

## Palliative care for people with serious mental illnesses



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In *The Lancet Public Health*, Guillaume Fond and colleagues<sup>1</sup> detail a known but largely ignored health service bias that shortens the lives of many people with serious mental illnesses. They used data for all in-hospital deaths from cancer in France between 2013 and 2016—which were recorded in Programme de Médicalisation des Systèmes d'Information, the French national hospital database for acute and psychiatric care—to examine end-of-life care among patients with a concomitant diagnosis of schizophrenia compared with those without any formal diagnosis of mental illness.

Fond and colleagues identified that patients with schizophrenia were more likely to die earlier, to have shorter durations from cancer diagnosis to death, to have comorbidities (including chronic pulmonary disease and peripheral vascular disease), to receive specialist cancer care, and to receive palliative care in the last 31 days of life than were patients without a diagnosis of mental illness.<sup>1</sup> Patients with schizophrenia were also less likely to have metastatic disease; to receive chemotherapy, surgery, or blood transfusions; to be admitted to acute care units (although they had longer stays in these units); and to die in intensive-care units or emergency departments than were patients without a diagnosis of mental illness.<sup>1</sup>

Fond and colleagues' findings are a welcome addition to the evidence base. However, the well established effect of serious mental illnesses on morbidity and life expectancy—with mortality as much as 22.2 times higher among affected patients than in the general population—emphasises the necessity to investigate all such illnesses and not only schizophrenia.<sup>2-4</sup> Consideration of serious mental illness as a collective entity—including long-term mental illnesses such as schizophrenia, schizophrenia spectrum disorders, and delusional disorders; mood or affective disorders; mental and behavioural disorders due to psychoactive substance use; and anxiety and eating disorders of long duration or high impact—broadens the potential application of research findings in clinical practice.

Fond and colleagues found that patients with schizophrenia seemed to receive palliative care more frequently than those without a diagnosis of mental illness. Although at face value, this outcome seems positive, when considered alongside the lower

use of chemotherapy and surgery in patients with schizophrenia, this increased use of palliative care probably resulted from late diagnosis of cancer and a reluctance to intervene in this patient population. Reluctance to intervene (eg, with chemotherapy or surgery) is often related to misperceptions that people with serious mental illnesses do not have capacity to consent or participate in decision making, that treatment could potentially destabilise patients' mental state, or that patients would be unlikely to engage.<sup>5-7</sup>

Fond and colleagues' findings also highlight that palliative care is most often considered relevant when curative attempts cease or close to the end of life. This focus seriously undermines the potential of palliative care to address quality-of-life issues in a wide spectrum of chronic health conditions and earlier in illness trajectories. Notions of palliative care have been extended and expanded: palliative care is now viewed as a human right, with the focus clearly placed on improving the quality of life of patients and families, not just on symptom management at the end of life.<sup>8</sup> Furthermore, palliative care and curative interventions are not mutually exclusive—principles of both can and should coexist when relevant and appropriate to a diverse range of illnesses that limit life.

People with serious mental illnesses and life-limiting physical health comorbidities are a vulnerable population who are underrepresented in health disparities research.<sup>9</sup> Disparities for this group originate at the patient, provider, and systems levels, and are affected by the pervasive stigma associated with serious mental illness. Fond and colleagues showed that the time from cancer diagnosis to death was shorter in people with than in those without a diagnosis of mental illness. It is well recognised that people with schizophrenia find physical health needs difficult to articulate.<sup>5</sup> Diagnostic overshadowing remains pervasive, which means that physical symptoms are ignored, disbelieved, or attributed to mental illness, resulting in delayed diagnosis and treatment, and increasing the likelihood of terminal diagnoses.<sup>5</sup> At system and organisational levels, divisions between physical and psychiatric medicine result in confusion about which sector of the health service—ie, primary, mental health, or acute care—should take responsibility

for management of patients with complex health needs. The resultant fragmentation is a barrier to care integration, which is associated with a serious risk of poor health outcomes.<sup>10</sup>

It is noteworthy that Fond and colleagues' clear results could be achieved only because of the welcome-but-rare juxtaposition of general and psychiatric hospital case-level summary data in France. Few countries have similar data available, with the result that the life-limiting disadvantages faced by people with serious mental illnesses are being overlooked, even where apparently sophisticated data systems exist. A substantial proportion of people with serious mental illnesses will require palliative care during their lifetime for a range of conditions. The evidence amassed over decades, including these new results from Fond and colleagues, leaves little doubt about the disadvantages relating to health care and end-of-life care in this patient group. The continuing challenge is to effectively identify and manage patients with serious mental illness and concomitant life-limiting conditions across diverse care settings so that this population has at-least equivalent physical health outcomes and quality of life to patients without serious mental illnesses.

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I declare no competing interests.

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