CLASS 6

ADDITIONAL RESOURCES

Culture and Psychotropic Medications

Culture	Effects with Psychotropic Medications
Caucasians	10 percent are poor metabolizers, while 1-2 percent are overall slow metabolizers.
Latinos & Hispanics	Under-utilize mental health services and express more physical symptoms, often seeking non-psychiatric physicians; 5 percent of this population are fast metabolizers; as a result they have very low plasma drug levels. More research is needed with this culture. May require lower doses of the antipsychotics Clozaril and Risperdal. US Hispanics respond better to lower dosages of antidepressants. It is unclear why this is so.
African Americans	Rely less on mental health services, using social support systems, prayer, folk remedies, etc. for assistance; 33 percent are slower metabolizers of psychotropic medications when compared to Caucasians; thus have higher risks for medication-related side effects; because of differences in enzyme activity, they respond more rapidly to neuroleptics and tricyclic antidepressants (TCAs) than Caucasians. A. They retain higher plasma levels per dose of TCA and show more side effects. Thus lower dosages may be needed. B. Frequently, they are reported to be receiving higher doses of neuroleptics, as well as more use of depot neuroleptics. Therefore, the risk of developing side effects (e.g., tardive dyskinesia) is higher. They have a higher red blood cell/plasma lithium ratio than Caucasians when under treatment for Bipolar Disorder. More side effects of lithium are reported. This suggests that lower doses of lithium therapy may be required.
Asians	More often view mental illness as stigmatizing, so delay psychiatric care until illnesses are severe; they often have more somatic (body) complaints, and try alternative remedies first. Due to the metabolism of Haldol in Chinese patients, higher plasma levels may occur with increased risk of extra-pyramidal side effects. (EPS) US Asians may respond better to lower doses of antidepressants; it is not clear why this is so. Asians respond therapeutically to lower doses of lithium. Chinese patients require lower doses of antipsychotics. Chinese patients will rarely complain about weight gain, but can be very upset if drowsiness or impaired memory compromises work performance.

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TMAP Schizophrenia Update

The Texas Medication Algorithm Project (TMAP) is a public-academic collaboration that generates guidelines for medication treatment of mental illnesses. TMAP algorithms are used in Texas and other states. In 2003, the leaders of TMAP began to update the algorithm for Schizophrenia, based on a consensus of experts, clinicians, and administrators. The following summarizes their recommendations.

Ziprasidone (Geodon) has joined other second-generation antipsychotics in the first stage of an antipsychotic algorithm. The experts were pleased with Ziprasidone's weight neutrality, slight effects on glucose and lipids, and low risk of cardiac events and death. At the clinician's choice, a patient with a first episode of schizophrenic psychosis who has never been treated before with an antipsychotic agent may be prescribed any one of the following single agents: Aripiprazole (Abilify), Olanzapine (Zyprexa), Quetiapine (Seroquel), Risperidone (Risperdal), or Ziprasidone. First-generation antipsychotics remain second-line options; they have not disappeared from the (typical) TMAP algorithm. Patients who are already responding well to and tolerating a first-generation agent may continue with it. Sometimes acutely agitated and potentially violent patients will benefit from a first-generation agent added to maintenance therapy with a second-generation drug.

Because it remains the ultimate "go-to" drug for difficult-to-treat cases, clozapine (Clozaril and other generic brands) has been elevated from stage 5 to stage 3 in the algorithm. The algorithm allows clinicians to try a third antipsychotic before initiating clozapine but, particularly for patients at high risk for suicide or violent behavior, clozapine should be considered early among treatment options. The experts recommend that the decision to use clozapine should be shared between clinician and patient. When clozapine alone is insufficient, it may be augmented with a first- or second-generation antipsychotic or electroconvulsive therapy.

