Diabetes Management for Persons with Mental Illness and Developmental Disabilities

with Becky Farley, RN

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Summary

The diagnosis of diabetes is serious, and of particular concern when an individual also has a mental illness or a developmental disability. People need to take an active role in the management of diabetes just as they do with a mental illness. In this presentation, Ms. Farley explains how diabetes is recognized and managed, and shares her experiences caring for people who have diabetes along with a developmental disability or a mental illness.

Presenter

Becky Farley, RN, graduated from nursing school in 1971. She served at Saint Louis University for five years in the Open Heart Unit, then in various emergency departments for about 25 years, including about ten years of management. She then served as an RN Consultant for New Horizons Community Support Services in Jefferson City, Missouri, and has been full time for about ten years at New Horizons, now serving as the Director for the Residential Services Program.

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References

www.WebMD.com

http://www.americanheart.org

www.Diabetes.org

http://www.forecast.diabetes.org

http://www.diabeteseducator.org

Glossary

Insulin --A hormone which promotes glucose use, protein synthesis, and the formation and storage of neutral lipids which is used in the treatment of diabetes.

Pancreas—The gland responsible for the secretion of insulin

Type I Diabetes, formerly called Juvenile Diabetes, occurs when the body's own immune system fights off and destroys insulin-producing cells of the pancreas

Type II Diabetes, formerly called Late Onset or Adult Onset Diabetes, occurs when the body produces insulin, but either not enough or the body doesn't use it properly.

Transcript

Thom Pancella: Hello and welcome to this MIMHraining.com presentation called: Diabetes Management for Persons with Mental Illness and Developmental Disabilities. I'm Thom Pancella with the Missouri Institute of Mental Health, thank you for joining us today. We are joined by Becky Farley who is a registered nurse. She graduated from nursing school in 1971. She served at Saint Louis University for five years in the Open Heart Unit, then in various emergency departments for about 25 years. She's got about ten years of management experience in the emergency departments. She then served as an RN Consultant for New Horizons Community Support Services in Jefferson City, Missouri; and has been full time for about ten years at New Horizons, now serving as the Director for the Residential Services Program. Becky, thanks for joining us today.

Becky Farley: You're welcome.

TP: A lot of this background information on you does not touch on diabetes it does not touch on developmental disabilities or mental illness. Would you bring some of that experience to the table for us?

BF: Sure. The group homes and the residential care facilities that I am responsible for overseeing the operations house, or serve, the severely or persistently mentally ill and those with developmental disabilities. Several of our clients do have diabetes who do reside in those facilities. It's my responsibility as the RN to help those individuals plus the staff understand diabetes how it affects their lifestyle and how to assist them with their treatment.

TP: So let's get a little background on diabetes itself as we get into this. Who gets diabetes? How do you get it? Is it contagious? Those sorts of questions.

BF: Okay. It's not contagious. It is an acquired disease in that there are certain risk factors that set people up. The primary risk factor is family history. If a parent or a sibling has diabetes that certainly sets you up for the possibility to eventually develop diabetes. The other factors can include obesity, lifestyle—a sedentary lifestyle, poor eating habits, with our fast foods that we have now and that we all probably tend to stop and get hamburgers, fries, and of course we get our dairy through

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chocolate shakes--sets us up again, too, for diabetes. Specific or certain ethnic groups have a higher prevalence of diabetes, African Americans, Hispanics, and Native Americans tend to develop diabetes more than other ethnic or race groups do. As we age also the risk of developing diabetes also increases. There are specific--two types of diabetes--and back when I was in nursing school primarily it was the first, the youngest group, that developed was called Juvenile Diabetes and those obviously developed primarily in childhood on up through teenage years and maybe young adulthood. There is Type II, or what we call back then, Late Onset Diabetes which was primarily in the age group from maybe 40 or 50 on up. Juvenile Onset Diabetes is caused or was caused by the body not producing insulin. Type II Diabetes or Late Onset Diabetes, as it was called then, was caused by the body made enough insulin but was unable to utilize it appropriately. Now we call diabetes--the two types of diabetes Type I and Type II; because over the past thirty years the incidents of those two types of diabetes has seem to crossed over the age lines. We have older people developing Type I Diabetes, and now and we have a large segment of our young people Type II diabetes. A lot of that is attributed to, especially for the younger group, developing type II, is our sedentary lifestyle and as I was talking about earlier our eating habits - we do eat a lot of processed food, a lot of fast food very few fruits, vegetables and foods that we actually sit at home and eat as a family, like we did when I was a child. Exercise--when I was a kid, I don't know about you, I could leave the home in the morning and play and be on my bicycle wherever I wanted to go and my parents didn't worry about it. Now, in our society it's--you wonder where your child is all of the time. So, our exercise for our children has really changed. Its computers, Nintendo's, Blackberry's and whatever else they play with and those electronic things that I don't know anything about--nor do I think I want to know anything about. So, that has really, really set our society up for that ... for diabetes. It is in epidemic forms now and I think if I remember my statistic right about 54 million Americans that may already have diabetes or are in the process of developing diabetes.

