Better Mental, Primary Care Coordination Urged

BY MARY ELLEN SCHNEIDER
New York Bureau

Members of the mental health community are working on ways to improve coordination of primary care and mental health in an effort to decrease early death among individuals with serious mental illness.

Individuals being treated for serious mental illness by public mental health systems die 25 years earlier, on average, than do members of the general population, according to a report released last fall by the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. About 60% of these premature deaths are attributable to medical conditions such as cardiovascular and pulmonary disease.

The report, "Morbidity and Mortality in People with Serious Mental Illness," outlines the factors contributing to this disparity in death and disease.

"This is a virtual epidemic of death," said Dr. Joseph Parks, medical director for the Missouri Department of Mental Health and president of the NASMHPD Medical Directors Council.

The report has become a sort of "rallying point," Dr. Parks said. NASMHPD is in the process of drafting a position paper on this topic and has held a series of meetings with stakeholders throughout the mental health community.

The report found that the increased mortality and morbidity is attributable in large part to preventable conditions such as cardiovascular disease, diabetes, respiratory diseases, and infectious disease, including HIV/AIDS. Mental health patients also are at greater risk for death and disease because they have generally higher rates of smoking, alcohol and drug use, poor nutrition and obesity, and unsafe sexual behavior.

Second-generation antipsychotic medications also have been associated with weight gain, diabetes, dyslipidemia, insulin resistance, and metabolic syndrome, according to the report.

Access to health care is another significant factor in the higher morbidity and mortality among the seriously mentally ill, the report noted.

The report recommends a variety of national, state, and clinician-level solutions including:

► Designating the seriously mentally ill as a health disparities population.
► Adopting national surveillance activities on the health status of individuals with serious mental illness.
► Improving access to physical health care services.
► Promoting coordinated and integrated mental and physical health care services.
► Increasing Medicaid funding to cover smoking cessation and weight reduction treatments for seriously mental ill patients.
► Improving comprehensive health care evaluations by physicians.

Individuals treated for serious mental illness by public mental health systems die 25 years earlier than members of the general population.

One key strategy to improving coordination is moving toward the co-location of mental health and primary care services, Dr. Parks said. The body of literature on integrating care shows coordination that requires patients to shuttle from one clinic to another often breaks down over time.

Co-location models generally involve either a nurse practitioner providing primary care at a mental health site or a clinician providing psychiatric care in a primary care setting. This type of physical proximity allows providers to work off the same chart and see each other in the hallway.

This could, in turn, lead to informal discussions that improve patient care, Dr. Parks said.

There's been a piecemeal movement toward co-location, he said, with federally qualified community health centers and community mental health centers leading the way. All new federally qualified community health centers have been required to provide mental health services, along with dental care and substance abuse services.

The problem with moving toward co-location is that historically, physical health care, mental health care, and substance abuse treatment have all been separated, said Dr. Mary Ellen Foti, state medical director for the Massachusetts Department of Mental Health.

"You basically have diagnosis identified treatment silos in many states," she said.

In addition, primary care physicians may be reluctant to take referrals of patients with serious mental illness because they feel inadequately prepared to deal with those unique issues. And many psychiatrists feel inadequately trained to handle even basic medical conditions.

It's not that providers aren't willing to coordinate their care, it's that they don't have the systems to do it well, said Dr. Foti, who was one of the editors of the NASMHPD report.

Dr. Foti is optimistic about making progress because the report takes the first step in identifying the problems and providing recommendations and solutions. Now state and federal agencies can begin to design quality improvement programs that target patients' risk factors for disease. For example, patients with serious mental illness are obviously in need of smoking cessation programs.

The implementation of evidence-based treatment guidelines combined with the widespread adoption of electronic medical records could also go a long way in improving care for the seriously mentally ill, said Dr. Clifford K. Moy, a psychiatrist based in Austin, Tex., and associate medical director for the Texas Medicaid and Healthcare Partnership.

Electronic medical records could help to ensure that physicians have complete information when patients seek either mental health or primary care treatment.

Without this, many physicians are left without a comprehensive, up-to-date view of the patient's medical needs, he said. ■

Consider Key Gender Differences When Treating Depression

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — Recognizing some important differences between women and men can help in treating depressed women, Dr. Holly A. Swartz said at Perspectives on Women's Health sponsored by OB.GYN. NEWS.

When treating women with depression, physicians should increase their attention to psychosocial stressors, work on strengthening social support, and treat comorbid anxiety or phobic symptoms. Psychotherapy may be especially helpful, said Dr. Swartz.

In the selection of pharmacotherapy, a selective serotonin reuptake inhibitor (SSRI) would be the first choice for younger women or postmenopausal women on hormone therapy, while a tricyclic antidepressant may be more effective in men and older women not taking hormones, said Dr. Swartz of the University of Pittsburgh.

"Atypical" depression with somatic symptoms and fatigue, sleep disturbance, and overeating or carbohydrate craving is more common in women than in men, who are more likely to have typical vegetative symptoms and low appetite when depressed. Comorbid anxiety also is more common in depressed women than in depressed men.

Interactions between an individual's underlying biology or genetics and events in the external environment play important roles in the causes and manifestations of depression.

A disruption in interpersonal relationships is more stressful to women than to men.

DR. SWARTZ

It is theorized that women evolved to be more focused on affiliative behaviors, child rearing, and maintenance of social bonds, compared with men. It is believed that, in general, a disruption in interpersonal relationships is more stressful to women than to men, while a threat to social status is more upsetting to men than to women.

"In treating depression in women, you need to attend to the interpersonal context," Dr. Swartz said.

Depression-specific psychotherapies can be as helpful as medication for depressed women and may have more lasting effects, she added.

Women are nearly twice as likely as men to develop major depression—21% vs. 13%, data suggest (Arch. Gen. Psychiatry 1995;52:1048). Approximately one in five women will have major depression at some point in their lifetimes.

Among people who develop major depression, 59% also will be diagnosed with an anxiety disorder, and in 86% of cases, the anxiety disorder precedes the depression. Depressed patients with comorbid anxiety are more likely to be severely suicidal and are less likely to respond to therapy, be it medication or psychotherapy. The risk for recurrent depression is higher in patients with untreated anxiety.

"If you're not paying attention to the anxiety, you're not doing the patient a service," Dr. Swartz said.

People with high-anxiety levels typically are very somatically preoccupied, either with hyperalgesia (increased sensitivity to pain) or increased attention to sensations. When you treat highly anxious patients with antidepressants, "in practical terms, they'll get every side effect in the book, and then some," she said.

High anxiety levels also may cause these patients to avoid treatment altogether.

Considering that depressed women often have comorbid anxiety, it's advisable to acknowledge their high degree of sensitivity and explain that this is hard-wired behavior that probably was adaptive at some point but has gone awry. Help them anticipate side effects to treatment, and assure them that side effects are transient and that they will reach a point where the treatment is tolerable.

Start with a low dose of an antidepressant and increase the dosage slowly, but forewarn the patient that she probably will need a high dose to achieve full remission. "It's typically a long process. I like to tell my patients about this up front," she said.

Physicians who are not comfortable prescribing tricyclics might consider such dual agonists as venlafaxine or duloxetine, which have receptor effects similar to those of older tricyclics, she said.

Dr. Swartz is a consultant for Novartis and a speaker for Bristol-Myers Squibb Co. and Pfizer Inc. and has given continuing medical education presentations for Astra Zeneca. All these companies make psychotropic medications.

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