Workshop Materials

Strategies for Promoting Staff and Patient Safety In the Midst of a Mental Health Crisis

NYSNA Convention 2020

https://www.statnews.com/2020/08/12/after-covid19-mental-neurological-effects-smolder/

Long after the fire of a Covid-19 infection, mental and neurological effects can still smolder

By Elizabeth Cooney, August 12, 2020

Early on, patients with both mild and severe Covid-19 say they can't breathe. Now, after recovering from the infection, some of them say they can't think.

Even people who were never sick enough to go to a hospital, much less lie in an ICU bed with a ventilator, report feeling something as ill-defined as "Covid fog" or as frightening as numbed limbs. They're unable to carry on with their lives, exhausted by crossing the street, fumbling for words, or laid low by depression, anxiety, or PTSD.

As many as 1 in 3 patients recovering from Covid-19 could experience neurological or psychological after-effects of their infections, experts told STAT, reflecting a growing consensus that the disease can have lasting impact on the brain. Beyond the fatigue felt by "long haulers" as they heal post-Covid, these neuropsychological problems range from headache, dizziness, and lingering loss of smell or taste to mood disorders and deeper cognitive impairment. Dating to early reports from China and Europe, clinicians have seen people suffer from depression and anxiety. Muscle weakness and nerve damage sometimes mean they can't walk.

"It's not only an acute problem. This is going to be a chronic illness," said Wes Ely, a pulmonologist and critical care physician at Vanderbilt University Medical Center who studies delirium during intensive care stays. "The problem for these people is not over when they leave the hospital."

Doctors have concerns that patients may also suffer lasting damage to their heart, kidneys, and liver from the inflammation and blood clotting the disease causes.

No one can yet tell patients with neurological complications when, or if, they'll get better, as doctors and scientists strive to learn more about this coronavirus with each passing day. Their guideposts are the experience they've gained treating other viruses and delirium after ICU stays, sparse results from brain autopsies, and interviews with patients who know something is just not right.

"We would say that perhaps between 30% and 50% of people with an infection that has clinical manifestations are going to have some form of mental health issues," said Teodor Postolache, professor of psychiatry at the University of Maryland School of Medicine. "That could be anxiety or depression but also nonspecific symptoms that include fatigue, sleep, and waking abnormalities, a general sense of not being at your best, not being fully recovered in terms of the abilities of performing academically, occupationally, potentially physically."

John Bonfiglio, 64, counts himself among the fortunate ones. He remembers nothing between sitting in Newton-Wellesley Hospital's emergency department with a fever and waking up 17 days later in the Massachusetts hospital's ICU. He'd been on a ventilator, lying prone until his failing kidneys meant he needed to be flipped over onto his back for dialysis. Weak and confused from his ordeal after moving to a regular hospital floor, he tried to slip around his bed's guardrails and slid to the floor. Nurses would routinely ask his name and if he knew where he was. One day he answered "Las Vegas."

Bonfiglio chalks that up to post-ICU disorientation that included his feeling more emotional. Ordinarily "not a crier," as he put it, he would choke up sometimes. More troubling were the persistent dizziness, muscle weakness, and tremors in his hands that made it impossible to put his contact lenses in his eyes.

He was discharged to Spaulding Rehabilitation Hospital in nearby Charlestown, Mass., where he spent the balance of his 51-day hospitalization — during which he saw no family members since suggesting to his daughter that she go home from the emergency room that night in April.

From his early days in rehab, when sitting up in bed was exhausting, to learning how to walk again with a walker, to finally going home to Waltham, Mass., Bonfiglio lost 40 pounds — "all muscle." He's regained some of his strength, and weight, now. His dizziness and tremors are gone. And his mind is clear.

He's back driving part-time for a food-delivery service, and he jokes that being in a drug-induced coma meant he missed the pandemic's surge in Massachusetts. When he visited the Newton-Wellesley ICU after a checkup, he couldn't remember any of the staff there. He does remember what one nurse said as he was leaving the hospital for Spaulding: "'You are the first person that is going to rehab and not to hospice,' she told me. So I feel extremely lucky, you know, just making it through."

Vanderbilt's Ely worries about patients who emerge from the ICU with more serious problems than Bonfiglio's, including delirium caused by high-potency drugs like benzodiazepines and nerve damage from low oxygen levels.

"And then they're getting isolated. When they're isolated and away from family, it makes it worse," Ely said. Later, "they're having either post-traumatic stress disorder, anxiety disorder, depression, or cognitive impairment, and some combination of all of that. So these people are really in for some neurologic and mental health problems."

Right now, there is little that researchers can say definitively about how best to prevent and treat neuropsychological manifestations of Covid-19. Nor do they know for certain why the brain is affected.

"It's sort of like you're trying to put out the fire and then a little bit later, you go look at the nervous system as the embers," said Victoria Pelak, professor of neurology and ophthalmology at the University of Colorado School of Medicine. "Because you are so concerned with the raging fire, you haven't really been able to pay attention to the nervous system as much as you normally would."

She and others are piecing the story together. So far the virus appears to cause its damage to the brain and nervous system not as much through direct infection as through the indirect effects of inflammation. Pieces of the virus, not actual viruses multiplying, can trigger an inflammatory response in the brain, said Lena Al-Harthi, chair of the Department of Microbial Pathogens and Immunity at Rush Medical College.

"If you have an uncontrolled level of inflammation, that leads to toxicity and dysregulation," she said. "What I am concerned about is long-term effects, obviously in the people who have been hospitalized, but I think it's definitely time to understand long-term sequelae for those individuals who have never been hospitalized. They're young, too. We're not talking about [only] older individuals, but people that are 30."

Fred Pelzman, who practices internal medicine in New York City, fell sick with Covid-19 in March but has yet to recover fully. He doesn't have his wind back, or his normal sense of taste and smell. His patients who have had Covid-19 are suffering from varying degrees of depression, anxiety, or Covid fog. One can't do simple math calculations in her head any more. Others don't feel as mentally sharp, struggling to find the right words to say. His colleagues tell him their patients, too, dread being reinfected with the virus.

“It’s hard to separate the physical from the psychological score, and we know they are intimately related,” he said. “It’s hard to separate the Covid-19 signal from the social justice upheaval and global warming and politics and the pandemic and anxiety of just being, you know, isolated and working at home and economic turmoil and all the rest.”

Neurocognitive testing, psychiatric evaluation, and diagnostic imaging might help determine the cause for these problems, Pelzman said, but not having a baseline for comparison could make that challenging, especially when hospitals are racing to keep patients breathing and prevent blood clots from forming and clogging blood vessels or triggering strokes — common problems caused by Covid-19.

