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PHYSICAL HEALTH SHOULD BE A PRIORITY OF THE MENTAL HEALTH SYSTEM AND MENTAL HEALTH SHOULD BE A PRIORITY OF THE HEALTH SYSTEM

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Over the past couple of years, it has become increasingly clear that physical health needs to be a priority of the mental health system and that mental health needs to be a priority of the health system. Why it took so long to realize this is not entirely clear to me because the basic facts have been known for quite some time. In part, it's that we've all been busy with other important matters like building an array of mental health services and supports to enable people with serious mental illness to live in the community. The development of housing, rehabilitation, outpatient treatment, inpatient services in general hospitals, improved quality of care in state hospitals, case management, and assertive outreach into the community have all been—and still are—vital areas of development for the mental health system. The other reason for the delay, of course, has been the perception that the health system is responsible for physical health and the mental health system is responsible for mental health. Neither system thought of itself as responsible for the considerable overlap between the two, so money didn't get invested in integrated services.

Why is it so important that policy shift to emphasize integration of physical and mental health services? A number of reasons have emerged including: (1) The low life expectancy of people with severe, long-term mental illnesses, (2) the cost of care for, and the suffering of, people with co-occurring severe behavioral and physical disorders, (3) the impact of mental and substance abuse disorders on the outcomes for people with serious, chronic physical health disorders—such as diabetes, (4) the large part that mental and behavioral disorders play in the placement of people in nursing homes, which are designed for people with physical disabilities but occupied by a lot of people with mental and behavioral problems, and (5) the fact that most people with mental disorders go first from their primary care physicians, who, unfortunately, often fail to identify mental illness or to treat it adequately.

Low Life Expectancy

It has been known for a quarter century or more that people with serious, long-term mental illnesses have a lower life expectancy than the general population. Until recently the number most often claimed was 10 years—a matter of great concern. But a recent study has resulted in the truly alarming claim that life expectancy is 25 years lower for this population. I'm not sure why the number has changed so dramatically. Let's hope it's an artifact of research rather than an indication that life expectancy has gone down

over the past quarter of a century, a period during which there has been a considerable reduction of inpatient services and a growth of community-based mental health services.

Although there have been different emphases on the causes of low life expectancy in different studies, it is reasonably clear that they include poor health, poor health care, exposure to the risks of street life, suicide, and "accidents", often overdoses of medication.

A comprehensive approach to increasing life expectancy needs to address all of these causes. But attention to health is particularly important. People with serious mental illness are at high risk of obesity (in part because of the medications they take), hypertension, diabetes, heart disease, pulmonary problems, and communicable diseases such as HIV/AIDS. Addressing these issues with preventive interventions such as diet and exercise is at least as important as improving health care for this population.

High Cost Cases

The rising cost of health care has become a matter of major social concern—even for the Presidential candidates. At the state level the primary concern is Medicaid costs. We have known for some time that a small portion of the covered population incurs the vast majority of the costs of Medicaid. (The 20-80 rule-of-thumb appears to be a modern metaphysical principle.) We have also known for years that people with disabilities and older people receive the most costly care (not to be confused with the best care.) Recently, John Billings did a study of Medicaid spending in NYC that revealed that the people on whom the most money is spent are not just disabled, but people with co-occurring serious health, mental health, and substance use disorders. This is true for all age groups—children, working age adults, and older adults.

It appears that many of these people get intensive health and mental health services intermittently. A crisis brings them to emergency rooms and to long periods of hospitalization, after which they often disappear for a while, only to re-emerge in crisis later. Many have not gotten the services that might sustain them in relative health in the interim.

Clearly, integrated physical health, mental health, and substance abuse services are needed at all points of contact with this population—in emergency rooms, during inpatient care, and in community-based services. Outreach is particularly important to this population.

What's tricky about this is that a number of studies have indicated that providing integrated services to everyone with serious co-occurring disorders does not result in cost savings—although it does improve lives for no or very little additional cost. As a result, Professor Billings and others have been working on the development of a method to predict who the high cost cases will be in the near future, which could be used to target services to those people. This, hopefully, would reduce costs and make it possible to

reinvest the savings over time in increasing services to more and more people. Of course, it's also possible that the state would take the savings so as to reduce the state budget.