Many patients with chronic mental illness end up taking more than one medication. The TMAP algorithm calls for due consideration of alternatives before antipsychotic combinations are employed. TMAP suggests that, for patients who refuse to take clozapine or do not respond adequately to it alone, a final monotherapy trial should be attempted before combining antipsychotics. The experts eschew a specific sequence of second-generation antipsychotics. They do suggest that clinicians consider differences in side-effect profiles among second- generation antipsychotics when selecting one for a patient.

Data suggest that a switch from one antipsychotic to another can be accomplished abruptly. However, many clinicians prefer to cross-titrate, gradually withdrawing the first agent while increasing the dose of the new drug. Elective discontinuation of clozapine should occur by gradual tapering over at least 3 months. New medications and new knowledge have expanded treatment options for patients with Schizophrenia and other mental illnesses. TMAP and other guidelines can help clinicians stay close to the evidence base in our field.

Coping with the Side-Effects of Medications

All medications have unwanted effects. These vary from person to person and depend on the type of drug and dose being given. Sometimes the side effects disappear after a few days or weeks. Other side effects are more troublesome and persistent. It is very important to report any unwanted effects the medication seems to be having to your doctor. The unpleasant effects can often be got rid of, made less severe or made more tolerable by making some simple changes.

Changes your Doctor may Suggest Include:

- changing to a different medication
- decreasing the dose
- taking the medication in several, smaller doses spread through the day
- taking the medication with appropriate food
- taking extra medication to counteract the side effects.

In addition, things that you can do yourself to deal with side effects include:

Side Effect	Strategy for Coping with it
Appetite Increase	Eat a diet that is low in fat and high in fiber Avoid sugary or fatty foods Drink low calorie soft drinks
Constipation	Increase exercise Increase fiber in diet Increase fluid intake
Dizziness	Get up slowly from lying or sitting Avoid excessively hot showers or baths Avoid alcohol, sedatives or other sedating drugs (eg marijuana)
Drowsiness	Take medication in a single dose before bedtime (talk to the doctor about this first). If you feel sleepy during the day, you should not drive or work with machinery
Dry mouth	Drink water regularly throughout the day Limit alcohol and caffeine (both enhance water loss) Use sugarless gums, fruit pastilles and lollies (sugar will promote dental decay) Suck on ice cubes If it is very bad, ask your doctor about artificial saliva (Luborant)
Sensitivity to Sunburn	Avoid the midday sun Regularly use sunscreen and wear a hat, sunglasses and shirt Ask your doctor for a prescription for sunscreen

Monitoring Guidelines for the Metabolic Syndrome

The clinician providing mental health treatment to the patient with Schizophrenia now, unequivocally, must take an active role in monitoring key features of the metabolic syndrome or confirm that the patient is receiving this care from another physician. Patients and their families have the right to know the potential metabolic abnormalities that may occur with the medication being administered to the individual. The following are useful monitoring guidelines:

Weight:

- Weigh the patient at treatment onset and at each visit.
- Calculate the body mass index (BMI) and recalculate if there is a weight increase.
- Measure waist circumference at least yearly.
- Counsel the patient on proper diet and exercise
- If possible, avoid antipsychotic agents associated with greater weight gain.
- Consider following the ADA/APA consensus panel recommendation of switching agents if there is > 5 percent weight gain or a 1.25 kg/m² BMI increase.

Glucose Imbalance:

- Order a baseline fasting glucose. Retest every 3 months for patients being administered benzodiazepine atypical antipsychotic agents (e.g. clozapine and olanzapine) and possibly more frequent (e.g., monthly) in those with multiple diabetes mellitus risk factors (e.g., obesity, ethnicity) and every 6 months for other atypicals.
- For patients with a number of risk factors, consider avoiding or switching away from medications more likely to induce glucose abnormalities (e.g., benzodiazepines).
- Monitor for classic symptoms of diabetes and DKA, including polyuria, polydipsia, and fatigue.
- Persistent, random glucose of 160 mg/dL is reason for concern; patients should be referred to a diabetes specialist or other qualified physician. A repeated fasting glucose of 126 mg/dL establishes the diagnosis of diabetes mellitus. The referring psychiatrist must have ongoing communication with the physician treating the glucose abnormality.

