Social considerations for transitions involving SMI

Chronic Condition Management

Presented by UIC-CON
Objectives

• Develop greater understanding of social and population variation in context of mental health
• Explore social considerations for transitions, as articulated by persons with SMI
• Gain an awareness of “community integration” as an idealized construct—the commonly understood ‘assumed definition’—that may at times be at odds with the lived experience of individuals with SMI
• Identify risks and mitigation strategies to support and manage persons with SMI and related emotional or behavioral needs
• Develop greater empathy and understanding of persons with SMI
• Develop sensitivity to the consumer experience in order to continue improving your ability to promote healthy community integration
Mental illness is a health condition marked by psychological pain and suffering

**Snapshot**

1 in 5 persons has a mental illness
- Roughly 50% do not receive treatment

**Any Mental Illness (AMI)** includes all mental illness and ranges of severity

**~vs~**

**Serious/Severe** Mental illness results in serious/severe functional impairment (excluding developmental and substance use disorders)
- Ex: Major Depressive Disorder, Schizophrenia and Bipolar Disorder
Basic terms used interchangeably, yet often incorrectly

- Chronic Mental Illness
- Serious mental illness
- Severe and persistent mental illness
- Severe mental illness

Serious Mental Illness (SMI) and Severe Persistent Mental Illness (SPMI) are distinct conditions

- All forms of SMI may be disabling, but are not always severe and persistent (that is, chronic and disabling)

The main take-away:

- “Severe” and “persistent” is chronic and disabling—meaning that symptoms are overwhelming, even with treatment
Poll Question #1

- True or False: Chronic Mental Illness (CMI), Serious Mental Illness (SMI), Severe mental illness (SMI), and Severe and persistent mental illness (SPMI) are interchangeable concepts that essentially mean the exact same thing.
Prevalence of any mental illness (AMI) in the U.S.:

- In 2016, there were an estimated 44.7 million adults aged 18 or older in the United States with AMI. This number represented 18.3% of all U.S. adults.
- The prevalence of AMI was higher among women (21.7%) than men (14.5%).
- Young adults aged 18-25 years had the highest prevalence of AMI (22.1%) compared to adults aged 26-49 years (21.1%) and aged 50 and older (14.5%).
- The prevalence of AMI was highest among the adults reporting two or more races (26.5%), followed by the American Indian/Alaska Native group (22.8%). The prevalence of AMI was lowest among the Asian group (12.1%).


Compared with those who do not have a mental health issue, people aged between 16 and 74 with a common mental health condition are more likely to:

- be women (59%)
- be between 35 and 54 years old (45% compared with 38%)
- be divorced (14% compared with 7%)
- to live alone (20% compared with 16%)
- be a one parent family (9% compared with 4%)
- not have a formal qualification (31% compared with 27%)
- be a tenant of a housing association or a local authority (26% compared with 15%)

These associations reflect the fact that mental health problems are more prevalent in socially deprived areas of the [UK].

https://www.counselling-directory.org.uk/social-influence-stats.html#socialfactorsaffectingmentalhealth
MI Prevalence (Graph)

Mental Health Treatment Received in Past Year Among U.S. Adults with Any Mental Illness (2016)

Data Courtesy of SAMHSA

In 2016, there were an estimated 10.4 million adults aged 18 or older in the United States with SMI. This number represented 4.2% of all U.S. adults.

The prevalence of SMI was higher among women (5.3%) than men (3.0%).

Young adults aged 18-25 years had the highest prevalence of SMI (5.9%) compared to adults aged 26-49 years (5.3%) and aged 50 and older (2.7%).

The prevalence of SMI was highest among the adults reporting two or more races (7.5%), followed by the American Indian/Alaska Native group (4.9%). The prevalence of SMI was lowest among the Asian group (1.6%).

Past Year Prevalence of Serious Mental Illness Among U.S. Adults (2016)

Data Courtesy of SAMHSA

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Poll Question #2

- It is estimated that roughly 1 in 5 U.S. adults has a mental illness, and close to 1 in every 20 suffers from a Serious Mental Illness.
In 2016, among the 10.4 million adults with SMI, 6.7 million (64.8%) received mental health treatment in the past year.

More women with SMI (68.8%) received mental health treatment than men with AMI (57.4%).

The percentage of young adults aged 18-25 years with AMI who received mental health treatment (51.5%) was lower than adults with AMI aged 26-49 years (66.1%) and aged 50 and older (71.5%).