“Strokes are larger, potentially more damaging with this disorder. Once inflammation or blood vessel problems occur within the nervous system itself, those people will have a lot longer road to recovery or may die from those illnesses,” Colorado’s Pelak said.

Doctors are also watching for a syndrome called demyelination, in which the protective coating of nerve cells is attacked by the immune system when there is inflammation in the brain. As in the autoimmune disease multiple sclerosis, this can cause weakness, numbness, and tingling. It can also disrupt how people think, in some cases spurring psychosis and hallucinations. “We’re just not sure if this virus causes it more commonly than other viruses,” Pelak said.

In Italy, three Covid-19 patients with no previous history of neurologic or autoimmune disorders developed myasthenia gravis, a disease that weakens the arm and leg muscles, causes double vision, and leads to difficulties speaking and chewing. While such symptoms could follow the viral infection of nerve cells, it’s also possible that an autoimmune mechanism — the body attacking healthy cells — is at work, the group reporting these cases said.

Recovery from Covid-19 often begins in rehab. Ross Zafonte, chief medical officer at Spaulding, said he is seeing some patients’ cognitive and brain-related issues last for much longer than expected. That includes depression, memory disorders, and PTSD, as well as muscle and peripheral nerve damage that makes mobility difficult. For some patients, their mental awareness has been slow to recover.

“We’re trying to follow people long term and do a longitudinal study to see what are the comorbid factors,” he said. “What are the characteristics of people who don’t get back to normal? How can early intervention try to deal with that? Are there some biomarkers of risk? Can we try to define better targets for early intervention?”

Maryland’s Postolache thinks Covid-19 infection might act as a “priming event” for problems to resurface in the future. Psychological stress could reactivate behavioral and emotional problems that were initially triggered by the immune system responding to the virus. “What we call psychological versus biological may actually be quite biological,” he said. “We don’t really say this is permanent … but considering all complexities of human life, it’s unavoidable.”

Ely of Vanderbilt suggests three things to do now.

“We can open the hospitals back up to the families. That’s important,” he said. “We can be aware of these problems and tell the families about them so that the families will know that this is coming. [And] we can do counseling and psychological help on the back end.”

Heroes, or just doing our job? The impact of COVID-19 on registered nurses in a border city

The Conversation, August 23, 2020

The Year of the Nurse brought increased attention to the "heroes of health care": nurses working on the front lines of COVID-19. However, despite public displays of thanks, it's becoming clear that many nurses are not getting the support they need to feel safe on the job and to maintain their own health and well-being.

As researchers in psychology and nursing at the University of Windsor, we sought an in-depth understanding of how nurses in a border city felt about working during the pandemic.

Evidence from SARS in 2003 indicated that nurses may experience significant, long-term mental health effects from working during the pandemic. Early research from China and Italy found that nurses working during the surge of COVID-19 cases in those countries reported high rates of depression, anxiety and sleep disturbances.

Commuting in a border city

As a border city, Windsor, Ont., is home to nurses who reside and work locally, but also a significant number who commute daily to hospitals in Detroit, Mich. Early in the pandemic, Detroit emerged as a "hot spot" partly due to significant racial inequalities and health disparities in the city's population.

Detroit hospitals depend on their Canadian nurse employees. In 2016, 20 per cent of the nurses working at Henry Ford Hospital were Canadian, and a total of 1,600 Windsor residents reported working in health-care settings in Detroit. The continued ability of these hospitals to operate during and after the pandemic depends on the retention of Canadian personnel.

In May and June 2020, our team interviewed 32 female and five male nurses living in Windsor and working in health-care settings in Windsor (20 nurses) or Detroit (17 nurses). They worked on intensive care units, COVID-specific units, labour and delivery units, in emergency departments and field hospitals, with experience in nursing ranging from 1.5 to 36 years.

Concerns about family and mental health

Nurses consistently reported increased mental health concerns, difficulties coping and substantial dissatisfaction with the level of support provided by their hospitals.

The support that nurses felt from their organization and managers varied from workplace to workplace and unit to unit. A few felt well supported, but many reported they were not valued, citing organizations that furloughed them, stopped employer contributions to retirement funds or did not provide adequate PPE. One participant noted:

“I didn’t sign up for not having myself protected, you know, I think I deserve as a nurse to at least have that.”

Despite increasing levels of depression and anxiety, there was a strong sense that referrals to employee assistance plans (EAPs) were not sufficient. Overall, we found that nurses were surprisingly resistant to the idea of formal mental health supports. They felt more comfortable seeking support from their coworkers or “work family” than non-nurse family/friends or organizational supports. Many expressed fears that seeking help from hospital administration would be perceived as a sign of weakness. One participant stated:

“Heaven forbid, you say mental health or stress … because then they’ll take you from your unit, and say, put you at the front door as a greeter.”

Nurses also expressed concerns about their own health and the health of family members. They described difficulties balancing quality patient care with “cluster care,” which limited their time in patient rooms, and the emotional toll of “death over Facetime” as one participant called it: holding electronic tablets as dying patients said their goodbyes to family.

They experienced difficulties navigating rapidly changing hospital policies (sometimes during a single shift), discrepancies between governmental and hospital recommendations, do not resuscitate orders that were either avoided or forced, and inadequate access to PPE.

Many reported sleep issues, nightmares, fatigue, increased irritability, increased alcohol consumption, unhealthy eating habits and use of sleep aids and cannabis. Many self-isolated from their families and missed out on the day-to-day moments and key developmental milestones of their children. One participant recounted:

“I missed my kid’s entire crawling stage.”

Many nurses spoke of inequity and moral injury. They expressed frustration about doctors and men with facial hair receiving better PPE, temporary employees (that is, travel nurses) getting better pay and/or hours, being reassigned to multiple units and doing non-nursing tasks like cleaning COVID-19 positive rooms. Nurses felt better prepared to be reassigned if they volunteered, but not if it was forced (and some were).

Some nurses were encouraged to purchase their own PPE to use at work, for example, face shields from Amazon or even dollar store raincoats. Almost everyone we interviewed expressed concern about second and third waves and whether the hospitals would be prepared.

Heroes … but stigmatized

Nurses expressed appreciation regarding the community responses (for example, clapping, food donations, skipping lines at businesses) but also felt a lot of stigma as potential “disease carriers.” One participant shared:

“[The public] keep saying: ‘Oh, nurses are heroes. Doctors are heroes. They’re doing so much for us.’ You’re out in scrubs and they’re like, ‘They’re contaminated, get them away, they’re infectious.’”

There were some differences in responses between nurses employed in Detroit and those working in Windsor. Overall, nurses working on the Michigan side of the border reported greater patient mortality, PPE shortages, community stigma and dissatisfaction with hospital administration. However, these findings are complicated by the much more rapid onset and greater intensity of the COVID-19 pandemic in Detroit compared to Windsor, and therefore can’t be interpreted with confidence.

