A Call for Cardiopsychiatry

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The shortened expected living years in severe mental illness (SMI) because of early deaths due to somatic disease are a major health challenge [1]. The causes for this increased mortality are complex and involve genetics, lifestyle habits and side effects of medications. Several reports have indicated that a major part of the problem is a failure to detect and adequately treat the somatic conditions [2, 3]. The authors of the present paper, cardiologists with a long record in addressing cardiac health in SMI, present data on patients with acute coronary syndrome (ACS) from the Danish national patient register in the period from 1996 until 2016. Their comparison of schizophrenia patients and nonpsychiatric patients confirm a gap in adequate cardiologic procedures, in the presence of risk factors for cardiometabolic disease between the groups. Earlier Danish registry studies have found increasing overall standardized mortality rates in schizophrenia from 1995 to 2014 [4], and there are indications that this increase is related to cardiovascular events [5]. Interestingly, a recent registry study of performed procedures prior to cardiac death shows a similar gap between nonpsychiatric patients and schizo-

phrenia patients in the Norwegian specialized health care [6].

The main finding of the present paper is however that this treatment gap has remained unchanged over the past decades. The increasing number of publications on cardiometabolic risk in severe mental illness could reflect an increasing awareness about the challenge. This could lead to the expectations that somatic service provision for SMI patients is improving and closing in on that of the general population. The current paper indicates that these hopes are not fulfilled. This is disappointing, especially as potentially available treatments are shown to be highly effective in SMI [7].

There are other interesting findings in this study. Patients with ACS and schizophrenia had a higher prevalence of diabetes and COPD and a lower prevalence of hypertension than psychiatric healthy controls with ACS. The prevalence of cardiometabolic risk factors and COPD in the schizophrenia population was increasing in the study period. This could possibly be due to increased detection of the conditions because of increased awareness amongst clinicians [2]. The interpretations of the results

are obscured by the lack of information on important risk factors such as smoking and obesity, which are known to be highly prevalent in the schizophrenia population. The study has not investigated changes in the prevalence of ACS in the schizophrenia population.

However, the main question remains. Why is it so difficult to achieve the same care for SMI patients as for the general population? Firstly, there are several patient-related barriers for seeking adequate help for somatic conditions in SMI. Understanding of these barriers is important at both the public health level and at the individual level. The shortened life span seems to be greatest for schizophrenia spectrum disorders [8], and a core feature of schizophrenia are the *negative psychotic symptoms*. Negative symptoms such as apathy, anhedonia, ambivalence and social withdrawal will reduce the patients' interest in their own well-being and the motivation and energy necessary for help-seeking behavior. The same symptom cluster is also partly responsible for the reduced ability in sustaining a healthy lifestyle and reduce cardiometabolic risk in the first place. Many patients will e.g. prefer fast-food options with poor nutritional value or spend much time passive on a couch in their homes. Accompanying symptoms such as hopelessness and reduced self-esteem, often as part of a depression, may also keep SMI patients from seeking help. Patients with active *positive psychotic symptoms*, such as delusions and hallucinations, may be afraid of going out on the street or may be more suspicious of the service providers' intentions. Many patients may have had negative former experiences from psychiatric treatment, e.g. in the form of compulsory measures. Delusions may also interfere with the understanding of the conditions themselves, denial or reduced ability to acknowledge a need for treatment. An additional important factor is the generally poor socioeconomic status in this patient group. Pursuing a healthy lifestyle is often more costly as food with high nutritional value tends to be more expensive and gyms have considerable membership fees. However, data from the current study interestingly suggest that education and income levels in schizophrenia are improving.

Nevertheless, most SMI patients will be able to be motivated to take better care of their somatic health. An important intervention to reduce the patient-related barriers is thus to work with the patients' motivation, e.g. using motivational interviewing [9]. Further, as several of the barriers are related to the SMI itself, adequate psychiatric treatment is crucial.

Service-related barriers consist of stigma, health personnel incompetence and the design of the services. Stigma

towards SMI patients may come in different guises and be expressed as lower treatment ambitions or misunderstood "benevolent" tolerance for risk behavior (e.g., towards smoking, unhealthy diet or sedentary behavior). As always, stigma is closely related to lack of knowledge. Lack of knowledge or focus is a probable cause for the lack of adequate procedures for detection, referral and treatment in many places. As a reduction of the patient-related barriers is interwoven with the psychiatric treatment and requires coordinated effort in order to achieve a behavior change, reducing the stigma also requires coordinated action for education and attitude change amongst service providers. Barriers related to service design might however be more straightforward to overcome. As stated by the authors, routines for monitoring somatic health in the psychiatric services are called for. Clinical practices have been shown to be insufficient [10], and guidelines for treatment of SMI have been generally been lacking in descriptions of how to deal with the increased mortality of somatic conditions. This is now about to change in many countries. Worth mentioning are the initiatives taken by the IPHYS group [11]. One of these initiatives is the development of a tool for screening for cardiometabolic risk and guiding interventions towards defined treatment goals in the SMI population. Adaptations of this tool have spread to several countries and are now part of national guidelines in countries like the UK and Norway [12, 13].

The current topic is an example of the fact that existing boundaries between psychiatry and somatic medicine in some perspectives may be arbitrary and counterproductive and that stigma and lack of awareness may have serious negative health effects. There is a need for more rigorous implementation of standards where general practitioners should have a high awareness of the comorbidity challenge in this patient group, psychiatrists and other mental health professionals should take greater responsibility for the somatic health of their patients and internists should adapt to the same standards for treatment regardless of any psychiatric condition.

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