

Testimony by
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Mr. Chairman, members of the Committee, thank you for inviting me to speak with you today about mental health and substance use disorders in the context of chronic disease. I am honored to have this opportunity and will do my best in the time available to demonstrate that it is impossible to consider a comprehensive approach to health reform in this country without understanding the many ways in which addiction, substance use, and a range of mental health disorders contribute to the overall picture of chronic disease.

I serve as Director of the Campaign for Mental Health Reform, a coalition of eighteen organizations working together on federal policy. All eighteen organizations agree that “mental health is integral to health” and collaborate on development of policy informed by this verity. I also have had the privilege of working closely with colleagues in the substance abuse community through the mechanism of the Whole Health Campaign, which was formed to promote the idea that health policy cannot be addressed without incorporating an understanding of both mental health and substance abuse. I am indebted to a large number of my colleagues for the help they have provided in the preparation of this testimony.

This hearing’s focus on chronic disease and prevention and the pairing of substance abuse and mental health with tobacco-use and obesity on this panel are propitious in several ways, and I applaud the decision to present these topics in this manner. It is important from the outset to understand that mental illnesses and substance use disorders are chronic conditions that are also intertwined with other chronic conditions, creating a complex web in which many lives are snared and much money is wasted.

Perhaps the first point to make about mental illnesses and substance use disorders is that they frequently travel together, wreaking havoc on individuals' lives with repeated cycles of dispiriting and destructive behavior and leaving a trail of pain and suffering that swallows whole families. In many people, it is impossible to separate one condition from the other. It is in part for this reason that the mental health and addictions fields, still largely separate in terms of funding and organization, are now recognizing the need for greater collaboration in practice and healthcare policy. They are treating many of the same people. Your invitation to discuss these issues together augurs well for the direction in which future health policy must head.

While we often use the term “co-occurring disorders” to describe concurrent mental health and substance use conditions, we are increasingly using the term to describe the overlay of mental disorders and a broader range of chronic disorders. It is important to note, also, that mental disorders themselves frequently co-occur. For example, according to the Multimodal Treatment Study of Children with Attention Deficit / Hyperactivity Disorders (MTA) conducted by the National Institute of Mental Health, 79% of children with AD/HD have at least one co-occurring mental disorder and according to the Centers for Disease Control and Prevention (CDC), 50% of children with AD/HD have a co-occurring learning disability. New data is beginning to show significant co-occurrence between AD/HD and autism.

Measures from different sources all point to the conclusion that the costs associated with the failure to appropriately treat mental health and substance use disorders are high. According to the National Institute on Drug Abuse, the economic cost of drug, alcohol and tobacco abuse in the United States is more than \$500 billion. Drug, alcohol and tobacco use currently cost schools throughout the country an extra \$41 billion per year in truancy, violence, disciplinary programs, school security and other expenses.

In 2002, mental illnesses and substance use disorders led to \$193 billion in lost productivity – more than the revenue of 499 of the Fortune 500 companies – and by 2013, this figure is estimated to rise to more than \$300 billion.

Using a measure called Disability Adjusted Life Years (DALYs) in its study of the Global Burden of Disease, the World Health Organization has found that depression was the fourth leading cause of disease-burden in 1990 and by 2020 will be the single leading cause. Indeed, mental illness is already the leading cause of disability for people between 15 and 44 in the United States and Canada.

When we examine mental health, substance use, and other chronic disorders, however, it is only by seeing how deeply interwoven they are that we truly appreciate the costs of failing to address them in an integrated approach. Mental health and substance use disorders are interwoven with other chronic disorders, including obesity, tobacco consumption, heart disease, pulmonary disorders, and hypertension. Failure to consider the co-occurrence of mental health disorders, substance use disorders, and other chronic conditions leads to worse outcomes and more costly treatment.

Many suffer from these conditions simply because they are not receiving appropriate healthcare. As Joseph Parks, M.D., director of the Missouri Department of Mental Health, points out, this is an issue for all people with limited income, which certainly includes those who utilize the public mental health system. Preventive care is all but unknown in this population. As a result, they overuse emergency rooms, get less primary care, and go for routine screens and tests at significantly lower rates. They also have very low rates of dental care, which is often not paid for by public programs. Finally, it would be a mistake to think that people receiving services in the mental health system have a direct link to general medical care; there is little integration of primary care and psychiatry.

