Integrating Health & Mental Health Services

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Think green.
Keep it on the screen.

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Overall Public Health Context

- Several health conditions differentially affect physical health of people in recovery
- Most are basic health risks related to all, including general population
- Others are related to aspects of mental health treatment itself, as well as lifestyle factors relevant to consumers
- Majority of conditions where disparities emerge are preventable illnesses
- Increased awareness of impact of depression & schizophrenia on physical health, emergence of other subgroup issues

Accessibility to Healthcare Coverage

- Primarily driven by employment status
- Correlate with educational achievement
- Opportunities to receive benefits affected by shrinking public funds and other economic factors
- Balancing expenditures on mental health treatment needs with physical health wellness

Co-factors for Health Disparities

- Few genetic disparities
- Majority are related to environmental factors: socio-political factors, institutional “isms”
- Provider attitudes and behaviors toward people in recovery, health protective behaviors, physical health needs
- Substance use is ~twice rate for those with mental disorders
- Some studies have documented co-morbid AOD use rates as high as 65%

Co-factors for Health Disparities

- Consumers have specific somatic health needs, based on:
  - primary diagnosis
  - medication regimen structure
  - co-morbidities
- Research also demonstrates continued disparities in quality of care when comparing race/ethnicity, gender, and SES

Race/Ethnicity, Gender

- Diverse groups have less access to, and availability of, evidence-based MH services
- Minorities are less likely to receive needed MH services
- Treatment is often of poorer quality
- Minorities are vastly underrepresented in MH research

Illness & Services Impact

- In non-White ethnic groups, women are more likely to receive pharmacological interventions (medication-driven)
- Non-White ethnic groups have lowest rate of return visits
- African Americans are more likely to be diagnosed with schizophrenia than Whites
- American Indians, Alaska Natives appear to suffer disproportionately from depression and substance abuse (most common MH disorders)

Convergence of Factors:
Empirical Example from the WIHS

National Multisite Study: HIV+ women

Even when MEDICALLY INDICATED by CD4 and vRNA indicators, *those still NOT prescribed HAART were*:

- African American
- Less then High School Education
- Lower SES (poverty or 200% below poverty)
- Past/Current Treatment for Depression

Cook et al. (2004)

Knowledge Base

Evidence-based epidemiology & surveillance

- Institute of Medicine
- Surgeon General's Mental Health Report (1999) & Supplement on Race/Ethnicity (2003)
- Centers for Disease Control & Prevention
- National Institutes of Health
- Department of Health & Human Services
- U.S. Census
- Medicaid claims data
- Medical Needs Among Consumers in CMHCs
- Morbidity & mortality patterns among consumers

Research Knowledge Base

- Dixon, Postrado, Delahanty et al. (1999)
- Dixon, Goldbert, Lehman, et al. (2001)
- Dickey, Normand, Weiss et al. (2002)
- Dickerson, McNary, Brown et al. (2003)
- Sokal, Messias, Dickerson et al. (2004)
- Razzano & Hamilton (2005)

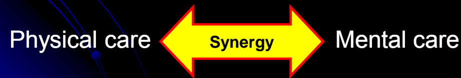
Focal Areas of Health Vulnerability for People in Recovery

- **Infectious diseases**
  - **HIV – rates are 8-70 times that of general population**
  - All other STDs
  - Hepatitis B & C
  - TB
- Diabetes
- Cardiovascular diseases & effects
- Decreased liver function (non-hepatitis)
- Decreased renal function
- Multiple physical co-morbidities
- Others?

Co-morbidities lead to:

- Negative perceptions of physical health status regardless of impairment/disability
- Increased severity of psychosis and depressive symptoms
- Increased suicidality, suicide attempts

The majority of consumers reported at least one medical problem, most report 2 or more.

Physical care  Mental care

Health Care Access & Barriers

In the last year, people in recovery report:

- visiting a general medical doctor ~2x
- having a complete physical examination ~2x
- have receive routine dental care ~0.5x
- perceived barriers to receiving medical care >3x

Dickerson, McNary, Brown, et al.

Influence of Substance Use

Those with psychiatric *and* substance use disorders had the highest risk for 5 of 8 impairments measured:

- **heart disease**
- **asthma**
- **gastrointestinal disorders**
- **skin infections**
- **acute respiratory disorders**

Recommendations:

- **AOD disorder are risk factors and requires early detection**
- **EBP: integrate medical and mental health care**
- **Develop specialized disease self-management techniques.**

Dickey, Normand, Weiss et al.