Most nurses said that they were not planning on leaving nursing, but several are considering changing units or looking to a career change if the pandemic continues for many months or even years. Nurses also highlighted issues that the public may not be aware of: a moratorium on organ donation, decreased quality of care or risk of family-patient online meetings getting hacked.

Rapid intervention and availability of supports are needed to quickly address symptoms of mental health issues and reduce loss in the nursing workforce that has been observed after previous outbreaks, such as SARS, which could exacerbate a pre-pandemic shortage of nurses in Canada.

Nursing is a profession with a reputation for trustworthiness and dedication to quality care. As a community, we need solutions that go beyond a pat on the back and “hero” label, and instead address unsafe working conditions and offer practical effective support.

Beth Daley Editor and General Manager

The historical roots of racial disparities in the mental health system

By Tahmi Perzichilli

Counseling Today, May 7, 2020

Racial disparities, or unfair differences, within the system of mental health are well documented. Research indicates that compared with people who are white, black, indigenous and people of color (BIPOC) are:

- Less likely to have access to mental health services
- Less likely to seek out services
- Less likely to receive needed care
- More likely to receive poor quality of care
- More likely to end services prematurely

Regarding racial disparities in misdiagnosis, black men, for example, are overdiagnosed with schizophrenia (four times more likely than white men to be diagnosed), while underdiagnosed with posttraumatic stress disorder and mood disorders. Additionally, concerns are compounded by the fact that for BIPOC, mental health care is often provided in prisons, which infers a multitude of issues.

BIPOC are overrepresented in the criminal justice system, as the system overlays race with criminality. Statistics show that over 50% of those incarcerated have mental health concerns. This suggests that rather than receiving treatment for mental illness, BIPOC end up incarcerated because of their symptoms. In jails and prisons, the standard of care for mental health treatment is generally low, and prison practices themselves are often traumatic.

The vast majority of mental health treatment providers in the United States are white. For example, approximately 86% of psychologists are white, and less than 2% of American Psychological Association members are African American. Some research has demonstrated that provider bias and stereotyping are relevant factors in health disparities. For nearly four decades, the mental health field has been called to focus on increasing cultural competency training, which has focused on the examination of provider attitudes/beliefs and increasing cultural awareness, knowledge and skills.

Despite such efforts, racial disparities still exist even after controlling for factors such as income, insurance status, age, and symptom presentation.Established barriers for BIPOC are the following:

- Different cultural perceptions about mental illness, help-seeking behaviors and well-being
- Racism and discrimination
- Greater vulnerability to being uninsured, access barriers, and communication barriers
- Fear and mistrust of treatment

In addition to emphasizing culturally competent services, other recommendations to bridging the gaps and addressing barriers have largely focused on diversifying workforces and reducing stigma of mental illness in communities of color.

One area not often noted is the historical (and traumatic) context of systemic racism within the institution of mental health, although it is well known that race and insanity share a long and troubled past. This focus may

begin to account for how racial differences shape treatment encounters, or a lack thereof, even when barriers are controlled for and the explicit races of the provider and client are not at issue.

Historical context

In the United States, scientific racism was used to justify slavery to appease the moral opposition to the Atlantic slave trade. Black men were described as having "primitive psychological organization," making them "uniquely fitted for bondage."

Benjamin Rush, often referred to as the "father of American psychiatry" and a signer of the Declaration of Independence, described "Negroes as suffering from an affliction called *Negritude*." This "disorder" was thought to be a mild form of leprosy in which the only cure was to become white. Ironically Rush was a leading mental health reformer and co-founder of the first anti-slavery society in America. Rush did observe, however, that "the Africans become insane, we are told, in some instances, soon after they enter upon the toils of perpetual slavery in the West Indies."

In 1851, prominent American physician Samuel Cartwright defined "drapetomania" as a treatable mental illness that caused black slaves to flee captivity. He stated that the disorder was a consequence of slave masters who "made themselves too familiar with the slaves, treating them as equals." Cartwright used the Bible as support for his position, stating that slaves needed to be kept in a submissive state and treated like children to both prevent and cure them from running away. Treatment included "whipping the devil out of them" as a preventative measure if the warning sign of "sulky and dissatisfied without cause" was present. Remedy included the removal of big toes to make running a physical impossibility.

Cartwright also described "dysaethesia aethiopica," an alleged mental illness that was the proposed cause of laziness, "rascality" and "disrespect for the master's property" among slaves. Cartwright claimed that the disorder was characterized by symptoms of lesions or insensitivity of the skin and "so great a hebetude [mental dullness or lethargy] of the intellectual faculties, as to be like a person half asleep." Undoubtedly, whipping was prescribed as treatment. Furthermore, according to Cartwright dysaethesia aethiopica was more prevalent among "free negroes."

The claim that those who were free suffered mental illness at higher rates than those who were enslaved was not unique to Cartwright. The U.S. census made the same claim, and this was used as a political weapon against abolitionists, although the claim was found to be based on flawed statistics.

Even at the turn of the 20th century, leading academic psychiatrists claimed that "negroes" were "psychologically unfit" for freedom. And as late as 1914, drapetomania was listed in the *Practical Medical Dictionary*.

Furthermore, after slavery was abolished, Southern states embraced the criminal justice system as a means of racial control. "Black codes" led to the imprisonment of unprecedented numbers of black men, women and children, who were returned to slavery-like conditions through forced labor and convict leasing that lasted well into the 20th century.

Scientific racism early on indicates motives of control and containment for profitability. Leading health professionals propagated the idea that blacks were "less than" to justify exploitation and experimentation. The mislabeling of behavior, such as escaping slavery, as a byproduct of mental illness did not stop there. Significant transformations in defining mental illness also occurred in the civil rights era, suggesting that institutional racism becomes more powerful in the context of moments of heightened racial tensions in the collective social consciousness.

Prior to the civil rights movement, schizophrenia was described as a largely white, docile and generally harmless condition. Mainstream magazines from the 1920s to the 1950s connected schizophrenia to neurosis and, as a result, attached the term to middle-class housewives.

Assumptions about the race, gender and temperament of schizophrenia changed beginning in the 1960s. The American public and the scientific community began to increasingly describe schizophrenia as a violent social disease, even as psychiatry took its first steps toward defining schizophrenia as a disorder of biological brain function. Growing numbers of research articles asserted that the disorder manifested by rage, volatility and aggression, and was a condition that afflicted "Negro men." The cause of urban violence was now due to "brain dysfunction," and the use of psychosurgery to prevent outbreaks of violence was recommended by leading neuroscientists.

