



Fall 2010, Vol. 3 No. 4 P. 16

Physical and Mental Health Nexus

By

Michael B. Friedman, LMSW; Lisa M. Furst, LMSW; and Kimberly A. Williams, LMSW

Healthcare practitioners must recognize the inextricable link between older adults' mental and physical health.

The importance of mental health to aging well—the obvious fact that one cannot age well without good mental health—is frequently lost in discussions of older adults' physical health. This is a remarkable omission because mental illness can have a terrible impact on physical health. An older adult with a chronic physical illness such as diabetes or heart disease and co-occurring depression or other mental disorder is at considerably higher risk for disability and premature death than an elder with the same physical illness without a co-occurring mental illness. In addition, depression and anxiety disorders often express themselves through physical symptoms—stomach problems, headaches, backaches, sleeplessness, fatigue, weight loss, or obesity.

One of the most common failures to recognize mental illnesses such as depression and anxiety disorders occurs in older adults diagnosed with dementia. In the early or midstages of a dementia, such as Alzheimer's disease, elders are likely to also be depressed and/or anxious, and these co-occurring mental conditions reduce already-compromised cognitive functions. Treatment of depression and/or anxiety often results in improved cognitive functioning even though the dementia continues its inevitable decline.

In addition, older adults with serious long-term mental illnesses are at extremely high risk of a range of physical disorders. Obesity, high blood pressure, diabetes, cardiac disease, pulmonary conditions, and infectious diseases, for example, contribute to the life expectancy of these elders being shortened by at least 10 years and perhaps as many as 30 years more than the general population.

In short, mental and physical health are inextricably linked. Former U.S. Surgeon General David Satcher, MD, PhD, tried to capture this relationship when he said, "There is no health without mental health." He might have added, "There is no mental health without health." This has important implications for the delivery of physical and mental healthcare at all ages but especially for older adults who are, after all, more likely to need care for physical health conditions than are younger adults.

In addition, older adults are more likely to be affected by ageist assumptions frequently made by healthcare providers that both physical and mental illness are unavoidable consequences of old age. Providers may suggest that "Of course you

don't have the energy you used to have because you're older now" or "Of course you're depressed. That's what happens at your age."

Yes, it's true that physical and mental functioning wear down with age but not nearly as much as most people believe is inevitable and, for many, not unavoidably so. Activity, social and civic engagement, and exercise of mind and body help older adults stay vital well into old age. And good treatment built on the recognition of the interaction of mind and body and the potential of old age can work wonders.

Integrating Mental Health Into Physical Healthcare

Because older adults with mental or substance use disorders frequently fail to realize they have a mental health problem, don't know where to find a good mental health professional, or may be uncomfortable seeking help from a mental health professional, physical healthcare encounters may offer the only opportunities to identify mental or substance use disorders that would otherwise go unrecognized or untreated. And because the morbidity and mortality of chronic illnesses are increased by co-occurring mental illnesses, it is critical for physical healthcare professionals to pay attention to the mental health of elders whose mental illnesses may not be apparent.

Fortunately, there is increased recognition among healthcare providers—and even in the new healthcare reform legislation—of the importance of integrating physical and mental healthcare. But it is still the exception rather than the rule. In fact, many healthcare providers believe they can readily identify mental illness and either provide treatment themselves, usually by prescribing medication, or simply refer their patients to mental health professionals for treatment. They are frequently wrong on all three counts.

First, mental illness is frequently nonobvious. Many older adults with depression are champions at hiding their feelings. For example, writer William Styron once noted that the night before he was hospitalized for suicidal depression, he ate dinner with friends who had no idea he was in profound despair. The authors know of a recent situation in which a patient noticed a kit about screening for depression on his physician's shelf and asked whether he used it since he himself had never been screened. The doctor responded that he didn't need to because he could tell when his patients were mentally ill. The patient then told the doctor that he had been in and out of major depression repeatedly over the years. The doctor didn't believe him because the patient, like many people who suffer from depression, kept his feelings to himself.

