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Invited State-Of-The-Art Review

Reducing excess mortality in severe mental illness - a narrative review

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ABSTRACT

People with severe mental illness die 10-20 years earlier than the general population, mostly from preventable physical diseases. Fragmented care, under-screening and undertreatment of cardiovascular, respiratory, infectious and cancer conditions widen this gap. Embedding physical screening, proactive treatment, smoking cessation, cancer checks and multidisciplinary, person-centred care into psychiatric services could close this mortality divide.

KEY POINTS

- Excess deaths in SMI are chiefly due to physical illness, not suicide.
- Routine screening, risk-factor therapy and smoking cessation must be part of psychiatric care.
- Integrated, multidisciplinary, person-centred models can potentially narrow the 10-20-year mortality gap.

Despite advances in modern medicine, individuals with severe mental illness (SMI) continue to experience a significantly shorter life expectancy, with 10-20-year reductions compared to the general population [1].

The SMI population is typically diagnosed as those diagnosed with by schizophrenia, bipolar disorder or major depressive disorder, conditions marked by a fluctuating clinical course, chronic nature and impaired cognition [1]. Whereas unnatural causes of death, such as suicide, contribute to the mortality gap between individuals with SMI and the general population, the majority of excess deaths (around 70%) are due to preventable physical illnesses, including cardiovascular disease, respiratory disorders, infections and cancer [2-4].

Background: A widening mortality gap

This persistent mortality gap has widened in recent decades, highlighting a fundamental inequity in healthcare. While life expectancy has steadily improved for the general population [5], individuals with SMI have not benefited equally from medical progress [6-8]. Systemic barriers – such as reduced access to preventive care, underdiagnosis and undertreatment of physical conditions, and the long-standing separation of psychiatric and somatic healthcare - continue to place this vulnerable group at a disadvantage [9]. The result is a healthcare system that inadvertently neglects the physical health of those with psychiatric disorders, exacerbating their already increased risk of morbidity and premature mortality.

While the healthcare community increasingly recognises this disparity, efforts to address it have been insufficient. The dominant paradigm of psychiatric care remains focused on stabilising mental health symptoms, potentially at the expense of physical health monitoring and intervention. Individuals with SMI are less likely to receive guideline-recommended treatments for chronic diseases [10, 11], undergo routine screenings for cardiovascular and metabolic disorders [10, 11] andadhere to prescribed medications, largely due to fragmented care pathways [10, 11]. If these trends continue, the mortality gap will persist, making it imperative to rethink how healthcare systems approach the intersection of mental and physical health.

What we are doing now: A system not designed for whole-person care

Currently, the management of SMI is largely compartmentalised, with psychiatric and physical healthcare delivered through separate, often poorly coordinated systems. This structural divide contributes to widespread gaps in care, particularly in the prevention, early detection and management of chronic diseases. As a result, individuals with SMI may become confined within the psychiatric setting, without access to necessary physical healthcare services. Likewise, physical healthcare providers may have limited involvement in psychiatric settings, further undermining integrated, whole-person care [12, 13].

One of the most glaring issues is the underdiagnosis and undertreatment of cardiovascular disease in patients with SMI [1, 14]. These persons are significantly more likely to smoke and develop hypertension, diabetes, obesity and dyslipidemia [15]. Even so, these conditions are often insufficiently treated in psychiatric settings [16] or even in primary care [17]. Even when diagnosed, individuals with SMI are less likely to receive standard, guideline-recommended treatments such as statins for high cholesterol, antihypertensives for high blood pressure or antiplatelet therapy following a cardiovascular event [18-21]. Medication adherence is also markedly lower in this group, likely influenced by cognitive impairments, side effects of psychotropic medications and limited engagement in preventive health measures.

Similarly, respiratory illnesses, particularly chronic obstructive pulmonary disease (COPD), are more prevalent among individuals with SMI, driven in large part by disproportionately high

smoking rates [22-24]. Many persons with SMI do not receive early testing for detection of COPD, and even when diagnosed, adherence to inhaled therapies remains low [25, 26]. Despite the well-established benefits of smoking cessation programmes, tailored interventions for this population remain scarce and are underutilised [27].

Another overlooked medical issue is the heightened risk of various infectious diseases, including human immunodeficiency virus (HIV), hepatitis B/C, tuberculosis (TB) and respiratory infections [28]. High-risk behaviours associated with SMI contribute to elevated rates of HIV and viral hepatitis. In contrast, TB is more common in individuals with SMI of low socioeconomic status experiencing homelessness or institutionalisation [28]. In addition, high smoking rates, poor nutrition and low vaccination rates increase susceptibility to respiratory infections, including pneumonia and influenza [28]. Given these challenges, along with cognitive impairment, fragmented healthcare and nonadherence to treatment, integrating infectious disease prevention, screening and treatment into psychiatric care settings is essential to reduce morbidity and improve life expectancy in this vulnerable population.

