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SSC 5c Elective Report

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Dates of elective: 5th May – 23rd May 2014

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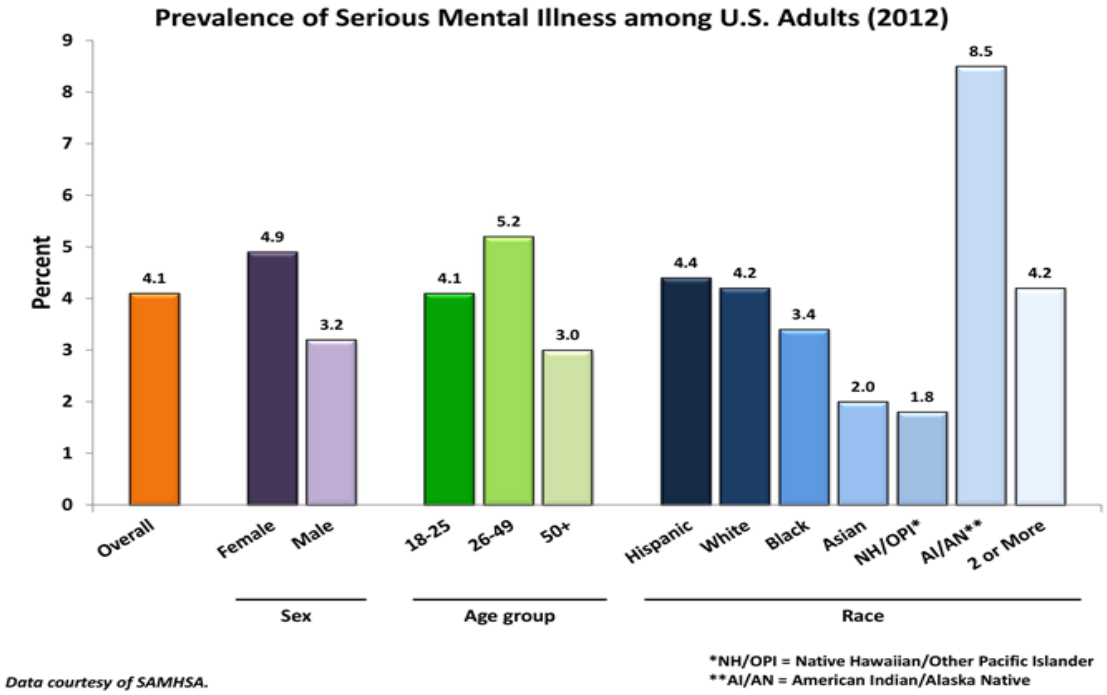
Subject: Advanced Clinical Psychiatry at Cedars-Sinai Medical Centre, Los Angeles

Elective Objectives

What is the prevalence of psychiatric conditions in LA? How does this differ from the UK and other major US cities, e.g. New York, Texas

It has been difficult to find data specifically for Los Angeles and so the focus for this objective looks at more national figures for the occurrence of mental health in the US. An estimated 26.2 percent of American adults, approximately one in four, suffer from a mental illness in a given year[1].

In 2012, there were an estimated 43.7 million adults aged 18 or older in the U.S. with AMI (any mental illness*) in the past year. This represented 18.6 percent of all U.S. adults. The table below shows the prevalence of mental illness in the US according to gender, age and race.



(source of table: http://www.nimh.nih.gov/statistics/SMI_AASR.shtml)

*Note AMI is defined as:

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- A mental, behavioral, or emotional disorder (excluding developmental and substance use disorders);
- Diagnosable currently or within the past year; and,
- Of sufficient duration to meet diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Based on epidemiological data from the 2001–2003 National Comorbidity Survey Replication (NCS-R), 34 million American adults, or 17 percent of the adult population, had comorbid mental and medical conditions within a 12-month period[2]. Further data from the NCS-R found that approximately 25 percent of American adults meet criteria for at least one diagnosable mental disorder in any given year[1].

According to data collected by the National Institute for Mental Health (NIMH) in 2006 mental health was the third most costly medical condition, behind heart conditions and trauma, with total costs estimated at $57.5 billion[3].

Comparing the US data with that of statistics that are available from the UK, there are some similarities. For example, The Office for National Statistics Psychiatric Morbidity report found that in any one year 1 in 4 British adults experience at least one mental disorder, and 1 in 6 experiences this at any given time[4]. The prevalence of specific mental health illnesses is documented in the table below and is gathered from a survey done every seven years in England[5]. The latest figures were collated in 2009.

Mental Illness	Prevalence (in 100 people)
Depression	2.6
Anxiety	4.7
Mixed anxiety and depression	9.7
Phobias	2.6
OCD	1.3
Panic disorder	1.2
Post traumatic stress disorder	3.0
Eating disorder	1.6

How is healthcare for major psychiatric conditions provided for within the USA? Is it different from that of services offered in the UK?

In LA several services exist to help treat patients with mental illness. I've listed a few below:

- Full Service Partnerships – this means a provision of care that involves a low staff to client ratio, a 24/7 crisis availability and a team approach that is a partnership between mental health staff and the patient. Services can be provided to individuals in their homes, the community and other locations and exist for different client groups, i.e. teenagers, adults and older adults.
- Wellness Centres
- Crisis Intervention services
- School-based projects
- Family Education and Support Projects
- Trauma Recovery services - provide short-term crisis debriefing, grief, and crisis counseling to clients, family members and staff who have been affected by a traumatic event

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- Primary Care and Behavioral Health Services - develop mental health services within primary care clinics in order to increase primary care providers capacity to offer effective mental health guidance and early intervention through the implementation of screening, assessment, education, consultation, and referral
- Integrated Peer-Run Model – this program supports people with mental health needs who also have additional health and/or substance abuse treatment needs to become well and stay well by providing new programs that are designed and run by people with lived experience of mental health issues.

