Providing Psychiatric Care to Disadvantaged Patients: A Pharmacist's Perspective

Learning objectives:
After the completion of reading the article, the reader will be able to:

1. Describe the relationship between low socioeconomic status and mental illness.
2. Explain four types of barriers to care that disadvantaged patients commonly experience and recommend approaches to help disadvantaged patients overcome barriers to care.
3. List three misperceptions patients with mental illness may have that can undermine medication adherence, and steps pharmacists can take to address misperceptions.
4. List eight methods pharmacists can implement to help disadvantaged patients with mental illness overcome challenges to access and adherence for their medications.

Type of activity: knowledge
Target audience: pharmacists including pharmacy residents

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Location: NCCCP eNewsletter (http://ncccp.net/activities/newsletter/)

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The ACPE Universal Activity Number: 0217-9999-18-146-H04-P
For the successful completion, readers should pass a post-test with a score of 70% or higher.

Go to: https://www.surveymonkey.com/r/MXYLHQ2 to take the post-exam. Pharmacists who pass the post-test with a score of 70% or higher by June 30, 2020 must have a valid NABP e-Profile ID and date of birth on file with ACCP and ACCP will submit credit to NABP. ACCP membership is not required; a free ACCP account can be created at https://www.accp.com/signin/register.aspx

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Background

One in six adults in the United States is affected by mental illness, accounting for 44.7 million in 2016.[1] Patients with mental illness suffer from psychiatric conditions including depression, anxiety, bipolar disorder, and schizophrenia. Mental health conditions can differ in severity, ranging from mild to moderate to severe. Although many people are affected by mental illness, it is not uncommon for mental health conditions to be left untreated, even after diagnosis.

Two categories are used to describe mental illness broadly: Any Mental Illness (AMI) and Serious Mental Illness (SMI). AMI is comprised of all mental illnesses that are recognized. SMI is a subset of AMI that is more severe.

Any mental illness (AMI): AMI encompasses any mental, behavioral, or emotional disorder, with all possible degrees of severity. AMI may cause little to no impairment, or it may impact a patient's life more significantly with moderate to severe impairment.[1]

Serious mental illness (SMI):
A mental, behavioral, or emotional disorder that can result in serious functional impairment, which interferes with or limits one or more major life activities. As would be expected due to disease severity, those patients with SMI (thus the greatest impairment) is the population in which the burden of mental illness is most concentrated.[1]

Figure 1. Adapted from the NIMH[1]

