



Joining up Physical and Mental Health

The case for a new approach in policies and services

Mental and Physical Health are Linked

Changing patterns of disease in the 21st-century, with an increasing prevalence of chronic disease and, in particular, an increasing burden of complex, chronic, physical and mental conditions, oblige us to rethink our fragmented ways of understanding health and to redesign the fragmented healthcare systems that have evolved on the basis of that understanding.

There are multiple associations between mental health and chronic physical conditions that significantly impact people's quality of life, demands on health care and other publicly funded services, and generate consequences to society.

1. Poor mental health is a risk factor for chronic physical conditions.
2. People with chronic physical conditions are at risk of developing poor mental health.

These connections and associations are poorly recognised and addressed by services currently. There is increasing evidence that better physical and mental health outcomes are achieved when both are factored into treatment and management regimes. So what is getting in the way of greater integration? Part of the answer lies in the weight of tradition.

Back to the Future?

The interconnectedness of physical and mental health is reflected in the origins of the word 'health' itself, which is derived from the Old English word '*hael*', meaning 'whole.' The Old English meaning implies that a person who was healthy was 'whole.' The ancient Romans understood this concept. The Latin phrase '*mens sana in corpore sano*', which means 'a healthy mind in a healthy body' has been quoted by philosophers and leaders throughout history as representing a kind of ideal state of being – and the proper goal of governance and leadership. Many contemporary societies and cultures also have a more holistic understanding of the nature of health. The World Health Organization (WHO) encompassed this understanding when, in the famous Declaration of Alma Ata; it defined health as a '*state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*'. The WHO states furthermore that '*there is no health without mental health*'.

This ancient concept of the connectedness of mind and body is well understood today. There is a widespread and taken-for-granted understanding that if someone is physically unwell they are likely not to be at their best emotionally. It is commonplace in daily conversation for people to implicate stress arising from life events, overwork or tiredness, for example, as either causing or contributing to physical illness or discomfort. However this intuitive, popular understanding is mostly not reflected in the ways in which research, health care and other services are organised or in the practice of healthcare professionals. It would seem that, in the west, a gradual shift in the meaning of health occurred during the 18th century as the evolution of medicine encouraged a focus on the physiology of the human body. An outcome of this is that modern medicine understands health as an absence of disease, and ill health as the presence of disease. Healthcare systems have evolved to reflect this way of thinking about health. These systems typically separate the physical from the psychological and emotional elements human wellness.

Amongst the consequences of that split, higher priority has been accorded to physical health by governments and the general public. Physical illness has come to be seen as more 'deserving' of funding and policy priority whilst mental illness, which has been viewed as less deserving (sometimes undeserving), has received much less funding and is still accompanied by stigma and discrimination. Perplexingly, human bodies are considered to be more important than what might be called human minds, a word which, in this context, includes feelings, thoughts, beliefs, values and meanings and the ill-understood concept of personality. Yet we have some tantalizing evidence that our minds can influence our bodies and vice versa.

- A range of mind/body interventions have been effective in addressing [co-occurring pain, fatigue, and sleep disturbance in patients with cancer](#).
- Mind-body techniques were found to be efficacious primarily as complementary and sometimes as stand-alone alternative treatments for [cardiovascular disease-related](#) conditions.
- Chronic diseases characterized by inflammation are particularly susceptible to exacerbation by stress and emotion. Likewise, rates of depression and anxiety are overrepresented in individuals suffering from [chronic inflammatory disease](#). Indeed there are questions to be asked about whether [depression itself is an inflammatory condition](#).
- [A recent longitudinal study in Australia](#) suggests that there is 'a bi-directional relationship' between the brain and gut in gastro-intestinal disorders and there is accumulating evidence that many signals go up to the brain from the gut as well as in the downward direction. So we are faced with the intriguing possibility that in some cases, changes in the gut are actually driving psychological disorders rather than the other way around. This has important implications for the treatment of both common mental disorders such as anxiety and mild or moderate depression and gastro-intestinal conditions such as irritable bowel syndrome or severe indigestion.
- Moreover, there is evidence that some [clinicians use placebos in clinical practice](#) and most believe in the mind–body connection.

Evidence shows that there is a genuine physical and reciprocal connection between the mind and the body defined by physiological pathways and organic, structural remodelling of the elements of these interactions. Further, interventions and practices such as biofeedback, relaxation therapies, and meditation appear to be effective in governing mind-body and mind-heart interactions. There is at this time a paucity of powerful studies exploring the potential contribution of mind-body interventions in the overall management of chronic disease. There is already sufficient evidence to alert us to the potential of mind-body interventions in addressing our major health challenges. We may be missing a major trick in continuing to disregard them.