Lipid Imbalance:

- Order a baseline fasting lipid profile. Retest the patients administered antipsychotics in the benzodiazepine family every 3 months for the first year. Retest other atypical drugs at 12 weeks and then every 5 years if normal, and more frequently with levels close to abnormal, particularly with patients who have a number of risk factors for the metabolic syndrome.

- Follow ATP III guidelines for monitoring.

- Patients with abnormal levels should be referred to a specialist. The referring psychiatrist must have ongoing communication with the physician treating the lipid abnormality.

Patients with Schizophrenia have an increased prevalence of medical morbidity and mortality. Mental health professionals must be educated about the basic monitoring for conditions which are overrepresented in Schizophrenia, such as diabetes and cardiovascular disease (CVD). The clinician providing mental health treatment to the patient with Schizophrenia must take an active role in monitoring key features of the metabolic syndrome or ensure that the patient is receiving this care from another physician. Following the above guidelines will prevent serious morbidity and potentially save lives. If there is to be any hope for individuals with Schizophrenia to effectively reintegrate and function in society, such serious metabolic abnormalities must be diagnosed and appropriately treated.

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RAISE (Recovery after Initial Schizophrenia Episode)

The goal of RAISE is to design and test an optimal model of intervention that will promote engagement and participation in treatment, foster recovery, and reduce or prevent disability in persons experiencing a first episode of psychosis (FEP) and to do so within publicly financed mental health systems. Given our current scientific knowledge and therapeutic capabilities, the best strategy for limiting the impact of Schizophrenia and related psychotic disorders and the costs associated with their care, is to intervene at the earliest identifiable stage. The RAISE study is based on the premise that early and optimized intervention can alter the course of Schizophrenia, reduce disability and promote recovery.

The key elements of our RAISE model involve:

1. Early implementation of evidenced-based therapeutic interventions drawn from evolving best practice guidelines;
2. Phase-specific and person-centered approaches;
3. Integrated care by involvement of family and social network, and by a specialized multi-disciplinary team providing multi-element interventions for mental and physical health and substance abuse issues, and finally
4. Continuity of care by focusing on proactive outreach and engagement, assessment, adherence monitoring and transition to follow up care

We believe that our intervention will maximize what is currently known about the care of persons with FEP and Schizophrenia and their needs. We aim to overcome the primary problem of continuous engagement and dropout from treatment, which is so prevalent among individuals experiencing their FEP. Participants will receive services for two years. Project staff will reach out to community organizations and providers to recruit study participants.

The Role of Consumers and Families

The meaningful participation of consumers and family members is critical to the design and implementation of our initiative. This will be achieved in multiple ways including the direct input of New York and Maryland's Offices of Consumer Affairs and representation of families and consumers on the project Executive Committee. Consumers and family members will also be invited to provide feedback about the intervention (including engagement and treatment strategies) using individual interviews and focus groups. We aim to obtain feedback both from individuals in leadership positions of regional and national organizations as well as the consumers and families residing in the communities where our RAISE study will be conducted. In addition, a critical part of our intervention will be built around utilizing family and consumer peer support services in the community.

Financing and Policy Considerations

There are important financing and policy considerations inherent in RAISE's challenge to implement and deploy an effective intervention rapidly in clinical practice. Conventional health insurance often does not cover the services needed by individuals experiencing their first episode of psychosis. Further, public mental health systems do not currently make individuals with FEP a priority population for clinical and support services, in part because many such

individuals are still covered by their parents' health insurance. The goal of RAISE is to prevent disability which is the most common criterion for demonstrating eligibility for public insurance (i.e., Medicaid or Medicare) or for public mental health services. We have established partnerships with two public mental health systems (i.e., Maryland and New York State) to test the RAISE model in the real world of clinical practice using public mental health resources, where reimbursement from private and public sources is not available. Newly dedicated public resources are essential because we are intervening before the person is so disabled as to qualify for usual public sector services and because we are proposing services beyond the inpatient and outpatient coverage of most private sector policies. We will characterize service utilization and costs, as well as financing strategies in use in the two participating States. We will project possible financing strategies for use in other public mental health systems, and we will offer ideas about using expanded health insurance to cover key services in the RAISE experimental intervention.

