**Developing Our Careers, Enhancing Our Leadership Skills:**

**Primary Care, Psychiatry and Public Health Module**

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**DISCLAIMER**

- We are not reinventing the wheel
- Slides # 4 was taken from: Sorel E., Enhancing Access to Psychiatric Care: Medicine and Psychiatric Medicine Collaboration Challenges, data from the National Comorbidity Survey, presented at the 2007 APA Annual Meeting, San Diego (Note: Eliot Sorel, M.D. is one of the authors of this presentation)
- Slides # 5-8, 14-18 were taken from: National Association of State Mental Health Program Directors (NASMHPD), Medical Directors Council Morbidity and Mortality in People with Serious Mental Illness, October 2006 Report and Powerpoint available at: [https://www.nasmhpd.org/publications.cfm](https://www.nasmhpd.org/publications.cfm)
- Slides # 19 was reproduced from: Donald C. Goff, Integrating General Health Care in Private Community Psychiatry Practice, J Clin Psychiatry 2007; 68 (Suppl. 4): p. 51

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**Literature Review: Table of Contents**

- Epidemiological data
  - Disability, morbidity and mortality in serious mental illness
- Problems with access to care in the seriously mentally ill
  - Patient factors, provider factors, system factors
- Primary care and psychiatry, psychiatry and public health
  - Guidelines and recommendations
  - National, State and Local level

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**Causes of Disability: United States, Canada, and Western Europe, 2000**

- Mental Illnesses: 24.0%
- Alcohol and Drug Use Disorders: 12.0%
- Alzheimer's Disease and Dementias: 7.9%
- Musculoskeletal Diseases: 7.8%
- Respiratory Diseases: 6.0%
- Cardiovascular diseases: 5.0%
- Nervous system diseases: 4.5%
- Injuries (disabling): 4.25%
- Digestive diseases: 3.1%
- Communicable diseases: 3.0%
- Malignant neoplasms: 2.9%
- Diabetes: 2.5%
- Migraine: 2.0%
- All others: 13.0%

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**Why Should We be Concerned About Morbidity and Mortality?**

- Recent data from several states have found that people with serious mental illness served by our public mental health systems die, on average, at least 25 years earlier that the general population

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**The Problem**

- Increased morbidity and mortality largely due to preventable medical conditions:
  - Metabolic disorders, CVD, DM
  - High prevalence of modifiable risk factors (obesity, smoking)
- Some psychiatric medications contribute to risk
- Monitoring and treatment guidelines to lower risk underutilized in SMI populations
**Recent Multi-State Study Mortality Data:**

Years of Potential Life Lost

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Colton CW 2006 Apr http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm

**SMI & Reduced Use of Medical Services**

- Fewer routine preventive services (Druss 2002)
- Worse diabetes care (Desai 2002, Frayne 2006)
- Lower rates of cardiovascular procedures (Druss 2000)

**Access and Quality of Care**

- **Patient factors**, e.g.: amotivation, fearfulness, homelessness, victimization/trauma, resources, advocacy, unemployment, incarceration, social instability, IV drug use, etc.
- **Provider factors**: Comfort level/attitude of healthcare providers, coordination between mental health and general health care, stigma
- **System factors**: Funding, fragmentation

**Psychiatry and Primary Care**

- Psychiatrists are responsible for diagnosing and treating medical conditions that occur as a result of their own therapeutic actions
- Need to remain alert for medical conditions that can cause, trigger, or exacerbate psychiatric conditions and/or interfere with treatment
- Need to monitor, screen and educate for medical conditions that disproportionately affect psychiatric patients

- Psychiatrists should medically evaluate and provide basic primary medical care for seriously mentally ill pts
- Need to become advocates and facilitators for access to care of disenfranchised pts

**Psychiatry and Primary Care**

- Integration of psychiatric and primary medical care models produces better services and outcomes at comparable costs
- Videoconferencing may facilitate integration of primary and psychiatric care
Psychiatry and Public Health

- Mental health should be regarded as part of public health
- Both psychiatry and public health should be regarded as preventive medicine
- Need for long-term planning, nation-wide programs of health education

Recommendations: National and State Level

1. Seek designation of people with SMI as both an at-risk and a health disparities population.
2. Establish coordinated mental health and general health care as a healthcare priority.
3. Promote integrated mental health and physical health care for persons with SMI.
4. Education and advocacy: policy makers, funders, providers, individuals, family, community

Recommendations: Local Agency/Clinician

- 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 antipsychotics)
- Treatment per practice guidelines

Recommendations Overview

- Prioritize the Public Health Problem
  - Target Providers, Families and Clients
  - Focus on Prevention and Wellness
- Track Morbidity and Mortality in Public Mental Health Populations
- Implement Established Standards of Care
  - Prevention, Screening and Treatment
- Improve Access to and Integration of Physical Health and Mental Health Care

Recommendations: Local Agency/Clinician

- Care coordination Models: 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 of all services.
- Routine sharing of clinical information with other providers (primary and specialty healthcare providers as well as mental health providers)
Guidelines for the Integration of Medical Care and Psychiatry

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