TP: You talked about increase in prevalence of both and the crossover in the age. Are you seeing more of one or the other now? Is

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one of them growing faster?

BF: I can't say 100% because I haven't really studied that; but it seems to me like the Type II diabetes seems to be a bigger problem than the Type I. Especially my big concern too is that our children are becoming obese, more of our children are obese. They are going on treatments that were before not even an issue at that age. I've had one client who was a resident in one of our facilities that developed a Type I diabetes and I think she was about in her 20 or 30's and was quite a surprise to me; because that point I hadn't really sat down and really thought about. She developed Type I and she's quite ill in the Intensive Care Unit upon her admission to the hospital until they got her diabetes under control. Which I guess is a pretty good segway to kind of talk about mental illness and diabetes. I was really concerned about her. I wasn't sure how she would handle it. She came back to our facility after several weeks at a skilled nursing facility learning how to handle her diabetes and her insulin regimen. She was on a very complicated insulin regimen, she took a daily dose, a scheduled dose, and then she was also on what we call a sliding scale that she would check her sugar throughout the day and depending on where her sugar was determined how much insulin that she took. Those of us who work in the mental health departments and work with mentally ill individuals realize that one of the most difficult diagnoses to work with, at least I found difficult to work with, is Borderline Personality Disorder, and this individual is a Borderline Personality Disorder--or has that diagnosis. My concern was not only did she have a very difficult insulin regimen but she had the Borderline issue also and Borderline individuals tend to use things to manipulate people. My concern was that she was gonna either omit a dose, or take a dose and not eat, or take too much and become very ill from it. It didn't prove to be an issue; I was very surprised. She knew her insulin regimen, she knew her schedule of her sliding scale and how much she was supposed to get when, and at least when she was with us in a residential care facility that wasn't a problem. But there certainly were issues that could come up that if an individual wanted to--say they have Major Depressive Disorder and they learned about insulin and how they could make themselves very ill or may be commit suicide that was a

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potential problem. If they're on insulin and they take their insulin and not eat it's going to cause their sugars to drop and it can drop to a point that they could die. So that is a problem. That also could happen inadvertently. Not necessarily a planned situation--they could possibly take their insulin and somehow get distracted and not eat when they need to. That can be handled as soon as they realize what's going on and if they eat then they can counteract the insulin and get enough food in their body for the insulin to...the food breaks down to glucose so the insulin can work on the glucose and get back into the cells and their sugar level rises. And that was very bad pathology there…

TP: You started talking about folks that may have a mental illness and you touched on Depression and Borderline and we have a lot of folks in the various mental health systems with Schizophrenia. How do you teach the people that work with those people about the diabetes management as it coincides with mental illness?

BF: I think first you need to understand diabetes and what causes--symptoms of diabetes. Basically it's a supply and demand or you can say demand and supply. As we eat our food the food is absorbed and broken down into glucose. Glucose is our fuel. Insulin is a hormone that is released from the pancreas and that hormone facilitates glucose getting into the cell. If you don't have any insulin your glucose is just going to continue to build up, build up, build, up and build up until your sugar gets to the point that you become very ill from the elevated sugar. If you have the insulin but your body is not able to utilize it appropriately, in other words, the cell's resistant to the insulin getting into the cell, again your blood sugar is going to be elevated. It won't elevate as rapidly as individual who doesn't have any insulin. It will be a very slow process but the sugar will still elevate. So the other thing that you need to know is what are the symptoms? How do you know you're getting diabetes? The major four symptoms that people have is increased thirst, increased urination, fatigue, hunger and weight loss; which may seem kind of odd that they have the hunger, they're eating a lot but they're losing weight. The hunger is triggered by the fact that the cells aren't getting the sugar they need or the fuel they need. The thirst is triggered by the dehydration they're getting because they are urinating so much. The weight loss is