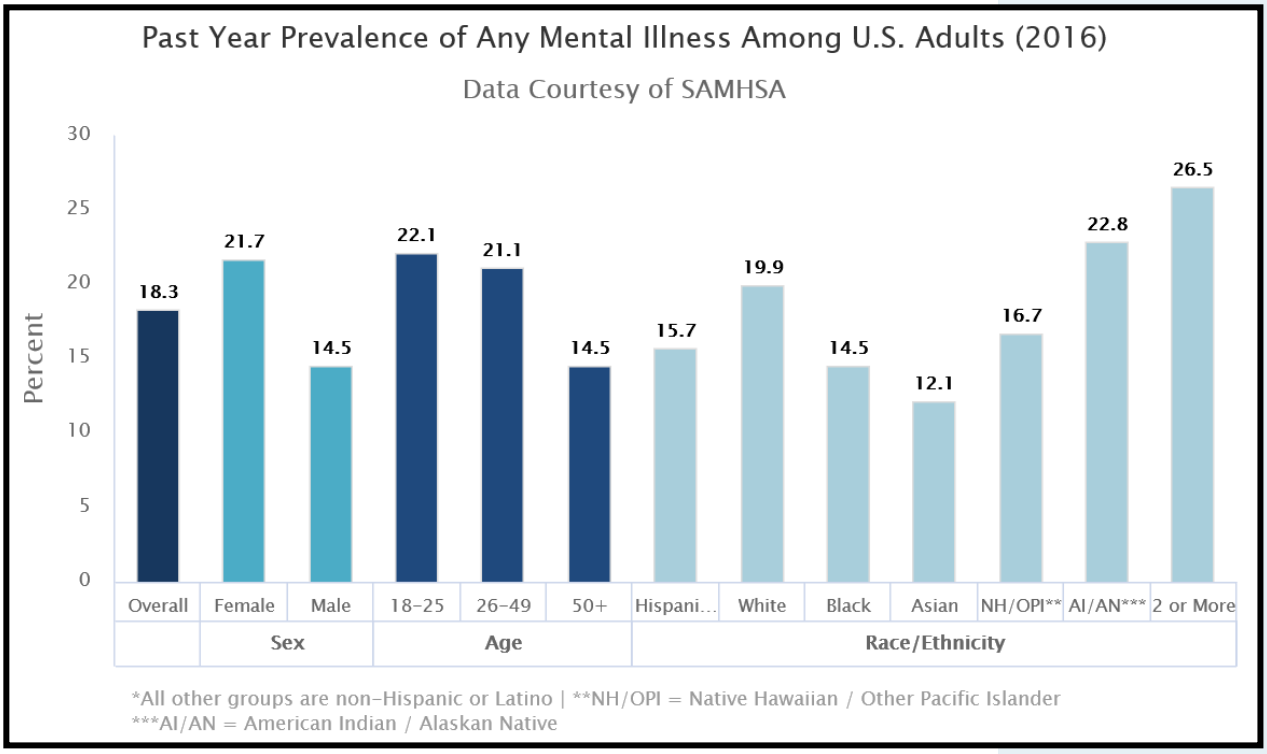


Figure 1. The prevalence of Any Mental Illness (AMI) across demographics including sex, age, race/ethnicity.

Providing Psychiatric Care to Disadvantaged Patients: A Pharmacist's Perspective

Figure 1 shows that the past year prevalence of AMI in the U.S. in 2016 was 18.3%.[1] It further provides a snapshot of the prevalence of AMI across various demographics including sex, age, race/ethnicity. As can be observed, the prevalence is greater in females (21.7%) than males (14.5%). The prevalence also varies across race/ethnicity categories, with the greatest prevalence in those identifying as 2 or more races (26.5%) and least in Asians (12.1%). Differences in prevalence may be due to a number of factors, one of which is diagnostic differences. Though mental illness occurs commonly in the population, stigma regarding being diagnosed with a psychiatric disorder and being treated for it still exists. Diagnosis and treatment of mental health conditions vary across ethnicities. A possible reason for the difference in prevalence of mental illness across various ethnicities may be that these conditions may be underdiagnosed in certain ethnic groups for some disease states and over-diagnosed for others.[2,3]

Figure 2. Adapted from the NIMH[1]