Second, the National Comorbidity Survey done in 2000 revealed that primary care physicians who provide treatment for mental disorders provide "minimally adequate care" less than 15% of the time.

Third, at least one half the individuals who are referred to mental health professionals—even in areas where there are enough mental health professionals to allow patients to schedule an appointment reasonably quickly—never connect with the provider to whom they've been referred. They may not call, may not get an appointment soon enough, or may not keep the appointment. And significant numbers who do go to a mental health professional never go back for a second or

third session. Integrating physical and mental health requires more than noticing obvious problems, prescribing a medication, and making referrals.

Screening, Assessment, and Treatment

Current research literature on the prevention and treatment of chronic conditions such as heart disease and diabetes recommends screening for mental disorders, especially depression. And there are good screening instruments available, most of which a patient can complete in the waiting room. These include the Patient Health Questionnaire-2 and -9 for depression, the Generalized Anxiety Disorder 7-item scale for anxiety disorders, and the Alcohol Use Disorders Identification Test-C for alcohol abuse.

But screening alone is not enough. If a screening instrument indicates the likelihood of depression, anxiety, or alcohol abuse, it is then critical for a well-trained professional to interview the individual and determine whether he or she does, in fact, have a diagnosable disorder and to make a provisional diagnosis. First impressions often give way to more accurate views over time, so it is important not to lock into a diagnosis.

Most important, of course, is the treatment, which can be provided in several ways, including the following:

- Primary healthcare providers can and frequently do provide treatment themselves, although the chances of their providing “minimally adequate care” are very low unless they have had special training, which is unlikely.
- Primary care providers can improve their chances of providing decent care by consulting with a mental health professional regarding diagnosis and/or treatment. This can be done over the telephone rather than in person if a mental health professional is available for this purpose.
- Primary care providers can work together with care managers who follow up with patients to assure adherence, monitor medication side effects, and sometimes provide psychotherapy. This usually takes the form of problem-solving therapy, a type of cognitive-behavioral therapy that is relatively easy to learn. There are several evidence-based care management approaches for treating older adults with depression in primary care settings. They include such programs as Improving Mood: Promoting Access to Collaborative Treatment (IMPACT), Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT), and Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E).
- Primary care providers can refer a patient to a mental health professional. But, as previously noted, this is often ineffective. The key is making a linkage and not just a referral (ie, ensuring that the patient and the mental health professional have connected, scheduled an appointment, and continue the treatment beyond a visit or two).

Integration of care is important not only in primary healthcare; it is also important for specialists such as cardiologists, endocrinologists, and neurologists who treat people with serious chronic physical illnesses to screen for mental disorders and ensure their patients receive the mental healthcare that will help them limit the disabling consequences of their illnesses. Unfortunately, specialists are likely to rely

on referrals, which frequently result in failure to connect with good mental health providers.

Organizational Models for Integrating Mental Health Into Physical Healthcare

There are a number of organizational models for the integration of physical and mental healthcare in primary healthcare practices, and more seem to emerge every time we look at the literature. We will note four fundamental approaches: co-location, coordination, integrated teams, and formal consultation relationships. These approaches can be used in private practices as well as in licensed, multiservice clinics.

Co-location simply means physical and mental health professionals are located in the same place. In theory, this increases the likelihood that these professionals will talk with each other about cases they share and that patients referred to mental health professionals will go down the hall to get the primary care they need. We have no doubt that co-location can be helpful, but it is important to be realistic about the amount of time providers can afford to spend talking with each other and about the possibility of getting an immediate appointment with mental health professionals. In addition, the hand-off is critical to transferring a doctor-patient connection from one doctor to another. Often it doesn't happen if the patient is simply given a slip of paper with a provider's name written on it.

