HEALTH AND WELLNESS SCREENING REPORT
Alternatives Conference 2009

Currently, Americans who have major mental illnesses die an average of twenty-five 25 years earlier than the general population (NASMHPD, 2006 and other sources). They experience the largest health disparity in the United States. This disparity in life expectancy is unacceptable and costly. People with serious mental illnesses have a right to and deserve to live as long and healthy lives as other Americans. As the National Association of State Mental Health Program Directors (NASMHPD) Medical Director's Council reported, the "increased morbidity and mortality are largely due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care." (NASMHPD, 2006, p. 4). That same report goes on to note (p. 6) "that the second generation antipsychotic medications" [very widely in use in the population of people with major mental illness, with and without symptoms of psychosis] "have become more highly associated with weight gain, diabetes, dyslipidemia, insulin resistance and the metabolic syndrome.

Sixty percent of premature deaths are due to medical conditions such as cardiovascular, pulmonary and infectious diseases which are frequently caused or worsened by controllable lifestyle factors (physical activity, smoking, access to adequate healthcare and prevention services, diet and nutrition, and substance abuse as well as others). In responses to these alarming statistics, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services which supports the annual Alternatives Conference to provides a forum for peers from all over the nation to meet, to exchange information and ideas, and therefore choose to offer effective proactive strategies through a health and wellness screening service.
The screening was conducted on October 20-30, 2009 and was planned, coordinated and managed by peer provider staff from the Institute for Wellness and Recovery Initiatives at Collaborative Support Programs of New Jersey. The event was staffed by peers with nursing and health care backgrounds, and included the following assessments:

- height,
- weight,
- Body Mass Index (BMI), calculated from height and weight,
- waist circumference, a measurement now credited by many authorities as a better predictor of obesity-related health risk than BMI (Janssen, Katzmarzyk & Ross, 2004)
- Current medications in use,
- blood pressure; and
- blood sugar levels doing an on-the-spot test known as Hemoglobin A1C (HA1C) which provides an estimate of blood sugar levels over the past 120 days, and is not impacted by a recent meal.

The following includes some individual information gathered from participants regarding their perception of the usefulness of this screening.

Individual Data was collected (N=72) from participants

- 32 % males and 68% females.
- 72 % Caucasian, 18% African American, 1% Latino, 3% Asian, 4% other and 2% not reported.

	Our Screening			General Population of US Adults			
Category	**Range**	**Mean**	**SD**	**Data**			**Source**
Number of Rx taken	0-15[1]	5.22	3.9	No stats or guidelines located.			
Height (inches)				Men: 69.4 Women: 63.8			CDC, 2009
Weight (pounds)	116-356	211	53	Men: 175.4, Women: 161.8			CDC, 2004
Waist Circumference (inches)	28-62	43.22	6.8	Men: 39.7, Women: 37			CDC, 2009
BMI	21.5-57			Men:27.8, Women:42.3.			CDC, 2004
HA1C	4.5-9.6	5.6	0.83	Recommended guideline that 6.5 or greater is diagnostic of diabetes			Kerr, 2009
Blood Pressure				National Guidelines			NHLBI, 2008
				Normal	"Pre-hyper tension"	Hyper-tension	
Systolic	79-188	122.9	18.6	<120	120-139	>139	
Diastolic	49-103	79.7	10	<80	80-89	>89	

The most significant finding from the screening was that 3 individuals were tested, who did not indicate that they were diagnosed or under treatment for diabetes, who registered A1C levels >7.0. While some factors can result in less than completely accurate HA1C results, it is very likely that these 3 peers have active diabetes, and this screening gave them information they can use to access medical care for that condition before resulting in more debilitating medical complications caused by the diabetes.

10 of the 70 others tested had HA1C values over 6.0. While these may be more equivocal markers of diabetes (and may include some combination of testing errors and people with "pre-diabetes," doubtless some of these individuals will be able to get care they were unaware they needed, and reduce the risks of diabetes related health issues.

The frequency of these high values is significant when coupled with some anecdotal observation that this seemed to be a population of people who were mostly engaged in getting medical care. Quite a few seemed conversant with their health

[1] 8 people reported not taking any medication

histories, and/or were on medication for other physical conditions. Therefore, it reinforces our perception that the proportion of peers who have undiagnosed chronic physical health conditions is significant.