Researchers further conflated the symptoms of black individuals with perceived schizophrenia of civil rights protests. In a 1968 article in the esteemed *Archives of General Psychiatry*, schizophrenia was described as a "protest psychosis" in which black men developed "hostile and aggressive feelings" and "delusional anti-whiteness" after listening to or aligning with activist groups such as Black Power, the Black Panthers or the Nation of Islam. The authors wrote that psychiatric treatment was required because symptoms threatened black men's own sanity as well as the social order of white America.

Advertisements for new pharmacological treatments for schizophrenia in the 1960s and 1970s reflected similar themes. An ad for the antipsychotic Haldol depicted angry black men with clenched fists in urban scenes with the headline: "Assaultive and belligerent?" At the same time, mainstream white media was describing schizophrenia as a condition of angry black masculinity or warning of crazed black schizophrenic killers on the loose. A category of paranoid schizophrenia for black males was created, while casting women, neurotics and other nonthreatening individuals into other expanded categories of mood disorders.

The black psyche was increasingly portrayed as unwell, immoral and inherently criminal. This helped justify the need for police brutality in the civil rights movement, Jim Crow laws, and mass incarceration in prisons and psychiatric hospitals, which at times was an exceedingly thin line. In general, attempts to rehabilitate took a back seat to structural attempts to control. Some state hospitals, presided over by white male superintendents, employed unlicensed doctors to administer massive amounts of electroshock and chemical "therapies," and put patients to work in the fields. Deplorable conditions went unchallenged as late as 1969 in some states.

Deinstitutionalization, a government policy of closing state psychiatric hospitals and instead funding community mental health centers, began in 1955. Over the next four decades, most state hospitals were closed, discharging those with mental illness and permanently reducing the availability of long-term inpatient care facilities. Currently, there are more than three times as many people with serious mental illnesses in jails and prisons than in hospitals. The shifts in defining what constitutes mental health reflects the reality that the definition is shaped by social, political and, ultimately, institutional factors in addition to chemical or biological ones.

Conclusion

Looking at the historical and systemic context of the mental health system may provide insight into why racial disparities continue to exist and why these disparities have been resistant to interventions such as cultural competency training and standardized diagnostic tools. Focusing primarily on the race of the provider and the client, while valid, is an approach that does not consider the system itself, the functions of the diagnosis, and its structurally developed links to protest, resistance, racism and other associations that work against the therapeutic connection.

Racial concerns, including overt racism at times, were written into the mental health system in ways that are invisible to us now. Understanding the past enables new ways of addressing current implications and identified barriers, including how schizophrenia became a "black disease," why prisons emerged where hospitals once stood, and how racial disparities continue to exist in the mental health system today.

Additional resources

- "In our own voices: African American stories of oppression, survival and recovery in the mental health system" by Vanessa Jackson (retrieved from http://academic.udayton.edu/health/01status/mental01.htm)
- "How lack of diversity in mental health jobs affects communities of color" by Victoria Kim (retrieved from https://www.thefix.com/diversity-mental-health-jobs)
- McGuire, T. G. & Miranda, J. (2008). "New evidence regarding racial and ethnic disparities in mental health care: Policy implications" by Thomas G. McGuire & Jeanne Miranda (doi: 10.1377/hlthaff.27.2.393)
- Black & African American Communities and Mental Health (retrieved from https://www.mhanational.org/issues/black-african-american-communities-and-mental-health)
- *The Protest Psychosis: How Schizophrenia Became a Black Disease* by Jonathan Metzl
- "Racial disparities in mental health treatment" by SocialWork@Simmons University staff (retrieved from https://socialwork.simmons.edu/racial-disparities-in-mental-health-treatment/)
- "How bigotry created a black mental health crisis" by Kylie M. Smith (retrieved from https://www.washingtonpost.com/outlook/2019/07/29/how-bigotry-created-black-mental-health-crisis/)

Tahmi Perzichilli is a licensed professional clinical counselor and licensed alcohol and drug counselor working as a psychotherapist in private practice in Minneapolis. Contact her through her website at www.tahmiperzichilli.com.

BEHAVIORAL HEALTH: FIXING A SYSTEM IN CRISIS

SPECIAL REPORT: **Breaking down stigmas and building new models of care are essential for tackling healthcare's overlooked disease**

By Steven Ross Johnson and Harris Meyer

Modern Healthcare, 2015

For decades, behavioral health has been an afterthought. An estimated 44 million adults live with a mental illness, yet nearly 60% don't receive treatment in a given year. There's a growing body of evidence as well that directly links behavioral and physical health. The tide seems to be turning, however, as policymakers and providers alike recognize the need to not only allocate more resources to behavioral health and substance abuse prevention, but also redesign care models to treat the whole patient. In this special report, Modern Healthcare examines national and local efforts aimed at fixing the crisis. Our series explores the link between behavioral health and chronic disease; assesses the promise of the 21st Century Cures Act; and profiles organizations making a difference on the front lines.

Addressing behavioral health to improve all health

By Steven Ross Johnson

Each year, the nation's health system spends billions of dollars trying to treat, manage and prevent an array of avoidable conditions that only continue to grow in prevalence.

Nearly two-thirds of all deaths annually are attributable to chronic conditions. Patients with chronic conditions account for 81% of all hospital admissions, 91% of all prescriptions filled and 76% of all physician visits. Roughly 86% of the $2.9 trillion spent on healthcare in 2013 was related to chronic disease.

More than 190 million Americans—58% of the population—have at least one chronic condition, while more than 30 million have three or more. Projections indicate that the number of people living with multiple chronic illnesses will more than double by 2050 to 83 million if current trends continue.

Yet the effort to stem or even reverse the rising numbers of Americans who develop chronic illness has fallen short.

It's a problem the healthcare system remains mostly unprepared to effectively address. Years of research and initiatives focused on prevention and promoting healthier behaviors have missed the mark because they fail to tackle arguably the single greatest contributor to the chronic disease epidemic—mental illness.

For years, behavioral health was largely ignored when it came to determining the factors involved in physical health. Primary-care physicians traditionally shied away from considering emotional or mental health as a root cause of chronic diseases. Yet, data show that the two are closely linked.

Behavioral health's impact on chronic conditions
Between 15% to 30% of people with diabetes also have depression, resulting in worse outcomes, such as higher body-mass index and increased risk of other conditions (e.g., coronary artery disease, cerebrovascular disease, and microvascular complications affecting eyes, kidneys, feet and sexual function.