Adapting & Expanding Services

- Address knowledge and health behaviors
- Ground activities in theory → Health Beliefs Model (HBM)
- Innovative programs with specific adaptations for people in recovery → tailor information to be relevant for people in recovery, those with HIV/AIDS, other subgroups

Adapting & Expanding Services

- Early detection → regular screenings for health risks, medical tests as follow up as indicated
- Build upon community programs → reduces stigma, normative in focus, adaptation of existing prevention & education resources
- Integrate & maintain services within existing programs → continue to address consumrs' needs, incorporate developmental components

Health Beliefs Model

Five Major Areas:

1. perceived *susceptibility*
2. perceived *severity*
3. perceived *benefits of taking action*
4. perceived *barriers to taking action*
5. identification of *cues to action*
   - Impact of *self-efficacy* → confidence in the ability to successfully perform an action
   - Included by Rosenstock, others (1988) to better fit the challenges habitual unhealthy behaviors, such as being sedentary, smoking, or overeating

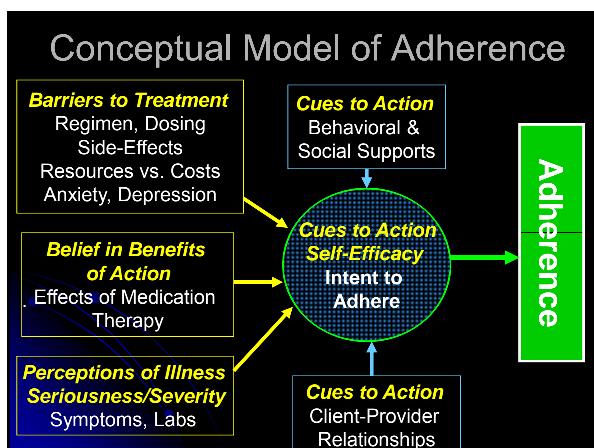
General HBM Application

Concept	Definition	Application
Perceived Susceptibility	One's opinion of chances of getting a condition	Define population(s) @ risk, risk levels; personalize risk based on a features/behaviors; heighten perceived susceptibility if too low
Perceived Severity	One's opinion of how serious is a condition, its consequences	Specify consequences of the risk and the condition itself
Perceived Benefits	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take; how, where, when; clarify the positive effects to be expected.
Perceived Barriers	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce barriers through reassurance, incentives, assistance.
Cues to Action	Strategies to activate "readiness"	Provide how-to information, promote awareness, reminders.
Self-Efficacy	Confidence in one's ability to take action	Provide training, guidance in performing action.

Building A Model Program

- Fundamental understanding of perceived susceptibility, seriousness, & benefits for action
- Must translate this into information that can be understood & used by consumers
- Must identify personal barriers, systemic barriers
- Identify consumers' strengths & weaknesses – core principle of PSR adapted here
- NORMALIZE health promotion – coordinate with community programs

Conceptual Model of Adherence



Model Program Developed @ UIC

Medication Adherence Program Services 1 & 2

- Coordinating activities in concert with existing treatment, known risks for those with mental health issues
- Selected strategies & activities with greatest relevance to people in recovery
- Tailoring existing information to extend to unique risks for consumers
- Multiple activities to ensure diversity, gender-related concerns are addressed

Using HBM: Integrated HIV Adherence & MH

Concept	Application	Tailoring Activities
Perceived Susceptibility	Define population(s) @ risk, risk levels; personalize risk based on a features & behaviors; heighten perceived susceptibility if too low	Increase overall knowledge of *disease progression* risks; 2º illness risks; psychotropic med interactions; metabolic issues
Perceived Severity	Specify consequences of the risk and the condition itself	Initial symptoms & limitations; long course of illness, complications of poor treatment
Perceived Benefits	Define action to take; how, where, when; clarify the positive effects to be expected	Increase immune function; when to initiate use of medications for HIV/AIDS
Perceived Barriers	Identify and reduce barriers through reassurance, incentives, assistance	Reducing medication interactions; identifying early symptoms, side effects
Cues to Action	Provide how-to information, promote awareness, reminders	CD4, vRNA monitoring; conversations with multiple treating docs
Self-Efficacy	Provide training, guidance in performing action	Development of regimen dosing plans; health testing routines

MAPS Intervention

- **One-to-one meetings** - Weekly individual meetings with medication specialists (M-Ss) over three months, for a total of 12 meetings.
- Individual Medication Adherence Plans (I-MAPs) - Participants' medication regimens are reviewed and Individual Medication Adherence Plans (I-MAPs) are completed
  - I-MAP outlines all medications prescribed, their purposes, dosage schedule, potential side-effects, strategies to address side-effects, and reminders the participant utilizes (or could) to promote adherence.
  - Participants receive a copy of their I-MAP; serves as a guide/reference for participant and the M-Ss, ensuring that changes to the regimen or other relevant issues can be fully documented.
- Personalized Medication Education - All participants receive personalized medication education tailored to address the unique features of their individual medication regimens.

