseases such as HIV, hepatitis and tuberculosis as compared with the general population[13]. Different factors contribute to premature death. Fig. 1 summarises the association of different proposed factors contributing to premature death among people with schizophrenia and other severe mental disorders.

Unhealthy life style and factors of risk

Heavy smoking is about 2-6 times more prevalent among people with schizophrenia as compared with the general population, with prevalence rates between 50 and 80%[14]. Even as compared with people with other severe mental illnesses, being a current smoker is 2-3 times more common among people with schizophrenia[15]. Particularly high rates of smoking are observed among patients hospitalised for psychiatric treatment[16].

Patients with schizophrenia are often at greater risk for being overweight or obese, with estimated prevalence rates between 45 and 55%[12,14,17]. People with schizophrenia have demonstrated lower levels of physical activity and physical fitness than the general population, which may be due to the limited ability to be physically active, being overweight or obese, higher smoking rates and side effects from anti-psychotic medication[18].

Impact of health and treatment systems

Institutionalization commonly robs service users of the space and the autonomy required for being mobile and physically active. Many institutions lack structured, balanced or individualised dietary regimes and people may gain weight and even become obese. Furthermore, many antipsychotic medicines increase appetite, and if not monitored regularly, may directly or indirectly contribute to substantial metabolic changes, which can lead to diabetes, hyperlipidaemia and hypertension[19]. Estimated prevalence rates for diabetes and hypertension in patients with schizophrenia are between 10 and 15% and between 19 and 58% respectively[14].

The elevated physical health risks associated with schizophrenia and other severe mental illnesses indicate a stronger need for close and regular health monitoring. Paradoxically, people with severe mental illness receive less medical care for their physical problems as compared with others[20].

Being in good physical health is a crucial aspect for quality of life; however, it is known that people living with schizophrenia and other severe mental illnesses have a higher prevalence of physical diseases compared to the general population[21]. Promoting collaboration between mental and physical health is vital for improving care of people with severe mental illness. The diagnosis of physical conditions is commonly overshadowed by a psychiatric diagnosis and delayed diagnosis makes interventions less effective or even impossible[22].

Mental and Social Health Problems

A common but harmful mistake is to identify people with schizophrenia simply as a clinical diagnosis. The inappropriate term "schizophrenic" is commonly used by the public and even by some care givers to refer to a person who is living with schizophrenia. This term eclipses the human and social nature of that individual, and renders them as purely a diagnosis. People living with schizophrenia experience discrimination and violations of their rights both inside and outside institutions. In everyday life they face major problems in the areas of education, employment, and access to housing. As previously mentioned, even access to health services is more challenging.

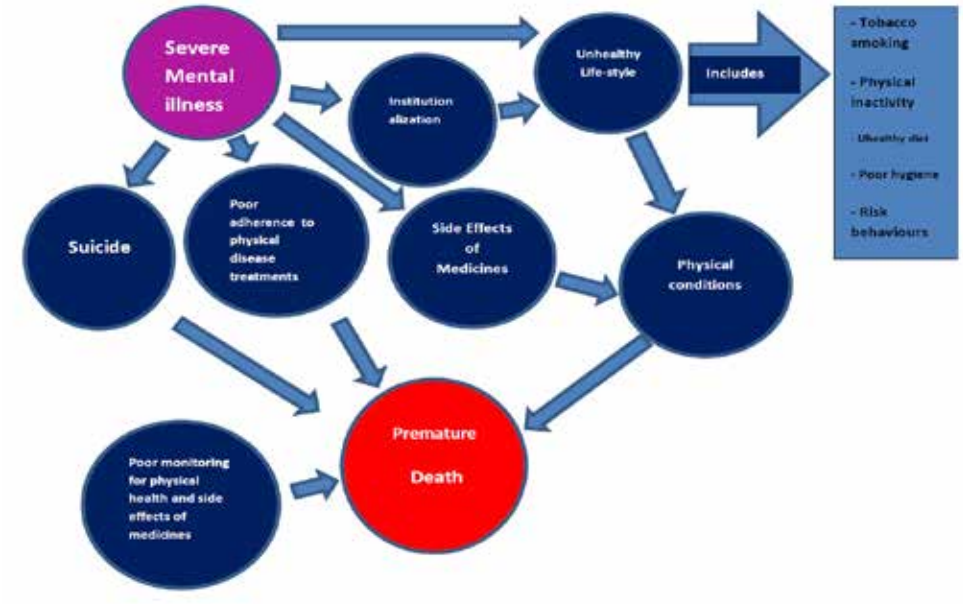
People living with a severe mental disorder are also likely to suffer from other mental disorders such as depression and substance abuse. Lifetime prevalence of suicide among those living with a severe mental disorder is around 5% which is much higher than that in the general population[23, 24]. Higher prevalence of substance use among people with schizophrenia along with some other factors contributes to the higher reported violent activity among them and to their higher rates of victimization alike[24]. People with severe mental illnesses, including schizophrenia are also more likely to be homeless, unemployed, or living in poverty[25,26].