The RAISE Team

Our RAISE team consists of 75 individuals from diverse backgrounds in many fields, including pharmacologic and psychosocial interventions, phenomenological assessment, psychiatric and medical co-morbidities, ethics of treatment and research with serious mental illness, cultural competence, promoting treatment adherence, developmental psychopathology and treatment of adolescents and young adults, mental health care policy, administration and financing, and health behavior change.

Our RAISE team includes individuals from the following institutions: Columbia University; University of Maryland School of Medicine; Johns Hopkins University; VA Maryland Health Care Network – Sheppard Pratt; University of California Los Angeles; University of North Carolina at Chapel Hill; Duke University; Westat; Dartmouth Medical School and Dartmouth Psychiatric Research Center; Harvard University Medical School; Maryland State Office of Mental Health; New York State Office of Mental Health; University of Southern California; University of Melbourne; University of Texas Southwestern Medical Center at Dallas; Emory University; NAMI Policy Research Institute; University of California, Davis; and Boston University. Our team is led by Dr. Jeffrey Lieberman as the RAISE Principal Investigator and Dr. Lisa Dixon as Co-Principal Investigator. Dr. Lieberman's expertise in first-episode psychosis research and psychopharmacology and Dr. Dixon's in psychosocial treatment development, services research and consumer involvement have prepared them well for these important roles on this project. In addition, the Offices of Mental Health and the public mental health systems of New York and Maryland and their respective Commissioners are partners to our team.

Supporting our experts in first-episode psychosis research are experts in intervention development, intervention and services research; assessment and longitudinal monitoring of clinical symptoms; testing of psychopharmacologic and psychosocial interventions; assessment and support of social, academic, and work functioning; and biostatisticians experienced in clinical trials, and public mental health system partners. Our team includes highly experienced researchers from Westat who are knowledgeable about all aspects of scientific protocol management and skilled in coordinating multi-site, community-based clinical trials, including all aspects of data collection and managemen

Switching to Generics

With restricted formularies and expensive “co- pays” for patented medications, patients have an increasingly high stake in whether they take branded or generic pharmaceuticals. A thoughtful review has looked at the issue of generic alternatives among antipsychotic drugs; the fundamental principles explicated carry over to other classes of medications.

Even though generic drugs contain the identical active principal as the brand-name original, there are important microscopic and chemical differences in formulation. These physical and chemical differences can affect clinical properties of the product, such as disintegration, dispersal, and dissolution in the gastrointestinal tract which, in turn, affect the rate and completeness of absorption.

Bioequivalence between products is normally studied in normal volunteers. The main criterion is that the ratio of the mean area under the concentration-time curve to the peak plasma concentration for a generic equivalent has to be within 0.8 and 1.25 that of the brand-name original. This allows the effective dose of the generic medication to be up to 25 percent higher or 20 percent lower than in the original. This variability alone could affect side effects and efficacy, plus it could be magnified by differences in individuals that may not be revealed by studying a small group of volunteers. In addition, doses of psychotropic medications studied sometimes are much lower than those used in treatment, because healthy volunteers cannot tolerate usual therapeutic doses for some medications (for instance haloperidol [Haldol and others] and clozapine.)

Several reports have found clinical effects when patients were switched between brands of clozapine. There are also many anecdotes of patients experiencing diminished efficacy when switched from a brand-name to a generic anti-depressant or between formulations of generics.

Another study found that patients on generic fluoxetine were more likely to suffer from “anxiety/ nervousness” and diarrhea at week 12, while patients taking brand-name fluoxetine (Prozac) showed greater clinical improvement. An additional study described six patients switched from brand-name to generic fluoxetine. Four of the patients showed decreased efficacy, while three experienced an increase in adverse effects.