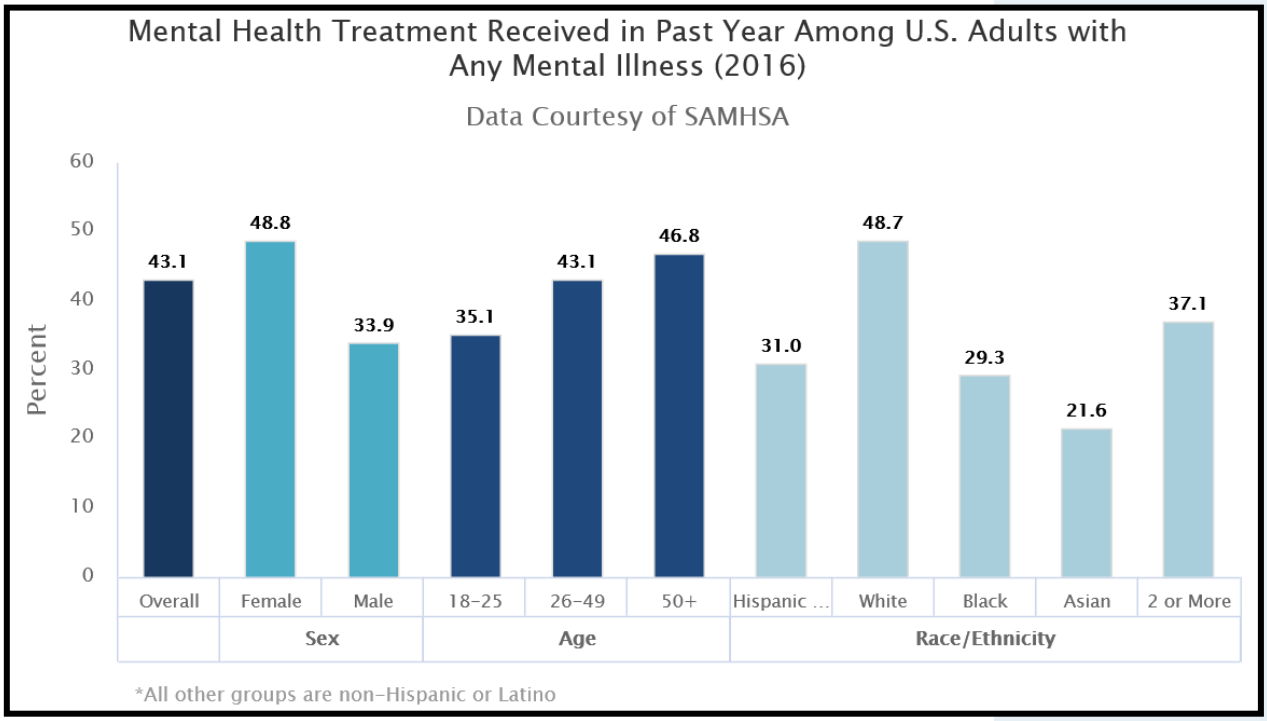


Figure 2. A depiction of AMI treatment received by U.S. adults in the past year across demographics including sex, age, race/ethnicity

Figure 2 shows AMI treatment received by U.S. adults in the past year across demographics including sex, age, race/ethnicity are displayed1 Females are more likely to be treated for AMI compared to males (48.8% vs. 33.9%). Treatment percentages increase gradually as adults' ages increase, from 35.1% to 43.1% and finally to 46.8% in those 18-25 years old, 26-49 years old, and 50+ years old, respectively. Across different ethnicities, participants who identified as white showed the highest percentage of treatment (48.7%) compared to Asians (21.6%). Despite demographic categories of female, 50+ years of age, and white came close to 50% treated, none of the groups assessed equaled or surpassed 50% emphasizes that the treatment of AMI is greatly lacking across all demographics.

Providing Psychiatric Care to Disadvantaged Patients: A Pharmacist's Perspective

Effect of Low Socioeconomic Status on Mental Health

An inverse correlation between socioeconomic status (SES) and mental illness has been well established in the literature, meaning individuals with lower SES are more likely to experience mental illness.[4] The American Psychological Association defines socioeconomic status as "the social standing or class of an individual or group." [5] SES is usually measured by a person's education, income, and occupation. A closer look at SES reveals inequalities with regards to access to resources including health care and tools needed to maintain a healthy lifestyle and struggles of power and control where social inequality results in one group dominating another. Improving the health outcomes in the underserved populations with low SES is a goal for the United States government, as well as other medical industries.

Studies have shown that there is a higher prevalence of psychiatric diagnoses including depression, anxiety, posttraumatic stress disorder (PTSD), substance abuse, and schizophrenia in low SES, urban neighborhoods.[6-9] Individuals who are impoverished receive less specialty care for mental health and, as a result, are at higher risk of receiving care in emergency situations in the acute hospital setting, relying more on emergency management instead of routine follow ups and chronic management.[10] Common psychiatric care needs that are addressed in the acute setting include schizophrenia and substance abuse.[8] Potential reasons for individuals with low SES not seeking regular follow up care are many. In general, some possible barriers to follow up care are long wait times for service, limited health insurance benefits, limited clinicians willing or able to provide services, and multicultural barriers such as perceived bias and cultural mistrust. The barriers to care that I commonly observe in my clinical practice will be further discussed later.

A major issue for the underserved populations is their increased risk for suffering from psychosocial stressors and mental health disorders.[11] The points highlighted in this article are from my personal observations from working with the underserved community in the bay area, providing medication management services to the Oakland community for the past six years. Currently, my clinical practice site is at the Pathways to Wellness Psychiatric Community Clinic in Downtown Oakland where I provide care to the Medi-Cal insured patients under a Collaborative Practice Agreement (CPA). In the outpatient psychiatric community clinic setting in downtown Oakland, the majority of the patients I treat on a daily basis come from a lower SES background in Alameda County. My patients are moderately to severely ill adults with at least one and often times multiple psychiatric diagnoses that impair their day to day functioning. Working with this population and providing medication management services as a clinical psychiatric pharmacist to the underserved has been truly an eye opening experience for me with regards to the negative impact of low SES on mental health. The challenges that these patients face on a day to day basis may seem foreign to most people who are not familiar with their situation. Being culturally aware is an important part of providing care to the lower SES minorities. From working with the disadvantaged population I have learned a great deal regarding providing care and individualizing my treatment regimens to best suit my patients.