Up to 33% of those who suffer a heart attack later experience depression.
Comorbid depression affects 15% to 25% of people with cancer.
Source: Navigant

More than one-quarter of adults in the U.S. experience some type of behavioral health disorder in a given year, according to the Centers for Disease Control and Prevention. While 29% of adults with a medical condition also have some type of mental health disorder, close to 70% of behavioral health patients have a medical co-morbidity.

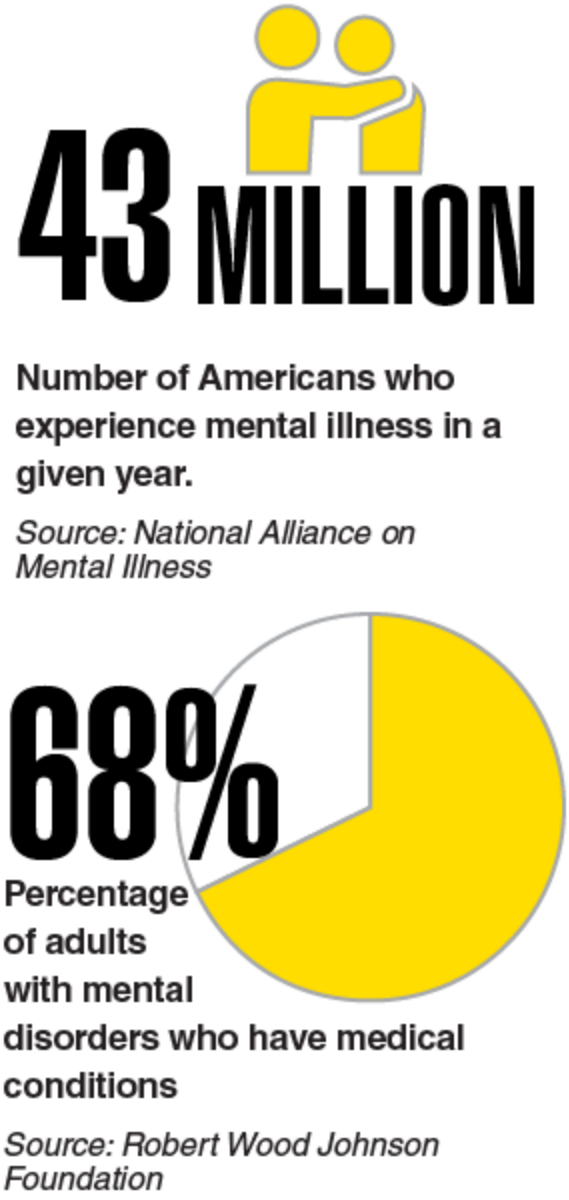
Both conditions often act as a driver for one another, heightening the risk that a person with a chronic disease will develop a mental health disorder and vice versa. The presence of both mental and chronic health conditions in a patient often increase their healthcare costs. Patients with untreated depression and a chronic illness have monthly healthcare costs that average $560 higher than those with just a chronic disease, according to the American Hospital Association.

Other studies have estimated it can cost as much as three times more to treat the physical health of a patient with underlying behavioral health issues than it does to treat the same physical health issues in a patient without a mental health disorder.

“The co-occurrence of chronic illness and depression is really striking,” said Dr. Alexander Blount, professor of clinical psychology at Antioch University New England. “If somebody is diagnosed with a chronic illness, they are twice as likely to have a behavioral health illness. But it’s true the other way around; someone with a mental health diagnosis is more likely to have a chronic illness.”

As healthcare migrates toward a value-based, coordinated-care model, a growing number of providers are trying to address the behavioral health needs of all patients as a means of improving their general health outcomes, albeit with varying degrees of success.

“For the most part, providers do a good job in managing hypertension and diabetes, but they still have patients that show up to emergency room,” said Dr. Will Lopez, senior medical director for insurer Cigna Healthcare’s behavioral health division. “I think providers are at a point where they’re going to have to start addressing the other factors that are affecting their patients’ bid to be successful in treatment, and behavioral health is at the top of that list.”



A mental health crisis

The current trend toward integrating behavioral and physical health is, in many ways, a response to a mental health system that has struggled to meet the demand for such care.

An estimated 44 million adults in the U.S. are living with a mental illness, according to the National Alliance on Mental Illness, a patient advocacy organization, yet nearly 60% of those with a mental health disorder didn't receive treatment in the previous year. This is despite the fact that spending on mental health hit $221 billion in 2014, making it the single most expensive medical condition in the U.S.

"What we're seeing now is the culmination of years of neglecting the mental health system," said Dr. Brian Dixon, an independent pediatric psychiatrist based in Fort Worth, Texas. "If you don't think very well of yourself because of anxiety or depression, it's going to be hard for you to be compliant with your medical care—the two are intimately and completely tied together."

Problems with access to behavioral healthcare services persist despite the considerable attention given to the issue from lawmakers in recent years. Mental health services became part of the Affordable Care Act's 10 essential health benefits that all health plans are required to cover, while mental health parity rules restrict insurers from placing higher limits on mental health services than ones applied to medical and surgical services.

Still, evidence points to a mental healthcare system that is still offering less access even as the number of people in need of such care is on the rise. A recent study conducted by researchers at NYU Langone Medical Center found that the number of American adults who experience severe distress or feelings of worthlessness and sadness intense enough to negatively impact their physical health increased from 3% of the population in 2006 to 3.5% by 2014, totaling more than 8 million. Of that number, 9.5% in 2014 reported not having sufficient health coverage to access care from a behavioral health specialist, compared with 9% in 2006.

The study also found the number of distressed adults who reported delaying getting treatment because of costs rose to 10.5 % in 2014, compared with 9.5% in 2006. The number of those who reported they could not afford psychiatric medications also increased.

Compounding the problem is a workforce without enough psychiatrists and counselors to fully meet the demand for services.

An analysis from the Kaiser Family Foundation found the U.S. as a whole was only fulfilling around 44% of its total need for mental healthcare professionals and that an additional 3,300 would be needed to eliminate the shortage.

A huge challenge has been the disjointed nature of healthcare. The health system has traditionally reimbursed mental health services separately and at a lower rate, which some say encourages providers to coordinate behavioral and physical health.

"Our payment system has really perpetuated this fragmentation of the mind from the body," said Mara Laderman, a senior research associate at the Institute for Healthcare Improvement. "It makes it really difficult for healthcare organizations that are paid through fee-for-service to figure out how financially they are going to afford to hire a behavioral health specialist to work in the primary-care practice."

The road toward integration

Blount estimated that nearly 75% of patients identified as having a behavioral health disorder while in primary care would not accept a referral to see a specialist. Several factors contribute to such a high level of reluctance. At most hospitals, referral systems are still inadequate. Plus, stigma associated with mental illness can deter patients from seeking treatment once they have left the doctor's office. Without timely access to a behavioral health specialist, it's more likely a patient will postpone treatment, a 2015 report by the Institute of Medicine concluded.