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caused by the fact that, again, their calories aren't being utilized. The body starts, since you can't get the glucose in, they start breaking down other parts of the body for fuel, primarily fat, and that's why you get the weight loss. The fatigue is from the fact that you're not getting the fuel in, so you are not getting the energy. So those are the four or five primary symptoms of people developing diabetes. And it wasn't unusual when I was working in the emergency department that people would come in and usually as a Type II diabetic and they had all of these symptoms and of course the first thought that people kind of have with the weight loss—unexplainable weight loss—is maybe cancer. It usually ended up being Type II diabetes. If it's Type I diabetes that pretty much becomes a medical emergency and they will get them into the Intensive Care Unit and they start treating their sugars and all of the complications that come from the elevated sugars in a new diabetic.

TP: How can you tell the difference between the Type I and the Type II in that environment?

BF: It's a little difficult but the Type I is a more rapid onset. It happens quicker; they become sicker faster. The Type II is a slow onset; the other thing they tend to have is a slow healing infections or wounds. Actually, I'm a diabetic too, and one of the first things that started happening with me I tended to have very dry hands and the skin would crack and it got to the point in the emergency room I couldn't pump a blood pressure cuff it was hurting so bad. I don't know if I was not too bright, or just denial was alive and well. Both my parents had diabetes and I wasn't putting two and two together. I went to dermatologists and we did all of these things for my hands. All that while, while I was working it seemed liked I was getting up and going to the bathroom frequently. When it got to the point that I was going about every hour and it was a copious amount finally I thought "duhhh I think I have diabetes." So, the swelling in the hands and not healing and that was a typical Type II diabetic symptom. So if you have a client or even a family member or a friend that seems to have--that seems more tired, complaining of being really hungry, it seems like they have lost some weight over the last few weeks and that they are talking about this thing that maybe they are working in the garden or something and got stuck by

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a thorn and that thing is just not healing like it used to. Those are some kind of clues that they need to be checked.

TP: Are there some psychotropic medications that cause some of the same symptoms then?

BF: Yeah, Zyprexa we know now can cause the onset of diabetes. I don't know that we know why; there may be someone out there who can tell us why. There are probably other psychotropics out there that I'm not aware of; but Zyprexa is well known for causing diabetes that individuals that come to us from hospitals they routinely check what we call a hemoglobin A-1C to see if that is elevating. A Hemoglobin A-1 C is a test that they can do to see what your blood sugar has been doing for the last two or three months; kind of keep a check on that plus, watching them for symptoms. We've had one client that I can think of right now is a resident in one of our RCFs that has been on Zyprexa and he did develop diabetes fairly rapidly after being on it, I think about after a year after being on the Zyprexa. So now not only does he have his mental illness he now has diabetes, and he is a Type II diabetic; but now he is also on insulin, so he has his mental illness, and his symptoms from that to deal with; plus he has to break through this symptoms to be able to use his insulin appropriately and take it appropriately. This particular client that I am thinking about does it just fine. He has been able to accept that he has a disease and he has to take the insulin. Does he really understand all of it? I don't think so; because he's not eating right. He will take his insulin and go back to bed and not eat breakfast and we are always "okay, you need to get up; you need to go and get your breakfast you can't take your insulin and not eat." It's a daily thing like he doesn't really quite get that part of it. So if you have a client similar to that; and then, they're living alone that's going to be an issue that someone is there to make sure that they eat after they take their insulin. We have another gentleman that—his illness is a little bit worse--that is diabetic. He is on a pretty complicated insulin regimen. He takes a scheduled dose plus he is on the sliding scale; but according to him he doesn't have diabetes and that he's just doing it because we want to me to do it. He is humoring us--several of his-- I can think of two of his hospitalizations had been directly related to the fact that he wouldn't take his insulin and his