Interventions

In many countries efforts have begun to better improve the physical health of people with schizophrenia, whilst simultaneously encouraging the social and education sector to provide better access to service for people with severe mental illness. Treatments should not be limited to pharmacotherapy. Non-pharmacological psychosocial interventions are gaining an increasing importance and should be considered an adjunctive component of mental disorder management. Psychosocial interventions are also effective at preventing some of the side effects of antipsychotic medications. A meta-analysis has shown the enduring effects of a range of non-pharmacological interventions at reducing antipsychotic-induced weight gain, namely individual or group interventions, cognitive–behavioural therapy and nutritional counselling[27].

Discussion

The severity of disability in general reflects the interaction between features of a person and features of the society. Disability and morbidity experienced by people living with schizophrenia are not purely caused by brain pathology. Similarly, poor physical health and premature death are consequences of interactions between people with schizophrenia and a society socially and functionally biased towards the population living with severe mental disorder. People with schizophrenia die earlier not because schizophrenia per se is fatal but rather because of the discrimination and lack of access to good health services, regular monitoring for other risk factors for health and physical diseases, and poor family and social support. A disempowered person with schizophrenia becomes incapable of self-care as well.



g.1. Proposed associations of different factors leading to premature death among people with severe mental illness.

The Way Forward

For decades, we have been rightfully advocating for "no health without mental health". This has been a popular slogan and is still valid. However, as coverage of mental health services has escalated, we have become more concerned about poor quality services worldwide. The time has arrived to call for "no mental health without physical health" as well[31]. Realizing this wish requires serious efforts from all stakeholders.

Our knowledge of mortality among people with severe mental illness and its correlates in low and middle income countries (LAMICs) is very limited. In a 2007 review, 86% of such studies came from industrialized countries[32]. In high income countries health literacy is higher, better quality services are available and there is overall better monitoring of the institutions and a greater frequency of regular check-ups for physical health of people with mental illness. The situation is expected to be much worse in low and middle income countries where the resources are poor, the institutions are poorly managed and access to sound mental health care and physical care is limited. WHO has started fresh evidence reviews and is sharing information on these important issues.

Many of WHO's ongoing programmes also contribute to paving the way towards recovery of people with severe mental disorders including schizophrenia.

WHO's Mental Health Action Plan[33], endorsed by the World Health Assembly in 2013 envisions and plans for all different aspects of services required to provide a healthy life for people living with mental disorders including

We are sharing two examples of services that integrate different aspects of health and are summarized in boxes 1 and 2.

Box 1. The example of Fountain House[28]

Fountain House, based in the US but with a global reach, has already developed an initiative which is community based, recovery oriented and at the same time very sensitive about the general well-being and physical health of the service users.

Their reports point to a high level of success and satisfaction of the service users and to "reversing the trend" in this regard and "Bringing hope to mind". The programmes are comprehensive. They include wellness, education, employment and housing. Their meticulous concern about the physical health of the service users is reflected across many of their reports of activities and achievements. The "Health Home" of their Sidney Baer Centre is a good example of responding to this commonly ignored need.

Box 2. The chain free initiative in Mogadishu[29, 30]

The "chain free initiative" in Somalia is an example of scaling up a community oriented service model in a poor resource country. WHO/EMRO started this low cost programme in Mogadishu and then expanded to similar contexts. The programme includes three phases: Phase 1. (Chain-free hospitals) includes removing the chains, and reforming the hospital into a patient friendly and humane place with minimum restraints. Phase 2. (Chain-free homes) organizing mobile teams and home visits, removing the chains, providing family psycho-education, and training family members on a realistic, recovery-oriented approach. Phase 3. (Chain-free environments) removing the "invisible chains" of stigma and restrictions affecting the human rights of persons with mental illness, and respecting the right to universal access to all opportunities with and for persons with mental illness, empowering and supporting the service users and ex-service users by mobilizing communities to provide them with job opportunities and shelter. The programme, which followed a results-based management approach, improved the situation in the psychiatric ward, and increased the number of those receiving services through home visits and outpatient visits. More and more ex-patients are now living and working in a community that is now more aware about the right of people with severe mental illness. The teams at the same time started to improve the service users' nutrition and provided them with treatment of physical conditions including TB.