Barriers to Care

Many barriers exist for patients from a low SES background when obtaining medical care is concerned. Being mindful of the potential barriers to care and problem solving with ways to work around them to optimize management are essential.

Providing Psychiatric Care to Disadvantaged Patients: A Pharmacist's Perspective

In my opinion, aside from their diagnoses, financial stressors have the greatest impact on my patients' well-being. Not being able to afford the basic necessities to live without day to day worry can be stressful and anxiety inducing. Lower SES and financial stressors can negatively impact many areas of patients' lives. From making healthy food choices, to deciding on housing options, and types of available transportations, lower SES can have a domino effect and cause impairments in quality of life overall.

Housing: Finding affordable housing in the Northern California Bay Area is a challenge for many, especially those suffering from mental illness. In a 2016 survey of approximately 300 patients with moderate to severe mental illness in the East Bay area, receiving care at Pathways to Wellness community clinics, the majority of participants reported that housing was one of their top three biggest concerns. Patients with severe mental illness are at high risk for homelessness.[12] Even though government subsidized housing programs exist to assist low socioeconomic status families in need, many other barriers to obtaining sustainable housing exist. For example, property managers may not accept government vouchers or the voucher may not allow be sufficient for accommodate living conditions in the bay area. For patients residing in the Oakland area, as well as the bay area in general, gentrification of the area has resulted in new struggles with regards to affordable housing as rents continue to increase.[13] Patients are faced with the challenge of needing to relocate to more undesirable neighborhoods that are often unsafe. From my observations, residing in impoverished neighborhoods can trigger psychiatric symptoms in patients with mental illness, especially those suffering from post-traumatic stress disorder (PTSD) or substance use disorders. Additionally, the high cost of living limits the ability to afford other essentials such as food, leading to food insecurity.

Transportation

Transportation is yet another great concern for patients suffering from moderate to severe mental illness. Unfortunately, I am a witness to this on a daily basis as patients struggle to make their clinic appointments on time or altogether. This serves as another barrier to accessing treatment. Multiple contributors exist for the lack of transportation. As mentioned previously, patients suffering from mental illness are already at high risk of having lower SES. As such, affordability of transportation plays a big role.

Some individuals may qualify for transportation vouchers, but using public transportation may not be easy or convenient for patients suffering from mental illness. Getting from location A to location B by public transportation, though straightforward for a healthy individual, may pose extreme difficulties for someone struggling with psychiatric symptoms such as the inability to concentrate, memory impairments, irritability, hallucinations, or delusions.

Private transportation, driving a car or being given a ride, may not be the best option. In addition to not being able to afford a car, some patients do not have their driver's license due to the severity of their symptoms impairing their ability to drive or comorbid substance use disorder, such as their previous history of driving under the influence of a substance. A lot of patients do not have a strong social support, so obtaining rides from friends or family members to the clinic may not be a possibility.

Looking for more CE?

NCCCP's first home-study CE, "An Introduction to Food Insecurity for the Advanced Practice Pharmacist," briefly discusses the impact of food insecurity on the medical and pharmaceutical care of patients, and offers suggestions on how to address these challenges.

This free CE module can be accessed at: https://ncccp.net/continuing-education/an-introduction-to-food-insecurity-for-the-advanced-practice-pharmacist/

Providing Psychiatric Care to Disadvantaged Patients: A Pharmacist's Perspective

Additionally, even when the patients do drive to clinic, availability and affordability of parking are some other major concerns. In my practice, phone-based encounters to check in regarding symptoms and medication management. Though phone encounters may be an option, the use of phone follow ups may present their own difficulties. For examples, in my experience, calls could easily be missed, it is difficult to assess a patient's affect over the phone, and not all patients have reliable access to a consistent phone. The psychiatric provider should try to consider these potential barriers that the patient may face with regards to transportation and have empathy for and attempt to accommodate the patient even if he/she presents late to his/her appointment.

