BEHAVIORAL HEALTH NEWS

YOUR TRUSTED SOURCE OF INFORMATION, EDUCATION, ADVOCACY AND RESOURCES
FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE
WINTER 2018

WHY INTEGRATED CARE FOR PEOPLE WITH CO-OCCURRING DISORDERS IS SO IMPORTANT

By
Michael B. Friedman, LMSW

Providing integrated treatment for people with co-occurring behavioral and physical health disorders has become a central goal of mental health policy reform. Why?

In part the answer is that the failure to provide effective integrated care drives up the cost of care. But the answer also is that the length and quality of life of people with serious, long-term mental disorders depends on addressing both behavioral and physical problems.

Premature Mortality: On average people with serious mental illness die considerably younger than the general population. It has become commonplace to claim that their life expectancy is reduced by about 25 years—roughly age 55 rather than 80. (Estimates actually range from 10 to 25 years.) But whether it's 10 or 25 years, the lost years of life are a tragedy that probably could be prevented.

For the most part, the premature death of people with psychiatric disabilities reflects physical rather than mental causes. Yes, people with serious mental illnesses complete suicide far more often than those without, but that is not the greatest driver of low life expectancy. Obesity, which contributes to high blood pressure, diabetes, and heart disease, is probably a greater factor. Smoking, which provides emotional relief to many people and is very common among people with serious mental illness, also is a major contributor. Excessive use of alcohol and other drugs also contributes to poor health. And people with psychiatric disabilities often have periods of hard homelessness that exposes them to terrible health risks including assault and rape as well as exposure to dangerous extremes of weather and to contagious diseases such as AIDS, hepatitis, sexually transmitted diseases, respiratory diseases, and more.

To make matters worse, people with serious mental illnesses often do not get decent health care. Sad to say but historically community mental health providers did not pay nearly enough attention to the physical health of the people they served, and physical health care providers did not—to put it mildly—welcome patients with serious mental illness.

All this has been known for a very long time, certainly since the late 1970s when physical health care was conceptually included as part of the Community Support Program. But funding drives action, and there has been no funding specifically dedicated to the physical health needs of people with serious and persistent mental

illness. As a result, premature mortality emerged as a major concern only about a decade ago—at the same time, the cynic in me observes, as it became clear that co-occurring physical and behavioral disorders were the greatest drivers of Medicaid costs.

The good news is that awareness of the mortality gap has galvanized some mental health providers to develop "wellness" initiatives to fight smoking and obesity and to organize health care programs that they operate on their own or in partnership with community health centers and hospitals.

Co-Occurring Substance Abuse: Many people with serious mental illness will have periods in their lives when they have co-occurring substance use disorders, which contribute to homelessness, incarceration in jails and prisons, and exposure to many other risks and barriers to achieving a satisfactory quality of life. For them too the efforts of the mental health, substance abuse, and physical health care systems have been feeble and inadequate.

Awareness of the problematic co-occurrence of mental and substance use disorders goes back to the very beginning of deinstitutionalization in the late 1960s and early 1970s. Over the years, there have been repeated announcements of efforts to integrate mental health and substance abuse services. Cross-training and inter-agency committees are old hat, and they've made some difference. But the schisms between the systems are still intact, driven by ideology, unwillingness to share power, competition for funds, and the inability to respond to clear data that integrated treatment is what's needed.

Hopefully, the recent push for integrated service systems will turn the tide on this old issue.

Co-occurring depression and serious health conditions: In addition to concerns about the unfortunate impact of physical illness on people with serious, long-term mental illness, awareness has grown in recent years about the impact of mental illness on people with serious chronic physical conditions such as heart disease. It is quite clear, for example, that people with depression and heart disease are more likely to suffer premature disability or death than are people with heart disease who are not depressed. In part this is a chicken and egg issue. Serious, chronic physical illness—especially if it is life threatening or results in reduced ability to perform basic life functions—often precipitates demoralization. Lack of hope contributes to resignation, lack of effort to recover, and ultimately to greater physical deterioration. But whatever the direction of causality, it is clear that addressing co-occurring mental issues is key to maximum recovery for people with serious physical conditions.

Opportunities for early identification and treatment of mental and substance use disorders: Most people with diagnosable mental and/or substance use disorders go without diagnosis and treatment. One reason for this is the widespread reluctance of people suffering from emotional distress to seek treatment from mental health providers (we usually call this "stigma") as well as the vast shortage of mental health providers in many parts of the country.

But people who will not seek help from a “shrink” generally do go to primary health care providers, who have an opportunity to identify, and to provide rudimentary treatment for, people who might benefit from behavioral health services.

