

GUEST EDITORIAL

Patients with mental–physical multimorbidity: do not let them fall by the wayside

Introduction

Although exact figures are lacking, many studies show that mental–physical multimorbidity is common in older people (van den Brink *et al.*, 2013). Particularly, older patients with a chronic disease often have psychiatric disorders (Verdurmen *et al.*, 2006). Conversely, medical comorbidity is common in psychiatric patients, especially cardiovascular, pulmonary, and neurological disorders and diabetes (Lyketsos *et al.*, 2002).

Patients with mental–physical multimorbidity can benefit from integrated mental and physical healthcare, and a variety of care models has been introduced accordingly (Bartels, 2004). For instance, in primary care there is a growing interest in collaborative care programs, in which primary care providers, care managers, and psychiatric consultants work together to provide care and monitor the patients (Craven and Bland, 2006; Thota *et al.*, 2012; Unützer *et al.*, 2013). In secondary care, integrated care for older patients with mental–physical multimorbidity is available on geriatric wards and psychiatric medical units of general, academic, and psychiatric hospitals. In spite of this, a group of patients is at risk of falling between two stools, namely chronic psychiatric patients who need long-term residential care because of additional physical disorders.

An example of this type of patients is a 63-years old woman with depression, panic attacks, and a mixed personality disorder with dependent and histrionic features, and concomitant multiple sclerosis. She lived alone and received intensive home care, because of immobility and full dependency in activities of daily living due to the progressive neurological deficits. After the relative who cared for her died, she often phoned the home care organization for help. The home care organization was not able to provide what she requested.

Another example is a man, aged 72 years, with psychotic depression, tardive dyskinesia, and serious diabetes insipidus. Psychiatric hospitalization was necessary because of severe symptoms of psychotic depression, including nihilistic delusions, suicidality, and delirium caused by dehydration as a result of the diabetes insipidus. After rehydration and intensive

psychiatric treatment, the patient stabilized. However, extensive care remained necessary, both to prevent dehydration as well as to prevent recurrence of a severe depressive episode. Because of these care needs and the high burden his wife experienced, discharge back home was impossible.

Previously, such patients would likely have stayed in psychiatric hospitals for the rest of their lives. However, since the 1950s, deinstitutionalization has dominated mental healthcare reforms in most industrialized countries. As a result, the total number of psychiatric hospital beds has decreased dramatically. Since then, long-term care (LTC) facilities have partly taken over the traditional asylum function of psychiatric hospitals (Bartels *et al.*, 2003; Davis *et al.*, 2012). Initially, there was a trend of the so-called transinstitutionalization: a part of the former psychiatric inmates moved to LTC facilities (Grabowski *et al.*, 2009; Novella, 2010). In addition, since the 1990s a trend of reinstitutionalization of people with long-term and more complex mental health needs and those with a forensic–psychiatric history is going on, resulting in increased numbers of forensic beds, places in prisons, and also in community-based nursing and residential care homes (Priebe and Turner, 2003; Priebe *et al.*, 2005; Priebe *et al.*, 2008). This reinstitutionalization has occurred largely unnoticed by policy-makers, and systematic research into its reasons, costs, and effects is lacking almost completely (Priebe and Turner, 2003; Fullerton *et al.*, 2009; Macpherson *et al.*, 2009). Given the differences in national healthcare systems, this has resulted in a wide range of LTC facilities for heterogeneous groups of residents with mental illnesses (World Health Organization, 2003; Caldas de Almeida and Killaspy, 2011; van den Brink *et al.*, 2013). However, it has been doubted whether these LTC facilities address the mental health needs of these residents adequately (Snowdon, 2010).

In the Netherlands, nursing homes have a long tradition of housing patients in units that provide specific care to a particular group of residents, needing multiprofessional care that cannot be offered by home care or in assisted living facilities

(Koopmans *et al.*, 2013). Individual treatment is based on personal needs and wishes of each resident within an appropriate social living environment. In order to achieve all this, a unique organization of nursing home care has been developed. Dutch nursing homes employ not only nursing staff but also their own medical, paramedical, and psychosocial staff, including a specially trained physician (Schols *et al.*, 2004). This so-called elderly care physician (ECP) has completed a three-year full-time training program that makes him or her a medical practitioner who has specialized as a primary care expert in geriatric medicine and qualified as a basic specialist with expertise in geriatric medicine (Koopmans *et al.*, 2010).

Some traditional nursing homes are evolving toward centers for specialized care, among others for older people with mental–physical multimorbidity (Dutch Health Care Inspectorate, 2007). The care needs of these patients differ from those of nursing home residents with dementia or with only physical conditions (Grabowski *et al.*, 2010). Therefore, we think these residents will benefit from living in specialized units, the so-called geronto-psychiatric nursing home units. Below we will discuss the preconditions for these units.