Contemporary health care, and contemporary health services, need to integrate long-standing, transcultural understandings of the holistic nature of human health with leading edge evidence and world-class technology if they are to be fit for purpose in addressing the changing patterns of complex, chronic ill health presented by modernity. Specialization will still have relevance for discrete conditions but most people with chronic disease require better care -coordination, team-based care and critically, whole-person care that recognises the interrelationship of mind and body. There is simply no point in fighting today's battles with yesterday's concepts and modes of organization.

The Facts and Stats

Mental health impacts of chronic physical conditions

[About 12 per cent of the Australian population](#) are estimated to have both a mental disorder and a chronic physical health condition. Women are 1.6 times more likely to have co-existing physical and mental health conditions than men. People with chronic ill health are two to three times more likely to experience mental health problems than the general population. Among patients diagnosed with physical health problems, the prevalence of probable mental health problems – particularly depression – has been found to increase as the number of chronic physical conditions rises.

- [Depression is two or three times more common in combination with cardiovascular diseases](#) including cardiac disease, coronary artery disease, stroke and congestive heart failure, and following a heart attack. Prevalence estimates vary from 20–50 per cent depending on the condition studied and the assessment approach used, but the two to threefold increase compared with controls is consistent across studies. Anxiety problems are also common in cardiovascular disease sufferers

- [People living with diabetes](#) are two to three times more likely to have depression than members of the general population. As observed for cardiovascular disease, prevalence estimates vary but the relative risk is consistent. There is also an independent association between diabetes and anxiety.
- [Mental health problems are around three times more prevalent among people with chronic obstructive pulmonary disease \(COPD\) than the general population.](#) Anxiety disorders are particularly common; for example panic disorder is up to ten-times more prevalent than in the general population.
- [Depression is common in people with chronic musculoskeletal disorders.](#) Up to 33 per cent of women and more than 20 per cent of men with all types of arthritis have co-morbid depression. For example, more than one in five people over the age of 55 with chronic arthritis of the knee have been reported to have co-morbid depression.

Physical Health Impacts of Severe Mental Illness

The mental health consequences of chronic physical disease are mirrored in extremely poor physical health outcomes experienced by people with severe mental illnesses. According to the [2010 Australian 2nd National Survey of Psychotic Illness](#), over one-quarter (26.8 per cent) of survey participants had heart or circulatory conditions and one-fifth (20.5 per cent) had diabetes. The prevalence of diabetes amongst this group is more than three times the rate seen in the general population. The mortality rate from physical illness amongst people living with mental illness is significantly higher than in the general population. [Schizophrenia is generally acknowledged as a life-shortening illness](#), with sufferers dying on average more than 10 years earlier than the general population; two thirds of this excess mortality is due to poor physical health.

- [Rates of ischaemic heart disease](#), stroke, high blood pressure and diabetes are higher than in the general population, with diabetes two to three times more common.
- Similarly, a clear [link between depression and cardiovascular disease](#) has been established.
- Mentally ill people aged 25 to 44 experience more than [six times higher cardiovascular mortality](#) than the age-matched general population.

The Relationship between Physical and Mental Health

The mechanisms underlying the relationship between [mental and physical health are complex](#) and not fully understood: a combination of biological, psychosocial, environmental and behavioural factors are likely to be involved.

- The most commonly cited reason for the excess mortality and morbidity found in people with physical and mental health conditions is their 'health behaviour'. Types of adverse lifestyle behaviours include alcohol and substance use, smoking, poor diet and a lack of physical activity. The complex and interrelated nature of physical and mental health problems means that 'health behaviours' should not be examined in isolation: increased morbidity is invariably linked to factors that occur in combination.
- People with mental health problems are less likely than other patients to report physical symptoms, while people with long-term physical conditions may avoid disclosing emotional complaints to their doctor due to the ongoing stigma attached to mental health problems. This can delay help-seeking behaviour and reduce the chance of a co-morbid illness being detected and diagnosed.
- The psychological burden that chronic and life-threatening physical conditions can place on people is another possible mechanism underpinning the relationship between mental and physical disorder

Fragmented Responses to Complex Multi-morbidity

Policy and service systems are not designed to respond to the complexities of health needs in the 21st century, and in particular to the rising burden of multimorbid chronic disease. There has been a longstanding tendency to view physical and mental illness as separate and distinct spheres of medicine. This view has manifested itself through the geographic, institutional, and professional division of physical and mental healthcare services in Australia. These structures inhibit the provision of an integrated, coordinated response to the multiple mental and physical health needs of people with chronic diseases, contributing to unmet health needs. They can also limit accountability for the patient, with responsibility for care being held by 'everyone and no one'; a problem that is exacerbated further by the 'demise of

the general physician within a hospital setting' and increasing subspecialisation. For example, the separation between mental and physical healthcare sometimes creates uncertainty surrounding who has responsibility for screening and monitoring the physical health of mentally ill patients in the community. Overt or covert discrimination and diagnostic overshadowing may also lead to inequalities in healthcare for people with mental health problems and intellectual disability.