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diabetes became worse. So basically he was committed because he wasn't taking his treatment, which was causing complications as far as his sugars rising and his psychiatric disorder also was becoming—was exacerbating and becoming worse. So that is one thing that we watch this gentleman for if he starts refusing his insulin. If he is talking more about how he doesn't have diabetes and he becomes more assertive, more aggressive. "I don't have this! I am not going to take it! You can't make me!" which is true. We're not going to wrestle him down and give him insulin; he is a pretty big guy. There is also talking to his case worker, and to his psychiatrist, and keeping an eye on him when it comes to the point that they decide that we need to do an involuntary commitment if he won't go into the hospital himself. That's one of the things that we watch with that particular individual. With him being in our residential facility we have the advantage of being able to see them and watching them and knowing what their baseline illness is and knowing our clients well enough to know when they start going down that slippery slope to becoming more ill. Their hallucinations may be getting worse. The delusions may be coming more fixed, that type of thing. In the community I can see it being, obviously, much more difficult. I'm not saying that the support workers and social workers and other health care providers don't know their individuals and they will learn what their baselines are but they are not with them. Our social workers see our clients maybe either once a week, twice a week, or every two weeks; depending on what their psychiatric needs are. So providing that medical backup may be much more difficult in a community setting.

TP: So what kind of approach do you think you would recommend for a community case worker, service coordinator in the community that's--how do they watch for the kinds of things that you are talking about?

BF: First off, if they are living with someone it's really very important to get that individual on board and help that individual understand the illness--the medical illness that they're significant other or roommate, or whomever—however they are related to this individual--so they can assist and help them with that. I think that is really important. It's a family affair, it effects everybody who is related to that individual;

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if they are even not that concerned about it it's still going to be a problem because it's going to effect what kind of food that they buy, how often they eat, when they eat, making sure they get the medications, making sure they have money for their medications. All of those issues that we deal with on a day-to-day basis with our clients who have problems as far as their disabilities--the money and working, and their income. Getting anyone they may be living with or who is a really close friend, getting them on board to be able to help monitor them in their living environment. There are other--many resources out there that can be used. If you are close to a university or a college, I would call them and contact them to see what kind of resources they have. Most hospitals … Diabetes is such a big thing now most hospitals have diabetic educators, which is usually a RN, who has gone through special training to be able to teach individuals about their diabetes. I would really utilize that. The social worker, the support healthcare provider could go with the client to their sessions, learn what they're learning, and be able to encourage and reinforce what their learning at their education sessions. Usually in that type of atmosphere, that area--hospital setting--they also get the dieticians involved so they are going to start learning about their foods and how best to eat, what they can—what's going to cause their sugars to go up rapidly, what won't make them go up rapidly, and how to gauge how much of what food to eat in relation to their medication and treatment.

TP: I'm seeing some kinds of parallels between educating people about their mental illnesses and educating people about their diabetes or any other physical illnesses. Do you see that? Is that kind of the approach that you are taking with this?

BF: Yes, uh huh. You have to understand where the client is coming from as far as their mental illness is and knowing how much they are able to understand, or willing to understand. We've had clients who come to us who are probably at their worst, as far as their illness goes, and our goal here at New Horizons is to move them on in life and get them out into their own apartment and we've been successful in many of our clients to move them on. As they are able to understand their mental illness and as they are able to come to terms with that, take their

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medications, as they are coming out of the little bit of the fog that they may have with their mental illness with maybe hallucinations and delusions and paranoia. As they are able to come out of that and handle their mental illness they are much more able to deal with their medical issues and able to understand their diabetes or their high blood pressure or hypothyroidism or whatever it is that they have and more able to deal with that. You have to understand though that's one more thing layered on top of their mental illness that they're going to have to deal with. Even people who don't have mental illness…who do have diabetes or any long term chronic illness there is a layer of denial at first and not wanting to recognize it, may be not deal with it at all. Depression on top of that, "I've got this long term illness, I'm going to have to live with it, it's not going to go away, I'll always have to eat what I put in my mouth, I can't go out on Christmas and just eat whatever I want to eat!" It's a pain, it's a problem, "Why do I have this? I don't want to be this way!" So you layer that on top of their mental illness it's a hard thing to deal with for the individual. It's difficult for the health care provider too. We want our clients to learn and move on and sometimes it just doesn't work that way.