Chronic Health Problems

More and more studies done over the past decade indicate that people who have chronic physical illnesses such as diabetes, heart disease, and neuro-muscular disorders with co-occurring depression are (1) at much higher risk for disability and premature mortality and (2) have much higher costs for their **physical** health care than people with the same chronic conditions who are not depressed.

Unfortunately, neither primary care physicians nor medical specialists generally have expertise in identifying or treating mental and/or substance use disorders that can seriously complicate their patients' physical health. The solutions? Better prepared health care providers and increased collaboration between health and mental health professionals. More on this in my comments on primary care below.

Long-Term Care

In the effort to contain the costs of Medicaid, one of the major targets is long-term care, which includes not only nursing homes but also day care, case management, and home health care. One way in which federal and state governments have approached reducing Medicaid costs is by decreasing the number of people eligible for Medicaid. This includes making it more difficult for people to transfer assets so as to become eligible for Medicaid prior to becoming impoverished.

The other major effort is to reduce utilization of nursing homes by enabling people to remain in their own homes longer. Both home health care, case management in the home, and day care are intended to do that. This process is known sometimes as "long-term care reform" and sometimes as "long-term care restructuring." (It is important to note that this restructuring effort is done not only to save Medicaid dollars, but also to make it possible for people to live where they want to live—generally in the community.)

The success of long-term care restructuring depends, of course, on identifying and addressing the reasons why people go to nursing homes, and public policy seems to be built on the notion that people go to nursing homes because of physical disabilities, including Alzheimer's disease. This, however, is a very partial truth. 50% or more of people in nursing homes have mental illnesses, such as depression, anxiety, and psychoses in addition to physical disabilities. And many are there only because of mental disabilities. Sadly these conditions are often ineffectively addressed both before people are placed in nursing homes and when they are in the homes.

The most important reasons why many—perhaps most—people are in nursing homes are (1) that their behavior creates a mix of risks and annoyances that those providing support in the community can't handle, (2) that they don't have families that can provide the

supportive care they need in the community, and (3) that there are not enough alternatives to housing people with disabilities in institutions.

The placement of people with "difficult" behaviors in institutions reflects in large part the inadequate training of staff who provide services in the home to deal with mental and behavioral problems. There is little doubt in my mind that the development of home care providers and day care workers with specialized expertise would significantly reduce referrals to institutions.
Similarly, I have no doubt that providing support for family caregivers—who provide 80% of the care for people with disabilities—would result in sustaining people where they want to live, almost always in the community. Some disabled older adults don't have family, of course. In other cases families who have tried their very best to provide care but ultimately burned out. They are at high risk for depression, anxiety disorders, and physical illnesses that rob them of their ability to bear the stress. Even though there are well-tested forms of family support that address the mental health needs of family members and result in substantial delays in nursing home placements, little has been invested in putting these supports in place.

Housing for people with co-occurring serious mental and physical disorders is also a critical need. Many people end up in nursing homes just because mental health housing programs and other supportive housing programs just don't have the capacity to deal with serious physical health concerns. It is easy enough to conceptualize appropriate housing, but close to impossible for the mental health and health systems to work together to do it.

Mental Health In Primary Care

Most people with mental and/or substance use disorders go to primary care physicians for health care or even for mental health care. Unfortunately most of these physicians are not trained to identify or to treat mental illness. As a result, according to the National Co-Morbidity Replication survey, primary care physicians provide "minimally adequate mental health care" only 13.8% of the time. And their ability to identify mental illness is so poor in general that upwards of 70% of older adults who commit suicide have seen their primary care physicians within 30 days, some even on the same day.

The answer is not just referral to mental health professionals because so many people do not follow through on referrals. And if they did, we would rapidly run out of mental health professionals to refer them to. There is simply no alternative to continued widespread reliance on primary care physicians to provide treatment for mental illness. How to prepare them to do this continues to be a serious problem. "Training" sounds like the right solution, but often doesn't work, except under particular conditions. However, screening tools are available to help physicians identify potential problems, and several collaborative treatment models in which physical and mental health providers work together at the same site have been well-tested. There also needs to be increased use of tele-psychiatry both for consultation and for treatment.

Conclusion

All of the above are compelling reasons for focusing mental health and health policy on the inter-relationship of health and mental health. But we will need to work hard to make the case compelling not just to those of us in the health and mental health professions, but to public officials, who need to adopt new policies stressing integration of care.

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