Lower Health Literacy

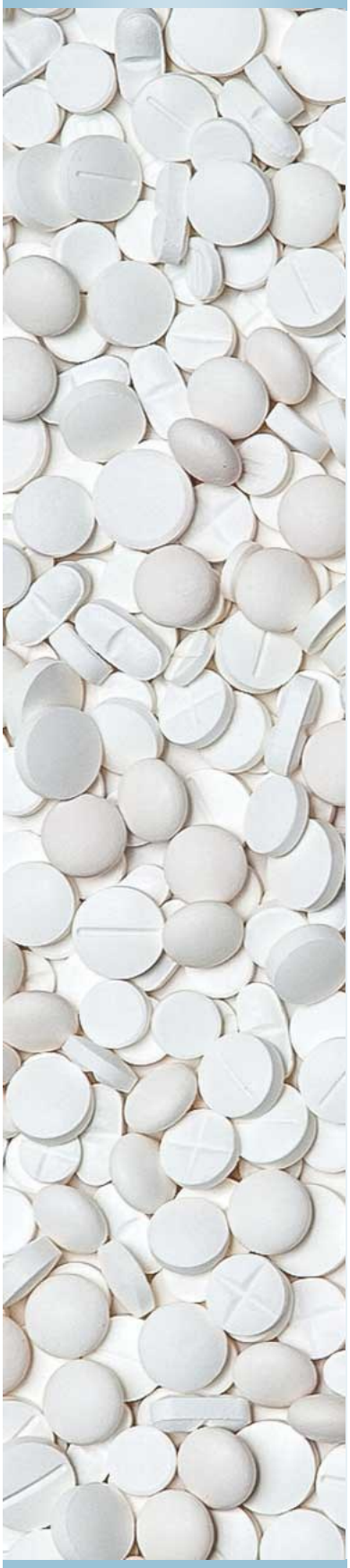
A barrier to management of a health condition in the disadvantaged community is low health literacy.[14] It poses a major problem in the United States. Approximately 80 million adults (36%) having limited health literacy.[15,16] Individuals with low health literacy may have trouble understanding, obtaining, and retaining health information.[17] With regards to mental health this can translate to difficulties with understanding the psychiatric condition being treated, understanding treatment options, and misconceptions about treatment of the disease. To address low health literacy and bridge the gap in patient understanding, healthcare providers may use a variety of strategies in the outpatient clinic setting. Offering patients printed health information including brochures, pamphlets, and journal articles regarding their psychiatric condition and treatment options available may be helpful.[18] Additionally, cultural sensitivity and drawing analogies to concepts that the patients may already be familiar with is another tool that can be applied.

Perceptions of Care Needs

Life experiences, history, and culture all shape the perception of health care needs of an individual. The false perception of an individual regarding their care can negatively impact their chances of seeking healthcare. An example perception barrier is that of "self-reliance and self-silence" coping among African American women.[19] This attitude can affect the treatment African American females receive. Additionally, a number of social, political and legal issues over the past decades have contributed to an epidemic of individuals with psychiatric disorders in the United States prison system.[20] Multiple investigators have reported increased rates of psychiatric disorders in those in the prison compared to the general population.[20] In my experience, negative experiences in institutions and medication management in those settings often times deter individuals who were institutionalized in the past from obtaining psychiatric care and maintaining compliance with medication treatments. Overall, consideration and further studies of the effect of racial and cultural experiences on engagement with psychiatric care are essential.[21]

Challenges for Medication Use

Disadvantaged patient populations with mental health disorders require careful considerations with regards to medication selection and use. Many psychiatric patients are skeptical of psychiatric medications and non-compliant, likely due to lack of acceptance of medications and poor insight, not believing that they have a chronic disease state requiring medication treatment.[22] As patients and family members may perceive their condition as transient, convincing a psychiatric patient they need long

