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MEETING THE MEDICAL NEEDS OF PEOPLE WITH SERIOUS MENTAL ILLNESS: WILL NEW INITIATIVES WORK?

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On average, people with serious mental illness die at a much younger age than people without serious mental illness. Estimates range from about 10 to 25 years younger. They are also much more likely to have serious physical disorders including obesity, high blood pressure, diabetes, heart disease, pulmonary conditions, hepatitis, sexually transmitted diseases, and HIV/AIDS. Unfortunately, psychiatric medications that reduce acute symptoms of mental illness can heighten the risk of obesity and its sequelae. Smoking, which is much more common among people with serious mental illness than those without, also has dreadful health consequences. In addition, because people with serious mental illness are more frequently victims of crime than people without serious mental illness, they are at high risk for injuries, which heal but wear down physical strength and resilience over time. And, because they are more frequently homeless, exposed to extreme weather conditions, and without access to adequate facilities for bathing and toileting, they are at high risk of developing skin conditions and infections that can be serious enough to be life threatening. These risks are greatest for people with co-occurring serious mental and substance use disorders.

Addressing medical needs was nominally part of the original community support program initiative in the late 1970s. But without targeted funding for this population, it fell to the generic physical health care system to meet their needs, which it did poorly. Access to health care has been limited, access to good health care even more limited. In part, this reflects the failure of the health care system—despite growing reliance on Medicaid—to provide good treatment for poor people. In part, it reflects the very common discomfort of physical health care providers with people who exhibit signs of mental illness.

Over the past decade, mental health providers and policy makers have become concerned about the failure to address the physical health needs of people with co-occurring disorders. In part, this concern was driven by the “discovery” of the vast mortality gap between people with serious mental illness and the general population. But in large part, the concern has become a policy priority because of the realization that the most costly Medicaid cases are usually people with serious co-occurring disorders. Failure to anticipate and to provide adequate treatment for conditions that will become critical and require long-term inpatient care results in a very high portion of Medicaid costs (perhaps 70% or more) for non-institutionalized populations.

Four major approaches have emerged to meet the medical needs of people with behavioral health conditions—(1) integrated physical and behavioral health care, (2) integrated managed care, (3) health promotion and (4) management of the use of psychiatric medications.

(1) Physical and behavioral health care can be integrated either in a physical health care setting or in a behavioral health care setting. The expansion of "medical homes", which are required to integrate behavioral health into physical health care, may be helpful for many people with physical and mental disorders. But for people with serious mental and/or substance use disorders who are engaged in treatment or rehabilitation for behavioral health conditions, it makes sense to build medical care into their behavioral health programs as much as possible. This can be done by including physical health care providers on the staff of the behavioral health program or through establishing formal arrangements for staff of physical health care organizations to work at the behavioral health care site.

    The specialized physical health services that people with serious behavioral health conditions often need can also be provided by establishing physical health clinics that specialize in serving people with mental disabilities or substance abuse disorders.

    It is also possible to achieve some degree of integration through informal, collaborative relationships between physical and behavioral health providers. After all, the essence of effective integration is actual communication and collaboration. That does not require a formal relationship. And, it is important to keep in mind that a formal relationship does not guarantee actual collaboration.

(2) Policy makers have become convinced that the best way to address the need for integration is with much more extensive Medicaid managed care. "Health homes", which emphasize coordination of services for people with chronic physical and/or behavioral health conditions and for which a federal financial incentive was created as part of health care reform, are one of the major new mechanisms for achieving integrated care. More comprehensive "special needs plans" and "accountable care organizations" are also under development.

(3) Health promotion, now called "wellness" promotion, has also become a major component of the overall effort to address the medical needs of people with serious mental illnesses. These emphasize smoking cessation, weight loss, good nutrition, exercise, and responsible management of serious chronic illnesses such as diabetes. The use of peers to help others to engage in wellness activities and to manage their illnesses is becoming increasingly widespread as part of this process.

(4) Programs to improve the use of psychiatric medication have also emerged. These medications are valuable for many people, quelling acute symptoms and enabling them to develop satisfying lives. But they have side effects, including obesity, which contributes to high blood pressure, diabetes, and heart disease. Psychiatric

medications are also problematic because accidental overdoses appear to be a major contributor to the mortality gap.

