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*Editorial*

# Closing the Mortality Gap: Cancer Inequities for People with Severe Mental Disorders

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In October 2025, a policy dialogue-day brought together clinicians, researchers, and patient advocates to examine an overlooked health inequality: the excess cancer mortality experienced by people living with severe mental illness (SMI). Organised by University College Dublin in collaboration with the European Observatory on Health Systems and Policies, the ECHoS Cancer Mission Hub Project [1] and the National Cancer Control Programme, the meeting sought to translate international evidence into policy responses. These disparities remain insufficiently recognised despite growing evidence of their consequences for patients and families nationally.

Ireland has made advances in cancer control and care. Improvements in screening, diagnosis, and therapeutic innovation have contributed to declining mortality from several cancers, with more people living well with and beyond cancer [2]. These gains have not been experienced equally across society, i.e. individuals living with a SMI (schizophrenia, bipolar disorder, and major depression) [3].

People with SMI experience a reduction in life expectancy compared to the general population, estimated at between 15 and 30 years [3]. Importantly, the disparity appears to arise less from differences in cancer incidence or biology than from inequalities in prevention, detection, and treatment [4].

International evidence shows that people with SMI are more likely to be diagnosed with cancer later. Participation in national screening programmes for breast, cervical, and colorectal screening is lower among this group [5]. Reduced screening uptake is likely to reflect factors including social disadvantage, difficulties navigating health services, and the limited

integration of preventive healthcare within mental health systems [4]. Considering that people with SMI have risk factors for developing cancer, such as smoking and obesity, this is a clear example of the inverse health law [6]: a group with the highest need are not accessing screening.

Disparities also emerge after diagnosis. Studies indicate that patients with SMI are less likely to receive guideline-concordant cancer treatment, including surgery, chemotherapy, or radiotherapy even where clinically indicated [4]. These differences cannot be explained by comorbidity or treatment refusal. Rather, they appear to reflect barriers within healthcare systems, including fragmented care pathways, challenges in coordinating services, and persistent stigma associated with mental illness.

These issues are relevant in healthcare systems where oncology and mental health services operate within separate organisational structures. In Ireland, psycho-oncology services now provide psychological support within designated cancer centres. Such services are essential in supporting patients experiencing cancer-related distress. However, pathways for individuals who enter cancer treatment with pre-existing SMI remain less defined.

In practice, oncology services and community mental health teams operate in parallel instead of integrated care models. Communication between services varies across regions, and continuity of care depends on local arrangements rather than consistent national pathways. This fragmentation creates additional barriers for patients already facing challenges navigating complex healthcare systems [7]. In such circumstances, general practice typically provides holistic care based on generalism. Notwithstanding this, supporting an individual with SMI through cancer screening, diagnosis and management, and their interaction with multiple specialist services is a complex and hidden, yet critical, function.

Evidence from other countries suggests that integrated care models can help address these difficulties. Collaborative care approaches that incorporate psychiatric expertise in oncology services demonstrate promising results [8]. These models involve psychiatric consultation, care coordination and patient navigation, allowing mental health needs to be addressed alongside cancer treatment. Interventions may reduce treatment disruption, improve engagement with oncology services and enhance patient outcomes.

Workforce capacity is also an important consideration. Oncology clinicians may have limited experience working with patients who have complex mental health needs, while mental health professionals may be less familiar with the demands of cancer treatment pathways. Education initiatives addressing communication, stigma reduction, and collaborative care would strengthen care at this interface [9].

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Data visibility represents a critical issue. In many healthcare systems, including Ireland's, mental illness status is not routinely recorded in cancer registries or screening programme datasets. Furthermore, persistent stigma may further impact how mental health disorders are recorded by practitioners, compared to other chronic conditions. This information gap limits the ability of policymakers and researchers to quantify disparities or evaluate interventions designed to address them. Routine recording of SMI within oncology information systems would enable monitoring of outcomes and inform policy development.

The next phase of national cancer policy presents an opportunity to address these challenges. The National Cancer Strategy 2017–2026 has played a central role in shaping cancer services and emphasises equity and patient-centred care as guiding principles. However, the specific needs of people living with SMI are not explicitly addressed within the strategy. As planning begins for the next national cancer strategy, there is an opportunity to incorporate commitments to reducing this disparity.

Several policy actions could support progress. Integrated care pathways linking oncology services with community mental health teams and primary care should be developed across designated cancer centres. Such pathways could include psychiatric consultation during cancer diagnosis, structured communication between services, and multidisciplinary case review for patients with complex needs.

Targeted strategies are also required to improve participation in cancer screening programmes among people with SMI. Outreach initiatives, patient navigation supports, and closer integration between screening services and mental health care would help overcome barriers to preventive care.

In addition, greater inclusion of individuals with SMI in cancer research and clinical trials is essential. Historically, this population has often been excluded from research [10]. Developing consent procedures and inclusive recruitment strategies would help ensure that advances in cancer treatment are relevant to all patient groups.

The policy dialogue highlighted the growing consensus that the cancer mortality gap experienced by people with SMI is avoidable and unacceptable. The available evidence suggests that structural interventions, particularly those that promote integration, continuity, and patient and family/caregiver engagement, can substantially improve outcomes.

Ireland has made significant progress in cancer control and care in recent decades. Ensuring these improvements extend to people living with SMI represents the next important step in building a more equitable cancer care system. As the next national cancer strategy is developed, addressing this disparity should be recognised not only as a clinical challenge but also as a public health priority.

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**Declarations of Conflicts of Interest:**
None declared.

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