LETTER TO THE EDITOR

A Cardiometabolic Psychiatry Consultation Service in a State Psychiatric Hospital

To the Editor: People with severe mental illness suffer increased morbidity and mortality from medical conditions. Patients with schizophrenia die 25 years earlier than agematched controls.¹ Cardiovascular disease is the leading cause of mortality in both schizophrenia and mood disorders.² Despite a higher prevalence of modifiable risk factors such as dyslipidemia, hypertension, and obesity,¹ patients with severe mental illness face a lack of access to care for these risk factors.³ Moreover, many patients with severe mental illness take second-generation antipsychotic medications (SGAs), which can exacerbate their risk.⁴

State psychiatric hospitals are uniquely poised to provide cardiometabolic risk assessments, brief programming, and recommendations for community follow-up. Yet, to date, little attention has been given to this important opportunity in the mental health service delivery system that routinely comes in contact with those most at risk.

Method. A cardiometabolic psychiatry consultation service was established at a 230-bed involuntary state psychiatric hospital in 2008 to improve management of high cardiometabolic risk patients.

An internist-psychiatrist evaluated SGA selection and commented on switching strategies, as well as medication augmentation approaches such as the use of metformin for weight loss. The physician also considered improvements in medical management of diabetes, hyperlipidemia, blood pressure, and tobacco cessation. The nutritionist provided diet counseling and outpatient referral. Inclusion of medical students contributed to their education, increased efficiency by gathering clinical information prior to rounds, and improved patient care by permitting individual motivational encounters with the student between visits. The patient's primary nurse served as liaison to the inpatient team.

Results. The evaluations of the first 11 patients were reviewed. Mean age was 45 years, and 7 patients were women. Mean body mass index was 32 kg/m², and 6 patients smoked. The most common *DSM-IV* psychiatric diagnoses were schizoaffective disorder and schizophrenia (3 each); 2 patients had posttraumatic stress disorder. Ten patients were taking SGAs. The most common medical diagnoses were diabetes and hyperlipidemia (5 patients each) followed by hypertension (3 patients) and hypothyroidism (2 patients). The most common reasons for consultation were for weight gain during treatment with an SGA (8 patients) and for general cardiometabolic risk management (2 patients). One patient was referred for high-risk pre–electroconvulsive therapy evaluation. Six patients responded to a 10-point Likert scale (1 = not at all, 10 = very confident or important) rating attitudes toward lifestyle changes. The mean importance attached to change was 8.2, and the mean confidence in making a change was 6.6, with 1 outlier who responded 0 to both items excluded.

The team made recommendations for medical or psychiatric medication changes in 8 patients, for hospital programming (exercise groups, wellness initiatives, or 1-on-1 exercise time) in 4 patients, and for behavioral strategies (dietary or cognitive-behavioral) in 6 patients.

Qualitatively, referrals were commonly sought to mitigate side effects of an SGA that the attending psychiatrist felt were necessary. A behavioral and programming approach was central to managing patients expected to have a long admission, whereas patients admitted briefly were best served by medication adjustment and referral to community resources.

A cardiometabolic consultation service has proved an efficient and well-accepted method of improving the access to interdisciplinary management of patients with severe mental illness at high cardiometabolic risk. Further systematic study of this model's ability to improve select outcomes is warranted.

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