Addressing the health care needs of patients with serious mental illness—it takes a system

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The paper in this issue by Wheeler and colleagues[1] echoes similar work and policy in the United States. The increasing prevalence of chronic physical health conditions among patients with serious mental illness (SMI) and its recognition has driven much of the impetus to consider how to best serve the physical health needs of this population. Two agencies working at our federal level in the United States to address these concerns are the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Agency for Healthcare Research and Quality (AHRQ). Both of these agencies have developed websites focusing on various aspects of integrated behavioural and physical health care (www.integration.samhsa.gov) and (www.integrationacademy.ahrq.gov). These agencies and their websites take slightly different approaches to integrated care, stemming from their policy roots in mental and behavioural health care (SAMHSA) and primary care (AHRQ).

SAMHSA has developed a four quadrant clinical integration model for describing various types of services that may be offered along axes of increasing behavioural and physical health risk and complexity.[2] The model is helpful in that it emphasises that patients with SMI could be served in settings consistent with any of the quadrants, with varying levels of primary and behavioural health care. This is consistent with the 'no wrong door' approach promulgated by many groups. The AHRQ Integration Academy is more oriented to integration of behavioural health services and care into primary care settings, and provides a wide array of useful documents, links and recorded webinars related to this topic, including an atlas of Integrated Behavioural Health Quality Measures.

Collaborative care models that are adapted from models focused on patients with mood disorders and other chronic illnesses show promise, but much of the evidence is still emerging, as indicated in a recent systematic review from Woltmann and colleagues.[3] Apart from solutions that directly embed or co-locate primary care providers into behavioural health clinics or vice versa, the need for care coordination between primary and behavioural health care is critical. The need for, and challenges associated with this, are well described in a recent qualitative study by Ezell et al.[4] Finally, regardless of the setting where patients with SMI receive care, maximising their engagement is critical. Research is currently underway to examine the best ways to improve SMI patients' engagement with care.[5]

In summary, health systems worldwide are grappling with the challenges of addressing the access and health disparities of patients with SMI. Identifying the disparities and issues experienced by patients with SMI is an important first step for national health care systems. Meeting patients where they are most comfortable and are best served, maintaining coordination across care providers and locations, and maintaining engagement are all likely to be necessary elements of a successful, systematic approach.

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