People with mental illnesses are uninsured at twice the rate of the general population: 34% of people with mental illness have no health coverage at this point. In other words, many people with mental illnesses are excluded from our nation's porous healthcare system right from the start. In addition, it is possible to identify "patient factors" (amotivation, fearfulness, homelessness, victimization/trauma, resources, advocacy,

unemployment, incarceration, social instability, IV drug use, etc.), “provider factors” (comfort level and attitude of healthcare providers, coordination between mental health and general health care, stigma), and “system factors” (funding, fragmentation) as reasons people with mental illnesses are receiving poor overall healthcare.

The result? As documented by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of State Mental Health Program Directors (NASMHPD), people with mental illness in the public mental health system die *on average 25 years earlier* than the general population. They die because they suffer from a host of chronic conditions that are largely preventable: respiratory ailments, complications associated with obesity and poor nutrition, diabetes, etc. Indeed, as alarming as this data about premature death is, we should not let it obscure the fact that people with mental illness may constitute the most unhealthy segment of our nation’s population. As best we can tell, no other identified group of Americans lives with so many chronic medical conditions or, as a consequence, dies so young. It is estimated that as much as eight percent of adult Americans – 17.5 million people – have a serious mental illness; the excessive morbidity and mortality they experience is certainly a public health crisis.

It is only relatively recently that researchers have begun to collect reliable data on this issue, but the scope of the problem has become clear. While suicide and injury account for about 30-40% of premature deaths in persons with schizophrenia, about 60% are due to “natural causes.” According to a 2000 study reported in *Schizophrenia Research*, people with schizophrenia die at 2.7 times the rate of the general population from diabetes, 2.3 times the rate from cardiovascular disease, 3.2 times the rate from respiratory disease, and 3.4 times the rate from infectious diseases.

Some very revealing work has been done using data from the Behavioral Risk Factor Surveillance System (BRFSS), the state-based surveys conducted by the CDC. It shows that persons with high health risks are highly likely to have a co-morbid mental illness. It also shows that persons with mental illness constitute a significant portion of the target

population of major public health programs. And the study leads to the conclusion that persons with mental illness appear to qualify as a Health Disparities Population.

A number of studies have looked at depression's link to various illnesses. Depression is a risk factor for stroke and coronary artery disease. The likelihood of developing myocardial infarction is four times greater for persons with depression than in general population; the likelihood of stroke is 2.6 times greater, according to two studies. Depressed men are 2.3 times as likely to develop diabetes, according to another. Other studies note the high impact of depression on outcomes of cardiovascular illness. This all adds up to more outpatient visits and hospital days for patients in whom depression accompanies a chronic condition than for those without depression. Medical/surgical costs for people also suffering depression were 1.4 times higher than for those who were not in one HMO. Myocardial infarction plus depression yielded 41% higher costs in another study.

A study of Medicaid patients in Maine had implications for policy on several levels. It revealed the importance of screening tools for depression in primary care and for health issues in mental health settings, the need for reimbursement for mental health interventions in primary care and health interventions in mental health settings, the benefits of integrated mental health/health care management for individuals with complex needs, and the need for integrated analysis of utilization and cost across both mental health and health care.

A new study of Medicaid patients in six states published in this month's issue of *Psychiatric Services* indicates that substance abuse also has an extreme impact on general medical costs. It shows that as patients with substance abuse disorders got older, their medical care costs increased at a far higher rate than behavioral health costs. For people with substance abuse disorders – on average, 29% of the Medicaid population – the six states paid \$104 million more for medical care than for those patients who did not have an alcohol or drug abuse diagnosis.

I earlier discussed the co-occurrence of mental health disorders and substance abuse. Given the scope of today's hearing, it may also be instructive to look more closely at the intersection of tobacco use with mental disorders. According to the Smoking Cessation Leadership Center, based at the University of California at San Francisco and funded largely by the Robert Wood Johnson Foundation, persons with mental illness smoke half of all cigarettes produced and are only half as likely to quit as smokers without mental illness. Approximately 50% of those with serious mental illness are smokers, compared with 23% for society at large. Evidence also points to people with mental illnesses consuming more of each cigarette they smoke and inhaling the smoke from them more deeply. We have already seen that mortality rates for persons with mental illness are much higher than those for others in society; half of these deaths are due to smoking related illnesses. There is evidence, too, that smoking is also associated with increased insulin resistance, which clearly holds implications for the high rates of diabetes in people with mental illnesses.

Where does this lead us?

It should be apparent from this summary of data that mental health and addictions treatment must be fully integrated into a coordinated health reform agenda. As the nation's health policy is reshaped, we must not overlook the interaction of mental health and addictions disorders with each other and with a range of chronic conditions. The committee's outreach to the substance abuse and mental health communities clearly indicates that you have no intention of crafting such an incomplete policy approach, so I am greatly encouraged and pledge the assistance of our communities in your ongoing work.