There are also inpatient and outpatient treatment plans available. Treatment and support offered in the US often depends on the health insurance policy that a patient has, although a psychiatric hospital cannot legally refuse to treat a patient based on their insurance policy. Fortunately many support projects and intervention programs, including some mental health hospitals, are publically funded or are not-for-profit organisations, making them more accessible to those who need them.

The services provided in the UK are very similar, except for the fact that the patient is not required to pay for their treatment, unless of course they choose to attend a private facility or pursue private consultations.

There are some minor differences when it comes to sectioning or holding a patient who refuses psychiatric treatment and so needs an involuntary admission. In California to place a patient into involuntary treatment they are placed on a "5150 hold", and this can be done by either a certified psychiatrist or a police officer. However, the hospital needs to have a permit that allows them to place patients on a 5150. Cedars-Sinai no longer holds such a permit and so they have to call in a Psychiatric Emergency Team (PET) for the patient to be assessed and subsequently transferred to a receiving mental health center.

In the UK, hospitals do not need to have a permit to hold/section patients within their institute. Additionally, professionals other than police officers and psychiatrists can place holds on patients, for example registered mental health nurses, other approved mental health professionals and relatives can co-sign papers that section patients for temporary periods (i.e.6-72 hours) until a formal assessment is performed. This occurs according to section 5 of the Mental Health Act in the UK, and is colloquially known as a nurse's or doctor's holding power. Patients can refuse treatment under section 5 but they will be detained until two independent assessments of their mental health status have been conducted.

What are the side effects of treatments used for patients diagnosed with schizophrenia?

Patients with schizophrenia are often treated with antipsychotics. These are split into two categories, the older typical agents and the newer, more widely used atypical agents. I've listed them below, with the American trade name in brackets.

Typical	*Atypicals*
• Chlorpromazine (Thorazine) • Haloperidol (Haldol) • Perphenazine (generic only) • Fluphenazine (generic only)	• Risperidone (Risperdal) • Olanzapine (Zyprexa) • Quetiapine (Seroquel) • Ziprasidone (Geodon) • Aripiprazole (Abilify) • Paliperidone (Invega) • Lurasidone (Latuda)

It is common for patients to experience side effects when they commence these treatments. Most side effects subside after a few days and are often managed successfully. It would be cautious to advise patients not to drive whilst taking these medications or at least until they have adjusted to them.

Side effects of many antipsychotics include:

- Sedation
- Positional vertigo
- Blurred vision
- Tachycardia
- Photophobia
- Skin rashes

It is widely known that a negative impact of the atypical drugs is major weight gain and changes in a person's metabolism. Furthermore, they can increase a person's risk of getting diabetes and high cholesterol[6]. Consequently, it is advisable to closely monitor a patient's weight, glucose levels, and lipid levels for the time period that they take any atypical agents.

Typical antipsychotic medications can cause extra-pyramidal side effects, due to dopamine blockade of nigrostriatal pathways in the brain. These include:

- Dystonia – involuntary, painful sustained muscle spasm
- Akathisia – unpleasant, subjective feeling of restlessness
- Parkinsonism – triad of resting tremor, rigidity and bradykinesia
- Tardive Dyskinesia (TD)

TD often results after long-term use of typical antipsychotics and means patients are unable to control their muscle movements, especially those that supply the mouth. For some patients it becomes an irreversible condition, which is why it is important to consider reducing the dose or stopping the medication and switching to an atypical agent.

It is vital to be aware that antipsychotics can cause neuroleptic malignant syndrome. This life-threatening condition can be triggered by a new drug or when increasing the dose of an antipsychotic. Psychiatrists should encourage their patients to seek medical treatment if they experience fevers, muscle cramps or tachycardia.

Personal/Professional development goals whilst on elective

I specifically organized an elective in the US because I have long term plans to move here and I wanted to find out more about the structure of the mental health system and also the steps I would need to take in order to have a license to practice in the States. Before my arrival I had been able to do some reading online about these two questions but it has been invaluable to be here in person and see things first hand.

The staff at the consultant-liaison psychiatry department have been extremely helpful in providing me with learning opportunities, i.e. attending ward rounds, grand rounds and being invited to partake in a new research group they have set up. I have been able to shadow a few different psychiatrists which enabled me to see the varying ways in which a psychiatric consultation can be conducted. I was given the opportunity to lead on a few patient consults and very much enjoyed this as I had to think on my feet and

liaise with both patients and their families. I received constructive feedback on my performance and it helped to highlight the weaknesses in my questioning format and diagnosis formulation. This is particularly useful for my immediate future as a doctor in the UK because I have a psychiatric rotation during my first year of practice.

With regards to the process of being able to practice in the States as a doctor, I have a much better understanding of what is required of me now and am grateful to the staff here at Cedars-Sinai for their guidance and support. If you are a Bart's student reading this report and want to know more about the USMLE examinations please do get in touch.

References

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4. Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H. Psychiatric Morbidity Among Adults Living In Private Households 2000 London: The Stationery Office p32, 2001.

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