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Who is Mental Health America?

- Formerly known as the National Mental Health Association
- Country's oldest and among the largest mental health advocacy groups
- Founded in 1909 by Clifford W. Beers, a young businessman who had a mental illness and experienced horrific treatment
 - Adolf Meyer
 - William James among founding members

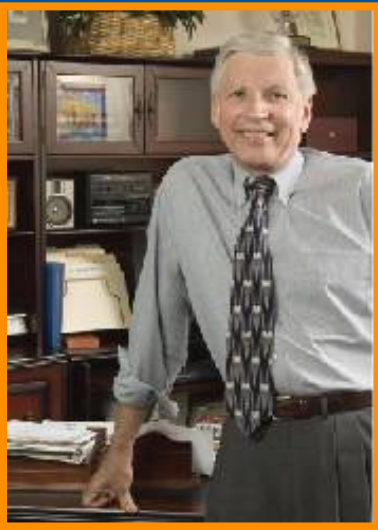
The Mental Health Bell



*“Cast from shackles which bound them,
this bell shall ring out hope
for the mentally ill and
victory over mental illness.”*

Who is Mental Health America?

- More than 320 affiliates nationwide
 - In 40 States
 - Covering over 90% of the US Population
- An annual budget of \$8 million in the national office and approximately \$170 million across the entire MHA network
- National staff of 45 individuals focused on three major audiences
 - Federal Government with National Partners
 - State and Local Governments – including school districts – with local affiliates and other partners
 - General Public



David L. Shern, PhD President & CEO

- Former **Dean of the Louis de la Parte Florida Mental Health Institute at the University of South Florida**, one of the largest research and training institutes in behavioral health services in the U.S.
- Worked for 20 years in the **Denver, Colorado, and New York Public Mental Health Systems.**
- Most work focused on **Adults with Severe Mental Illness** – including longitudinal treatment outcome studies
- First noticed **excess mortality** in own research in 1990

New Tagline: Bringing Wellness Home

- **Reflects** the growing recognition of the fundamental connection between good mental health and overall health
- **Signals** our focus on the overall health and well-being of every individual, and particularly people with mental illnesses
- **Communicates** the major recovery goal of mental health consumers to live a full life in the community
- **Broad appeal** tagline that equally as appropriate for individuals with a mental illness as it is for persons who are not ill.

Premature Mortality Among Persons with SMI

- 66 Studies between 1934 – 1996
 - Many published in the late 70s and 80s
 - Why the delay in attention?
- NASMHPD study shows situation may be worsening
- Powerful representation of link between Health and Mental Health
- Excess mortality associated with co-morbid cardiac illness and depression in general population – 2 times more likely to die after two years with co-morbid depression.
- Compelling rationale for better integration between general and specialty care
- Compelling rationale that everyone is at risk for poor health outcomes with untreated mental illness
 - Further normalizes mental health conditions

Implications of the NASMHPD Study

- Omnibus Mental Health Bill written by the Campaign for Mental Health Reform – The Mental Health is Integral to Health Act of 2007
 - Common theme around which advocacy groups can coalesce – MHA and NAMI among them
 - Resonates to dire consequences of the lack of integration
 - Section 8 - Requires HHS to launch initiative to reduce premature mortality
- Featured on Cover of Appropriations Recommendations of the Mental Health Liaison Group
- Broadly Cited at American College of Mental Health Administration 2007 Santa Fe Summit on the Integration of Health and Mental Health Services
- MHA Adopted Policy Statement 58 Adopted in March 2007

Position Statement 58: Health and Wellness for People with Serious Mental Illnesses

- Mental Health America (MHA) is committed to ensuring that there is a significant reduction in the alarmingly high rates of overall health problems (morbidity) and premature death (mortality) among individuals with serious mental illnesses. For mental health consumers to have a fair chance to live healthy and long lives, MHA believes that medical practice, health policy and public dialogue must reflect the fact that overall health and mental health are intertwined.
- Adopted NASMHPD Policy Recommendations in toto

Overarching Principles

- **To prioritize the public health problem of morbidity and mortality among people with serious mental illnesses as a priority health disparities population.**
- **To track and monitor morbidity and mortality in populations served by our public mental health systems (surveillance).**
- **To implement established standards of care for prevention, screening, assessment, and treatment.**
- **To improve access and integration with general medical care services.**

NASMHPD/MHA Recommendations

1. Developed for the National, State and Local Level with specific recommendations for Providers, Purchasers, Regulators, Consumers and their Families
2. Goals – Identify persons with SMI as a high priority, health disparity population and assure adequate strategies are developed, tested and implemented to reduce pre-mature mortality and excess morbidity.
3. Integration of general and specialty care with a focus on systematic assessment and competent, integrated intervention focal strategy.

