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Piloting Integrated Illness Management and Recovery with Assertive Community Treatment Teams: Targeting Physical Health in Persons with Serious Mental Illness

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A number of recent studies have shown that individuals with serious mental illness (SMI) die on average 20 to 25 years earlier than the general population. This outcome is largely due to poor access to health care and compounded by the use of medications that often contribute to increased health risks among individuals with SMI (De Hert et al., 2011; Parks, Svendsen, Singer, Foti, & Mauer, 2006; Trangle, Mager, Goering, & Christensen, 2010). The Minnesota 10 by 10 initiative, led by the Minnesota Department of Human Services, has set a goal to increase the life expectancy of individuals with SMI by 10 years, in 10 years from its commencement in 2011 (Minnesota Department of Human Services, 2011). This initiative targets key physical health needs of this population, including: Body Mass Index (BMI), alcohol and tobacco use, blood pressure, LDL cholesterol, and blood sugar (Trangle et al., 2010). The first step to improving physical health needs has traditionally been to increase awareness, an initial key strategy of this initiative. Practitioners can partner with their clients to improve a person's health and wellbeing using an integrated approach.

As part of the Minnesota 10 by 10 initiative, resources were developed to create opportunities for increasing discussion surrounding physical health screenings between health care providers, practitioners, clients, and their family members (Minnesota Department of Human Services, 2011). The next phase in the initiative was to explore effective interventions that could improve collaboration between mental and physical health care providers, as well as client outcomes in physical health. In June 2014, the Minnesota Center for Chemical and Mental Health (MNCAMH) piloted an integrated intervention- Integrated Illness Management and Recovery (I-IMR) for six months- using Assertive Community Treatment (ACT) teams across Minnesota. The ACT model is a multidisciplinary, team-based approach for providing intensive community-based services to persons with complex and severe mental illness (Allness & Knoedler, 2003). MNCAMH trained 10 ACT teams across Minnesota in the I-IMR model to examine the feasibility of an individualized intervention to address both mental and physical health needs.

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Integrated Illness Management and Recovery (I-IMR)

I-IMR is a recovery-oriented, illness self-management intervention that is aimed at improving the self-management of both psychiatric and general medical conditions (Mueser et al., 2012). I-IMR was adapted from the Illness Management and Recovery (IMR) model, one of Substance Abuse and Mental Health Services Administration's (SAMHSA) evidenced-based practices for people with SMI (Mueser, Bartels, Santos, Pratt, & Riera, 2012; SAMHSA, 2009). Just as in standard IMR, I-IMR facilitates the learning and use of illness self-management strategies that help people make progress towards personally meaningful goals. Each session includes strategies for clients to learn information, practice skills and develop hope in a better future. In I-IMR, clients review and discuss topics over 10 modules focused on improving both mental illness and physical health, which include relapse prevention planning, coping skills training, illness education, and promoting a healthy lifestyle. Practitioners can be flexible in tailoring I-IMR materials to suit the client and utilize strategies based on an individual's goals and needs.

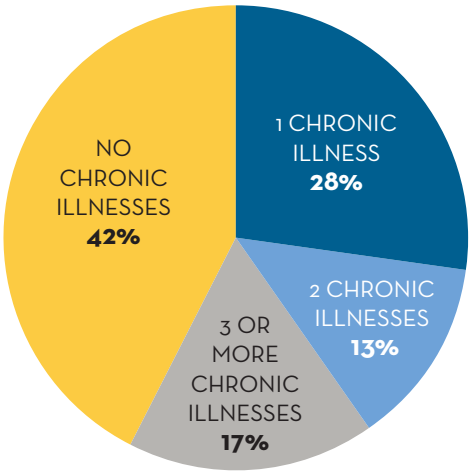
The ACT Pilot I-IMR Intervention

This pilot included 42 mental health practitioners and 153 clients who were receiving care from 10 participating ACT teams in Minnesota. Practitioners implemented the I-IMR intervention over a six-month period with evaluations conducted at the beginning and six months following the intervention. Of those enrolled, 61% of clients had a mental health schizophrenia spectrum diagnosis, 25% had a diagnosis of Bipolar Disorder, and 18% had a diagnosis of Major Depressive Disorder. More than half of the ACT clients (58%) had a diagnosis of one or more chronic physical illnesses as described in Figure 1. In a study of Medicaid recipients with SMI, 75% had at least 1 documented chronic health condition and 50% had 2 or more chronic health conditions (Jones et al., 2004). These rates are higher than those found in our study and this is likely the result of underreporting or identification of physical health conditions among the study participants. Physical health diagnoses were collected through a combination of client self-report, practitioner report, and Minnesota Department of Human Services data. This is an area in need of further exploration, as it may hold crucial information regarding the health care disparities faced by this population.

The top five most frequent physical health conditions in this study sample were: diabetes, hyperlipidemia, hypertension, respiratory disorders, and obesity (Table 1). These are conditions, if not identified and treated appropriately, place an individual at a 2 to 3 times increased risk level for developing cardiovascular disease which is the leading cause of death among individuals with SMI (De Hert et al., 2009; De Hert et al., 2011). Clients and professionals can work together to intervene and change the course of these health conditions, reducing the chance of cardiovascular disease and long-term health problems.

FIGURE 1

REPORTED PERCENTAGE OF CLIENTS WITH CHRONIC PHYSICAL ILLNESSES



Out of the total study sample of 153 clients, this figure shows the reported percentage of clients diagnosed with 0 (n=65), 1 (n=42), 2 (n=20) and 3 or more (n=26) chronic illnesses.

