California Health Homes
Advanced Training Series:
Serious Mental Illness
June 3, 2016
Overview

• Serious Mental Illness (SMI)
  – Definition & Diagnoses
  – Treatment options

• Clinical Case

• Review of medical co-morbidities among people with SMI, with a focus on metabolic abnormalities

• Best practices to improve the care of people with SMI
Learning Objectives

• Be able to define serious mental illness and understand the type of care this population requires

• Be familiar with needs *outside* of typical medical care that are beneficial for this population

• Be aware of the early mortality rates among people with serious mental illness (SMI)

• Understand the low prevalence of screening and treatment of medical disorders among people with SMI
Serious Mental Illness (SMI)

- SMI includes a range of DSM-IV psychiatric disorders that result in severe impairment in functioning (e.g., schizophrenia, schizoaffective disorder, bipolar disorder).

- In 2014, there were 9.8 million adults living with SMI in the US (4.2% of the US population).

- People with SMI utilize community mental health clinics significantly more often than primary care and require medication management.
Specific Disorders

- **Schizophrenia**
  - Schizophrenia is a chronic and severe mental disorder that affects how a person thinks, feels, and behaves.
  - The symptoms of schizophrenia fall into three categories: positive (hallucinations, or delusions), negative (flat affect), and cognitive (thought disorder).

- **Bipolar disorder**
  - Bipolar disorder is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks.

- **Schizoaffective disorder**
  - Combination of symptoms typical of schizophrenia and mood disorders

- **Major depressive disorder**
Medical Treatment of SMI

• Best treatment is always combination of medications and psychotherapy
  – Schizophrenia
    • Antipsychotic medications (e.g., risperidone, olanzapine, haloperidol)
  – Bipolar Disorder
    • Mood stabilizers (e.g., Lithium, Depakote)
  – Schizoaffective Disorder
    • Combination of antipsychotics and mood stabilizers
  – Major Depressive Disorder
    • Antidepressant medications
Management in the Clinic

• Treat respectfully
  – Remember, this is a highly stigmatized population

• Check in to make sure they have basic needs met (are not hungry or cold)

• Connect to services for basic needs
  – Housing
  – Food (high prevalence of food insecurity)
Violence

• Most people with SMI are NOT violent
• Most violent acts are NOT committed by people with SMI
  – In fact, people with SMI are actually at higher risk of being victims of violence than perpetrators
• Most common form of violence associated with mental illness is not against others, but rather against oneself with suicide.
• Treatment with psychotropic medications and reduction of drug and alcohol abuse are key to reducing violence risk
• That said, if you are ever uncomfortable, trust your gut and leave the room.
Suicide

- All mental illnesses increase risk for suicide
  - Prior history of suicide attempts is a risk factor
  - Recent discharge from a hospital is a risk factor

- What you can do
  - Screen for suicide (asking does not make people want to hurt themselves)
  - Encourage medication adherence
  - Encourage patients to ask their providers for medications to treat their active and distressing symptoms (anxiety, psychosis)
  - Provide information on the suicide hotline (1-800-273-8225)
Specialty Mental Health

• People with SMI meet medical necessity to be treated in specialty mental health settings

• The best thing you can do for these patients is to reinforce the importance of connecting with their specialty mental health providers
  – Each county in California has a specialty mental health system of care that serves this population.
  – Contact your local health department to find out the best way to connect.
Other Treatment Recommendations

• Schizophrenia PORT Psychosocial Treatment Recommendations
  – Supported Employment
  – Family Based Services
  – Alcohol and Substance Abuse Treatment
  – Weight management interventions
Supported Employment

• **Target population**
  - Any person with schizophrenia who has the goal of employment

• **Key elements**
  - Individually tailored job development
  - Rapid job search
  - Availability of ongoing job supports
  - Integration of vocational and mental health services

• **Outcomes**
  - Employment outcomes are better when there is greater fidelity to the supported employment model
Example of Supported Employment
Family-Based Services

• **Target population**
  – People with ongoing contact with families

• **Key elements**
  – Illness Education
  – Crisis intervention
  – Emotional support & training in how to cope
  – Collaborative decision making (patient, family, clinician)
  – Ideally 6-9 months; thought 4 sessions can be OK.