Poor coordination of care is not only experienced by people with mental health problems. While evidence-based models for single diseases work well for patients with one disease, they can lead to the 'siloing' of care when applied to people with multiple physical health conditions and may ultimately deliver chaotic, fragmented treatment as well as poorer health outcomes. Clinical guidelines tend not to consider co-morbidity, creating the risk that the diagnosis and / or treatment of one disease, delivered as recommended by the disease-specific guidelines, interacts harmfully with the treatment (or natural development) of a coexisting disease.

AHPC Position

In a recently published report [Beyond the Fragments: Preventing the Costs and Consequences of Chronic Physical and Mental Diseases](#) the AHPC has called for an integrated approach to the prevention, treatment and management of chronic physical and mental conditions and proposed an initial 'road map' for achieving this. The road map emphasises the important role that the new Primary Health Networks (PHNs) can play in leading the way towards better care for co-morbid mental and physical chronic diseases: PHNs are recently established Australian primary health care organisations with the key objectives of increasing the efficiency and effectiveness of primary health services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive 'the right care in the right place at the right time'. The important staging posts for PHNs on this road map include:

1. **Establishing effective integration of mental and physical health care** as a priority and engaging with GPs and primary care providers to develop innovative service models in primary care offering proactive and coordinated care to people with complex chronic health conditions.
2. **Developing new approaches to joint working and care coordination** between primary care and specialist mental health services reflecting the best, available evidence in supporting the mental and physical health of people with severe mental illness.

Government has a critical role to play in implementing the road map. PHNs will be unable to achieve the required transformation unless governments collaboratively take action on healthcare funding reform to reflect changing patterns of population health and illness, including the rising burden of chronic disease and multimorbidities. Bundled funding packages which reflect the need for integrated, multidisciplinary and coordinated care would provide better health care for patients and be more cost effective for health care payers, whether these are governments, health insurance organisations or patients themselves.

Governments and service providers must invest in workforce development. The new approach requires a differently-skilled clinical and non-clinical workforce. New skills and attitudes are required in all clinical arenas but have special impact in primary care, where most people at high risk of chronic illness are managed. Professional bodies, in all clinical disciplines, need to adapt training curricula and refine professional practice to meet the challenges presented by 21st century healthcare needs.

There is an urgent need for good-quality research, including controlled intervention studies, into the contribution of mind-body interventions in chronic disease prevention and management strategies. In the interim, we should use the evidence we have at the moment, which suggests that these approaches are highly promising and acceptable to patients. It would be unwise to conclude that any absence of evidence reflects anything more than the traditional biases of researchers, research-funders and the continuing conceptualisation of health which splits body from mind and which objectifies and prioritises the physical over every other element that frames human wellbeing.

Delivering 'whole person care' has been hampered by the historical, geographic, institutional, and professional division of mental health and physical healthcare that remains apparent across the healthcare system. These factors inhibit the delivery of a coordinated response to the multiple needs of patients presenting with comorbidities and contribute to poor outcomes, premature mortality and huge societal costs. It is counter-productive and irrational to maintain current arrangements in the face of the evidence that these are not working as they should. The primary barriers are cultural ones. We need to move beyond the current paradigm in which body and mind are viewed in isolation. This means that important interrelationships between mind and body in the causes, treatment and management of diseases are ignored and lower priority is accorded to mental health. Shifting this paradigm to recognise the relationship between

mental and physical health and giving parity to mental health is a monumental task but it is hard to think of a more important or necessary change in addressing the chronic diseases that are an increasing feature of 21st-century existence. It is counter-productive and irrational to maintain current arrangements in the face of the evidence that these are not working as they should.

The AHPC has proposed a road map to improve outcomes for people with chronic conditions of body and mind. Shifting organisational structures and mind-sets requires a coordinated and concerted effort, from strong government leadership at the highest level, all the way through PHNs to doctors and healthcare professionals working in their local communities. PHNs have the potential to act as catalysts for a new approach provided, and it is a big proviso, that governments set a coherent policy direction and address the things that get in the way including the weight of tradition.