"They're going to get their substance abuse treatment or mental health treatment in primary care or nowhere," Blount said.

Such was the case with Drew, a 43-year-old from Wilmington, Del., who requested his last name not be used. Drew had always led a healthy lifestyle, remaining physically active and had no issues with stress. So, it came as a surprise when in 2016 he suddenly found himself feeling extremely fatigued, sleeping erratically, and experiencing a tightness in his chest.

"All of those things really started to affect my general, overall health," Drew said. He went to see his primary-care physician, an internal medicine specialist at Christiana Care Health System, a two-hospital, 1,100-bed not-for-

profit network based in Wilmington. After a battery of tests to find physical causes turned up negative, Drew's physician gave him a mental health screening where it was discovered that he was experiencing anxiety. Drew's doctor then mentioned a behavioral health program offered at Christiana Care.

"When he asked if I would like to speak to one of their behavioral health physicians I immediately said'No.' I just didn't feel I needed it," he said.

Since 2014, Christiana Care has embedded behavioral health consultants within at least 11 of its primary-care practices and one specialty-care practice. The program's focus is on collaboration between patients and providers in real time to avoid the risk that a patient might skip an appointment with a behavioral healthcare specialist. The program has since expanded to integrate behavioral health within Christiana Care's cancer, cardiac and pediatric programs, as well as its intensive-care unit.

Drew ultimately agreed to see David York, a clinical psychologist at Christiana Care. After a 15-minute session with Drew, York was able to trace the source of his anxiety back to a childhood trauma that he had repressed.

"At the conclusion of that conversation I truly felt like this overwhelming weight had been lifted off my body that I didn't know had existed," Drew said. After two weeks, which included a follow-up session with York, Drew's physical symptoms had subsided.

Had it not been for his meeting with the psychologist during his primary-care visit, Drew is convinced he would have never called to make an appointment.

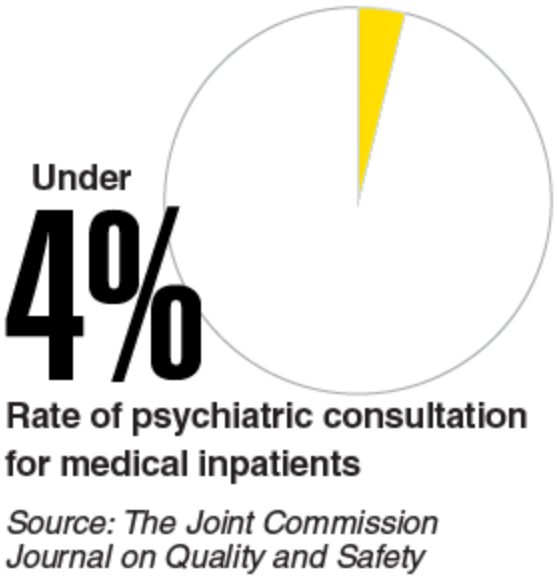
"If I had left that office and didn't see Dr. York, I am 150,000% convinced that right now I would be taking whatever was prescribed to me to deal with the symptoms of the anxiety," Drew said. "Having him be right there and having the trust of my primary-care physician was ultimately for me the most powerful thing."

Crossing the cultural divide

Successfully integrating behavioral and physical health services requires some cultural shifts; it's not just a matter of embedding a psychologist or mental health professional within a medical unit.

"When a behavioral health provider comes to a primary-care practice, they are often not practicing in the way in which they were trained," Laderman said. "It can be difficult for a traditionally trained behavioral health provider to practice in primary care, and on the medical side, a lot of physicians and nurses haven't necessarily been exposed to a lot of information about behavioral health."

For integrated programs such as Christiana Care's, it required some adjustments by embedded behavioral-care specialists to provide shorter-term interventions than the more traditional 45-minute psychotherapy sessions that can go on for months or years.



One size does not fit all

Although a number of health systems have taken steps toward integration, there isn't a single model that works for every environment. Some approaches call for behavioral healthcare services to be on the same premises as medical care, but mostly separate in terms of practice except when a patient is referred. A second calls for coordination between behavioral and physical health providers that includes a constant exchange of information between the two despite them being in different settings. A third fully integrates mental health as part of a care team that works with a primary-care physician at every point of the patient's care.

Advocate Health Care targets patients with a medical diagnosis who may also have a behavioral health co-morbidity. Advocate, based in the Chicago suburbs, has embedded a behavioral health specialist at two of its outpatient primary-care practices and plans to expand access through a telemedicine platform.

In 2012, the system found that 26% of its medical inpatients had a behavioral health issue, which amounted to approximately $26 million a year in excess healthcare costs and added to their length of stay by an average of 1.07 days.

Advocate has been conducting mental health screening within its primary-care physician practices as well as screening all emergency department and hospital inpatients over the age of 65. "We did not want to miss the opportunity to screen patients and begin treatment if needed while they were in our EDs and inpatient units," said Jeannine Herbst, executive director for Advocate's behavioral health service line.

Successfully integrating behavioral and physical health services requires some cultural shifts; it's not just a matter of embedding a psychologist or mental health professional within a medical unit.

A role for primary care?

The role of primary care in addressing behavioral health continues to be debated. Some feel the workload of the average primary-care physician is heavy enough without adding the responsibility of being a mental health provider.

There's also the question of whether a patient can be effectively treated for a behavioral health disorder by a physician who has little time to spend on issues that may go beyond their expertise.

"If a patient is not eager to say I've been depressed, I've been anxious and I have a backache, it's not common that the primary-care physician is going to pull that information out of him," said Catherine Sreckovich, managing director of the healthcare practice for consulting firm Navigant.

But the demands on primary care are constantly evolving to address the public's health needs. The record number of overdose deaths from prescription opioid painkillers and heroin abuse seen over the past decade has fueled demand for substance abuse treatment. Such care is not as effective without a behavioral healthcare component, which is only going to add to the demand for such services now and in the foreseeable future.

How the nation's health system ultimately defines mental health's role as part of the larger healthcare framework will determine the future of not only behavioral health in the U.S., but overall health itself.

Excerpt. For the full report go to: WWW.Modernhealthcare.com.

Managing mental health care at the hospital

Care integration is more of an attitude than a system

The Hospitalist, December 7, 2017

Author(s): Suzanne Bopp

The numbers tell a grim story. Nationwide, 43.7 million adult Americans experienced a mental health condition during 2016 – an increase of 1.2 million over the previous year. Mental health issues send almost 5.5 million people to emergency departments each year; nearly 60% of adults with a mental illness received no treatment at all.

