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The Largest Health Disparity We Don't Talk About

Americans with serious mental illnesses die 15 to 30 years earlier than those without.

By Dhruv Khullar

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I didn't think our relationship would last, but neither did I think it would end so soon.

My patient had struggled with bipolar disorder his entire life, and his illness dominated our years together. He had, in a fit of hopelessness, tried to take his life with a fistful of pills. He had, in an episode of mania, driven his car into a tree. But the reason I now held his death certificate — his sister and mother in tears by his bed — was more pedestrian: a ruptured plaque in his coronary artery. A heart attack.

Americans with depression, bipolar disorder or other serious mental illnesses die 15 to 30 years younger than those without mental illness — a disparity larger than for race, ethnicity, geography or socioeconomic status. It's a gap, unlike many others, that has been growing, but it receives considerably less academic study or public attention. The extraordinary life expectancy gains of the past half-century have left these patients behind, with the result that Americans with serious mental illness live shorter lives than those in many of the world's poorest countries.

National conversations about better mental health care tend to follow a mass shooting or the suicide of a celebrity. These discussions obscure a more rampant killer of millions of Americans with mental illness: chronic disease.

We may assume that people with mental health problems die of "unnatural causes" like suicide, overdoses and accidents, but they're much more likely to die of the same things as everyone else: cancer, heart disease, stroke, diabetes and respiratory problems. Those with serious mental illness are more likely to struggle with homelessness, poverty and social isolation. They have higher rates of obesity, physical inactivity and tobacco use. Nearly half don't receive treatment, and for those who do, there's often a long delay.

When these patients do make it into our clinics and hospitals, it's clear that we could do better. A troubled mind can distract doctors from an ailing heart or a budding cancer.

For doctors, two related biases are probably at play. The first is therapeutic pessimism. Clinicians, including mental health professionals, often hold gloomy views about whether patients with serious mental illness can get better. This can lead to a resigned passivity, meaning that certain tests and treatments aren't offered or pursued.

As Lisa Rosenbaum, a cardiologist at Brigham and Women's Hospital in Boston, writes: "Many of us have internalized the directive to seek a test or procedure only if 'there's something you can do about it.' For mentally ill patients with medical illness, however, this principle often justifies doing nothing."

Taking blood for a test. Too often, research finds, the physical ailments of mentally ill people are overlooked. Bertrand Langlois/Agence France-Presse — Getty Images

The second is a concept called diagnostic overshadowing, by which patients' physical symptoms are attributed to their mental illness. When doctors know a patient has depression, for example, they're less likely to think her headache or abdominal pain portends a serious illness.

In a recent article in The New England Journal of Medicine, Dr. Brendan Reilly, a physician at Dartmouth, describes his late brother's devastating story. Over the course of months, he wrote, countless physicians, hospitals and rehab facilities missed the spinal cord damage that left him quadriplegic — instead variously ascribing his inability to move to his mental illness, his medications or his will.

"Once they find out you have a mental illness," Dr. Reilly quoted his brother as saying, "it's like the lights go out."

This isn't an isolated event. Patients with mental illness are much less likely to undergo cardiac catheterization when they show heart attack symptoms. They're also less likely to get standard diabetes care like blood tests or eye exams, or to be screened and treated for cancer.

This is, at times, understandable, particularly when it comes to managing complex chronic diseases. For both clinicians and loved ones of patients with serious mental illness, contending with an episode of psychosis or severe depression can be so overwhelming that controlling cholesterol or managing blood pressure seems like mowing the lawn while the house is on fire.

It may help to organize and pay for mental health care more like physical health care. We've been redesigning care for patients with diabetes, heart failure or knee problems, but have made few dedicated efforts for those with mental illness. A recent review, for instance, found that there are currently no good trials on how to increase cancer screening for people with mental illness.

The few tailored programs that do exist have shown promise in meeting the distinct needs of these patients and overcoming the health system's biases. One study recruited nearly 300 overweight patients from community-based psychiatric programs and randomly assigned them either to "usual care" — general nutrition and exercise information — or a behavioral weight loss program. The weight loss program was devised for patients with serious mental illness, who often struggle with memory, attention and learning issues.

The patients were taught material in small chunks with frequent repetition; role-played the selection of healthy foods; and got help organizing their homes to enable a healthier lifestyle. At the end of the study, patients in the control group weighed essentially what they did at the beginning. But those in the specialized program lost on average 7.5 pounds; nearly 40 percent had lost 5 percent of their total body weight.

Across the country, heart failure patients leaving the hospital are routinely seen in specialized clinics within a week of discharge. Not so for psychiatric patients, who often wait months before seeing a mental health professional.

To narrow that gap, UT Health San Antonio created a transitional clinic for patients with mental illness discharged from hospitals and emergency departments throughout the city. The goal is to get these patients evaluated within days. They meet with psychiatrists, social workers and therapists. They receive training in how to buy groceries and use public transportation. They're visited at home by case workers who help organize not only their psychiatric drugs, but also their cholesterol and blood pressure medications.

"With the right kind of care, people with serious mental illness can integrate back into society," said Dr. Dawn Velligan, professor at UT Health San Antonio and a director at the clinic. "They can have regular jobs, relatively normal lives. We just need to intervene before things get unmanageable."

Early results are promising: Historically, about 7 percent of psychiatric patients return to the hospital within a month, but only 1 percent of those seen in the transitional clinic do. Despite the program's success, inconsistent funding has limited the number of patients the clinic can reach — a reflection of how society continues to undervalue mental health.

"When there's a commitment to these patients, there's a lot we can do," Dr. Velligan said. "But right now, they're not a priority. People have to want to care for them. We have to care."

After decades of fragmenting medicine into specialties and subspecialties, it's perhaps not surprising that a siloed system often fails those in need of whole-person care. I still sometimes wonder if I had let my patient's mental illness overshadow his physical needs. Did I overlook some subtle cue?

I may never know the answer, but next time, I hope I'm not asking the question.

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