Improving physical health

- Schizophrenia
- Bipolar disorder
- Recurrent depression

Why we need to work together

Carol Paton
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11-year follow-up of mortality in patients with schizophrenia: a population-based cohort study (FIN11 study)

Jari Tiihonen, Jouko Lönnqvist, Kristian Wahlbeck, Timo Klaukka, Leo Niskanen, Antti Tanskanen, Jari Haukkia

‘the gap in life expectancy between patients with schizophrenia and the general population was 25 years in 1996 and 22.6 years in 2006’

‘Overall risk of death was 30% lower during treatment with any antipsychotic drug’
Twenty-five year mortality of a community cohort with schizophrenia

Steve Brown, Miranda Kim, Clemence Mitchell and Hazel Inskip

**Background**
People with schizophrenia have significantly raised mortality but we do not know how these mortality patterns in the UK have changed since the 1990s.

**Aims**
To measure the 25-year mortality of people with schizophrenia with particular focus on changes over time.

**Method**
Prospective record linkage study of the mortality of a community cohort of 370 people with schizophrenia.

**Results**
The cohort had an all-cause standardised mortality ratio of 289 (95% CI 247–337). Most deaths were from the common causes seen in the general population. Unnatural deaths were concentrated in the first 5 years of follow-up. There was an indication that cardiovascular mortality may have increased relative to the general population ($P=0.053$) over the course of the study.

**Conclusions**
People with schizophrenia have a mortality risk that is two to three times that of the general population. Most of the extra deaths are from natural causes. The apparent increase in cardiovascular mortality relative to the general population should be of concern to anyone with an interest in mental health.

**Declaration of interest**
None.
**Fig. 4** Changes in cardiovascular disease standardised mortality ratios (SMRs) in 5-year periods of a community cohort of 370 people followed over 25 years.
Antipsychotics and metabolic risk factors – CATIE study (McEvoy et al 2005)

Large pragmatic randomised study in people with schizophrenia

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
<th>Proportion NOT receiving treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension (BP &gt;140/90)</td>
<td>27%</td>
<td>40%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>11%</td>
<td>30%</td>
</tr>
<tr>
<td>Raised TG</td>
<td>50%</td>
<td>90%</td>
</tr>
<tr>
<td>Low HDL</td>
<td>50%</td>
<td>90%</td>
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- 68% cigarette smokers
- 10 yr CHD risk significantly higher than in matched controls
# CVD risk factors in people with SMI

## Estimated prevalence and relative risk

<table>
<thead>
<tr>
<th>Modifiable risk factors</th>
<th>Schizophrenia</th>
<th>Bipolar disorder</th>
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<tbody>
<tr>
<td>Obesity</td>
<td>45–55% RR: 1.5–2</td>
<td>21–49% RR: 1–2</td>
</tr>
<tr>
<td>Smoking</td>
<td>50–80% RR: 2–3</td>
<td>54–68% RR: 2–3</td>
</tr>
<tr>
<td>Diabetes</td>
<td>10–15% RR: 2</td>
<td>8–17% RR: 1.5–2</td>
</tr>
<tr>
<td>Hypertension</td>
<td>19–58% RR: 2–3</td>
<td>35–61% RR: 2–3</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>25–69% RR: ≤ 5</td>
<td>23–38% RR: ≤ 3</td>
</tr>
<tr>
<td>Metabolic Syndrome</td>
<td>37–63% RR: 2–3</td>
<td>30–49% RR: 1.5–2</td>
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RR: relative risk.
Monitor and record the following regularly and systematically throughout treatment

1. Physical health (primary care)
2. Side effects of treatment

**QOF**

**MH08.** The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses (4)

**MH09.** The % of patients with SMI with a review in the last 15/12…… evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status (23)

**MH06.** The percentage of patients on the register who have a comprehensive care plan (6)

**MH07.** The % of patients with SMI who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance
Figure 22: Proportion of patients for whom side effect assessments/measures were documented, and the change in profile between baseline and re-audit in the TNS.

Figure 23: Proportion of patients for whom side effect assessments/measures were documented, and the change in profile between baseline and re-audit in your Trust.
People with depression

QOF

**DEP01:** The percentage of patients with diabetes and/or heart disease for whom case finding for depression has been undertaken on one occasion during the previous 15 months (8)
Psychiatric Characteristics Associated With Long-term Mortality Among 361 Patients Having an Acute Coronary Syndrome and Major Depression

Seven-Year Follow-up of SADHART Participants

Alexander H. Glassman, MD; J. Thomas Bigger Jr, MD; Michael Gaffney, PhD

**Context:** Major depressive disorder (MDD) after acute coronary syndrome (ACS) is associated with an increased mortality rate. We observed the participants of the Sertraline Antidepressant Heart Attack Randomized Trial (SADHART) to establish features of MDD associated with long-term mortality.

**Objectives:** To determine whether the following variables were associated with long-term mortality: baseline depression severity, previous MDD episodes, onset of MDD before or after the ACS event, 6 months of sertraline hydrochloride therapy, and mood improvement independent of treatment.

**Design:** SADHART was a double-blind, placebo-controlled, randomized trial comparing the safety and antidepressant efficacy of sertraline vs placebo in 369 patients with ACS who met criteria for MDD. The trial was completed in June 2000, and follow-up for vital status was completed in September 2007.

**Setting:** Academic research.

**Participants:** SADHART participants.

**Main Outcome Measures:** Vital status was determined in 361 participants (97.8%) during a median follow-up of 6.7 years.

**Results:** During the study, 75 participants (20.9%) died. Neither previous episodes of MDD, nor onset before or after the index ACS, nor an initial 6 months of sertraline treatment was associated with long-term mortality. Cox proportional hazards regression models showed that baseline MDD severity (hazard ratio, 2.30; 95% confidence interval, 1.28-4.14; \( P < .006 \)) and failure of MDD to improve substantially during treatment with either sertraline or placebo (hazard ratio, 2.39; 95% confidence interval, 1.39-2.44; \( P < .001 \)) were strongly and independently associated with long-term mortality. Marked improvement in depression (Clinical Global Impression-Improvement subscale score of 1) was associated with improved adherence to study medication.

**Conclusions:** Severity of MDD measured within a few weeks of hospitalization for ACS or failure of MDD to improve during the 6 months following ACS predicted more than a doubling of mortality over 6.7 years of follow-up. Because persistent depression increases mortality and decreases medication adherence, physicians need to aggressively treat depression and be diligent in promoting adherence to guideline cardiovascular drug therapy.

*Arch Gen Psychiatry.* 2009;66(9):1022-1029
How we can work together

Annual physical for everyone with SMI/recurrent or chronic depression

- BP
- BMI
- Glucose
- Lipids
- Cardiovascular risk assessment
- Advice/encouragement/help with smoking cessation

Ensure primary and secondary care are aware of

- All diagnoses (chronic illness)
- Results of investigations/tests
- Medication prescribed