Many of our patients take multiple medications, often for more than one illness. For most people, the co-pay costs of several brand-name medications can be prohibitive. Therefore, there is strong pressure from consumers as well as insurers to prescribe less expensive generic “equivalents.” Generic drugs now make up 44 percent of all prescription drugs sold in the United States. Patients and family members should be on the alert during a change between brands. Every change should be an occasion for heightened awareness of possible loss of efficacy or increased (or new appearance of) side effects. If there are problematic changes it may be possible for the doctor to adjust the dose of medication up or down to get the same amount of medications as the prior brand. But if the side effects or the changes in effectiveness are severe and you cannot wait for an adjustment in dose to take effect, talk to your doctor about a change back to the previous product.

Much Ado about Area 25

An estimated 16 percent of the American population will suffer from Major Depressive Disorder at some point during life. The disease strikes down nearly 19 million Americans each year, and it's likely to happen more than once. A whopping 50 percent will experience an encore performance within two years of their initial depressive episode, and the stats get even worse after the second recurrence. What does this mean? It means that if you're wired for depression, you'll likely spend most of your adult life on some form of antidepressant—a fate that many do not relish given the side effects and philosophical ramifications. And that's discounting entirely the 30 percent of depression sufferers who get no relief from the current crop of antidepressants. All of which explains why breakthroughs in our understanding of depression make for such good headlines. Millions of Americans are waiting for a quick fix for depression and the media wants to give them good news.

The current superstar of depression research is area 25. (See The New York Times, Scientific American Mind, NPR—the list goes on and on.)Yes, I know. It doesn't sound very sexy. But trust me, it is. Here's why: if current findings prove correct, area 25 may one day be the key to curing depression. Not managing depression, or blunting depression, or masking depression (as many argue the current crops of drugs do) but curing it.

For those who don't spend their time geeking out over breakthroughs in mental health, allow me to explain. After years of researching the mechanics of depression, Emory University Neurologist Helen Mayberg noticed something unusual. If you looked at MRI scans of depressive's brains next to scans of healthy people's brains, the people with depression showed two things: reduced activity in the frontal cortex, and hyperactivity in an obscure section of the brain known as area 25.

Mayberg grew curious, so she did some scans of people with depression pre- and post-treatment. As she predicted, once the patient's medications took effect, normal frontal cortex activity was restored, and area 25 showed decreased activity. Mayberg's team began to suspect that area 25 served as gateway of sorts--the bridge between the part of the brain responsible for negative rumination (the frontal cortex) and the seat of anxiety and fear (the limbic system). She wondered whether psychiatric drugs worked because they unintentionally reduced activity in area 25. To test her thesis, she decided to perform an experiment on 12 subjects whose chronic depression had stubbornly withstood drugs, talk therapy, and frequent bouts of electroconvulsive therapy. The only way to test her theory was to bore two holes into the skulls of her subjects and insert electrodes directly into their brains—a stark reminder that neuroscience is still in its infancy. Yes, it sounds barbaric, but Mayberg's hope was that delivering a small jolt of electricity to this site would effectively reboot it. And it looks like she was right. Eight of her 12 subjects experienced relief, some instantaneously. Their melancholy evaporated as if by magic and it has yet to return. A quick shock to area 25 appears to lower the gateway between negative thoughts and painful feelings,

effectively eliminating both the emotional and physiological components of depression. All of this is good news and certainly worthy of note. If area 25 proves to be the conductor of depressive thoughts, learning how to regulate it could eventually render SSRIs and the like obsolete. But when The New York Times Magazine runs a cover story called the "The Depression Switch?" people are likely to jump to the conclusion that a cure for depression is just around the corner. And this is patently untrue. Even if Mayberg's theory is born out in future studies, the average person living with depression will have to wait years to reap the benefits.

