professionally rewarding, and we believe that many physicians value the opportunity to solve problems and help patients in their most vulnerable moments, as well as advocate for change. For some, promoting resilience initiatives has helped empower other providers and elevate self-care.

However, we also believe that there are many challenges brought forth by systematic issues outside of the practice of medicine that affect physicians' ability to work and cannot be solved through a focus on cultivating personal well-being or resilience. In addition, although we agree that properly implemented wellness programs can certainly be helpful in supporting practitioner well-being, we maintain that the discourse of resilience shifts the blame for—and situates the origin of—systemic problems onto the individual and promotes acquiescence to the status quo. We also acknowledge that the dichotomy between the personal and the systemic is somewhat artificial, and it is difficult to disentangle all of the complex issues (including nuanced and constantly changing electronic health record systems, insurance limitations, and changing work volume and efficiency demands) facing our profession. Resiliency initiatives should indeed not be the metaphorical babies thrown out with the bathwater, but we must caution against systematization of wellness programs that enforce particular ways of cultivating resilience (e.g., mandatory wellness lunchtime lectures or workshops and required wellness events outside of work hours, including assigned wellness readings) that often and increasingly infringe on physicians' personal time and individual choices. Resilience is important, but wellness initiatives should be malleable and optional for individuals. Perhaps initiatives that also focus on how to advocate for larger change may best incorporate the personal with the institutional and political. In summary, we do not believe that providers suffer "burnout"; instead, they are frequently victims of systematic and increasingly internalized "arson."

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Psychiatric Services 2019; 70:1181–1182; doi: 10.1176/appi.ps.701206

Effects of Mental Health on the Costs of Care for Chronic Illnesses

TO THE EDITOR: We are pleased that Dr. Kaplan et al. (1) are interested in advancing knowledge about the interaction of medical and psychiatric illness; however, we have several concerns about their findings. These concerns fall into three areas: use of the 12-item Short Form (SF-12) to uncover psychiatric morbidity, significant limitations in use of the scientific literature, and failure to recognize that most patients with psychiatric conditions present only in the medical sector. We will address each concern in sequence.

Although the SF-12 is a commonly used generic health rating scale, it has problems inherent to the interaction of Physical and Mental Component Summary (PCS and MCS, respectively) scores (2). Because the PCS and MCS interact in unpredictable ways, which obfuscates interpretation of findings, we suggest that mental and substance use disorders (or behavioral disorders) among general medical patients should be identified via diagnoses recorded in the patient's medical record, as has been done in most previous studies. This can be an effective method, even in Medical Expenditure Panel Survey (MEPS) data sets, as noted below, and typifies more accurately patients with impairing behavioral health conditions.

The second issue of concern is the study's failure to include previously published data sets on the frequency with which behavioral health issues are seen and treated in medical patients and the impact on total health care costs when not treated. For instance, two large studies looking at the interaction of "diagnosed" medical and behavioral health conditions, identified by review of 290 and 342 million MEPS records, respectively, showed that 14%–16% of Medicare, Medicaid, and commercially insured individuals, before and after the Affordable Care Act was implemented, have comorbid medical and behavioral health conditions (3). In 2018, those with comorbid conditions used an estimated $406 billion in extra health services annually, 80% of which was for medical, not behavioral health, services. Interestingly, although the number of patients included in the pre-post studies is not as large as those of Melek et al. (3), collaborative care, an evidence-based approach to outpatient integrated care with over 90 positive randomized controlled trials, has been shown to effectively improve behavioral health outcomes of medical patients (adults and children) while decreasing the total cost of care per patient, mainly for medical services (4).

This leads to the final issue, that in order for high-cost, high-need comorbidly ill populations to show the improvement and cost savings described, behavioral health professionals must work where patients show up for health care. Seventy percent of patients with behavioral health conditions refuse to be treated in the behavioral health sector (5). Expecting providers in behavioral health settings to alter outcomes when they work in a segregated health care sector is unrealistic. Most behavioral health patients are seen primarily in the medical setting. Thus, behavioral health providers should be paid by medical, not behavioral health, benefits so that they can work in the same location as their medical colleagues.

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Psychiatric Services 2019; 70:1182–1183; doi: 10.1176/appi.ps.201900433

Effects of Mental Health on the Costs of Care for Chronic Illnesses: In Reply

IN REPLY: Dr. Kathol and colleagues offer important feedback about our article. We recognize the limitations of the 12-item Short Form (SF-12) and describe these concerns in the limitations section of our article. Kathol et al. argue that the Physical and Mental Component Summary scores (PCS and MCS) "interact in unpredictable ways." In theory, PCS and MCS are uncorrelated because they were derived through factor analysis, and we appreciate the reference to Hagell et al. (1), who offer different scoring options.

Kathol and colleagues suggest that we should have obtained mental diagnoses from patient medical records instead of MCS scores. Epidemiologic studies show that only a small proportion of people with mental health challenges see mental health providers and even fewer have a psychiatric diagnosis. The advantage of the population-based MCS measure is that it may provide a better representation of mental health functioning in the general population. However, we agree with Kathol and colleagues that our evaluation should be complemented by investigations that define the study population differently. Each approach has advantages and disadvantages, and studies using different methods may lead to a clearer understanding of the issues. The Milliman study (2), although impressive, does not offer a test of the synergistic effect of mental health comorbidity on the costs of caring for chronic diseases. That requires cost estimates for people with and without each chronic disease diagnosis in addition to those with and without psychiatric diagnoses.

Our article does not address the value of embedding mental health providers in primary care settings. We recognize that people with mental health conditions may use more services in the medical as opposed to the behavioral health system. That is why we chose total expenditures as the outcome. We examined the Panagioti et al. article (3) and agree that it provides persuasive evidence that collaborative care is valuable for people with and without a general medical diagnosis. But the authors did not consider costs, and we do not see how the article supports the assertion that collaborative care decreases "the total cost of care per patient, mainly for medical services." To be clear, our results show a significant relationship between mental health problems and cost. We do not dispute the value of mental health care and embedded mental health services. Our focus was on a very specific issue—whether the combination of poor behavioral health and medical illness has synergistic effects on cost.

In summary, we appreciate the feedback from Kathol and colleagues and encourage replication of our work by using established diagnosis of mental health conditions instead of population-based scores from the SF-12. We recognize the value of collaborative care and encourage more systematic research on the costs and benefits of embedding mental health providers in primary care settings.

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Psychiatric Services 2019; 70:1183; doi: 10.1176/appi.ps.701203