Principles

- Physical healthcare is a core service for persons with SMI
- MH systems have a primary responsibility to ensure:
 - Access to preventive healthcare
 - Management and integration of medical care

Recommendations Relevant to State Hospital Leaders

- Screen for general health with priority for high risk conditions
- Offer prevention and intervention especially for modifiable risk factors (obesity, abnormal glucose and lipid levels, high blood pressure, smoking, alcohol and drug use, etc.)
- Screen, monitor and intervene for medication risk factors related to treatment of SMI (e.g. risk of metabolic syndrome with use of second generation anti-psychotics)
- Treatment per practice guidelines: eg, heart disease, diabetes, smoking cessation, use of novel anti-psychotics

Preventive Monitoring

- Are vaccinations up to date – hepatitis, pneumovac, tetanus
- Weight, blood pressure
- Review of symptom checklists
- American Academy Family Practice Preventive Care Recommendations

ADA/APA/AACE/NAASO Consensus on Antipsychotic Drugs and Obesity and Diabetes: Monitoring Protocol*

	Start	4 wks	8 wks	12 wk	qtrly	12 mos.	5 yrs.
Personal/family Hx	X					X	
Weight (BMI)	X	X	X	X	X		
Waist circumference	X					X	
Blood pressure	X			X		X	
Fasting glucose	X			X		X	
Fasting lipid profile	X			X		X ←	X

*More frequent assessments may be warranted based on clinical status

ADA/APA/AACE/NAASO

Consensus Recommendations on Responding to Antipsychotic-associated Metabolic Changes

- If weight gain is $\geq 5\%$ of body weight, consider interventions, including switching to another second generation antipsychotic
- If glycemia or dyslipidemia worsen, consider switch to an second generation antipsychotic not associated with significant weight gain or diabetes
- Gradually discontinue/cross-titrate
- Closely monitor psychiatric symptoms during changeover

Medical Needs Have Same Priority as Mental Health Needs

- Obtaining a “medical home” – a primary care provider responsible for overall coordination
- Medication adherence – just as important for non-MH meds
- Assisting in scheduling and keeping medical care appointments

Integrate Healthcare Issues Into Facility Care Mechanisms

- Include healthcare goals on Treatment Plan
- Include healthy life style goals on Treatment Plan
- Identify your internal health care expert/champion
- Proven practice – nurse healthcare case manager

Coordinate Care

Assure that there is a specific practitioner in the MH system who is identified as the responsible party for each person's medical health care needs being addressed and who assures coordination all services.

Routine sharing of clinical information with other providers (primary and specialty healthcare providers as well as mental health providers

Provide Information to Healthcare Providers

- HIPAA permits sharing information for coordination of care
- Nationally consent not necessary
- Exceptions:
 - HIV
 - Substance abuse treatment – not abuse itself
 - Stricter local laws

Support Patient Wellness and Empowerment to Improve Mental and Physical Wellbeing

- Implement a physical health/wellness approach that is consistent with recovery principles, including supports for smoking cessation, good nutrition, physical activity and healthy weight.
- Educate patient on implications of psychotropic drugs
- Teach/support wellness self-management skills
- Teach/support decision making skills
- Use motivational interviewing techniques
- Attend to cultural and language needs

Self-Management

- Train providers and other key staff on how to help patients with self management goals
- Set and document self management goals collaboratively with patients
- Follow up and monitor self management goals
- Use group visits to support self management
- Encourage participation in community



LIMITATIONS

UNTIL YOU SPREAD YOUR WINGS,
YOU'LL HAVE NO IDEA HOW FAR YOU CAN WALK.