If that massive – and growing – need is one side of the story, shrinking resources are the other. Mental health resources had already been diminishing for decades before the recession hit – and hit them especially hard. Between 2009 and 2012, states cut $5 billion in mental health services; during that time, at least 4,500 public psychiatric hospital beds nationwide disappeared – nearly 10% of the total supply. The bulk of those resources have never been restored.

Provider numbers also are falling. "Psychiatry is probably the top manpower shortage among all specialties," said Joe Parks, MD, medical director of the National Council for Behavioral Health. "We have about a third the number of psychiatrists that most estimates say we need, and the number per capita is decreasing." A significant percentage of psychiatrists – more than 50% – only accept cash, bypassing the low reimbursement rates even private insurance typically offers.

This is all evidence of our broad unwillingness, as a society, to invest in mental health, said Teresa Nguyen, LCSW, vice president of policy and programs at Mental Health America. "If we can't reimburse people fairly for doing really important work, we're not going to drive up the demand for more people to think about how to better serve people from a mental health perspective."

Hospitals, of course, feel those financial disincentives too, which discourage them from investments of their own. "It's a difficult population to manage, and it's difficult to manage the financial realities of mental health as well," said John McHugh, PhD, assistant professor of health policy at Columbia University, New York. "If you were a hospital administrator looking to invest your last dollar and you have the option of investing it in a new heart institute or in behavioral health service, more likely than not, you're going to invest it in the more profitable cardiovascular service line."

Providers of last resort

But much of the burden of caring for this population ends up falling on hospitals by default. At Denver Health, Melanie Rylander, MD, medical director of the inpatient psychiatric unit, reports seeing this manifest in three categories of patients. First, there is an influx of people coming into the emergency department with primary mental health issues.

"We're also seeing an influx of people coming in with physical problems, and upon assessment it becomes very clear very quickly that the real issue is an underlying mental health issue," she said. Then there are the people

coming in for the same physical problems over and over – maybe decompensated heart failure or COPD exacerbations – because mental health issues are impeding their ability to take care of themselves.

Some hospitalists say they feel ill equipped to care for these patients. “We don’t have the facility or the resources many times to properly care for their psychiatric needs when they’re in the hospital. It’s not really part of an internist’s training to be familiar with a lot of the medications,” said Atashi Mandal, MD, a hospitalist and pediatrician in Los Angeles. “Sometimes they get improperly medicated because we don’t know what else to do and the patient’s behavioral issues are escalating, so it’s really a difficult position.”

It’s a dispiriting experience for a hospitalist. “It really bothers me when I am trying to care for a patient who has psychiatric needs, and I feel I’m not able to do it, and I can’t find resources, and I feel that this patient’s needs are being neglected – not because we don’t care, and not because of a lack of effort by the staff. It’s just set up to fail,” Dr. Mandal said.

Ending the silo mentality

Encouraging a more holistic view of health across health care would be an important step to begin to address the problem – after all, the mind and the body are not separate.

“We work in silos, and we really have to stop doing that because these are intertwined,” said Corey Karlin-Zysman, MD, FHM, FACP, chief of the division of hospital medicine at Northwell Health. “A schizophrenic will become worse when they’re medically ill. That illness will be harder to treat if their psychiatric illness is active.” This is starting to happen in the outpatient setting, evidenced by the expansion of the integrated care model, where a primary care doctor is the lead physician working in combination with psychologists, psychiatrists, and social workers. Communication among providers becomes simpler, and patients don’t fall through the cracks as often while trying to navigate the system.

“How do we promote even more of that? If we make things easier for patients and increase the odds of compliance, then maybe they won’t need to go to the hospital,” Dr. Karlin-Zysman said. “Patients with behavioral health issues are just not getting the level of care and attention they need, and we have to figure it out. They’re going to be a bigger and bigger proportion of patients that we’re going to see in the hospital setting, but it doesn’t have to be dealt with in the hospital setting if it’s better treated in the outpatient setting.”

That idea of integration is also making its way into the hospital setting in various ways. In their efforts to bring the care to the patient, rather than the other way around, Dr. Karlin-Zysman’s hospital embedded two hospitalists in the neighboring inpatient psychiatric hospital; when patients need medical treatment, they can receive it without interrupting their behavioral health treatment. As a result, patients who used to end up in their emergency department don’t anymore, and their 30-day readmission rate has fallen by 50%.

But at its foundation, care integration is more of an attitude than a system; it begins with a mindset.

“We talk so much today about system reform, integrated systems, blah, blah,” said Lisa Rosenbaum, MD, a cardiologist at Brigham and Women’s Hospital, Boston. “I don’t want to make it seem like it’s not going to work, but what does it mean for the patient who is psychotic and has 10 problems, with whom you have 15 minutes? Taking good care of these patients means you have to take a deep breath and put in a lot of time and deal with all these things that have nothing to do with the health system under which you practice. There’s this ‘only so much you can do’ feeling that is a problem in itself, because there’s actually a lot we can do.”

Hospitals and communities

It's axiomatic to say that a better approach to mental health would be based around prevention and early intervention, rather than the less crisis-oriented system we have now. Some efforts are being made in that direction, and they involve, and require, outreach outside the hospital.

"The best hospitals doing work in mental health are going beyond the hospital walls; they're really looking at their community," Dr. Nguyen said. "You have hospitals, like Accountable Care Organizations, who are trying to move earlier and think about mental health from a pediatric standpoint: How can we support parents and children during critical phases of brain growth? How can we provide prevention services?" Ultimately, those efforts should help lower future admission rates to EDs and hospitals.

That forward-looking approach may be necessary, but it's also a challenge. "As a hospital administrator, I would think that you look out at the community and see this problem is not going away – in fact, it is likely going to get worse," Dr. McHugh said. "A health system may look at themselves and say we have to take the lead on this." The difficulty is that thinking of it in a sense of value to the community, and making the requisite investments, will have a very long period of payout; a health system that's struggling may not be able to do it. "It's the large [health systems] that tend to be more integrated … that are thinking about this much differently," he said.

Still, the reality is that's where the root of the problem lies, Dr. Rylander said – not in the hospital, but in the larger community. "In the absence of very basic needs – stable housing, food, heating – it's really not reasonable to expect that people are going to take care of their physical needs," she said. "It's a much larger social issue: how to get resources so that these people can have stable places to live, they can get to and from appointments, that type of thing."

Those needs are ongoing, of course. Many of these patients suffer from chronic conditions, meaning people will continue to need services and support, said Ron Honberg, JD, senior policy adviser for the National Alliance on Mental Illness. Often, people need services from different systems. "There are complexities in terms of navigating those systems and getting those systems to work well together. Until we make inroads in solving those things, or at least improving those things, the burdens are going to fall on the providers of last resort, and that includes hospitals," he said.