• **Outcomes**
  – Reduce relapse rates and re-hospitalization
  – Increased adherence, less symptoms, less stress
  – Family has less distress and improved relationships.
Example of Family-Based Services

A series of 12 weekly classes

Structured to help family members, partners and friends understand and support individuals with serious mental illness.
Psychosocial Interventions for Alcohol and Substance Use Disorders

• **Target population**
  - People with comorbid alcohol or drug use

• **Key elements**
  - Motivational interviewing techniques
  - Behavioral strategies focusing on engagement in treatment, coping skills training, and relapse prevention
  - Integrated with mental health care

• **Outcomes**
  - Reducing substance use
  - Improving psychiatric symptoms and functioning
Example of Psychosocial Interventions for Alcohol and Substance Use Disorders
Psychosocial Interventions for Weight Management

- **Target population**
  - Overweight or obese (BMI 25.0–29.9; ≥30)

- **Key elements**
  - At least 3 months, group treatment preferable
  - Psychoeducation focused on nutritional counseling, caloric expenditure and portion control
  - Goal setting
  - Regular weigh-ins
  - Self-monitoring of daily food and activity
  - Dietary and physical activity modification

- **Outcomes**
  - Weight loss
Clinical Case
The Institute of Medicine and the Surgeon General recognize significant health disparities for people with mental illness.
People with serious mental illness die 25 years earlier than the general population.
What is the Primary Cause of Death?

Cardiovascular Disease
Prevalence of Medical Comorbidities Among People with SMI

- **Diabetes ~15%**
  - 2x general population

- **HIV 6%**
  - 10x higher than general US population (0.5%)
  - Huge range (3-23%)

- **Hepatitis C 17%**
  - 17x greater than the general population (1%)
Special Populations to Consider Regarding Cardiometabolic Risk

- Children and adolescents
- Women
- African Americans
- Latinos
Why Do So Many People with SMI Have So Many Medical Co-morbidities?

• Antipsychotic medications \( \leftrightarrow \) *Remember the case!*

• Health behaviors
  – Tobacco use
  – Substance use
  – Poor diet & lack of physical activity
  – High-risk sexual activity

• Social determinants of health

• Quality of health care
ADA/APA Monitoring Guidelines for Patients on Second-generation Antipsychotic Medications

**TABLE**

*Recommendations for Metabolic Monitoring in Patients Receiving Atypical Antipsychotic Agents*¹²

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<th>Baseline</th>
<th>4 Weeks</th>
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*More frequent assessments may be warranted based on clinical status. BMI=body mass index.

Health Behaviors: Tobacco & Substance Abuse

• Tobacco
  – 31-41% of all cigarettes smoked in the US are consumed by people with mental illness
  – 44-64% of people with SMI smoke
  – Encourage smoking cessation! There is a strong evidence base for bupropion in this population

• Substance Abuse
  – 50% of people with mental illness use drugs or alcohol
  – Misuse of substances can lead to poor self-care, decreased adherence, risky sexual behavior
Health Behaviors: Exercise & Diet

• Exercise
  – People with SMI engage in less physical activity than the general public
  – Strong association between social isolation and inactivity
  – Psychiatric disorders & medications cause sedation

• Diet
  – Socioeconomic disadvantage leads to poor diet and contributes to elevated rates of obesity
    • Food insecurity (71% among people with SMI vs 46% in a safety net population vs 12% in general population)
Food Insecurity Study (N=110)

Food Security: General Population vs General Medical Population vs CCFC SMI Population

- **General Population**
  - Food Secure: 88%
  - Low Food Security: 7%
  - Very Low Food Security: 5%

- **SFGH General Medical Clinic**
  - Food Secure: 54%
  - Low Food Security: 26%
  - Very Low Food Security: 20%

- **CCFC SMI Population**
  - Food Secure: 29%
  - Low Food Security: 27%
  - Very Low Food Security: 44%

Mangurian, et al., *Psych Services*, 2013
**Health Behaviors:**  
**High Risk Sexual Activity**