schizophrenia. The global plan emphasizes that persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health. WHO promotes global actions using guidelines that are not only based on evidence but also observe the human rights of service users, which is why obtaining recovery has been observed as one of the favourable outcomes of access to services.[33]

The Mental Health Gap Action Programme of WHO[34] and its Intervention Guide[35] are examples of WHO's new approach in emphasizing psychosocial interventions in addition to pharmacotherapy and in terms of a better focus on the health of service users in its totality. The revision of mhGAP-IG is underway and the updated version will be published in 2015. The updated version will provide us with guidelines that can further assure that harm is reduced to its minimum and benefits are maximized in terms of a holistic approach to service users' health.

The Quality Rights Project of WHO and its checklist provides a good opportunity for monitoring the quality of services for people with mental illness including schizophrenia[36].

There are a range of actions that could be taken by different stakeholders; examples are summarized here:

People with schizophrenia: Exercising self-care and demanding their rights, including the right to comprehensive health care. Participation in decision-making and implementation of programmes on mental health.

Families: Supporting and empowering the family members of people with schizophrenia

Communities and civil societies: Empowering the people with schizophrenia, removing stigma and discrimination, respecting their rights, facilitating inclusion in economic and social activities, as well as including socially and culturally appropriate supported employment. Meeting the families' physical, social and mental health needs. Working with local agencies to explore employment or educational opportunities, based on the person's needs and skill level.

Health sector: Taking certain measures such as downsizing and ultimately terminating institutionalization. Also providing high quality physical services and regular monitoring for risk factors and side effects of treatments, tackling unhealthy life styles, as well as identifying and treating common chronic physical conditions among people with schizophrenia. Adoption of smoking cessation strategies for and with service users and promoting smoke free service environments. Coordinating with the service users as well as social, education, housing, employment and other sectors.

Social sector: Empowering and supporting people with schizophrenia to obtain education, employment and housing as well as coordinating with health and other sectors.

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References:

1.Bellack AS. Scientific and consumer models of recovery in schizophrenia: Concordance, contrasts, and implications. Schizophrenia bulletin. 2006;32(3):432-42.

2. Sklar M, Groessl EJ, O'Connell M, Davidson L, Aarons GA. Instruments for measuring mental health recovery: a systematic review. Clinical psychology review. 2013;33(8):1082-95.

3.RAISE Project Overview. National Institute of Mental Health; Available from: http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml.Accessed 16.07.2014.

4.Thornicroft G. Physical health disparities and mental illness: the scandal of premature mortality. The British journal of psychiatry : the journal of mental science. 2011;199(6):441-2.

5.Thornicroft G. Premature death among people with mental illness. BMJ. 2013;346.

6.Cuijpers P, Smit F. Excess mortality in depression: a meta-analysis of community studies. Journal of affective disorders. 2002;72(3):227-36.

7.De Hert M, Correll CU, Bobes J, Cetkovich-Bakmas M, Cohen D, Asai I, et al. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. World Psychiatry. 2011;10(1):52-77.

8.Lawrence D, Hancock KJ, Kisely S. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. BMJ. 2013;346:f2539.

9.Saha S, Chant D, McGrath J. A systematic review of mortality in schizophrenia - Is the differential mortality gap worsening over time? Arch Gen Psychiat. 2007;64(10):1123-31.

10.Svendsen D, Patricia Singer, Mary Ellen Foti, and B. Mauer. Morbidity and mortality in people with serious mental illness. Alexandria, VA, USA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, 2006.

11.Larsen JI, Andersen UA, Becker T, Bickel GG, Borks B, Cordes J, et al. Cultural diversity in physical diseases among patients with mental illnesses. Aust Nz J Psychiat. 2013;47(3):250-8.

12.De Hert M, Dekker JM, Wood D, Kahl KG, Holt RI, Moller HJ. Cardiovascular disease and diabetes in people with severe mental illness position statement from the European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (ESC). European psychiatry : the journal of the Association of European Psychiatrists. 2009;24(6):412-24.

