Screen for CVD Risk in Mentally Ill Patients

BY MIRIAM TUCKER

VIENNA — A new joint position statement from three European medical organizations is aimed at reducing cardiovascular disease risk and improving diabetes care in people with severe mental illness, as well as improving their overall health.

The statement is from the European Psychiatric Association and supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (www.em-consulte.com/article/223719). It was discussed at a press briefing held during the EASD's annual meeting.

People with severe mental illnesses (SMI), including schizophrenia, depression, and bipolar disorder, have worse physical health and reduced life expectancy, compared with the general population. Data suggest that they die years prematurely. It's also much harder for these individuals to access health care services, statement coauthor Dr. Richard Holt said at the briefing.

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People with SMI are more likely to be overweight, to smoke, and to have diabetes, hypertension, and dyslipidemia. Antipsychotic medications also can induce weight gain and worsen other metabolic CVD risk factors, he noted.

"The problem is that as well as the devastating effects of SMI, people with bipolar disorder and schizophrenia die on average 10-20 years earlier than the general population," said Dr. Holt, of the department of endocrinology and metabolism, University of Southampton, England.

Because of the reduced access to physical health care services, the rate of screening for diabetes and CVD is significantly lower than that in the general population. In fact, while about 20% of diabetes in the general population is undiagnosed, that rate is about 70% among people with mental illness. People with mental illness also have high rates of untreated dyslipidemia and hypertension, Dr. Holt noted.

With this new statement, "we have an opportunity here of bringing together psychiatry and physical health services—in both primary care and secondary care—to try to address this problem, to increase the amount of screening for CV risk factors, to identify individuals at high risk, and to then come together with a strategy to treat them," he said.

Establishing baseline CVD risk at initial presentation is advised, and recommendations are given for assessment of medical history and examination of all CVD risk factors, including lipids, glucose, smoking habit, and blood pressure. Electrocardiography also is recommended. Monitoring should be carried out at regular intervals, depending on the patient's individual risk level. Weight should be closely monitored in patients taking psychotropic medications, the document advises.

Psychiatric centers and diabetes centers should cooperate in the care of patients with SMI and diabetes. A diabetes nurse-educator also should be involved in the care of those on insulin. The document also outlines management of blood lipids and blood pressure, along with smoking cessation counseling.

The choice of psychotropic medications should take into account the potential effects of the agent on CVD risk factors, particularly in patients who are overweight or obese. A dilemma may arise with clozapine, which is recommended by many guidelines as the antipsychotic of choice for patients with refractory schizophrenia, but it is also the antipsychotic associated with the highest risk of weight gain and related CVD risk factors, the document says.

In the United States, a similar set of recommendations from the National Association of State Mental Health Program Directors (NASMHPD) was issued in 2006 and 2008 (www.nasmhpd.org). In

addition to clinical recommendations, the NASMHPD guidelines focus on the establishment of systems of care for people with SMI at both the national and state levels.

In an interview, Dr. Joe Parks, the lead author of the NASMHPD papers, said the problem in the United States is that it's often not clear who is responsible for ensuring that evidence-based standards of care are provided.

"Are the recommendations the responsibility of the individual health care provider? Or the local health care organizations such as hospitals and clinics? Or the payers such as private insurers and Medicaid? Because of this lack of accountability, implementation has been fragmented and spotty," said Dr. Parks, medical director for the Missouri Department of Mental Health, Jefferson City.

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Some states have made progress. The New York State Department of Mental Health, for example, has implemented tracking of obesity and blood pressure in its state-operated hospitals and clinics. In Missouri, the Department of Mental Health has just begun to require and fund annual screening and some interventions for obesity, blood pressure, diabetes, high cholesterol, and dyslipidemia in its programs serving people with mental illness.

Several private insurers encourage and attempt to incentivize clinics and individual providers to follow these recommendations, but Dr. Parks said he is unaware of any that actually require compliance.

"If we want to see widespread adoption of these kind of evidence-based standards of care, then the payers—whether private or governmental—need to require it in their contracts.

"Within our current system if you really want something to happen routinely and systematically throughout the health care delivery system, there must be either a legal requirement or financial incentives. Everything else is just wishful thinking," Dr. Parks said. ■