Premature Death and Co-morbidity of People living with Serious Mental Illness (SMI) i.e. Schizophrenia, Psychosis, Bipolar Depression and Anxiety

✓ At increased risk of poor physical health, and their life-expectancy is reduced by an average of 15–20 years mainly due to preventable physical illness.
✓ Double the risk of obesity and diabetes.
✓ 3 times the risk of hypertension and metabolic syndrome.
✓ 5 times the risk for dyslipidaemia than the general population.
✓ Less than a third of people with schizophrenia in hospital have received the recommended assessment of CVD risk in previous 12 months.
✓ Less access to cancer screening and early intervention than the general population.
✓ 3.2 times more A&E attendances and 4.9 times more unplanned inpatient admissions than the general population with significantly higher length of stays.
✓ Less access to planned physical care, use more emergency hospital care than those without mental ill health

What are the statistics in diabetes in patient with a SMI condition?

✓10-15% diabetes prevalence (De Hert et al, 2009)
✓Obesity rates approximately double in people with schizophrenia
✓Patients are motivated about their physical health but less able to prioritise physical well being
✓Altered body composition
✓Increased visceral fat
✓Higher waist to hip ratios
✓Historically high rates of undiagnosed diabetes
✓Reduced screening in this group

What is the problem in the UK with SMI & Diabetes?

Compared to those with diabetes only, individuals with diabetes and mental health disorders have:
✓Decreased medication adherence
✓Decreased compliance with diabetes self-care
✓Increased functional impairment
✓Increased risk of complications associated with diabetes
✓Increased healthcare costs and an increased risk of early mortality

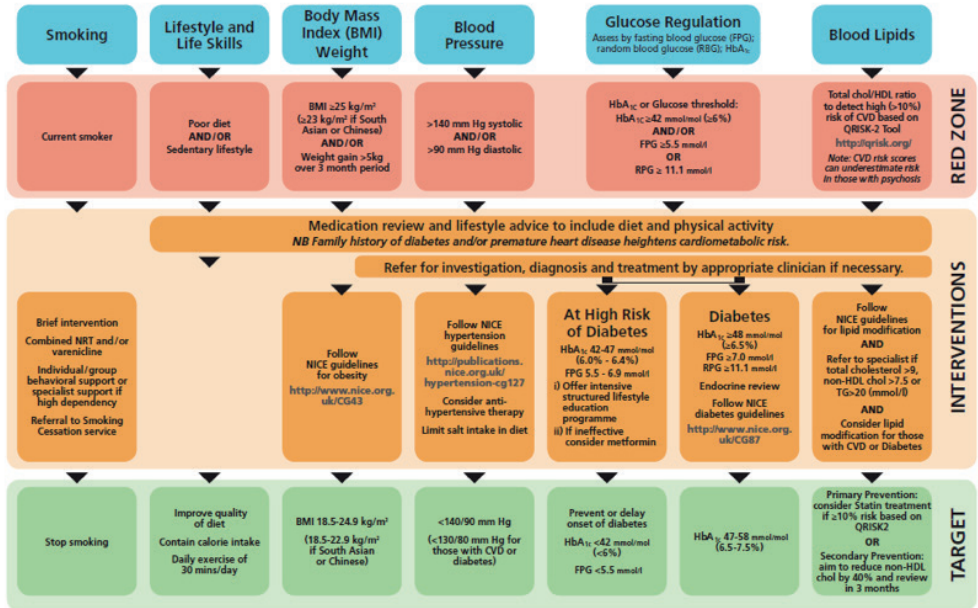## Identifying where the gaps in knowledge/joint working lie?

The following treatment modalities should be incorporated into primary care and self-management education interventions to facilitate adaptation to diabetes:
✓ Reduce diabetes-related distress and improve outcomes:
✓ Motivational interventions, family therapy and collaborative case management.
✓ Individuals taking psychiatric medications, particularly atypical antipsychotics, benefit from regular screening of metabolic parameters. Lester Tool Screen and Intervene!!!
✓ Empowering our patients to understand the condition and take control is key but someone with SMI may not be able to do this without support
✓ All health care professionals have a role in promoting better diabetes self-management but need to know how SMI will impact on ability to manage consistently
✓ Management of cardiovascular risk factors including blood pressure and lipids is as / more important than glucose control, is this fully understood for patients with co-morbid Mental Health risk factors
✓ Early and aggressive glucose lowering treatment needed
✓ Drug treatments need to be individualised to the patient