TP: Diabetes isn't curable is it? Much like most of the mental illnesses it's not actually something that is cured; it's treated, right?

BF: It's treated, it's not curable. At this point, we don't even know what causes the diabetes--what factors in the body work to make the body develop diabetes. We know the symptoms, we know how to treat it, we know what happens but we don't know why. Hopefully, maybe, somewhere down the road that we'll figure that one out. Especially for our young little tikes; there are very young children who have diabetes which is quite a challenge to deal with.

TP: So how is diabetes managed? How is it treated? We talked a little bit about insulin we talked a little bit about diet. Give us kind of a composite.

BF: The first thing is diet and exercise, especially Type II diabetics when you are first diagnosed if you can make the lifestyle change that's needed as far as making sure you get exercise everyday. It has to be

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everyday. At least in most people… I have to do exercise everyday if I want to keep my blood sugars down. And eating foods in the appropriate amounts--as long as you can do that you may be able to ward off medications for a long time; which is a good way to talk a little bit about the different foods we eat and how they are categorized. There are carbohydrates, proteins, and fats. Carbohydrates are the ones that really causes—that are really—let me say metabolized most rapidly and causes the blood sugar to spike very rapidly. So those are the ones that we really watch the most. Proteins and fats are broken down slower; they will make your blood sugar rise eventually, but not as rapidly as carbohydrates do. So that is why we have to look at fruits, vegetables--and cookies, pies all of those good things that we all like. The dietician will help you figure out what to eat, what should I have for breakfast, what is the best thing to do, what should I have for lunch, how far apart do I need to do this and give you some guidance. It's a learning process; you're not going to learn everything that you need to know or don't want to know in the first thirty minutes with a dietician. It's a learning process and it's a life journey that as you go on you learn what how your body reacts to certain foods. "Oh, I have to stay away from this food because it really spikes my sugar, whereas this one doesn't." You get two people with diabetes together, you get a group together and they're going to be talking about that. "Well, that didn't bother me, but this one does!" So it's learning how your body responds to foods. So we're talking about diet and we're talking about exercise and then maybe at some point as your disease progresses you may have to start taking medications. There have been so many advances just in the last five to ten years with medicines that it's just amazing. Metformin or Glucophage is a very common one that people are put on. It helps the liver slow down the production of glucose. And there are other medications. Actose that makes the cells more sensitive to glucose and there are some other ones out there. Those are the oral ones. Then it's just going to your doctor and checking your sugars, doing your tests to make sure that how you're doing with your blood sugars and things are added as needed. So, in both, whether Type I or Type II, it's diet, exercise, and medications.

TP: And roll in then somebody who may have a mental illness, or

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somebody who is developmentally disabled and you talked about getting the right kinds of diet and right kinds of exercise and some of the special complications that people face there.

BF: It …well if you have an individual that is paranoid and thinks that someone is poisoning their food its going to be hard to get them to eat. Which we have had individuals at our facilities doing that--they thought someone was poisoning them--which could be a fairly common scenario. We do whatever we can do. "Okay, you think we're poisoning your food so what will you eat?" That could be a scenario out in the community too. "You think that your food is being poisoned okay what can we get you to eat?" Maybe at that point what can we get to eat not so much following the diet as you need to get some food into you. That could be a simple as going and buying SlimFast--the liquid diet drink--or Ensure or Boost or even anything that is in a container that they know couldn't be tampered with. We did have one gentleman that lost a great deal of weight because he thought he was being poisoned and ended up being psychiatric hospitalized so they could get him--fine tune him--get his medications for his mental illness fine tuned so that his paranoia would maybe not necessarily go away but kind of come down a few notches so that he could eat. I have one client, in particular, who is in our group home for developmentally disabled who is diabetic. He's a special challenge. I think his mental retardation puts him about 12-13 year old. He is about 26 or 27. So here you have a gentleman who appears to be an adult but he is right at that 12 or 13 year old--teenage years--who doesn't want to do anything that anybody tells him to do; here he has diabetes, he's on insulin and he has to control what he eats. So we as the caretakers and the professional have to be able to develop a way to help this gentleman just like any 12 or 13 year old adjust to and make terms with the fact that he is diabetic. He's also on insulin, he's also on a sliding scale, he's also very manipulative and we have over the past two years worked with him. We figure out he is doing one thing, we take care of that and he starts another thing. We found that he was taking his vials of insulin and his—he was getting a hold of his insulin syringes and kind of stockpiling them. So when he ate too much he'd just give himself another injection of insulin. So we needed to lock up his insulin