A number of models and approaches that have entered the health reform debate in recent months hold promise for improvement in the nation's ability to address chronic conditions and prevention, but their implications for mental health and substance abuse

have not, as yet, been fully explored. For example, most descriptions of the coordinated care models known as “medical homes” (or “clinical homes”) make little reference to mental health or substance abuse. We have seen that the lack of coordination in medical care may, in fact, be most pronounced when it comes to mental health and substance abuse disorders, so it is extremely important that the place of these disorders in the medical home receive more attention.

Similarly, much hope for the improvement of our nation’s healthcare delivery system has been placed in expansion of health information technology. While we feel it very important to achieve appropriate standards for privacy and security in HIT systems, we would not want such standards to somehow exclude or separate mental health and substance abuse treatments from the rest of the medical community. Properly implemented, in fact, HIT can be an instrument of consumer empowerment, leading to much greater awareness of one’s health status and providing the opportunity for improved self-management strategies.

The emphasis on quality and effectiveness characterizing much healthcare discussion these days must also be cast in terms that accommodate mental health, substance abuse, and their interaction with other conditions. Approaches to the care and treatment of people with the chronic conditions discussed earlier – diabetes, heart disease, respiratory illnesses – should always include mental health and substance use screening. By the same token, mental health and substance abuse service providers should ensure their clients and patients are receiving primary medical attention. As in much of medicine, the trend should be towards payment for outcomes.

We also should give considerable thought to how the bad outcomes we are now seeing can be avoided through preventive efforts. As members of this committee know so well, prevention comes in a variety of packages. In this instance, it seems evident that a baseline preventive approach must be public education promoting the understanding that “mental health is essential to overall health.” Widespread acceptance of this concept

would begin to enable individuals and systems to overcome the barriers to effective care I have tried to identify in this testimony.

We must also approach prevention across the lifespan and work to provide the appropriate screens, starting with well-child visits, that can identify the co-occurrence of mental health, substance abuse, and chronic conditions. It has long been a popular belief that mental illnesses and addictions begin in late adolescence or early adulthood. In fact, this is a misconception. The average age of onset for mental disorders is 14. Addictions to alcohol, marijuana, and tobacco also start in adolescence or childhood, and studies are clear that when use of these substances is started at an early age, the consequences later in life are much more pronounced than they otherwise would be. For example, youth who first smoke marijuana under the age of 14 are more than five times as likely to abuse drugs in adulthood.

We must develop a better understanding of role trauma plays in mental health conditions and substance abuse and then employ approaches that mitigate trauma's effect. We must understand and address maternal depression, the consequences it can have on a young child's physical and emotional development, and the ways it can play out over the span of that young child's life.

With respect to the contributions of mental health and substance abuse disorders to the range of chronic conditions, work can be done to address modifiable risk factors, including: smoking, alcohol consumption, nutrition, exercise, intravenous drug use, unsafe sexual activity, time spent in group care facilities (leading to TB and infectious diseases). It is in our failure to pay attention to these factors that we can begin to identify the roots of many chronic conditions afflicting people with mental health and substance use disorders.

Indeed, such prominent practitioners as members of NASMHPD's Medical Directors Council point out that established monitoring and treatment guidelines to lower risk are underutilized in the population of people with serious mental illnesses. This is true both

in the case of practitioners in mental health and addictions treatment facilities and practitioners in the larger medical arena who see people with mental health or substance abuse disorders. The failure to treat metabolic syndrome in patients with schizophrenia is an unfortunate but common example of the sort of missed opportunities common today. If mental health professionals, who often spend much of their energy making sure their clients are taking their prescribed psychotropic medications, could monitor their follow-up with other medical interventions and lifestyle modifications, the lives of many people with mental illnesses would be extended.

We need to know more about the interplay of mental health, substance abuse, and chronic diseases. Surveillance tools that analyze both physical health and mental health and their interaction will be a boon to our growing understanding of their complex relationships. With that information, we can begin to develop public health programs aimed at risk reduction or chronic disease prevention that address mental health issues in program design, implementation and assessment. We need also to encourage collaboration between public behavioral health and public health authorities and remove financial disincentives to their coordination.

There is much to be done, and the effort now underway to reform our nation's approach to health provides an unparalleled opportunity to address these issues. Thank you once again for the opportunity to discuss the ways in which substance abuse and mental health disorders contribute to the picture of chronic diseases in our nation. My hope is that by beginning this examination, we are able to move towards a general improvement of the health status of millions of Americans and a reduction in unnecessary costs in our health system.