Coordination means the professionals involved go out of their way to communicate with one another and coordinate care. This can be made easier if there is an electronic medical record shared by providers who are either co-located or part of the same professional network. But whether it is face to face, over the telephone, or through the review of the electronic record, coordination takes time, which most physicians cannot spare because of high caseloads and the economic structure of the healthcare system. Coordination is certainly desirable but difficult to achieve.

Integrated team approaches are built on recognition of both the importance and the difficulty of communication, coordination, and collaboration in the treatment of physical and mental disorders. Teams consist of primary care physicians (gerontologists for older adults, if they are available), psychiatrists, psychologists, nurse practitioners, social workers, and care managers. Teams meet to develop a joint treatment plan, and there is routine follow-up by the team to assess treatment progress and change treatment plans as necessary. Lately, integrated team approaches have become conceptually popular, using such names as medical homes and accountable care organizations. By whatever name, they appear to be the ideal way to provide integrated treatment but are difficult to implement because of both funding problems and workforce shortages.

Consultation involves one professional asking another for help with the diagnosis and/or treatment of a patient who presents with issues the professional does not feel competent to address. Specialists in chronic diseases—particularly with patients in the hospital—frequently ask for psychiatric consultations that may result in referrals. Formal structures that ensure consultants will be available at specific times and responsive make it more likely that consultation will actually take place. In general, consultation is more realistic in areas of the country where there are

adequate numbers of competent primary care physicians, specialists, and psychiatrists or other mental health professionals. However, in other areas of the country, the use of telephonic or televisual methods offers increasing hope that competent and integrated treatment for psychiatric and/or substance abuse problems can be provided despite severe workforce shortages.

Integrating Physical Healthcare Into Mental Health Settings

Elders with long-term serious mental illnesses are at high risk of chronic conditions such as heart disease and diabetes. In addition, as they age, they are as likely as the general population to develop dementia, neuromuscular disorders, arthritis, etc. However, this population frequently has no access to physical healthcare of even average quality, in part because they rely on healthcare settings where the quality of care is inconsistent and in part because they are frequently regarded as undesirable patients.

For this reason, approaches have emerged that provide physical healthcare in community mental health settings, including the following:

- Some mental health and substance abuse treatment organizations collaborate with primary health programs, establishing satellites in outpatient, rehabilitation, or residential mental health programs.
- Some mental health and substance abuse treatment organizations operate healthcare facilities that specialize in serving people with mental and/or substance use disorders.
- Some organizations develop formal or informal but consistent coordinative relationships with local primary care providers.

Wellness

However integrated physical and mental health services are organized, a fundamental goal is not just to treat disorders but also to promote physical and mental health with wellness initiatives. These focus on encouraging older adults to eat well and exercise to control their weight, thus reducing risks for developing diabetes and heart disease. Wellness initiatives also encourage people to stop smoking, limit their use of alcohol, and remain socially and mentally active.

But behaving in ways that promote good physical and mental health is easier said than done. Some health providers are integrating motivational interviewing into their work to help their patients change their behavior. Other psychosocial approaches such as dieting and exercising in groups may help effect behavior change in older adults who are set in their ways, but more study of such approaches is needed. And the approaches that are effective will have to be translated into everyday practice.

Summary

Integrating physical and mental healthcare is critical to identifying and providing treatment for mental health and/or substance use disorders and reducing the risks of disability and premature death among older adults with chronic health conditions such as heart disease and diabetes and co-occurring mental or substance abuse disorders. A number of models for integrated care and treatment in community settings have emerged, such as the medical home. Their importance is recognized

in the recent healthcare reform legislation that provides grant funding to develop and test such models. This offers hope that recognizing the link between body and mind will become the basis of standard medical and mental health practice in the years to come, particularly for older adults.

— Michael B. Friedman, LMSW, is honorary chair, Lisa M. Furst, LMSW, is director of education, and Kimberly A. Williams, LMSW, is director of the Geriatric Mental Health Alliance of New York.