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From the editor

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Dying too young

Cardiovascular neglect of the mentally ill

The life span of the seriously mentally ill is even shorter than we had thought. Earlier studies showed a loss of 20% of the average life span—or 15 to 16 years.[1] Recent figures are alarmingly higher, however, and vary from state to state.

Virginia has the "best" mortality rate among the seriously mentally ill with a loss of "only" 13.5 years of potential life, according to the Center for Mental Health Services (CMHS) and the Centers for Disease Control and Prevention (CDC).[2] Perhaps persons who suffer from schizophrenia should move to Virginia because the loss of potential life years in other states is much worse:

- Arizona: 31.8 years
- Texas: 29.3 years
- Missouri: 27.9 years
- Utah: 26.9 years
- Oklahoma: 26.3 years.

A recent Ohio study of mortality and medical illness found an average loss of 32 years of life among persons with schizophrenia.[3]

Why is the life span of mentally ill persons so short? Apart from their high rates of death from unnatural causes (suicide, homicide, and accidents), the most frequent killer is cardiovascular disease. High mortality rates are well-documented in schizophrenia from various ailments but especially heart disease.[4] Bipolar disorder and major depression are also associated with high death rates from cardiovascular disease.[5]

The sad truth is that a 'dual neglect' contributes to patients' premature mortality

The sad truth is that a "dual neglect" contributes to premature mortality of the seriously mentally ill: the system fails to provide ongoing basic primary healthcare, and patients neglect to seek or adhere to medical care.

Persons with serious mental illness often have risk factors associated with preventable causes of heart disease and stroke, including smoking, obesi-

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ty, sedentary life styles, and poor nutrition. In addition, the metabolic syndrome—obesity, hypertension, hyperglycemia, and dyslipidemia—is highly associated with schizophrenia,[6] bipolar disorder,[7] and unipolar depression.[8]

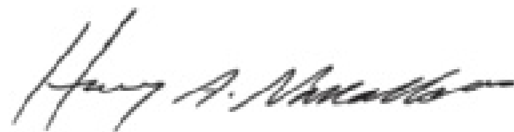
Cardiovascular risk associated with metabolic syndrome requires ongoing medical follow-up, which many mentally ill patients do not receive. The Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) found shockingly low treatment rates for diabetes, hypertension, and hyperglycemia among outpatients with schizophrenia around the country.[9]

Let us mobilize to correct this shameful health disparity, one patient at a time

Let us mobilize to correct this shameful health disparity, one patient at a time. The message to mental health professionals is clear:

- In addition to controlling symptoms of psychosis, mania, depression, or anxiety, routinely screen patients for weight gain, hypertension, high fasting serum glucose, and elevated lipid levels.
- Refer overweight and obese patients to primary care providers, dietitians, and exercise counselors to reduce their cardiovascular risks.

Psychiatrists and nurse practitioners must address both mental and medical health needs when formulating assessments, treatment plans, and patient education. For practical recommendations on managing medical comorbidities, see "7-point checkup for stable schizophrenia outpatients," by Britton Ashley Arey, MD, and Stephen R. Marder, MD (*page 20*). The public mental health system also could help the seriously mentally ill by integrating primary healthcare with mental healthcare in community settings across the nation. There are no excuses to do anything less.



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