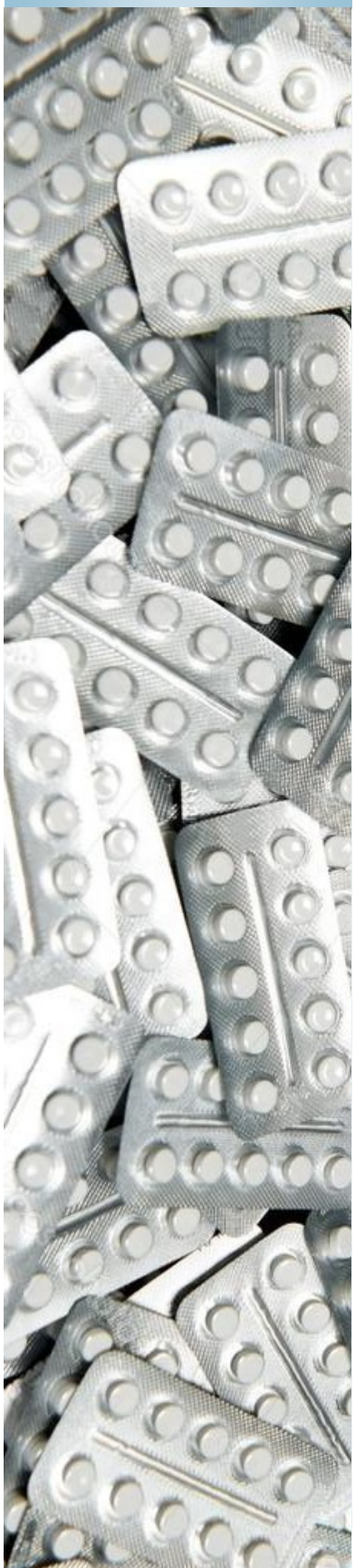


term medications for symptom management may be difficult. Additionally, patients with symptoms in remission for a short period of time may believe that they no longer need treatment to address their symptoms. In my practice, not realizing the importance of medication continuation once symptoms resolve and early discontinuation of medications are common reasons that patients may experience early relapse. A conversation with the patient and their support team, about the medications' effects, and appropriate duration of treatment to avoid relapse is important. Upon discontinuation or changes to a medication regimen, education on tapering doses should occur under the care of a health care provider to allow for safe discontinuation of medications whenever warranted.

Access to the prescribed psychiatric medications may pose a significant difficulty in itself. The trip to the pharmacy to pick up medications can be challenging for patients suffering from severe psychiatric symptoms such as memory impairments or those who are acutely psychotic. In such cases, the health care provider and patient recognizing this issue and seeking help from the patient's family members, friends, or in-home care provider is essential. Alternatively, some outpatient pharmacies provide medication delivery services for patients.

Adherence to medications can be a great challenge for the disadvantaged patients as well. Minimizing the number of prescribed doses throughout the day, whenever possible, increases the potential for adherence to medications.[23] It is thought that the single most effective action from a health care provider to improve compliance is to choose medications that allow for the lowest prescribed dosing frequency.[23] This is made possible when sustained release and extended release formulations of medications are considered to decrease pill burden. Adherence tools to assist patients with taking medications consistently can be implemented. Setting up alarms, using pill boxes, and medication bubble packs may be effective strategies to promote adherence. Family members or friends can help in setting up pill boxes. Some pharmacies can pack regularly scheduled medications in bubble packs for the patient when pill boxes are not an option or to decrease caregiver burden of setting pills in pill boxes. For patients who are still at risk of missing medication doses, even after implementation of adherence strategies, selection of a medication with a long half-life, when possible, may be appropriate. This assures that the patient does not have side effects from abrupt discontinuation of the medication if they miss a dose.

Another possible option exists for psychiatric patients requiring chronic antipsychotic medications for psychiatric symptom management. For patients diagnosed with schizophrenia or bipolar disorder, and struggling to maintain adherence with their antipsychotic medication regimen, consideration of a long acting injectable (LAI) antipsychotic option may be appropriate. LAI antipsychotic medications have been shown to increase adherence rates in psychiatric patients.[24] However, LAI are used in a minority of patients who have the appropriate indication.[24] Under-use may be due to negative attitudes, perceptions, and beliefs of patients and psychiatric providers. Investigators have found that LAI antipsychotic use results in lower rates of discontinuation, relapse, and hospitalizations.[24] Ultimately, LAI antipsychotic use leads improved functioning, better quality of life, and also greater patient satisfaction.[24] Data assessing the effect of initiation of LAI or oral antipsychotics on cost and adherence in a Medicare population reveal that though drug costs were significantly ($p < 0.001$) higher with LAI use, health care costs, both inpatient and outpatient, were significantly ($p < 0.001$) lower with LAI.[25] Additionally, adherence was significantly higher ($p < 0.001$) with LAI use as compared to oral antipsychotics.[25] Other studies confirm that



