Lifestyle interventions are feasible and acceptable and may help to reduce premature mortality in schizophrenia: A response to Galletly

Philip B Ward, BMedSc, PhD, School of Psychiatry, UNSW Sydney and Schizophrenia Research Unit, Ingham Institute of Applied Medical Research, Liverpool, NSW AUSTRALIA
Email: p.ward@unsw.edu.au; Telephone: +61 2 9616 4308; Fax: +61 2 9602 5917

Joseph Firth, BSc, Division of Psychology and Mental Health, University of Manchester, Manchester, UK

Simon Rosenbaum, BSc, PhD, School of Psychiatry, UNSW Sydney and Black Dog Institute, Randwick NSW AUSTRALIA

Katherine Samaras, MBBS, PhD, Diabetes and Obesity Program, Garvan Institute of Medical Research, and Department of Endocrinology, St Vincent’s Hospital, Darlinghurst, NSW AUSTRALIA

Brendon Stubbs, PhD, Physiotherapy Department, South London and Maudsley NHS Foundation Trust, and Health Service and Population Research Department, Institute of Psychiatry, Psychology and Neuroscience, King’s College London, UK

Jackie Curtis, MBBS, District Mental Health, South Eastern Sydney Local Health District, Bondi Junction, and School of Psychiatry, UNSW Sydney, AUSTRALIA
Galletly’s commentary on new data describing years of potential life lost for people with schizophrenia broadens discussion beyond excessive rates of obesity and premature metabolic syndrome, highlights social concomitants of living with a severe mental illness, and outlines how poverty and social disadvantage contribute to poor medical care in these patients. We agree that addressing socioeconomic disparities, improving access to medical care and changing prescribing practices are priorities in improving physical health outcomes in people with schizophrenia.

There is no ‘silver bullet’ to reducing these physical health disparities and a multi-faceted, committed response is needed. However, we dispute the statement that lifestyle interventions show little evidence of reducing cardiovascular risk, especially since such interventions are broadly as effective as pharmacological interventions. The evidence shows that appropriately-designed behavioural interventions that provide sufficient support to patients to increase their autonomy significantly reduce cardiometabolic risk factors in the short to medium term. If maintained over the long-term, we can expect physical health outcomes and life expectancy to improve, as is well-documented in the general population.

Galletly asserts that “It is time to look beyond trying to coerce patients with schizophrenia to improve their lifestyles”. We contend that patients are interested in achieving lifestyle change, and targeted interventions have a major role to play in a wholistic approach to addressing the major health inequalities in this vulnerable population. Indeed, ingrained inequality is one key reason why lifestyle interventions are an essential part of integrated
‘best practice’ care. Adequate sleep, regular exercise and a healthy diet should be key contributors to well-being a healthy life for everyone in society, but these are sadly absent for most people living with schizophrenia.

There is a critical need for more research to address the challenges of implementing behaviour change in a cost-effective fashion as part of routine care. Behavioural interventions beginning at the same time as antipsychotic treatment is one promising approach that requires further research, to determine whether ‘early intervention’ for physical health in people with schizophrenia is a feasible and effective method for reducing risk.

We believe it is important that therapeutic nihilism does not limit access to the benefits of lifestyle interventions for people living with schizophrenia. Rather, the growing evidence-base will enable clearer understanding as to how and when to implement lifestyle interventions as part of multi-faceted strategies to reduce premature death in people with schizophrenia.

References