DPC Toolkits

Diabetes management for patients with a serious mental illness (SMI)

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NHS Foundation Trust

Lester UK Adaptation | 2014 update

Positive Cardiometabolic Health Resource

An **intervention framework** for people experiencing **psychosis** and **schizophrenia**

Smoking	Lifestyle and Life Skills	Body Mass Index (BMI) Weight	Blood Pressure	Glucose Regulation (Assess by fasting blood glucose (FPG); random blood glucose (RBG); HbA₁c	Blood Lipids	
Current smoker	Poor diet AND/OR Sedentary lifestyle	BMI ≥25 kg/m² (≥23 kg/m² if South Asian or Chinese) AND/OR Weight gain >5kg over 3 month period	>140 mm Hg systolic AND/OR >90 mm Hg diastolic	HbA₁c or Glucose threshold: HbA₁c ≥42 mmol/mol (≥6%) AND/OR FPG ≥5.5 mmol/l OR RPG ≥ 11.1 mmol/l	Total chol/HDL ratio to detect high (>10%) risk of CVD based on QRISK-2 Tool http://qrisk.org/ Note: CVD risk scores can underestimate risk in those with psychosis	**RED ZONE**

Medication review and lifestyle advice to include diet and physical activity
NB Family history of diabetes and/or premature heart disease heightens cardiometabolic risk.

Refer for investigation, diagnosis and treatment by appropriate clinician if necessary.

| Brief intervention / Combined NRT and/or varenicline / Individual/group behavioral support or specialist support if high dependency / Referral to Smoking Cessation service | | Follow NICE guidelines for obesity http://www.nice.org.uk/CG43 | Follow NICE hypertension guidelines http://publications.nice.org.uk/hypertension-cg127 Consider anti-hypertensive therapy Limit salt intake in diet | **At High Risk of Diabetes** HbA₁c 42-47 mmol/mol (6.0% - 6.4%) FPG 5.5 - 6.9 mmol/l i) Offer intensive structured lifestyle education programme ii) If ineffective consider metformin | **Diabetes** HbA₁c ≥48 mmol/mol (≥6.5%) FPG ≥7.0 mmol/l RPG ≥11.1 mmol/l Endocrine review Follow NICE diabetes guidelines http://www.nice.org.uk/CG87 | Follow NICE guidelines for lipid modification AND Refer to specialist if total cholesterol >9, non-HDL chol >7.5 or TG>20 (mmol/l) AND Consider lipid modification for those with CVD or Diabetes | **INTERVENTIONS** |

| Stop smoking | Improve quality of diet / Contain calorie intake / Daily exercise of 30 mins/day | BMI 18.5-24.9 kg/m² (18.5-22.9 kg/m² if South Asian or Chinese) | <140/90 mm Hg (<130/80 mm Hg for those with CVD or diabetes) | Prevent or delay onset of diabetes HbA₁c <42 mmol/mol (<6%) FPG <5.5 mmol/l | HbA₁c 47-58 mmol/mol (6.5-7.5%) | Primary Prevention: consider Statin treatment if ≥10% risk based on QRISK2 OR Secondary Prevention: aim to reduce non-HDL chol by 40% and review in 3 months | **TARGET** |

FPG = Fasting Plasma Glucose | RPG = Random Plasma Glucose | BMI = Body Mass Index | Total Chol = Total Cholesterol | HDL = High Density Lipoprotein | TRIG = Triglycerides

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What are the team in Northumberland Tyne and Wear Mental Health and Disabilities Trust doing?

✓ Dedicated Diabetes Clinical Reference group within the Trust focussed on Learning from incidents and best practice

✓ Presented and gained support for collaborative working from North East and Cumbria Diabetes Clinical Network - NHSE/NHSI/Commissioners /Primary Care

✓ Joint work with local Diabetologists and Specialist Nurses to review access to specialist Diabetes practitioners and local patient pathways across 5 Acute Trusts on our patch

✓ Developing in house training programmes for all multi professional Nursing Medical and Allied Health Professional staff

What can you as an HCP do to help drive forward this initiative?

✓ Tell us what you need to know about mental health conditions to help you manage the care and treatment for patients who also have diabetes

Contact us at DPCtoolkit@diabetespc.com to get involved, and for further information and resources