Providing Psychiatric Care to Disadvantaged Patients: A Pharmacist's Perspective

related hospitalizations and hospital charges were reduced with LAI antipsychotic use.[26] Use of LAI antipsychotics lowered schizophrenia-related costs by $5,576 and hospital costs by $7,744 annually.[26] Additionally, a post hoc analysis of paliperidone ER compared to paliperidone palmitate (LAI) revealed that tardive dyskinesia and incidence of dyskinesias were similar.[27]Underuse in patients who could benefit from LAI should be addressed. A thorough discussion of benefits and risks of LAI antipsychotics, especially in those with a history of nonadherence to the oral antipsychotic medications, should be considered. Dispelling myths regarding use of LAI antipsychotics is of extreme importance as it may be beneficial for overall patient outcomes.

Resources for pharmacists gaining expertise in mental health care

A number of organizations exist as resources for not only pharmacists seeking to build psychiatric expertise, but also psychiatric patients and their families.

A well-recognized organization is the College of Psychiatric and Neurologic Pharmacists (CPNP).[28] CPNP is an organization that is devoted to promoting psychiatric pharmacy practice and education. CPNP is involved with advancing research in the area of psychiatric pharmacy and developing knowledge for treatment of psychiatric and neurologic disorders. This organization also promotes board certification in the area of psychiatric pharmacy. Indirectly, CPNP enhances the mental health care of patients and their families by providing education on psychiatric and neurologic disease states and treatment options.

Another reputable organization is the National Alliance on Mental Illness (NAMI), the largest grassroots mental health organization in the United States.[29] NAMI aims to improve the lives of patients with mental illness. In addition to mental health advocacy, NAMI has great educational programs for patients, families, and providers. NAMI builds public awareness of mental health, promotes understanding, and fights stigma through various events and activities such as the Mental Illness Awareness Week and NAMI Walks.

Pharmacists are encouraged to take part in these organizations to further their education, share experiences with others who have the same interests, and in turn better the mental health care of affected individuals. These organizations allow for many volunteer opportunities, providing a chance to get involved and give back to the community.

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Providing Psychiatric Care to Disadvantaged Patients: A Pharmacist's Perspective

Self-Assessment Questions

1. Disadvantaged populations experience the same rate of mental illness as middleclass populations.
    A. True
    B. False

2. Which group is most likely to receive needed care for mental illness?
    A. Asians
    B. Blacks
    C. males
    D. females

3. Which of the following factors are associated with non-compliance in disadvantaged psychiatric patients?
    A. Psychosis
    B. History of incarceration
    C. Symptoms improving with drug treatment
    D. All of the above

4. Which of the following is FALSE?
    A. Patients with severe mental illness are at higher risk for homelessness
    B. Finding affordable housing in the Bay Area is a challenge for many psychiatric patients
    C. Belief of not having a chronic illness can lead to medication non-compliance
    D. Impoverished individuals are at lower risk of seeking emergency psychiatric care

5. Prison inmates have increased rates of psychiatric disorders compared to the general population
    A. True
    B. False

6. Investigators have found that the use of long acting injectable (LAI) antipsychotics result in better adherence, lower rates of discontinuation, relapse, and hospitalizations. Which of the following antipsychotic medications is available in a LAI formulation?

    A. Saphris
    B. Invega
    C. Latuda
    D. Vraylar

7. Offering patients printed health information including brochures, pamphlets, and journal articles regarding their psychiatric condition and treatment option is helpful in addressing low health literacy.

    A. True
    B. False

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Reviewer Information:
Reviewer Patrick Finley, PharmD, BCPP reports no conflicts of interest.
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Reviewer Diane Wong, PharmD, reports no conflicts of interest.
Reviewer Patty Montgomery, PharmD, HACP reports no conflicts of interest.
Reviewer Tina Denetclaw, PharmD, APh, BCPS reports no conflicts of interest.