Preconditions

Competences of the multidisciplinary team

Geronto-psychiatric nursing home units have to be run by a specialized multidisciplinary team that consists of at least an ECP (or other physician with similar expertise), a psychologist, and a nurse specialist. It is their job not only to assess, treat, and support residents but also to coach the nursing staff. It is difficult to interpret signs, symptoms, and care needs of residents with mental–physical multimorbidity. Psychiatric diseases and personality disorders affect the way patients present their physical symptoms and needs (Health Council of the Netherlands, 2008). Alternatively, symptoms caused by a physical condition, such as decreased responsiveness and lack of energy, can also be interpreted as symptoms of a psychiatric disorder, for example depression (Alexopoulos *et al.*, 2002; Krishnan *et al.*, 2002; Hackett *et al.*, 2014). Besides, guidelines mostly focus on a single disease whereby the issues arising from multimorbidity are neglected.

Therefore, all members of the specialized multidisciplinary team must have appropriate skills to identify signs of mental and physical disruptions at an early stage. They must have broad knowledge about medical and psychiatric conditions and their mutual influence and should be

able to apply this knowledge in the diagnostic and therapeutic process. In addition, to complement the predominantly physical care, professionals should be trained in counseling strategies and recognize the influence of their own personal characteristics when interacting with these residents to prevent iatrogenic counter-transference dynamics.

Collaboration

Unfortunately, the availability and quality of mental health services in nursing homes is perceived as a bottleneck in many countries (Bartels, 2004; Grabowski *et al.*, 2010; Li, 2010; Snowdon, 2010). Even if a specialized multidisciplinary team is available for residents of a geronto-psychiatric nursing home unit, this team has to collaborate with medical and mental healthcare specialists in order to provide optimal care to these residents. On the one hand, it is important to arrange routine presence of qualified mental health clinicians for ongoing consultation and follow-up during episodes of acute illness, for management of maintenance treatment, and for programmatic consultation to the facility and its staff (Bartels *et al.*, 2002). On the other hand, clear agreements are required about referral of residents for diagnostic investigation, and for therapy that cannot be carried out in the nursing home. Staff members should thus know the limits of their professional competence and refer residents timely if that is indicated.

Supportive environment

A supportive environment includes physical design concepts as well as the social environment and organizational setting. This environment can strengthen or undermine mental health (Evans, 2003; Canadian Coalition for Seniors' Mental Health, 2006). The literature on supportive environments for nursing home residents with mental health problems focuses on residents with dementia. The resulting design principles (Lawton *et al.*, 2000; Fleming and Purandare, 2010) may not be appropriate for achieving a supportive environment specifically tailored to the needs of residents with mental–physical multimorbidity.

Interestingly, there is a risk that nursing homes, from their proficiency in caring for residents with dementia, provide an environment that is too supportive for residents with mental–physical multimorbidity. Based on the experience of inpatient mental health, it seems to be appropriate for residents of a geronto-psychiatric nursing home unit to create a therapeutic milieu, including the following practices: containment (meeting the basic needs and providing physical care and safety to the people within the environment), support

(giving kindness as the basis for a structure that fosters predictability and control), structure (having a predictable organization of roles and responsibilities as well as setting limits when necessary), involvement (practices in which the resident engages in the social environment), and validation (affirming a resident's individuality) (Gunderson, 1978; Mahoney *et al.*, 2009). In addition, there must be daytime activities adjusted to the wishes and capabilities of these residents of whom several are relatively young (van den Brink *et al.*, 2013).

A unit for specialized care should consist of private rooms, where residents can store their property and where their privacy is ensured, and also of rooms for social, labor-oriented, and therapeutic activities. There must be multiple rooms, so that the size of the group and the amount of stimuli can be varied. Safety and oversight have to be guaranteed.

Recommendations

Nursing homes can play an important role in caring for patients with severe mental–physical multimorbidity if these will evolve toward specialized care centers, which have fulfilled the preconditions described above. We conclude with some recommendations:

1. To fulfill these preconditions optimally, regulatory and funding barriers need to be overcome (Grabowski *et al.*, 2010); reimbursement policies should at least enable consultation, the provision of psychotherapies, staff education, and evaluation of therapeutic milieu (Reichman *et al.*, 1998; Reichman and Conn, 2010).
2. “Good practices” of care for residents with mental–physical multimorbidity should move toward “best practices” with best evidence-based care. For this purpose, guidelines tailored to the specific characteristics and care needs of these residents should be developed.
3. The above-described preconditions generate the following research agenda: it is essential to investigate the care needs of these residents, most effective therapies and care models, and the required knowledge and skills of the members of the multidisciplinary team. Furthermore, the assessment of psychiatric and physical symptoms in patients with mental–physical multimorbidity is complicated. For the use in this group, we recommend clinimetric evaluation of potentially useful screening and diagnostic instruments designed for other patient groups. Where necessary, new instruments should be developed. Finally, research is needed for a better insight into all aspects of the supportive environment that maintain and enhance quality of life of nursing home residents with mental–physical multimorbidity without dementia.

4. There are considerable differences in long-term residential care arrangements between countries. Precisely because of different experiences, we can learn from each other. Hence, the International Psychogeriatric Association (IPA) has established the Long-Term Care Shared Interest Forum (SIF). Main objectives of SIF are to gather cross-national input when optimizing mental healthcare in LTC facilities and to support and strengthen mental health services in the LTC sector. Therefore, we recommend international collaboration, as in SIF, for both the development of guidelines and carrying out the research agenda (http://www.ipa-online.net/ipaonlinev4/main/programs/sif/sif_ltc.html).

Conflict of interest

None.

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