

Making Evidence-Based Lifestyle Modification Programs Available in Community Mental Health Centers: Why So Slow?

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Lifestyle modification programs to promote healthy diet and physical fitness should be an integral component of the treatment provided in community mental health centers. Over 50% of adults with serious mental illness are obese.¹ Persons with schizophrenia consume more calories and saturated fats, on average, than the general population, while fewer than 20% engage in regular physical activity.² These poor health behaviors lead to a markedly increased risk of premature death among individuals with serious mental illness, largely due to cardiovascular disease and other chronic medical conditions associated with obesity.

Until recently, community mental health centers have neglected physical health promotion as a core service for clients. This is rapidly changing. In 2009, in response to growing concerns about the excess morbidity and mortality among mental health consumers, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) issued the Primary and Behavioral Health Care Integration grant program.³ Since 2009, this grant program has provided more than \$20 million per year of funding to 100 community mental health organizations across the country to provide primary care, preventive, and wellness services to their clients.⁴ In addition, the Medicaid health home option in the 2010 Affordable Care Act offers new opportunities for behavioral health agencies. By becoming behavioral health homes (ie, health homes for individuals with mental health disorders), these agencies can implement practices and programs to optimize the physical health of clients.

These innovative models to integrate primary and preventive care into community mental health centers present a critical need for effective interventions to improve health outcomes among individuals with serious mental illness. Lifestyle modification interventions, the focus of the review by Ward et al,⁵ are an excellent example of interventions that should be widely disseminated. Among individuals who are overweight or obese, weight loss of 5% or more of body weight can have tremendous clinical significance, reducing the risk of diabetes, hyperlipidemia, and cardiovascular disease. As detailed in the review by Ward et al,⁵ there is substantial evidence that lifestyle modification interventions lead to clinically significant weight loss for one-third to one-half of participants in studies of general population samples.

Moreover, in rigorous randomized controlled trials,^{6,7} up to 38% of individuals with serious mental illness can similarly lose a clinically significant amount of weight when they participate in such interventions.⁶ From a public health perspective, this magnitude of weight loss across a population represents a substantial return on a small investment by community mental health agencies to implement lifestyle modification programs.

At least 12 effective lifestyle modification interventions are currently available for implementation in community mental health centers.² But despite substantial evidence for effectiveness, these programs are still not typically available in these settings. It is puzzling why community mental health agencies have had such difficulty embracing these evidence-based programs. In the past, there was a pervasive perception that lifestyle changes to promote weight loss were too difficult to warrant intervention, especially among individuals with serious mental illness. Mental health clinicians felt discouraged that patients were not motivated or lacked the resources to make necessary changes, or they believed that biological factors (such as the metabolic effects of second-generation antipsychotic medication) precluded clinically significant weight loss. But clinical trials^{6,7} over the past several years have demonstrated that individuals with schizophrenia and other serious mental disorders can make clinically significant changes and that community mental health centers can support them and be partners in these positive changes. Just as we have acknowledged the health risks of smoking and the need for us to act to mitigate these risks, we are now recognizing our responsibility to provide obesity treatment as part of the “whole person” care we provide in our community mental health centers. We recognize obesity as a public health crisis and believe we are doing something about it.

The critical problem may be that resources are being directed to interventions with no evidence to support effectiveness. In this issue, Ward and colleagues⁵ identify the critical components of effective lifestyle modification interventions. In a recent white paper for SAMHSA, Bartels et al² identify the critical components for effective lifestyle modification interventions for individuals with serious mental illness—and reach very similar conclusions. First, the intervention should involve multiple components, addressing (at least) nutrition and physical activity. Second, longer duration interventions (at least 4 months) and increased frequency of contact—in particular face-to-face contact—appear to result in increased effectiveness. Finally, and perhaps most importantly, utilizing trained providers to deliver manualized interventions increases effectiveness.

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But interventions currently available in community mental health centers do not typically employ these key elements. Specifically, they often lack a structured curriculum and are not long enough or do not have contact that is frequent enough to be effective. Manualized interventions are rarely employed. Typical interventions involve education about nutrition but not the active weight-management interventions (food diaries and monitoring of weight) that have proven effectiveness.²

There are logistical barriers to providing lifestyle modification programs at community mental health centers: nutrition and physical fitness programs require space for group exercise and perhaps dining and kitchen facilities, and they also require resources for training interventionists and printing manuals and patient education materials. In the clinical trials evaluating lifestyle modification interventions, these resources (and therefore the services) typically disappear when the grant ends. Our group at the University of Washington and King County Mental Health, Seattle, has shown that training community mental health clinicians to deliver an evidence-based lifestyle modification intervention could be an effective strategy to increase the sustainability of high quality interventions. In our recent pilot study in King County Washington, 20 community mental health center clinicians were trained to deliver the Diabetes Prevention Program (DPP) in 6 county mental health agencies. Twenty-two percent of the 60 participants who participated in DPP groups lost 5% of their initial body weight. Mean weight loss among these participants after 6 months was 4.4 lb, comparable to the magnitude of weight loss in randomized controlled trials.⁸

But community mental health centers are more than just a convenient location to deliver lifestyle modification programs for persons with serious mental illness. As these settings are where clients receive mental health treatment, they provide an opportunity to integrate weight loss goals into mental health treatment, capitalizing on frequent clinical contacts with case managers, peers, nurses, and psychiatrists to reinforce goals and progress. For example, lifestyle modification group facilitators can interact directly with prescribers regarding the cardiometabolic risk of psychiatric medications. Clinicians can support attendance at groups and assist clients in practical ways to attain their goals (eg, help with tracking of diet and activity minutes, walk with clients during sessions so they reach physical activity minute goals). Such true integration of these services will require

a shift in the roles and responsibilities of clinical providers and processes of care. Providing an evidence-based lifestyle modification program as a core treatment service represents a transformational change for a community mental health agency.

The reduced life expectancy for adults with serious mental illness is among the greatest health disparities experienced by any subgroup in the United States, and failure to embrace evidence-based interventions may be the biggest obstacle to bridging the mortality gap for these patients. We can no longer afford to dedicate scarce resources to providing ineffective treatments. Payers should (and will) demand that we provide evidence-based practices and interventions. There is still much work to be done, including large-scale effectiveness trials in real-world settings and comparative effectiveness studies of implementation strategies. Implementation of evidence-based lifestyle modification interventions is a critical step in achieving the goals of better quality, improved outcomes, and reduced costs of care for a clinically complex, vulnerable population.

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