Why? Because, at present, the only way to target area 25 is through invasive brain surgery. And, let's face it, few among us would be willing to let a neurologist drill a hole in our heads and feed wires directly into our brains. Even if you were game, the odds of being admitted into one of Mayberg's studies are very, very slight.

So, the vast majority of depression sufferers will have to bide their time and wait for a drug capable of:

1. Overcoming the blood brain barrier, and
2. Effectively regulating activity in area 25.

To say that this is a Herculean task is a huge understatement. Right now, the only way scientists have found to breech the blood brain barrier (the barricade between the blood stream and the brain) is to design drugs that act like carpet bombs. SSRIs, for example, work by bathing the brain in serotonin. This has proven effective in alleviating depression in many people, but it also impacts the functioning of systems better left untouched (i.e., the dopamine pathways that control libido). A drug capable of making a beeline for area 25 is going to be a long time coming.

So while Mayberg's findings offer hope to many, they won't deliver relief for years to come.

Odds of Beating Depression Diminish as Additional Treatment Strategies are Needed (Report on STAR*D Study)

An overall assessment of the nation's largest real-world study of treatment-resistant depression suggests that a patient with persistent depression can get well after trying several treatment strategies, but his or her odds of beating the depression diminish as additional treatment strategies are needed. The conclusions from the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study, funded by NIMH, were published in the American Journal of Psychiatry on November 1, 2006.

The analysis also found two important indicators of treatment success. Those who become symptom-free have a better chance of remaining well, as measured in the follow-up period, than those who experience only symptom improvement. Those who need to undergo several treatment steps before they become symptom-free are more likely to experience a relapse during the one- year follow-up phase, reminding clinicians that even if a patient overcomes the depression, he or she still needs attention. These results underscore both the need for a better understanding of how different people respond to different depression treatments, and the challenges in finding broadly effective, short- and long-term depression treatments.

"This new STAR*D report reminds us that treating depression remains a formidable challenge," said NIMH Director Thomas Insel M.D. "While roughly two-thirds of patients report remission, many subsequently relapse. We need new treatments that are rapid, enduring, and individualized to facilitate recovery." The paper examined all four medication levels of the STAR*D trial. About half of the participants became symptom-free after the first two treatment levels. After that, rates at which participants beat their depression slowed. Over the course of all four levels, about 70 percent of those who did not withdraw from the study became symptom-free.

Those who required more treatment levels tended to have more severe depressive symptoms, and more co-existing psychiatric and general medical problems at the beginning of the study than those who became well after just one treatment level. In addition, the rate at which participants withdrew from the study rose with each level—21 percent withdrew after level 1, 30 percent withdrew after level 2 and 42 percent withdrew after level 3. "Clinicians need to pay particular attention to those patients with chronic depression and identify any co-existing conditions that may be exacerbating the depression or interfering with treatment," said lead author A. John Rush, M.D. of the University of Texas Southwestern Medical Center. "They need to closely monitor both the symptoms and side effects of these most vulnerable patients throughout treatment and suggest different treatment strategies when needed. Diligent follow-up, even after a patient becomes symptom-free, is essential to avoid relapse."

The STAR*D trial provides robust, real-world data that can be applied broadly to both primary and specialty care settings. The study confirms that different people respond to different treatment strategies, but it does not pinpoint what treatments work best for whom. The STAR*D team concluded that future research should be targeted to identify the best multi-step treatment options for individuals, especially those with treatment-resistant depression.

A Mind and a Body: Another Dimension of Recovery

by Ken Duckworth, M.D.

One of my most memorable moments as a psychiatrist came from a lovely woman whom I was treating for Schizophrenia.

She said to me, "What is it with you shrinks? Can't I have a mind and a body?"

She was, of course, alluding to the side effects she was experiencing while on clozapine. She had, thankfully, burst my bubble. She was "doing great" by all measures, except that she was gaining weight and drooling; she worried about seizures and blood count changes; and she felt sedated all the time. In short, she was "doing great" above the neck , but struggling below it. Together we figured out how to improve in these important areas.

