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Reducing global disparities in cancer screening for people with mental illness

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Cancer is the second leading cause of death for individuals with serious mental illness. Delays in diagnosis and unequal access to cancer care contribute to cancer mortality that is two to four times higher in people with mental illness than in the general population.^{1,2} Who is being left behind, and why? How can we intervene?

The systematic review and meta-analysis by Marco Solmi and colleagues provides compelling evidence that people with mental illness have inadequate access to cancer screening globally.³ Previous reviews have primarily focused on one type of cancer screening in specific populations, such as individuals with schizophrenia. By contrast, Solmi and colleagues' Article summarises 47 publications from ten countries and territories for an aggregate population of 501 599 adults with mental illness. This large-scale, comprehensive approach allowed the authors to compare proportions across cancer screening types, psychiatric diagnoses, and geographical regions. Compared with the general population, adults with mental illness were nearly 25% less likely to receive any cancer screening (odds ratio [OR] 0.76 [95% CI 0.72–0.79]).

This summarising result shows that a substantial population of people with mental illness have disparities in cancer screening, including people with depression. With 300 million people affected by depression worldwide,⁴ reducing this disparity is a widespread public health issue. Given most people with mood disorders are cared for in primary care, integrated care models will be essential to connect patients to cancer prevention and meet people where they are.⁵

The next largest disparities emerged when the general population had a high screening rate, such as in breast cancer screening (OR 0.65 [95% CI 0.60–0.71]). The smallest gaps occurred when screening rates in the general population were low, as in colorectal cancer screening, probably as a result of a floor effect (1.02 [0.90–1.15]). Like other marginalised populations, people with mental illness are not benefiting equally from advances in cancer prevention. Without targeted interventions, the inequality will likely increase.

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Individuals with psychotic disorders, who have high rates of poverty and unstable housing, appear particularly vulnerable to be missed from screening.⁶ Breast cancer screening rates for women with schizophrenia and psychosis drive the overall disparity in cancer screening. Women with schizophrenia were half as likely to receive breast cancer screening compared with the general population (OR 0.52 [95% CI 0.43–0.62]). Further research is needed to examine why cervical cancer screening rates were relatively higher in women with schizophrenia and other non-affective psychoses (0.75 [0.60–0.93]). Primary care clinicians might be able to provide cervical cancer screening (eg, pap smears) during an office visit. By contrast, for a mammogram, a woman might need to schedule a separate appointment at an unfamiliar location, creating additional barriers to accessing services. Tailored interventions for adults with schizophrenia, including mobile mammography vans and collaborative care models in which patients can meet with psychiatry and oncology together, are promising strategies to increase access to care.^{7,8}

Finally, this broad review shows gaps in our evidence base. None of the included studies examined colorectal screening for people with schizophrenia. Additionally, the Article did not cover lung cancer screening disparities, which are particularly important for people with mental illness, given the high rates of tobacco use. Moreover, there were no studies from Africa or central and south America, and only three studies from Asia. A more diverse sample including low-income and middle-income countries is needed to understand geographical and cultural contexts and to identify targets for effective interventions.

To advance cancer epidemiology, governments and health systems must invest in data collection infrastructure specific to individuals with mental illness. To inform intervention development, research needs to extend population-based studies to reach understudied groups who face distinct barriers to care, including people who are incarcerated and people with undiagnosed mental illness. Additionally, research needs to identify modifiable targets that might facilitate access to cancer prevention including insurance status, income, illness severity, and engagement with primary care and mental health care. To close the gap in screening, we need to design, rigorously test with large-scale randomised trials, and scale up multilevel targeted interventions to increase cancer screening uptake for individuals with mental illness, especially for serious mental illness.⁹

In summary, Solmi and colleagues' results provides further support to designate people living with serious mental illness as a disadvantaged population. This recognition would encourage governments to include serious mental illness in annual reports, incentivise health systems to develop quality metrics, and expand investment in research.¹⁰ To turn WHO's slogan on its head, "No mental health without health" means individuals with mental illness deserve equal attention to their physical wellbeing.⁵ Advancing equity in cancer screening is a crucial step towards closing the mortality gap globally for this marginalised population.

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