Beyond Depression – Serious Mental Illness and Diabetes: Role of the Educator

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Embrace Change, Strengthen Our Future, Celebrate!

AADE American Association of Diabetes Educators

Outline

1. Serious Mental Illness (SMI)
   Schizophrenia, Bipolar Disorder, OCD, Major Depressive Disorder, Personality Disorders
2. Types of SMI
3. Treatment of SMI
4. Role of diabetes educator
5. Resources

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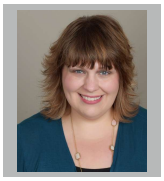

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- "Diabetes is a disease which often shows itself in families in which insanity prevails" -Sir Henry Maudsley (1879)
- in 17th century Thomas Willis speculated that diabetes was caused by "*long sorrow and other depressions*."
- Insulin coma therapy was used as a psychiatric treatment within a decade of isolation of insulin
- "…there can be no health without mental health", (Prince et al, 2007, The Lancet)

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What is Serious Mental Illness (SMI)?

(NIMH, 2016)

- A mental, behavioral, or emotional disorder (excluding developmental and substance use disorders)
- Meets DSM-5 criteria
- Resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities

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Prevalence of SMI (NIMH, 2016)

- In 2014, 18% of US adults were diagnosed with ANY mental illness
- 4.2% of those were diagnosed with SMI
- Difference is degree of impairment

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Bipolar Disorder

- Manic or hypomanic criteria to include euphoria, reckless behavior, increased self-esteem, lack of need for sleep, rapid speech, flight of ideas
- Must occur for AT LEAST 4 DAYS
- Not simply angry one minute, then depressed the next

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Diabetes & SMI

- 2-3x higher rates of T2D in those with SMI
- But why…
- Weight gain associated with anti-psychotics and mood stabilizers
- Typical lifestyle risks
- Lower rates of monitoring by PCP's due to lack of pt participation in routine appts

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Obsessive Compulsive Disorder

- Engaging in repetitive thoughts or compulsive behaviors that prevents the fulfillment of obligations
  - Monitoring the CGM, micro-managing blood sugars with insulin, determining precise carb counts
- Very common in those with T1D & Eating Disorders!!

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Schizophrenia (DSM-5)

- Delusions
- Hallucinations
- Disorganized Speech
- Disorganized or catatonic behavior
- Negative symptoms

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Personality Disorders

- 4 components
  - Perception of self and of others
  - Appropriateness of emotional reaction
  - Interpersonal functioning
  - Impulse Control

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Personality Disorders

- Cluster A – detachment from relationships, interpersonal deficits
- Cluster B – disregard for others, unstable/intense relationships, emotional lability, grandiosity
- Cluster C – feelings of inadequacy, need to be taken care, preoccupation with order

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Psychotropic Medications

- Sleeping aides
  - Zolpidem, temazepam, eszopiclone
- Anxiety Medication
  - Alprazolam, clonazepam, lorazepam, diazepam, gabapentin (off-label)

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Major Depressive Disorder

- vs diabetes distress/burnout
- Must last at least 2 weeks and include sadness or loss of pleasure
- Cannot be a typical reaction to stress

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But Why? (ADA, 2004)

- Drug-induced insulin resistance due to weight gain or body fat distribution
- Effect on insulin-sensitive tissue
- Changes in fasting or postprandial insulin levels
- Changes in hypothalamic regulation of serum glucose levels
- Blocking of histaminergic receptors
- Does not appear to affect beta-cell function

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Psychotropic Meds, Weight Gain, & Impaired Glycemic Control (Balhara, 2011)

Class	High	Intermediate	Low
Antidepressants	Amitriptyline, mirtazapine	Paroxetine*, sertraline, fluoxetine*, citalopram	bupropion
Antipsychotics	Clozapine, olanzapine	Risperidone, quetiapine	
Mood Stabilizers	Lithium, divalproex sodium	Carbamazepine	topiramate

