BEHAVIORAL HEALTH NEWS

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FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE

FALL 2015

Integrated Care At Last?

By
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This issue of *Behavioral Health News* is devoted to current efforts to integrate care for people with behavioral health conditions. So many complex mechanisms are being created that I get lost in the maze of confusing names and acronyms. "Health home", "medical home", "HARP", "DSRIP", and more. I confess I know little about the specifics. I considered sitting this issue out or writing about something else. But having been involved in efforts to achieve integration for over 40 years, maybe I can offer a couple of observations that will be useful to the architects of today's new systems.

The "fragmentation" of the mental health system has been a matter of concern at least since the early 1970s, when—for example—New York State passed the Unified Services Act in an effort to end the fragmentation of the state hospitals and local mental health services. That effort collapsed (except in 5 counties) because it shifted financial risk to local governments without giving them full control of the state hospitals. Since then, there have been numerous efforts to integrate care, including the federal Mental Health Services Act, the Community Support Systems initiative begun in the late 70s, Child and Adolescent Service System Program (CASSP) and Intensive Case Management in the 1980s, the Special Needs Plans in the 1990s, and many more. Over this period of time, more and better services in the community have been developed, but complaints about the fragmentation have not abated in the least.

There are many lessons to be learned from the failures or very limited success of prior efforts to integrate care. One of the most important, I think, is that the meaning of "integrated care" has varied over the years.

1970s: In the 70s the primary meaning of integration" was building effective working relationships between state hospitals and local mental health services. In New York State, the Unified Services Act and the long-forgotten Triangle Plan were aimed at solving that problem of fragmentation. Neither succeeded, but over time there was some improvement in working relationships depending largely on the particular people who were directors of state hospitals and those who were directors of community services for local governments.

1980s: By the early 80s, it was clear that there was also fragmentation among local mental health providers. A person admitted to a hospital generally was not followed there by providers in the community, and a person discharged from a hospital (even with a decent discharge plan) was not followed by anyone at the hospital. People in community residences went to day programs where they might or might not get their clinical services so that some people had three or more sets of providers (housing, rehabilitation, and clinics) who rarely communicated. Case managers were supposed to

coordinate their care, when they had case managers. This was no doubt helpful to some people. But complaints continued that people in various programs were largely left to drift on their own, with no provider taking overall responsibility for their care.

"Intensive case management" and, later, Assertive Community Treatment were important and somewhat successful responses to this form of fragmentation. (It strikes me that the concept of "care coordination" at the heart of several of the new integrative mechanisms is an effort to build on the partial successes of ICM and ACT.)

During the 1980s concern also emerged about integrating care for people with both mental and substance use disorders. Battles of treatment philosophy as well as conflicting service, administrative, and financing structures plagued efforts to integrate treatment for people sometimes called MICA (mentally ill chemical abusers) and sometimes called "dually diagnosed", (although it was clear that most were dually undiagnosed). During the late 90s NYS and SAMHSA developed a grid to clarify which system was responsible for whom, but that did little to increase the number of people actually receiving integrated treatment. Apparently, the vast majority still do not get integrated treatment.

Also during the 1980s much concern emerged about the failure to integrate services for children with serious emotional disturbances. Overcoming fragmentation in this context meant primarily that different systems serving children need to work together. This includes mental health, child welfare, education, juvenile justice, and more. The Child and Adolescent Service System Program (CASSP) was largely devoted to building "systems of care" that would bring together all the child caring systems to coordinate care case by case. Various interesting models emerged around the country including the Coordinated Children's Services Initiative (CCSI) in New York State. These had some success, largely depending on the interest and cooperative nature of particular people from different service systems.

1990s: During the 1990s the first efforts were made to integrate care via Medicaid managed care. In New York and some other states, serious mental and substance abuse conditions were excluded from managed care. But by the mid-1990s many experiments were underway around the country to provide managed care for people with serious, long-term mental and substance use disorders on Medicaid. All such efforts envisioned the use of care coordinators to plan and authorize a broad range of services, including some social services such as housing, for people who would likely be hospitalized without such services in the community. In NYS, an effort was made to develop "Special Needs Plans". It failed largely because it did not include people covered by Medicare as well as Medicaid (about half of all people with serious and persistent mental illness) and because the state legislature was persuaded (correctly, I think) that it was not financially viable as proposed. (Current Medicaid managed care approaches have been designed to include people covered by Medicare as well as Medicaid.)

2000s: Towards the beginning of the current century, integration of physical and behavioral health care emerged as a major goal due to research that revealed that people with serious mental illnesses have comparatively low life expectancy (largely due to physical illness), that people with co-occurring serious and chronic physical and behavioral disorders are the major drivers of Medicaid costs, and that people with

untreated mental disorders, especially depression, and physical health conditions, such as heart disease, are at high risk for disability and premature death.

Integration of care, therefore, has come to mean integrating “behavioral health” care (treatment for mental illness and/or substance use disorders) with physical health care. This is a huge conceptual leap that adds enormously to the complexity of integrating care if only because the separation of the roles of mental health and substance abuse providers and physical health care providers is well-entrenched in the tradition of medical practice.

Complexity is also increased because the current goal of “integrated” care does not focus only on people with severe, long-term behavioral disorders but also on the general population, 50% of whom will have a diagnosable mental or substance use disorder in their lifetime. That’s a very large target population.

So, in the first 5 decades of the shift from institution-based care to community-based care, several meanings of “integration” have driven several quite different approaches to achieving integration. This has included attempts to (1) develop effective working relationships between state and local mental health providers, (2) develop collaboration and clear responsibility among local providers, (3) integrate treatment for mental and substance use disorders, (4) build “systems of care” for children and for adults including service systems outside the mental health system, (5) extend Medicaid managed care to people with severe, chronic mental and/or substance use disorders, and (6) integrate the treatment of behavioral and physical health conditions for **all** people with diagnosable co-occurring conditions, roughly 50% of the American population.

There is, I think, much to be learned from this history, which is largely a history of brilliant ideas crashing on the rocks of reality. It is a history that makes me skeptical that the complex systems now being put in place can work. I would be delighted to be wrong. Integrated care at last? That would be wonderful.

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