Thus began my journey toward becoming a more complete doctor. Today, as the chief psychiatrist for the Commonwealth of Massachusetts, I often look at our professional obligation to consider the whole person, not just reduce their psychiatric symptoms. We ask questions like these:

How do we best attend to the physical elements of what it means to have a psychiatric illness?

How do we create a culture of care where opportunities abound for people who are ready to improve their physical health?

I leaned quickly that timing is everything. Not all people with psychiatric conditions are ready to look at this issue. People in the early stages of recovery will have many other challenges.

I have also come across many professionals who view good physical health as an unrealistic goal for people with serious psychiatric illnesses, creating a landscape of missed opportunity. And, in my experience, almost everyone wants good health. So how do we begin to support ourselves and each other in this quest?

First we need to be able to support people who want to make choices for themselves that promote their health. I was taught as a doctor that controlling symptoms was my job, and that lifestyle choices were the patient's job. But now, as our treatments increasingly affect people's lifestyles and health we have an obligation to address this. One example is obesity, which I have come to think of as the new tardive dyskinesia. The U.S. Surgeon General has declared obesity a national epidemic, but many psychiatric medicines compound this risk. Yet, as a field I believe that psychiatry is not being proactive in helping people minimize this predictable side effect.

In Massachusetts, we did a study of the causes of death for people with serious psychiatric illnesses. My work at a community mental health center was the impetus; the individuals there experienced a lion's share of health problems; some of them very serious and some causing premature death. My new role as the Department of Mental Health's chief psychiatrist gave me a unique opportunity to delve into this vexing problem.

We found that the risk of cardiovascular-related death was much higher for people with psychiatric illnesses in Massachusetts for 1998 and 1999. It ranged from twice as high to about six times as high, depending on age. Also, the usual protections women enjoy were not evident in the review—their rates were the same as those for men. We don't know exactly why, but our findings appear to be multifaceted. I'll try to review what we assess as the biggest risks, and how we can think and work together to address and ultimately find solutions to these problems.

Smoking

Research shows what we already know--smoking is a form of self-medication, working as a mild antipsychotic and antidepressant. People with psychiatric illnesses tend to smoke more often, more cigarettes per day, and smoke more deeply. At one Boston clinic, 80 percent of individuals there smoke, compared to less than 20 percent statewide. My interest now lies not in a "temperance model" of quit or else, but in one that promotes harm reduction. Can people be supported to reduce their intake? How does a reduction impact their symptoms? We are funding research in Massachusetts to help people with Schizophrenia who want to reduce their smoking.

Obesity

Many of the new psychiatric medications cause weight gain, though no one is sure how. One prominent theory is that people lack the sensation of fullness--or satiety—which is the cue to stop eating, so they keep eating. This is the kind of information people should have before they start taking any medication. Along with that, they should be able to plan for side effects, and expect support in dealing with them. Prevention of weight gain is easier than reduction. Can we offer dietary counseling, support for walking groups, and a scale for people who are beginning a medication regimen? I believe we need to, but my observation reveals the reality that many clinicians aren't active in this area. Keeping information from people is a mistake in my experience--once weight gain takes hold, people frequently stop taking their prescribed medicines. There are medical interventions for weight gain, but lifestyle choices remain a key.

Diabetes

People with serious psychiatric illnesses are at risk for developing diabetes. Type II diabetes, also known as adult onset diabetes, is commonly caused by weight gain, which changes the shape of the cells making them more resistant to insulin. This increases the amount of sugar in the blood. Diabetes sets the stage for a number of

health complications, particularly if sugar levels are not well controlled. People who live in our residential system in Massachusetts have about twice the incidence of diabetes as their age-matched counterparts. Diabetes is a treatable condition, but we all need to consider it before it can be assessed. Common symptoms include frequent urination and fatigue, and diagnosis is often delayed for years.