Virtually all states now have preferred drug programs in Medicaid, which are primarily designed to reduce Medicaid costs but which also *claim* to be designed to improve physician's prescribing practices. Some states have instituted initiatives that provide training regarding the appropriate use of psychiatric medications and monitoring of prescribing practices. For example, in New York State, the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) "uses administrative data to generate quality indicator reports for use in quality management and clinical decision-making".

These initiatives are promising, but it is not clear yet whether they will succeed in improving the physical health of the overall population of people with serious mental illness or in reducing the mortality gap. And there are reasons for concern that they will not be effective.

Integration of care within the mental health system and between the mental health and substance abuse systems has been an elusive goal since at least 1977 when it was set as one of the two major goals of the community support program. There are examples of somewhat effective coordination of systems and care, but the complaint that the systems are fragmented and operate in "silos" has not abated over the past 35 years. Obviously, achieving integration is easier said than done.

Now the effort is underway to integrate the behavioral health systems (not themselves adequately integrated) with the physical health care system. This will probably be even more difficult than integration of behavioral health care services. It will not be surprising if there ends up being more lip service than achievement. This appears to be true already with regard to medical homes, where the requirement to integrate physical and behavioral health care is so weak that some physicians' groups have gotten formal "recognition" as medical homes without providing any behavioral health care at all.

Managed Care: The use of more extensive managed care in Medicaid is also of questionable promise. The goal is admirable—to engage people with serious behavioral and/or physical health conditions in care before they are in crisis and need extensive and very expensive treatment. In theory, expanded Medicaid managed care will result in more aggressive outreach to engage people in services. But the administrative complexity of these initiatives is so great that, at best, they will take years to work. In the process they will consume a great deal of money, money that could be better invested in, for example, an expansion of assertive community treatment programs. Will Medicaid managed care ultimately save money spent on unnecessary and expensive forms of treatment, and will those savings be re-invested in expanded community-based care? That is yet to be seen. In general, it is just not clear that health homes, special needs plans, and accountable care organizations will result in improved integration of care in the field and better health outcomes for people with serious mental illness.

Wellness initiatives are also promising, but it is far from clear that they will be effective enough to make a significant difference in health outcomes. Of course people with serious mental illness who smoke should stop, but this is a tough addiction to break for everyone and all the more so for people who appear to get a psychological benefit from smoking. Weight loss is also much to be desired, but will wellness initiatives help people with serious mental illness keep their weight under control? Maybe, but weight control is exceedingly difficult in a nation in which obesity has become a major problem even among people not taking medications that stimulate appetite. The use of peers to help people with serious mental illness to stop smoking, lose weight, eat well, get exercise, and manage their illnesses appropriately is also very promising. But again, it is not yet clear that this will all result in improved health outcomes and longer life for most people with serious mental illnesses.

Managing Medication Use: There are also reasons for concern about programs designed to improve the use of psychiatric medications. It is not at all clear that preferred drug programs result in overall savings if added inpatient costs due to failure to provide appropriate medication are taken into account. More importantly, it is not at all clear that preferred drug programs result in improved prescribing practices.

Programs like PSYCKES in New York State are more promising, but may not address the fundamental question about psychiatric medications. Do they contribute to reduced life expectancy even when they are used well?

Life On The Streets: It is very important to note that none of the current initiatives address one of the major reasons for the poor health and premature deaths of people with serious mental disorders, especially those who are also addicted to alcohol or other drugs—the dangers of life on the streets. Stable housing is the single most important need of people with serious mental illness (in fact of everyone). Absent the development of more housing, integrative models, expanded managed care, wellness initiatives, and better management of psychiatric medications are likely to have limited impact on the mortality gap. The good news is that more housing is planned. The bad news is that it is, as it has always been, very little housing compared to the overall need. Of course, incremental improvement is better than no improvement. But we should not fool ourselves that it is enough.

Conclusion: Despite the many reasons to doubt the ultimate effectiveness of the initiatives now underway to meet the medical needs of people with serious mental illness, the mere existence of these efforts gives reason for hope that over time their health will improve and the mortality gap will be reduced. But hope is not certainty, and it is critical to monitor the outcomes of these initiatives carefully and to make changes rapidly if they are not working.

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