SMI Treatment Statistics

Mental Health Treatment Received in Past Year Among U.S. Adults with Serious Mental Illness (2016)

Data Courtesy of SAMHSA

SAMHSA has reported >90% of U.S. adults with SMI suffering from a co-occurring disorder

…and that only 7.5% of those persons with co-occurring substance use are enrolled in a treatment program

= Significant Lack of Engagement
Causes of Mental Illness

A mix of two models:

- **Diathesis: Vulnerability**
  - Genetics/hereditary predisposition
  - Injury
  - Traumatic Event(s)

- **Stress: The body’s response to demand or threat**
  - Danger (e.g. environmental)
  - Reactions to positive events…
Excepting intellectual disabilities and substance use-based mental illness, development of a mental illness is believed to stem from a mix of multiple factors—hereditary predisposition and various sources of stress.
Four Experiences Integral to Concepts of Community

According to 30 individuals with serious mental illness treated in two public mental health Clinics:

- Receiving help,
- Minimizing risk,
- Avoiding stigma,
- Giving back

Bromley, et al. (2013).
In their words:

• **Symptoms**
  - Stress increases, even when a change in routine is thought of as a positive one
    - *ex*: a transition to the community
  - Tendency to (e.g.) isolate worsens—other symptoms worsen

• Leading to rightfully perceived lack of acceptance second to difference in presentation—this, stemming from stigma

Bromley, et al. (2013).
People are complex,…can a person exhibit:

- Empathy,
- Respect,
- Ethics,
- Non-judgmental orientation,
- Compassion,…

…yet continue with making jokes that disparage?

To do so would be incredibly confusing
In their words:

- **Stigma**
  - History of cultural derision
    - Stigmatization: The process by which a society bestows its own negative meaning on the behaviors, signs, or attributes of an individual
  - Effectively a limiting force on one’s potential to truly integrate into the larger community
    - A dent in motivation—”Why bother…?”
In their words:

“they described the need to manage community contact in order to protect themselves and others from their symptoms and from discrimination”

- Support
  - E.g. Reasonable accommodation in employment settings

“Participants looked for communities that provide reliable support”

Bromley, et al. (2013).
Juxtaposing variance in diagnostic presentations…
  • E.g. Not all depression looks the same

…with population/social variation
  • I.e. Individual and culturally-specific variations(s)

= Complexity
How Does DSM-5 Address This?

- First published on 5/18/2013
  - Arguably, largely devoid of guidance in the area of varied population/social considerations

- Also published in May of 2013
  - Independent Review Of Social And Population Variation In Mental Health Could Improve Diagnosis In DSM Revisions (journal analysis/commentary)

We have a problem…

- Psychiatric presentations *do* vary based on a person’s culture,
- BUT there is also a lack of quality cross-cultural and cross-national research that would be needed to thoroughly identify such variations

So, how do we address this problem at present, in the field?

- Let’s not reinvent the wheel…

True or False: We can be sure that two different persons who share an ethnic background will express symptoms of a like SMI diagnosis in much the same way.
Client consultation: Building a Cultural Formulation

- We don’t rely on generalizations and stereotypes
  - These reflect a lack of effort in assessing the individual
    *Instead,...*
- Outline for developing a cultural formulation:
  - Cultural identity of the individual
  - Cultural conceptualizations of distress
  - Psychosocial stressors and cultural features of vulnerability and resilience
  - Cultural features of the relationship (individual-to-clinician)
  - And an overall cultural assessment, or summary

(American Psychiatric Association, 2013)
Outline for developing a cultural formulation:

- **Cultural identity of the individual**
  - Racial, ethnic, or cultural reference group(s)—whatever may influence their relationships with others, with access to resources, with conflict, (etc).
  - For minorities and/or immigrants, it must be considered the comparative influences of origin vs host cultures.
  - Language abilities, patterns of use and preferences are useful for identifying difficulties
- **Consider gender identity as a factor, here**

http://transhealth.ucsf.edu/trans?page=guidelines-mental-health
Outline for developing a cultural formulation:

- Cultural conceptualizations of distress
  - Describe cultural constructs that influence how a person experiences, understands, and communicates symptoms and problems.
  - Cultural syndromes, idioms of distress, and explanatory models of perceived causes.
  - Severity and meaning attributed to distressing episode(s)/experience(s) are assessed relative to cultural reference group(s).
  - Assessment of coping and help-seeking behaviors.
  - Assess for use of “Western” vs traditional medicines, alternative and complimentary interventions.
• Outline for developing a cultural formulation:
  • Psychosocial stressors and cultural features of vulnerability and resilience
    • Identify key stressors and supports in the individual’s social environment
      • E.g. Sources: religion, family, other social networks
  • Why is this so important?
    • Both stressors and supports vary greatly, according to cultural interpretation of events, family structure, and social context
Outline for developing a cultural formulation:

- Cultural features of the relationship (individual-to-clinician)
  - Identify differences in culture, language and social status between an individual and clinician—particularly those which may interfere with communication or influence diagnosis and course of treatment.
  - E.g. Consider the challenge of establishing trust, in either direction, when one party has a history of experiencing racism/discrimination, or another form of derision.
Outline for developing a cultural formulation:

- And last, an overall cultural assessment, or summary
  - Summarize what the points identified throughout assessment mean for the person’s individualized course of management and/or treatment.
  - This is an opportunity to put forth what types of interventions or approaches to providing care might work better for an individual, and to explain why.
In DSM-5, there exists a field-tested interview …it systematically assesses all of the features we just reviewed:

- 16 questions
- Generally should be incorporated into a mental health assessment
- Simplifies the process of collecting information
- Find it, here: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_Cultural-Formulation-Interview.pdf
Shifting Our Attention

- How do we promote social and community Integration?

- Should we rethink our approach?
…in the research, Community Integration is…

- Sometimes “described as an avenue that moves people away from illness”
- It is defined “in contrast to the illness experience.”

…But,

- It can often be experienced as “immersion in worlds created by and managed by mental health professionals”

Bromley, et al. (2013).
Social Considerations: Rehabilitation vs Habilitation

A key consideration:

Rehabilitation:
- Regaining lost skills or functioning

Habilitation:
- Services for those who may not have ever developed the skill (e.g. cooking, budgeting)
The Trouble in Exploring Social and Community Integration

- …for Transitions Involving Persons with SMI
  - A more communal life can be challenging, …
  - Although social contact can provide support, it is not all healthy in nature…

- How do we tend to address these issues?

Bromley, et al. (2013).
This does not mean we want to stop providing our full range of services…

*Psychosocial Rehabilitation works*

The question may be one of, ‘how to offer a more balanced/therapeutic approach to integration?’

Bromley, et al. (2013).
Let’s take the example of smoking…*the number one cause of preventable disease and death*

- The tobacco industry has a history of targeting populations, including those with SMI, with the goal of increasing usage and loyalty
  - …Resulting in persons with SMI being 70% more likely to smoke than persons who do not have mental illness
  - Thirty-one percent of all cigarettes are smoked by adults with mental illness
- **We need to counter myths within our professional culture**
  - Evidence shows cessation strategies work
  - Studies show that quitting smoking does not worsen psychiatric symptoms
  - Consider teaching aimed at conveying the history of targeted marketing
True or False: Habits, like smoking, can be social in nature and should not be considered a pressing issue for those with SMI, particularly against the backdrop of all their other, very serious concerns.
WHAT HAPPENS WHEN A SMOKER QUITS
A 15 YEAR TIMELINE

20 MINUTES after quitting
The heart rate and blood pressure drop back to normal levels.

2 WEEKS after quitting
Circulation and lung function improve.

1 YEAR after quitting
The risk of getting coronary heart disease is half as high as a smoker’s.

10 YEARS after quitting
The risk of dying from lung cancer is half that of smokers’. Risk of getting pancreatic and larynx cancer also decreases.

12 HOURS after quitting
The level of carbon monoxide in the blood drops to normal.

1-9 WEEKS after quitting
Smoker “norms” (like a constant cough and shortness of breath) become less pronounced. The tiny hairs lining the lungs (aka “cilia”) work normally again and clean the lungs to reduce risk of infection.

5 YEARS after quitting
The risk of contracting mouth, throat, esophagus, and bladder cancers is half of what it is for smokers. Risk of cervical cancer and stroke fall, too.

15 YEARS after quitting
The risk of heart disease is equivalent to non-smokers’ risk.
In summary, we should:

- Check ourselves
  - End our participation in inappropriate joke/talk scenarios and interfere in such episodes when at all possible—do not reinforce stigma
- Conduct a cultural assessment and developing a formulation
  - Review the client’s care plan and refine, as indicated
- Listen to our clients and their impressions of different interventions
  - Consider where *they* are at(?), and how to offer a more balanced, therapeutic, individuated plan
    - Keep in mind, rehabilitation vs habilitation
- NOT avoid addressing unhealthy habits, and continue teaching
  - Compassionate, knowledgeable care coordinators can improve the likelihood that persons diagnosed with SMI (or any mental illness) will obtain the appropriate information to make lifestyle choices and changes that may improve/decrease their own health risks
Questions
Resources