Screening Participant Feedback		N	Strongly Agree	Agree	No Comment	Disagree	Strongly Disagree
1.	The screening was well run.	66	73%	23%	3%	--	1%
2.	The screening was useful.	65	72%	25%	1%	--	1%
3.	The screening was definitely worth my time.	66	73%	23%	3%	--	1%
4.	I would like to see screening like this at future peer-oriented events.	65	83%	14%	1%	--	1%

Participants were asked to identify what test or examinations could be added to this screening. The following responses were provided:

Visual	Dental	Vital capacity	Weight Loss/ Assessment	Cancer HIV/AIDS	Labwork
▪ Glaucoma screening ▪ Eye exam	▪ Dental exam	▪ Stress test ▪ Lung capacity ▪ CO2 monitoring ▪ Oxygen Saturation ▪ Breath tests for smoking	▪ Body fat index ▪ Weight loss contest ▪ Pedometers ▪ Treadmill ▪ Easy exercise demonstration	▪ Mammograms ▪ Orasure (HIV) Test ▪ Skin cancer screening	▪ Cholesterol ▪ Non-fasting glucose screening

Peer-operated settings

Participants were also asked to report on what kinds of peer-operated events and programs could make use of a health and wellness screening. The responses to this question seemed to indicate that people are picturing health screenings at a wide variety of events inside and peripheral to mental health settings including:

- Drop – in centers, statewide meetings of consumers, respite house
- Health and Resource Fairs
- Clubhouses, mental health centers

- Conference, state meetings, awareness events at state capitols, advocacy opportunities, community mental health center, leadership trainings

Usefulness of Screening

Participants were the asked to report what they plan to do with the health information they learned. The majority of attendees reported they intended to use the information in 2 major ways, both consistent with goals and objectives of the screening:
- to consider and implement changes in their own health behavior (weight, exercise and smoking, etc), and
- to follow up on identified issues with their own physicians (follow up with my doctor or set a plan to see a doctor).

The process ensured that every individual left the screening site with a personal copy of their results. People with unusually high values were encouraged to seek medical care promptly. It should be noted that may people SEEMED willing to take high values (even weights) as an impetus to seek medical care. This may or may not generalize to screenings in a less self-selecting population, or one with less motivation than the typical Alternatives attendee. The Health Fair offered a wide variety of literature with practical advice regarding dealing with various health and health-related conditions. We have talked about "print on demand systems," so that people could select (or automatically be provided) literature related to their individual needs. This would be superior, but would require even more resources than currently available.

Summary

Participants were then asked to report any other inputs of suggestions. Many reported that this was very good ("This was a great learning tool regarding my health", "great literature"). The obvious, frustration reported was the time factor ("the screening took longer than expected", "a quieter situation would be nice, more privacy for weighing and measuring"). It takes at least 20 minutes if not more for a participant to complete all the steps of the screening we offered. Many of the attendees provided feedback that they felt that the process took longer than it should have. It is true that an appointment system could have kept the flow of people more uniform and therefore greatly reduced some people's total time in the screening. The initial concern was that strong appointments would result in fewer attendees. Total time could also be reduced by moving to a large-scale screening on an "Assembly line" model. This of course, would require a larger workforce and greater space."

Responses to the survey make clear:
1) that many of the attendees believe that this kind of screening could fit into a wide variety of events and venues, and
2) That there are many other kinds of health metrics which could be assessed in a screening.

3) that people with mental health problems are willing and eager to partake in health prevention and promotion activities.

Suggestions for Convening a Screening

Participants expressed a consensus that a wide variety of ways exist in which peer and non peer groups can conduct health screenings. Many will be working with local opportunities, such as transporting peers when the mobile ophthalmic or mammography screening comes to town. Others can be very self-service, such as ensuring that people have access to a scale and a sphygmomanometer in the mental health/peer support setting. A good deal of the content of intentional screenings is dictated by costs. Oral AIDS rapid-screening kits cost nearly $18 apiece. HA1C kits cost about $10 apiece. Test strips for cholesterol and triglycerides can be purchased for about $5 apiece. (Separate products). Mouthpieces for spirometry testing cost just over $1 apiece.

There are some things which could be added to a screening at little or no cost, such as a vision-only screening. It might also be interesting to couple screenings with institutes on getting good medical care, developing and maintaining a personal health record, diet improvements, helping our peers to do these things, etc.

CMHS staff along with peer provider staff from Institute for Wellness and Recovery Initiatives, Collaborative Support Programs of New Jersey believe that peer driven screenings create an opportunity to help people become aware of their health and wellness, which is a very good investment. We encourage peer and peer-partner agencies interested in or currently engaged in health screenings for mental health events and are open to sharing our experiences. If you would like more information about this event or assistance in planning a screening in your own community please contact Peggy Swarbrick of the Institute for Wellness and Recovery Initiatives at her e-mail address pswarbrick@cspnj.org.

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