- Session #1: MAPS-2 Overview & Introduction
  Discuss meeting format, determine scheduling preferences; confirm contact information; begin discussing strengths & barriers to adherence;
  Materials Needed
- Understanding My Medications" module handout "*A Look at Common HIV Treatment Terms*"

- Session #2: Introduction of MAPS-2 Intervention materials; completion of Individual Medication Adherence Plan (I-MAP); ask 3 anchor questions and discuss;
  Materials Needed
- **I-MAP**
- **Handout** *"A Look at the Solutions of Medication Management"* – discuss which strategies might be useful
- **I-MAP Daily Schedule tools** – begin working on these

3 Anchor Questions

- **Questions that anchor every session.**

1. Have you missed any doses?
2. Have you had any doctor's appointments since I last saw you? How did it go? What happened?
3. When is your next doctor's appointment?

- Session #3: Return personalized I-MAP; ask 3 anchor questions; watch DVD and discuss with participant

Materials Needed

- **Personalized and completed I-MAP**
- **DVD of HIV Treatment Issues**

- Session #4: Ask 3 anchor questions; continue discussion of strengths & barriers to adherence; use of I-MAP, I-MAP Daily Schedule,

Materials Needed

- "Understanding My Medications" Module handout *"A Look at HIV Resistance to Medication"*
- **Handout** *"A Look at Using Multiple Medications to Fight HIV/AIDS"*

- Session #5: Ask 3 anchor questions; continue discussion of strengths & barriers to adherence;

Materials Needed

- **"Understanding My Adherence Decisions"** - discuss
- **"A Look at Side Effects"** - review with participant
- **Biological marker & blood test materials/charts –**introduce them to participant and help begin to fill them out

- Session #6: Ask 3 anchor questions; continue work with biological marker and blood test materials and charts; continue discussion of strengths & barriers to adherence; identify & address participants' unmet needs, identification of potential/untapped resources; identify referral needs; discuss support system

Materials Needed

- **Biological marker and blood test materials/charts**

- Session #7: Ask 3 anchor questions; continue discussion of strengths & barriers to adherence; discuss strategies to raise health questions & concerns with physicians & other treatment providers;

Materials Needed

- Handout from module "Building and Maintaining My Good Health", *"A Look at How to Develop a Good Working Relationship with your Provider"*

- Session #8: Ask 3 anchor questions; continue discussion of strengths & barriers to adherence; address ways to improve health over the long-term

Materials Needed

- "Building and Maintaining My Good Health" module, review **handouts on eating, drinking liquids, and exercise,**

- Session #9: Ask 3 anchor questions; continue discussion of strengths & barriers to adherence;

Materials Needed

- "Building and Maintaining My Good Health" module, review handouts on **sleep, bad habits, stress and alternative therapies**; Refresher review of **"Understanding My Medications"**

- Session #10: Ask 3 anchor questions; continue discussion of strengths & barriers to adherence;
- Begin action planning for end of MAPS-2 meetings; discuss potential resources & referrals for support after MAPS-2 sessions are completed

- Session #11: Ask 3 anchor questions; continue discussion of strengths & barriers to adherence;
- Continue action planning for end of MAPS-2 meetings; provide web resources & additional information to support ongoing adherence

- Session #12: Final session
- Closure/termination between medication specialist & participant
- Reminder that evaluation staff will be conducting interview;

Findings from MAPS-1

- Sample published in literature; no major issues or unexpected findings
- Results examine baseline (T1) and 6-month follow up (T2) data
- Intervention group (MAPS) demonstrated stronger improvement in adherence in contrast to comparison group (CG), $p < .02$.
- Impact: Missed dosages decreased by 59% among MAPS participants vs. 26% among CG participants.

MAPS-1 Findings

- The MAPS participants also reported significant improvements related to impairment from HIV/AIDS symptoms compared to the CG, $p < .01$
- Impact: reported impairment related to HIV/AIDS symptoms decreased by as much as 50% for MAPS compared to 28% in CG.

MAPS-1 Findings

- Analysis of indicators for alcohol and recreational drug use revealed significant reductions in use of all substances by condition, $p < .03$
- Impact: on average, MAPS participants demonstrated a 70% decrease in use of alcohol and other drugs compared to a 36% decrease in the CG.

MAPS-1 Findings

- Perceptions of health and well-being (MOS-HIV) also revealed significant differences in average change for 3 subscales:
  - physical functioning, $p < .04$
  - social functioning, $p < .03$; and
  - health distress, $p < .03$.
- Impact: in each case, MAPS participants demonstrated significantly more positive health perceptions than those in CG.

Improving Comprehensive & Recovery-Focused Health Care

- Increase public awareness of effective treatments
- Overall quality of life improves tremendously when a co-occurring physical illnesses are diagnosed early, treated appropriately
- Parity in service provision
- Ground services & interventions in theory
- Promote harm reduction
- Community-based approaches
- Culturally competent physicians
- Reduce financial barriers to treatment
- Tailor treatments to age, gender, race & culture

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