A collaborative effort may be needed, but hospitals can still be active participants and even leaders.

"If hospitals really want to address these problems, they need to be part of the discussions taking place in communities among the various systems and providers and advocates," Mr. Honberg said. "Ultimately, we need to develop a better community-based system of care, and a better way of handing people off from inpatient to community-based treatment, and some accountability in terms of requiring that people get services, so they don't get rehospitalized quickly. You're increasingly seeing accountability now with other health conditions; we're measuring things in Medicare like rehospitalization rates and the like. We need to be doing that with mental health treatment as well."

What a hospitalist can do

One thing hospitalists might consider is starting that practice at their own hospitals, measuring, recording, and sharing that kind of information.

"Hospitalists should measure systematically, and in a very neutral manner, the total burden and frequency of the problem and report it consistently to management, along with their assessment that this impairs the quality of care and creates patient risk," Dr. Parks said. That information can help hospitalists lobby for access to psychiatric

personnel, be that in person or through telemedicine. “We don’t have to lay hands on you. There’s no excuse for any hospital not having a contract in place for on-demand consultation in the ER and on the floors.”

Track outcomes, too, Dr. Mandal suggests. With access to the right personnel, are you getting patients out of the ED faster? Are you having fewer negative outcomes while these patients are in the hospital, such as having to use restraints or get security involved? “Hopefully you can get some data in terms of how much money you’ve saved by decreasing the length of stays and decreasing inadvertent adverse effects because the patients weren’t receiving the proper care,” he said.

As this challenge seems likely to continue to grow, hospitalists might consider finding more training in mental health issues themselves so they are more comfortable handling these issues, Dr. Parks said. “The average mini-psych rotation from medical school is only 4 weeks,” he noted. “The ob.gyn. is at least 8 weeks and often 12 weeks, and if you don’t go into ob.gyn., you’re going to see a lot more mentally ill people through the rest of your practice, no matter what you do, than you are going to see pregnant women.”

Just starting these conversations – with patients, with colleagues, with family and friends – might be the most important change of all. “Even though nobody is above these issues afflicting them, this is still something that is not part of an open dialogue, and this is something that affects our own colleagues,” Dr. Mandal said. “I don’t know how many more trainees jumping out of windows it will take, or colleagues going through depression and feeling that it’s a sign of weakness to even talk about it.

“We need to create safe harbors within our own medical communities and acknowledge that we ourselves can be prone to this,” he said. “Perhaps by doing that, we will develop more empathy and become more comfortable, not just with ourselves and our colleagues but also helping these patients. People get overwhelmed and throw their hands up because it is just such a difficult issue. I don’t want people to give up, both from the medical community and our society as a whole – we can’t give up.”

A med-psych unit pilot project

Med-psych units can be a good model to take on these challenges. At Long Island Jewish Medical Center, they launched a pilot project to see how one would work in their community and summarized the results in an SHM abstract.

The hospital shares a campus with a 200-bed inpatient psych hospital, and doctors were seeing a lot of back and forth between the two institutions, said Corey Karlin-Zysman, MD, FHM, FACP, chief of the division of hospital medicine at Northwell Health. “Patients would come into the hospital because they had an active medical issue, but because of their behavioral issues, they’d have to have continuous observation. It would not be uncommon for us to have sometimes close to 30 patients who needed 24-hour continuous observation to make sure they were not hurting themselves.” These PCAs or nurse’s assistants were doing 8-hour shifts, so each patient needed three. “The math is staggering – and with not any better outcomes.”

So the hospital created a 15-bed closed med-psych unit for medically ill patients with behavioral health disorders. They staffed it with a dedicated hospitalist, a nurse practitioner, a psychologist, and a nurse manager.

The number of patients requiring continuous observation fell to single digits. Once in their own unit, these patients caused less disruption and stress on the medical units. They had a lower length of stay compared to their previous admissions in other units, and this became one of the hospital’s highest performing units in terms of patient experience.

The biggest secret of their success, Dr. Karlin-Zysman said, is cohorting. “Instead of them going to the next open bed, wherever it may be, you get the patients all in one place geographically, with a team trained to manage those patients.” Another factor: it’s a hospitalist-run unit. “You can’t have 20 different doctors taking care of the patients; it’s one or two hospitalists running this unit.”

Care models like this can be a true win-win, and her hospital is using them more and more.

“I have a care model that’s a stroke unit; I have a care model that’s an onc unit and one that’s a pulmonary unit,” she said. “We’re creating these true teams, which I think hospitalists really like being part of. What’s that thing that makes them want to come to work every day? Things like this: running a care model, becoming specialized in something.” There are research and abstract opportunities for hospitalists on these units too, which also helps keep them engaged, she said. “I’ve used this care model and things like that to reduce burnout and keep people excited.”

The persistent mortality gap

Patients with mental illness tend to receive worse medical care than people without, studies have shown; they die an average of 25 years earlier, largely from preventable or treatable conditions such as cardiovascular disease and diabetes. The World Health Organization has called the problem “a hidden human rights emergency.”

In one in a series of articles on mental health, Lisa Rosenbaum, MD, a cardiologist at Brigham and Women’s Hospital, Boston, raises the question: Might physician attitudes toward mentally ill people contribute to this mortality gap, and if so, can we change them?

She recognizes the many obstacles physicians face in treating these patients. “The medicines we have are good but not great and can cause obesity and diabetes, which contributes to cardiovascular morbidity and mortality,” Dr. Rosenbaum said. “We have the adherence challenge for the psychiatric medications and for medications for chronic disease. It’s hard enough for anyone to take a medicine every day, and to do that if you’re homeless or you don’t have insight into the need for it, it’s really hard.”

Also, certain behaviors that are more common among people with serious mental illness – smoking, substance abuse, physical inactivity – increase their risk for chronic diseases.

These hurdles may foster a sense of helplessness among hospitalists who have just a small amount of time to spend with a patient, and attitudes may be hard to change.

“Negotiating more effectively about care refusals, more adeptly assessing capacity, and recognizing when our efforts to orchestrate care have been inadequate seem feasible,” Dr. Rosenbaum writes. “Far harder is overcoming any collective belief that what mentally ill people truly need is not something we can offer.” That’s why a truly honest examination of attitudes and biases is a necessary place to start.

She tells the story of one mentally ill patient she learned of in her research, who, after decades as the quintessential frequent flier in the ER, was living stably in the community. “No one could have known how many tries it would take to help him get there,” she writes. His doctor told her, “Let’s say 10 attempts are necessary. Someone needs to be number 2, 3 and 7. You just never know which number you are.”

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