

# Bridging the mental–physical divide in health care

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It is well established that mental disorders account for a substantial proportion of years lived with disability, with depressive disorders alone accounting for 50 million years lived with disability worldwide in 2015.<sup>1</sup> Patients with comorbid medical and psychiatric illness are known to have increased health care costs, length of stay in hospital and rates of hospital readmission compared with those without medical comorbidity.<sup>2</sup> How mental and physical comorbidity influence people's health trajectories has crucial implications for the way we fund and organize health care, and even for our understanding of the illnesses themselves. However, a nuanced understanding of the relationship between psychiatric and medical conditions remains elusive.

In a linked study, Gaulin and colleagues used logistic regression modelling to show synergistic effects of comorbid mental and physical illnesses on frequent visits to the emergency department (defined as  $\geq 3$ /yr) across the province of Quebec.<sup>3</sup> That is, the combination of the 2 types of disorders was associated with more visits than would be expected if one assumed a simple additive effect. Specifically, the researchers found that synergy between mental and physical disorders accounted for 13%–24% of emergency department visits in those with mental disorders. It also accounted for 5.8% of all emergency department visits across the province (24 388 additional visits over 14 months). This would equate to more than \$15 million in yearly excess health spending on emergency department visits alone, excluding physician billings.<sup>4</sup>

Gaulin and colleagues further found that the synergistic effect was more pronounced in those with serious mental disorders (psychotic or bipolar disorders). It may be that the magnitude of effect is underestimated, as the authors had to rely on diagnosed medical and psychiatric comorbidities, and disparities in diagnosis and treatment of physical disorders are known to exist among individuals with serious mental disorders.<sup>5</sup>

The linked study used rigorous methodology to show and quantify what should be intuitive to those of us who routinely treat patients with comorbid psychiatric and medical conditions. It contributes to a growing understanding of the interrela-

## KEY POINTS

- New research adds to growing scientific knowledge showing the important influence of physical comorbidity on use of health care resources in mental disorders.
- This evidence has important implications for how we conceptualize mental illness, and how we organize and fund health care.
- Correcting the inaccurate historical schism between physical and mental health requires us to rethink health care strategy, organization and funding.

tionship between mental and physical illness and suggests the need for a parallel synergy in the treatment strategy of these conditions, which is already beginning to occur. The emergence of the anesthetic ketamine as a treatment for depression and suicidal ideation has led to greater collaboration between psychiatrists and anesthesiologists in hospital settings.<sup>6</sup> In 2015, one of us (B.G.) became the first psychiatrist to lead a scientific statement by the American Heart Association that highlighted the link between mood disorders and cardiovascular disease.<sup>7</sup> At a system level, the Medical Psychiatry Alliance in Ontario is Canada's first provincially funded collaboration to improve knowledge, expertise and treatment models for comorbid mental and physical illnesses, as well as quality of life, in sufferers.<sup>8</sup>

Just as we understand the heart and lungs to be separate but interdependent organ systems, the field of medicine is increasingly recognizing brain and body as a single system. Correcting the inaccurate historical schism between the two requires us to rethink health care strategy, organization and funding. Research regarding treatment outcomes for comorbid mental and substance use disorders, for example, has repeatedly shown that integrated treatment outperforms parallel or sequential treatment strategies.<sup>9</sup> An analogous approach may yield similar benefits for mental and physical comorbidity. That would require continued efforts to reduce the stigma of mental disorders that remains in medicine and to shift from viewing

these disorders as an impediment to treatment of physical disorders, toward a justification for more intensive patient care efforts. It would also require us to more clearly position traditional primary and secondary prevention efforts, such as healthy diet and exercise counselling, as being equally important for mental and physical health.

Such a change, long overdue, might also benefit from a reconsideration of how we position mental disorders within medicine overall. Currently, a myocardial infarction and a tibial fracture are both considered “physical” health problems, and major depression a “mental” health problem. Yet there appears to be a relationship between the pathophysiology, specifically endocrine changes and inflammatory and immunological activation, that underlie both cardiovascular disease and depression,<sup>10</sup> and antidepressants may even lower mortality for patients after myocardial infarction.<sup>11</sup> These findings underscore the need for a reorganization of our conceptual frameworks of illness and greater integration between our approaches to what were previously considered disparate conditions.

The Canadian Mental Health Association has called for a national *Mental Health Parity Act*, like the one already in existence in the United States, to create greater parity in mental health funding and access to mental health care.<sup>12</sup> Although such a step is an important one for the future of Canadian health care, we must carefully consider the implications of studies, like the one linked here, for that effort. There will certainly remain a role for independent mental health providers and facilities in the near to mid-term, but the close interplay between mental and physical disorders strongly suggests that health care should ideally be provided via a collaborative approach in centres with expertise in both types of conditions. Although standalone facilities may exist, we generally do not have gastroenterology hospitals or endocrinology hospitals, owing to an acknowledgement that many other areas of medicine coexist and affect conditions in these areas. The evidence suggests that treatment of mental disorders likewise must be integrated within hospitals and the greater health system.

We work in one of Canada’s largest teaching hospitals and, like many of our psychiatry colleagues working in hospitals around the country, routinely collaborate both clinically and in research with internists, anesthesiologists and colleagues from other

medical and surgical specialties. These interactions yield reciprocal benefits that clearly improve the care, health and well-being of our patients. The study by Gaulin and colleagues is an important reminder of why we organize our hospital and our practices in this way, and of the need for this approach to become the standard of care across Canada.

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