Activity Level

Walking is all it takes to reduce our heart risk. A good pair of walking shoes can be just as effective as the latest technology and medication in terms of reducing your heart risk. Walking with another person is very helpful for many people—it is a natural support system.

Understanding that most people start and stop exercise programs is important, too—few people are always on a program. Walking a few blocks or taking a flight of stairs may be all it takes to reduce our risk. Clubhouses in Massachusetts are moving in the right direction with an increasing interest in setting up gyms. The good news is people are using them—this is a healthy trend.

From my vantage point I can say that most of us are trying to do better in these areas—heart disease is a national problem that is a higher risk for ourselves and our loved ones with serious psychiatric illnesses. It is also important to have an annual checkup with a physician who can assess your cholesterol, triglycerides, risk of diabetes, blood pressure, weight—the major risk for heart disease—and can evaluate whether you need more intensive medical assessment. Most people like myself have a natural aversion to going for a checkup—we might find out bad things even though we feel fine. But it is another important step to a better heart risk profile.

Finally, I'd like to see some resources devoted to understanding the best lifestyle interventions for people with mental illnesses. I am pleased to say that NAMI is leading the way on education in this crucial area.

Together with NAMI's Consumer Education and Support Staff and the NAMI Consumer Council, the Massachusetts Department of Mental Health has developed Hearts and Minds, a curriculum for interested consumers and family members that features successful risk-reduction accounts, outlines the medical risks that accompany many psychiatric disorders, and offers strategies to deal with them. I am delighted to partner with NAMI on this urgent and important issue.

Psychiatric illnesses challenge and stretch our hearts in a figurative way—let us use our advocacy and passion to raise the awareness of the issue of heart health in a literal way as well.

How to Select a Doctor

The partnership between you and your physician is the key to successful management of your mood disorder. And just as it is essential that you be open and forthcoming with your doctor, it is important for your doctor to meet your needs and expectations. That, after all, is how good partnerships are made. Here are some serious considerations:

Is your doctor competent to prescribe and monitor the proper use of medications?

Your doctor should have done a thorough medical evaluation before prescribing medications. If your doctor prescribes a drug, be sure he or she is aware of other medications you may be taking or other health conditions you may have developed that could interfere with or be exacerbated by medication for manic-depressive illness.

Is your doctor willing to explore treatment options in order to find the best "fit" for you?

No single approach to treatment is perfect for everyone. In the case of medication, you need to work with your doctor to balance the side effects of some drugs against their effectiveness for you. Similarly, regarding psychotherapy, some people may benefit most from a support group setting while others may find one-on-one therapy to be better suited to them. It is essential that your doctor work with you to find the best solution for you, and then monitor its success over time.

Is your doctor comfortable with the idea of you seeking a second opinion about treatment?

Because manic-depressive illness has symptoms and challenges that are unique to each person, it may be important for you to seek advice from more than one physician. Your doctor should recognize this and be supportive of your decision. He or she should also work with you to evaluate therapies recommended by other physicians you have consulted.

Is your doctor treating "the whole person"?

Because they can affect your thoughts and behaviors, depressive illnesses are complex conditions that will impact your personal development, your relationship with friends and family, your employment, and almost every other aspect of your life. Manic-depressive illness can be associated with an increased risk for other problems, such as substance abuse, eating disorders, and suicide. In addition to simply prescribing medication, your doctor should recognize when it is appropriate for you to receive other treatments, including psychotherapy, for these related conditions.

Is your doctor understanding and caring?

When you are diagnosed with a depressive illness, there can be no more important objective for you than to receive the right treatment as soon as possible. If your physician, no matter how apparently qualified, seems not to listen to you or take a genuine interest in your recovery, he or she may not be the right doctor for you.

Is your doctor ready to work with your family and friends?

While not everyone relies on the support of family in their treatment program, when feasible, it can be a vital component of treatment. Your doctor should be willing to help educate those closest to you about manic-depressive illness and explain what their roles can be in helping you manage it.