13.Scott D, Happell B. The high prevalence of poor physical health and unhealthy lifestyle behaviours in individuals with severe mental illness. Issues in mental health nursing. 2011;32(9):589-97.

14.Correll CU. Acute and long-term adverse effects of antipsychotics. CNS spectrums. 2007;12(12 Suppl 21):10-4.

15.de Leon J, Diaz FJ. A meta-analysis of worldwide studies demonstrates an association between schizophrenia and tobacco smoking behaviors. Schizophr Res. 2005;76(2-3):135-57.

16.Stockings EA, Bowman JA, Prochaska JJ, Baker AL, Clancy R, Knight J, et al. The impact of a smoke-free psychiatric hospitalization on patient smoking outcomes: a systematic review. The Australian and New Zealand journal of psychiatry. 2014;48(7):617-33.

17.Shin JK, Barron CT, Chiu YL, Jang SH, Touhid S, Bang H. Weight changes and characteristics of patients associated with weight gain during inpatient psychiatric treatment. Issues in mental health nursing. 2012;33(8):505-12.

18.Vancampfort D, Probst M, Scheewe T, De Herdt A, Sweers K, Knapen J, et al. Relationships between physical fitness, physical activity, smoking and metabolic and mental health parameters in people with schizophrenia. Psychiat Res. 2013;207(1-2):25-32.

19.Cerimele JM, Katon WJ. Associations between health risk behaviors and symptoms of schizophrenia and bipolar disorder: a systematic review. Gen Hosp Psychiat. 2013;35(1):16-22.

20.Mitchell AJ, Lord O. Do deficits in cardiac care influence high mortality rates in schizophrenia? A systematic review and pooled analysis. J Psychopharmacol. 2010;24(4 Suppl):69-80.

21.Maj M. Physical health care in persons with severe mental illness: a public health and ethical priority. World Psychiatry. 2009;8(1):1-2.

22.Organization WH. Greater needs, limited access. B World Health Organ [Internet]. 2009; 87(4). Available from: http://www.who.int/bulletin/volumes/87/4/09-030409/en/. Accessed 16.07.2014.

23.Hor K, Taylor M. Suicide and schizophrenia: a systematic review of rates and risk factors. J Psychopharmacol. 2010;24(4 Suppl):81-90.

24.Fazel S, Gulati G, Linsell L, Geddes JR, Grann M. Schizophrenia and violence: systematic review and meta-analysis. PLoS medicine. 2009;6(8):e1000120.

25.Maniglio R. Severe mental illness and criminal victimization: a systematic review. Acta psychiatrica Scandinavica. 2009;119(3):180-91.

26.Eriksson A, Romelsjo A, Stenbacka M, Tengstrom A. Early risk factors for criminal offending in schizophrenia: a 35-year longitudinal cohort study. Soc Psych Psych Epid. 2011;46(9):925-32.

27.Alvarez-Jimenez M, Hetrick SE, Gonzalez-Blanch C, Gleeson JF, McGorry PD. Non-pharmacological management of antipsychotic-induced weight gain: systematic review and meta-analysis of randomised controlled trials. The British journal of psychiatry : the journal of mental science. 2008;193(2):101-7.

28.Wellness. Fountain House; Available from http://www.fountainhouse.org/content/wellness. Accessed 16.07.2014.

29.Organization WH. Mental health unlocking the asylum doors. Bugs, drugs and smoke: stories from public health: World Health Organization; 2011. p. 18.

30.Organization WH. Chain Free Initiatives. Available from http://www.emro.who.int/mental-health/chain-free-initiative/. Accessed 16.07.2014.

31.No mental health without physical health. Lancet. 2011;377(9766):611-.

32.Leucht S, Burkard T, Henderson J, Maj M, Sartorius N. Physical illness and schizophrenia: a review of the literature. Acta psychiatrica Scandinavica. 2007;116(5):317-33.33. Organization WH. Mental health action plan 2013 - 2020. Geneva, Switzerland2013.

34.Organization WH. mhGAP Mental Health Gap Action Programme Scaling up care for mental, neurological, and substance use disorders: WHO; 2008.

35.Organization WH. mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings: World Health Organization; 2010.

36.Organization WH. WHO QualityRights tool kit to assess and improve quality and human rights in mental health and social care facilities: World Health Organization; 2012. 338 p.

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Department of Mental Health and Substance Abuse
yasamym@who.int