- Although a lower percentage of people with SMI engage in sex, those that do display high-risk behaviors
  - ~60% do not use condoms
  - ~50% with multiple sex partners in the prior year
  - ~30% traded sex for money or goods
- 12% of sexually active people with schizophrenia had partners with risky behaviors (HIV, IVDU or blood transfusions)
Other Causes of Excess Morbidity and Mortality

• Social determinants of health
  – Economic and social conditions that influence health status (e.g., SES, psychological stress, early childhood development, social exclusion, unemployment, lack of social support networks, availability of healthy food, and safe transportation)

• Quality of health care
  – People with SMI receive lower quality of medical care
  – Focus of the remainder of the talk on this lack of screening and treatment of CVD
Screening for Medical Co-morbidities Among People with SMI
## ADA/APA Monitoring Guidelines for Patients on SGAs

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Impact of the ADA Consensus Statement on Metabolic Screening

Low Diabetes Screening Among People with SMI in California

• Only 30% of people were screened for DM, despite guidelines in place 10 years ago.

• The strongest predictor of diabetes screening was having at least one primary care medical care visit (36% vs 20%)

• Young adults (18-27) were less likely to be screened than any other category of older adults with SMI. «Remember the clinical case!»
Additional Findings*

- **HIV**
  - Only 7% are tested (3,817/57,170) despite a 6% prevalence (0.5% in the general population)

- **Hep C**
  - Only 4.7% (2,674/57,170) are tested (12.7% in the general population), despite a 17% prevalence (1% in the general population)

- **Breast Cancer**
  - Only 23.2% (5,352/23,087) get mammograms (43% in general population)

*Unpublished data, except Trager et al. AJPH, In Press*
Multiple Barriers Impede Metabolic Screening of This Population

• **Patient factors**
  – Amotivation, cognitive difficulties, or paranoia can make fasting labs or attending primary care appointments challenging

• **Provider factors**
  – Psychiatrists may believe guidelines go beyond their scope of practice.
  – Primary care physicians lack knowledge and comfort dealing with people with SMI.

• **Systemic Factors**
  – Separation between medical and mental health care (geographically, financially, organizationally, culturally)
  – Difficulties coordinating care
Treatment for Medical Co-morbidities Among People with SMI
Even If Screened, Treatment Rates Are Low

- Less likely to receive treatment for dyslipidemia, hyperglycemia, and hypertension
- Less likely to receive drug therapies of proven benefit after having a heart attack
- More likely to have premature mortality after a heart attack
Prevention Opportunities Missed: Low Rates of Treatment for Metabolic Disorders In Schizophrenia in CATIE

*Non-white women* had lower rates of treatment than their male counterparts

Courtesy of John Newcomer, MD
Will People with SMI Accept Treatment?

- People with SMI appear receptive to treatment of metabolic disorders when options are made available.
  - A VA study found that adherence to oral hypoglycemic medications was better among diabetes patients with schizophrenia than diabetes patients without this diagnosis (57% vs 48)
  - People with schizophrenia attend weight loss programs if these are provided to them, although whether attendance rates are comparable to those without SMI has not be directly studied.
Best Practices to Improve the Medical Care of Your Patients with SMI?
Providers Should…

- Show empathy
- Ensure housing stability and food security
- Reinforce importance of specialty mental health to get additional services
- Encourage screening and treatment for medical co-morbidities
  - ADA/APA guidelines recommend annual screening (BMI, blood pressure, lipids, A1c)
    - Remember young adults!
  - Annual screening for HIV & Hep C
  - Don’t forget women’s health (mammograms and pap smears)
- Recognize and encourage treatment for modifiable risk factors:
  - Facilitate smoking cessation
  - Recommend substance abuse treatment
  - Recommend feasible diet and exercise plans
  - Encourage safe sex practices
Summary

- People with SMI die 25 years earlier than the general population, often from CVD
  - This is a major health disparity
- People with SMI are less likely to receive screening for medical conditions.
- Even if medical conditions are identified, people with SMI are unlikely to receive treatment.
- **YOU** can do something:
  - Reinforce importance of treatment in specialty mental health.
  - Encourage them to get screened and treated for common medical conditions
Thank you!

Please feel free to contact me with questions
(christina.mangurian@ucsf.edu)