TABLE 1 *N = 153*

CLIENT PHYSICAL HEALTH DIAGNOSES

	Frequency	%
Diabetes	38	24.8%
Hyperlipidemia	29	19.0%
Hypertension	23	15.0%
Respiratory Disorders	22	14.4%
Obesity	19	12.4%
Thyroid Disorders	17	11.1%
Arthritis	7	4.6%
Other	119	_

Physical Health Diagnoses Note: Percentage of total sample is not included for the "other" category because some clients reported multiple physical health diagnoses fitting into this category.

Setting Physical Health Goals

One of the most valuable aspects of I-IMR is the opportunity for practitioners and clients to keep physical health issues on the table by weaving physical health topics throughout the modules. The I-IMR intervention includes one module titled the Brain Body Connection, which walks clients through the process of examining the connections between genetic and environmental vulnerabilities. Additionally, the module identifies interactions between stress and physical health and mental health, where reducing stress is an important target to also improve mental and physical health (Pratt, Santos, Mueser, Bartels, & Meyer, 2012). Another module entitled Healthy Lifestyles, takes a more in-depth look at the effects of healthy eating, exercise, and cutting down or stopping smoking, where once again a person can develop strategies to address the connection between mental and physical health.

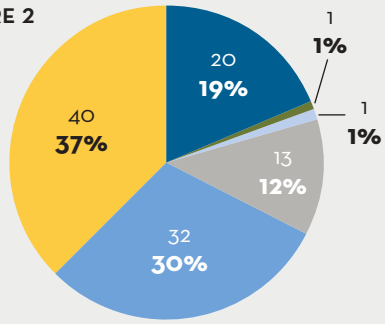
Setting goals is at the heart of the recovery process in I-IMR. At the beginning of the intervention clients collaborate with practitioners in identifying a long-term goal. The long term goal then gets broken down into short-term goals each with steps that are individualized and achievable. Through this process, clients are able to make incremental progress towards their hopes and dreams which may have seemed otherwise unattainable. As shown in Table 2, the examples illustrate how a goal can be broken down into smaller steps, making them more manageable and increasing their likelihood of success. In the ACT pilot I-IMR intervention, clients who completed their physical health goals also had an increased sense of self-efficacy in managing their chronic health conditions.

In I-IMR clients check in with a practitioner using weekly Goal Tracking Logs to set and monitor the progress of their goals. In the ACT I-IMR intervention, more than 80% of clients who completed a Goal Tracking Log identified a physical health goal in at least one area of their log. A total of 67% of clients in the study included physical health goals in 2 or more areas. Figure 2 details where on the Goal Tracking Log clients identified physical health goals (n=107).

TABLE 2

LONG TERM GOAL: Manage COPD so I can participate in games and physical activities with friends	
SHORT TERM GOAL: Walk around the block in my neighborhood and cut back to 4 cigarettes/day	**SHORT TERM GOAL:** Talk to my doctor about improving my physical activity
Short term goal steps: 1. Replace one cigarette with one glass of water each day 2. Walk to the end of my street each morning with my neighbor to help with my low energy 3. Make a list of other things I want buy instead of cigarettes	**Short term goal steps:** 1. Schedule an initial appointment at clinic 2. Make a list of my goals and challenges about physical activity to discuss with my doctor 3. Discuss with my doctor options for nicotine gum and patches
LONG TERM GOAL: Lose weight to improve my health so I can make sure I am around for my niece as she gets older	
SHORT TERM GOAL: Learn how to cook	**SHORT TERM GOAL:** Go to gym and bike
Short term goal steps: 1. Call to schedule appointment with dietician this week 2. Explore healthy food ideas and recipes 3. Identify a new recipe and develop a grocery list and list of cooking tools	**Short term goal steps:** 1. Look over bus schedule and identify which bus to take to the gym 2. Set alarm as a reminder to go to gym every Tuesday at 2pm 3. Use relaxation strategy to decrease activity before riding bike for 10 minutes 1x/week at the gym

FIGURE 2



INCLUSION OF PHYSICAL HEALTH GOALS IN GOAL TRACKING LOGS

Participants in ACT I-IMR who included physical health goals in their long-term goals, short-term goals, short-term goal steps and in two areas (i.e., long-term and short-term goals or long-term goals and steps of a short-term goal, etc.) and three or more of these areas (long-term and short-term goals and steps of short-term goals).

NONE LTG STG STG-STEPS 2 AREAS 3+ AREAS

Continued

Conclusion

Changing physical health outcomes for persons with SMI begins by addressing health care disparities. Practitioners can support client health and wellbeing and address the common barriers by using flexible and innovative techniques. In I-IMR clients and practitioners are encouraged keep physical health concerns on the table by considering the relationships between physical and mental health issues and by tailoring skills and strategies in each module. Clients collaborate with practitioners to develop personally meaningful goals, which can include improvements in physical health.

More than half of the clients enrolled in the ACT I-IMR intervention had at least one chronic physical health condition. Because the comorbidity observed in this sample is comparatively low, this study highlights the need for increased attention to identification and diagnosis of chronic illnesses and confirms the need to integrate the Minnesota 10 by 10 Initiative into all services for individuals with SMI. The most frequent chronic physical health conditions in our study sample suggest that people could be at a significantly higher risk of cardiovascular disease. By utilizing interventions such as I-IMR, and addressing the increased high-risk of chronic physical health conditions, practitioners have the opportunity to support persons with SMI as they cultivate longer, healthier lives.

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