

NEWS NATIONAL COUNCIL

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

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About this issue

Behavioral Health and Primary Care Coordination

This issue is focused on the coordination of behavioral health and primary care. Articles from experts in healthcare emphasize the need for integrated care to promote overall wellness and provide insights on funding, clinical, and structural models for coordination. Behavioral health and primary care providers share success stories (see pages 12–18) from coordinated care models that they have implemented. One clear theme emerges, as the National Council President and CEO Linda Rosenberg emphasizes in her editorial, “Just as screening and evaluation for behavioral health disorders is appropriate in primary care settings, screening and evaluation for general health problems should be available to individuals in behavioral health settings.”

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Each issue provides in-depth perspectives and tools on a key issue in behavioral health. We would love to hear from our readers about whether this newsletter is helpful to you and about themes you would like to see covered in future issues. Please email your feedback and suggestions to MeenaD@nccbh.org.

The Quiet Tragedy of Premature Death Among Mental Health Consumers

Ronald W. Manderscheid, PhD, Director, Mental Health and Substance Use Programs, Constella Group, LLC

Persons with serious mental illnesses die 25 years younger than the general population, based on reports for consumers served by state mental health agencies. Male consumers are likely to die at about 53 years and female consumers, at 59 years. The 25-year disparity is due to two factors, chronic physical disabilities (which account for 15-20 years of the difference) and mental disabilities such as suicide (which account for 5-10 years).

These troubling numbers were uncovered by Craig Colton and me and reported in *Preventing Chronic Disease* in April 2006.¹

The data used in the study that we reported on was submitted by public mental health agencies in eight states (Arizona, Missouri, Oklahoma, Rhode Island, Texas, Utah, Vermont, and Virginia) for 1997 through 2000. The data was

submitted during the 16-State Study on Mental Health Performance Measures, funded by the Substance Abuse and Mental Health State Administration’s Center for Mental Health Services in collaboration with the National Association of State Mental Health Program Directors.

Compared with findings from a much earlier related study,² mental health consumers’ disparity in length of life appears to be worse in 2006 than in 1986. The causes of premature death among persons with mental illnesses are equally disturbing. The chronic physical disabilities contributing to premature death result from the lifestyle problems of many Americans.

The disabilities are obesity, high blood pressure, diabetes, stroke, chronic heart disease, and heart attack. Collectively, these chronic health

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CMHC and CHC Collaborate to Expand Mental Health Services in Kansas

Lougene Marsh, Executive Director and Lanis Dieker, LCSW, Behavioral Health Consultant — Flint Hills Community Health Center, Emporia, Kansas

The Flint Hills Community Health Center (Lyon County Health Department) and Mental Health Center of East Central Kansas in Emporia, KS, have come together in an excellent example of collaboration between public health, mental health, and primary care providers. Such collaboration is essential in light of the fact that psychological distress, which most often contributes to or is the result of medical illness, can complicate medical treatment and increase medical costs. Psychosocial factors are related to poor general health status, functional disability, and long term health morbidity and mortality. Almost

70% of all health visits have a psychosocial basis. In turn, mental illnesses can have an impact on chronic conditions. Left untreated, these conditions may trigger unhealthy behaviors, diminished immune functioning, and poor prognosis outcomes for the patient.

FHCHC participates in the Health Disparities Collaborative for depression and successfully applied for a mental health expansion grant through the Bureau of Primary Health Care (Health Resources Service Administration). MHCECKS supported that grant application

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Perspectives on Premature Death Based on the Upcoming NASMHPD Technical Report

Barbara Mauer, MSW, CMC, National Council Consultant, interviews Joseph Parks, MD, Chair of the Medical Directors Council of the National Association of State Mental Health Program Directors, on the technical report — publishing in fall 2006 — on chronic disease and premature death in the population with serious mental illness.

Dr. Parks, why did the Medical Directors Council decide to focus a technical report on the issue of chronic disease and premature death in persons with serious mental illness?

In the last four years, several new state studies and one large multistate study have found that persons in the public mental health system die 25 years younger than the general population. This is absolutely shocking! The Medical Directors Council concluded that these findings represent a public health emergency that calls for immediate action. We wanted to alert other stakeholders and advocates and provide them with information to fight this epidemic of early death.

Has there been a change in what we know about premature deaths in the population with serious mental illness?

Yes, previous studies from one to two decades ago reported that the persons we serve die 10-15 years younger than the general population. The new studies have found that persons with serious mental illness die earlier of heart disease, hypertension, stroke, diabetes and other general medical conditions. In fact, many more persons with severe mental illness are dying of general medical conditions than are dying of suicide. If we want the people we serve to recover from their mental illnesses, we have to keep them alive and healthy.

Why are people with serious mental illness dying so much earlier than the general population?

The marked increase in early death is due to several factors. Our whole country is in the middle of an epidemic of obesity and decreased physical activity, which has led to a general increase in heart disease and other medical conditions. Persons with mental illness have always had greater difficulties in these areas and now their rates are increasing even faster those of the general population. Second, many of the newer psychiatric medications have metabolic side effects that lead to these conditions and we haven't made managing those risks the same kind of focus that we made tardive dyskinesia. Third, we have failed to adequately address addictive disorders, in particular smoking. Approximately 70% of the people we serve smoke and smoking increases the rates of all these medical conditions. These factors multiply one upon another.

What should National Council members, community-based mental health/behavioral health treatment organizations, be doing to improve the health status of the people they serve?

Like most public health crises, this one is being driven by many factors and addressing them will require multiple approaches. To be successful, we will have to change our

thinking and redirect our efforts in several broad areas. First, we need to focus on overall wellness as a central part of promoting recovery. Second, treatment plans must address how to achieve a healthy lifestyle. Third, we need to prioritize and emphasize adherence to general medical care and good preventive care as much as adherence to mental health treatments. The NASMHPD technical report will contain a wealth of background information and evidence-based practices that National Council members can draw from to develop their own action plans to keep the people they serve alive to enjoy their recovery.

Joseph Parks, along with Dale Svendsen, MD, led a workgroup convened by the Medical Directors Council of the National Association of State Mental Health Program Directors in Columbus, Ohio, in May 2006 to address the problem of premature death in persons with mental illnesses as revealed by multistate studies. The workgroup provided input for a technical report, which is intended to serve as the basis for developing a national strategy for the coordination of mental health and primary care. The report will be available in fall 2006 at www.nasmhpd.org/publications.cfm#meddirectors.

The Quiet Tragedy *Continued from page 1*

problems are known as the “metabolic syndrome.” However, unlike many other Americans, public mental health consumers are much less likely to receive care for these problems. As a result, they die prematurely.

Mental disabilities experienced by consumers can lead to suicide. Although effective treatments exist for many of these mental disabilities, the public mental health system has only recently begun to embrace the concept of recovery and its related notions of hope and independence.³ Frequently, persons with mental illnesses tell us that they have lost hope and don't envision for themselves a future in which they can live valued and productive lives in the community.

Addressing this silent tragedy must be a very high priority for the entire mental health field. Solutions are likely to be found through coordinating good care for chronic physical disabilities with good mental health care. The concept of recovery encompasses both types of care. It is the persons with mental illnesses that can and should provide leadership for such coordination. They have great insight about how current care systems can be improved. The “wellness model,”⁴ published more than 25 years ago, can also provide guidance in this work. The recent Institute of Medicine report on Improving the Quality of Healthcare for Mental and Substance Use Conditions⁵ is also a blueprint for coordinating mental health and primary care.