Awareness of this fact has led to calls for increased behavioral health screening in primary care—especially screening for depression—and for meaningful responses to positive findings including professional diagnosis and treatment or referral to treatment.

The problem, of course, is that most primary care physicians do not have the expertise to make sound diagnoses or to provide adequate treatment. According to the National Co-Morbidity Survey, more than 85% of people treated for mental disorders by primary care physicians do not get even “minimally adequate” treatment. Mental health providers are somewhat more likely to provide minimally adequate care, but about half of people referred to them do not follow up.

It’s reasonably clear that primary care could do more to identify and treat behavioral disorders. Fortunately, there are some signs of improvement in the push for person-centered medical homes, which provide both behavioral and physical health services and require coordination of care if only through electronic medical records. And some medical practices now have behavioral health specialists on staff. Others—especially in areas with few behavioral health specialists—are using tele-psychiatry for consultative advice or even to see patients via Skype and the like. More sophisticated medical practices are using one form or another of coordinated care management, which follows patients after diagnosis, prescription, or referral to be sure that they get the treatment they need.

Suicide Prevention: Primary health care may also be a key place for suicide prevention. Now the 10th leading cause of death in the United States, suicide is gradually becoming a public health priority, though not fast enough to stop the rapid rise in suicides, which has spiked to over 40,000 deaths per year.

Since the discovery that a large proportion of people who complete suicide see a primary care physician within the 30 days prior to their death (the current estimate is 45%), there has been a perception that doctors ought to be able to identify people at risk and to intervene to prevent suicide. This, of course, is far easier said than done. Very few people reveal their suicide intentions to doctors, who, in any event, are usually ill-prepared to respond appropriately when patients share their suicidal thoughts.

As a result, there has been a widespread call for primary care practices to use one or another of the screening instruments that have been developed to flag depression, substance use, and other behavioral disorders. Recently, the Joint Commission has required the health care facilities that it accredits to screen specifically for suicide risk. This is highly controversial because according to the U.S. Preventive Services Task Force there is little evidence to support screening for suicide risk. They recommend screening for depression.

Despite the controversy about what sort of screening to do, there is widespread consensus that primary care physicians need to pay far more attention to their patients' emotional distress in the hopes of averting the suffering of mental disorders and of reducing the rising incidence of suicide.

Long-term Care Reform: The issues I have noted above—the mortality gap, co-occurring mental and substance use disorders, the impact of depression on chronic health conditions, opportunities for identification and treatment of behavioral disorders and perhaps to reduce the incidence of suicide through primary care are the issues that most commonly drive concern about co-occurring disorders.

Less frequently noted is the importance of co-occurring disorders to long-term care reform. Simplistically speaking, the goal of long-term care reform is to reduce the use of nursing homes and to have more people with disabilities live in the community rather than in institutions. Most people in nursing homes, of course, have serious physical disabilities and/or dementia. Most of them—yes most of them—also have co-occurring mental and behavioral disorders including depression, anxiety disorders, psychotic conditions, etc. And these conditions contribute to behavioral problems that often make it very difficult to help people stay in their homes rather than in institutional settings. For example, distrust—often of paranoid proportions—can make home health aides unwelcome in the homes of people who need health care in order to survive; and bizarre or volatile behavior often makes them undesirable patients.

So, addressing mental illness as well as dementia and physical health conditions effectively is critical to being able to avert the need for nursing home care.

Sadly, the officials who are pressing for long-term care reform do not seem to understand that behavioral health services are critical to achieving their goals. For example, in NYS the Managed Long-term Care Program, which organizes and provides a comprehensive array of services and supports to people with severe disabilities so as to help them remain or return to the community, does not include a behavioral health benefit.

Money Drives Hope: As I said at the beginning, in large part the interest in providing managed, integrated treatment for people with co-occurring disorders arises from the realization that they are the drivers of high Medicaid costs. Is it cynical to suggest that if it weren't for the need for cost containment, the system would coast on providing inadequate services on a fee-for-service basis? I have no doubt that the hope of cost containment is what has led the federal government and many states, including New York State, to invent very complex systems of integrated care for people with co-occurring disorders.

It is not at all clear how these adventurous experiments will turn out, but it's a lovely twist that for once cost cutting is driving hope for better care in a health and human services environment that is otherwise sadly bleak.

(Michael B. Friedman, LMSW is Adjunct Associate Professor at Columbia University School of Social Work and Chair, The Geriatric Mental Health Alliance of New York. www.michaelbfriedman.com)