Cancer care presents another area of inequity. Individuals with SMI are significantly less likely to undergo routine cancer screenings, leading to later-stage diagnoses and poorer prognoses [29-31]. When cancer is detected, further treatment disparities emerge: persons with SMI are more likely to receive palliative care and less likely to receive curative interventions such as surgery or chemotherapy [29-31]. This trend reflects a broader systemic bias, where assumptions about poor treatment adherence or limited capacity to tolerate aggressive therapies influence clinical decision-making.

Beyond specific disease areas, multimorbidity represents a critical but often overlooked challenge. Individuals with SMI frequently have multiple chronic conditions, compounding their health risks. However, the standard model of care remains ill-equipped to address the complexities of managing psychiatric illness alongside medical conditions such as diabetes, cardiovascular disease and COPD. Individuals are often referred between different specialists, with little coordination or continuity of care, increasing the risk of poor health outcomes [32-36].

What needs to change: A roadmap for integrated care

To close the mortality gap in SMI, a fundamental shift in healthcare delivery is required, moving away from siloed care models towards integrated, person-centred approaches. This transformation must be driven by three key principles: prevention, proactive treatment and coordination across care settings [37, 38].

First, embedding physical health screening and management into psychiatric care should become standard practice within the psychiatric setting. Routine monitoring of blood pressure, cholesterol levels, blood glucose and body weight is, indeed, being conducted within psychiatric settings. Still, there is a lack of clear treatment protocols for managing any identified risks. Cardiometabolic risk

reduction strategies, including prescribing statins for dyslipidemia, glucagon-like peptide-1 (GLP-1) receptor agonists for obesity and antihypertensives for hypertension, should be initiated early by mental health specialists and integrated seamlessly into psychiatric treatment plans. Additionally, electrocardiogram (ECG) screening in psychiatric settings should extend beyond assessing QTc interval prolongation related to antipsychotic treatment. Various ECG abnormalities are frequently overlooked or misinterpreted, potentially placing patients at a higher cardiovascular risk [39, 40]. Given the higher rates of cardiometabolic comorbidities in patients with SMI, a more comprehensive approach to ECG interpretation is necessary. Early collaboration with cardiologists can help identify high-risk patients, facilitate timely specialist examination and intervention and prevent adverse cardiovascular outcomes. As such, expanding the role of mental health specialists to include routine assessment of somatic health risks and initiating first-line treatments would ensure that unnecessary referrals do not delay early intervention.

Second, smoking cessation must be a priority within psychiatric care. Given the extraordinarily high smoking rates among individuals with SMI, evidence-based cessation therapies should be offered, including cytisine, varenicline or nicotine replacement therapy, combined with tailored behavioural support [27]. Smoking cessation programmes must be embedded in mental health services rather than left to general practitioners or municipalities, ensuring that interventions are accessible and actively promoted.

Third, cancer screening and treatment pathways must be adapted to better serve individuals with SMI. Screening programmes should be proactively offered within psychiatric settings, with dedicated case managers to facilitate follow-ups [29-31]. Oncology teams should receive training on managing individuals with SMI to prevent biases that result in undertreatment. Furthermore, standardised protocols should be established to ensure that treatment decisions are based on clinical need rather than assumptions about adherence or capacity to tolerate therapy.

Fourth, integrated care models to handle multimorbidity must replace fragmented treatment pathways. Psychiatric and somatic healthcare providers should collaborate within multidisciplinary teams to ensure continuity of care [41]. Embedding general medical services within psychiatric hospitals and outpatient clinics could bridge existing gaps, allowing for more comprehensive management of multimorbidity [41]. Additionally, digital health tools, including shared electronic health records and coordinated care plans, could further enhance communication between providers and streamline patient management.

Finally, systematic outcome monitoring is essential to evaluate the effectiveness of interventions and drive continuous improvement. Data collection should include metrics such as changes in cardiovascular risk scores, smoking cessation rates, adherence to medication regimens and long-term health outcomes [14]. A research agenda focused on optimising integrated care approaches for individuals with SMI should be prioritised to refine best practices and ensure that interventions are evidence-based.

Conclusion: Closing the gap requires action, not awareness

The persistent mortality gap in individuals with SMI is not necessarily an inevitable consequence of mental illness. It is partly a failure of healthcare systems to provide equitable and integrated care. The current paradigm, which isolates psychiatric and physical health treatment, has resulted in preventable deaths and avoidable suffering. Addressing this crisis requires a fundamental shift in how care is delivered, ensuring that physical health is prioritised alongside mental health in all psychiatric settings.

By embedding preventive interventions, enhancing access to routine screenings, proactively managing cardiometabolic and respiratory risk factors, and fostering collaboration between mental and physical healthcare providers, we may transform outcomes for this vulnerable population. A genuinely person-centred approach that recognises the interdependence of mental and physical health has the potential to extend the life expectancy in individuals with SMI while also enhancing their overall quality of life.

The challenge is clear, and some of the solutions are within reach. The question is no longer whether we should act but how quickly we are willing to implement the necessary changes to bridge this unacceptable mortality gap.

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