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syringes and getting another little refrigerator away for--where he couldn't get them. Then we found that the glucometer—these guys have to check their sugar real frequently—that he would get a high blood sugar, he didn't like it, so he would dial in the memory until he found one that he liked then he'd show us what his sugar was. Okay, so now we're watching him do it. Well, now we're finding that he's just testing his sugar five or six times until he gets the one that he wants. It's just been really very interesting. Every time you think that you've covered all of your bases he will think of something else.

TP: I think that what I'm hearing mostly is that there isn't a real set pattern or wet of guidelines that a service coordinator, that a nurse, that a social worker, that anybody is going to be able to follow, they have to follow their instincts.

BF: Right.

TP: Talk to them directly, how would you--because you have brought your experience to the table and it sounds like that is what you are asking them to do as well.

BF: Right, your experience all your experience as a mental health worker can also not only be utilized with helping your clients or individuals with their mental illness you can also use that--extrapolate that experience with whatever issue they may be having to handle--whether it be diabetes or don't have enough money to buy the food. So your instincts can go on to, "I know this client something is not quite right. I wonder if he ate before he came. Did he have his breakfast? I know he's on insulin. He seems just a little off. His speech is a little slurred. Gee I wonder if he had breakfast?" Ask them, "did you eat?" or if you know that he's not going to fess up to it and you've got something there, you know, here I've got this fruit bar would you like one while I eat one?" That may kind of go against our Code of Ethics or Boundaries or whatever but you're trying to keep that client from crashing. So you're gonna to go ahead and give them that bar. We just all that little thing in the back of our head, you know, it makes you wonder. You need to pay attention to that and investigate and find out what's going on with them. Just like you do with, "Gee I haven't heard from this client for awhile I wonder if they're isolating and barricading themselves in their

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apartment. I wonder if they're paranoia is getting worse." That type of thing. You can have that same kind of feeling for their physical illnesses too. Especially if you're educating yourself and you have a fair understanding of how an illness can affect an individual.

TP: Are there resources? I know that you talked about certain educational resources that are available to people as they are being diagnosed and learning how to deal with it. Are there other resources that the professionals can tap into to help themselves learn more?

BF: Sure. I was just getting online to just look up to see what was going on before we did this and I just go online and type in 'diabetes' and see what comes up. I got onto a site that was specifically for healthcare workers. That is a wide range from dentists, physicians, RN's, social workers, that you can log in and put your own little password in there and you can get into whatever thing you are interested in whether it be diabetes, schizophrenia, hypothyroidism, you can get into the latest information about that. I will have to warn you though a lot of it is very into--some of it I didn't even understand because there was too much medical terminology in there even for me. We're talking like PhD and researchers and they get into own little conversations--but I was able to glean enough from that I can take a word and go research that word and get some more information. There is the American Heart Association that also deals a lot with diabetes and because diabetes sets people up for cardiovascular disease so they're really into understanding diabetes as far as cardiovascular problems go. There is the American Diabetes Association; there are many publications out there like Forecast and other magazines. Publications are--I can't remember right now. Just go online and type in 'diabetes,' 'insulin' and any other drug that you are interested in you will get a whole lot of information on that. If you have a medical doctor, if you do have a nurse I would really encourage talking with them. I would really encourage calling the hospital and finding out if they have a diabetic educator and could they talk with them; dieticians. I would even go to the health food store and talk with people down there and ask them what they know about diabetes and what kind of treatments that they are doing. That may be a little off some peoples' beaten path but you never know what you will find out.

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TP: Any closing thoughts for our groups?
BF: Just follow your instincts educate yourself as best you can. Learn from your clients, learn from each other and enjoy yourselves while you're out there taking care of everybody as best you can.
TP: Well, thank you Becky. I appreciate your time and your expertise. I appreciate your time today. This program was developed specifically at the request of our constituents the people who use our services to meet their training needs and we look forward to hearing from you with regards to your needs.

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