* High risk for impaired glycemic control

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Co-morbid DM & SMI

- Taking psych meds PRN vs scheduled or vice versa
- "over-medicated" – "zombie" like
- Mental health often trumps diabetes management
- If substance abuse is added, challenges are compounded
- Similar physical reactions

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Interaction Between DM & Psychiatric Disorders (Balhara, 2011)

- Present as co-occurring independent conditions
- Diabetes as a risk factor for psychiatric disorder development
- Overlapping clinical presentation
- Interaction of medications
- Poor treatment adherence

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Important Roles for DM Educators (Kent et al., 2010)

- recognize that the PWD need to be involved in creating the treatment plan
- reinforce positive behaviors and avoid focus on the negative
- recognize and reinforce the small goals undertaken by the person with diabetes.

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Which is the Priority, DM or SMI? (Rubin & Peyrot, 2001)

- In a psychiatric crisis, this should be #1
- If there is no dx of a SMI, but tensions are high, there must be a balance
- Diabetes-specific stress can be easier to problem solve

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Important Roles for DM Educators

- See yourself as in integral part of the treatment team
- Develop rapport
- Engage in active listening
- Use non-judging tone and be aware of body language, including non-intentional
- 1st visit is extremely important for this population

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Non-Medication Levels of Treatment

- Outpatient
- Intensive out-patient (IOP)
- Partial hospitalization program (PHP)
- In-patient programs
- Residential treatment
- Condition specific facilities

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Reasoning for Not Seeking Treatment (Kessler et al., 2001)

- Wanted to solve problems on own (72%)
- Thought problem would get better by itself (61%)
- Too expensive (44%)
- Unsure about where to go for help (41%)
- Help probably would not help (38%)

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Barriers for HCP's to Treat Psychiatric Disorders

- Top 3 (Beverly et al., 2011)
  1. Time Constraints
  2. Perceived lack of expertise
  3. Limited treatment options
- Brief interventions done by HCP's should NOT replaced mental health referrals

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Community Based Resources

- Crisis Centers/Mobile Units
- Case Management Services
- Faith Based
- Local substance abuse treatment programs
- Outpatient mental health professionals – ideally who are knowledgeable about DM
  - State association for psychologists or counselors
  - Consult hospital based social worker
  - Certified eating disorders specialist (www.iaedp.org)

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When to Refer to Mental Health

- Possibility of self harm or harm to others (SI/HI)
- Disregard to diabetes self-management
- Stress affecting work-life-health balance
- Severe mental illness
- Signs of an eating disorder
- Better to refer early than wait for a problem

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Examples of Health Coping (Kent et al., 2010)

- Fulfilling health care obligations (keeps appointments, takes medication)
- Expressing emotions
- Seeking help; looking for answers
- Demonstrating basic problem-solving skills
- Incorporating physical activity into one's life
- Being proactive
- Demonstrating self-efficacy
- Overcoming barriers
- Having an adaptive coping style
- Being motivated
- Being optimistic

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National Mental Health Resources

- Agency for Healthcare Research and Quality
- American Association of Suicidology
- American Psychiatric Nurses Association
- *Anxiety Disorders Association of America
- CDC
- *Salvation Army
- *Depressive and Bipolar Support Alliance
- Institute of Medicine
- *Mental Health America
- Mental Health Liaison Group
- National Association for Rural Mental Health
- National Association of Anorexia Nervosa and Associated Disorders
- National Association of County Behavioral Health and Developmental Disability Directors
- National Association of State Mental Health Program Directors
- *1-800-SUICIDE
- National Council for Community Behavioral Healthcare
- *American Counseling Association
- *National Institute of Mental Health
- The National Institute of Alcoholism and Alcohol Abuse
- National Institute on Drug Abuse
- * American Psychological Association
- *SAMHSA
- *Catholic Charities

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Ultimately….

- Regardless of population, identify specific personal problems in living with diabetes and develop effective ways to deal with these problems

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