Health Promotion as Brief Treatment: Strategies for Women with Co-morbid Health and Mental Health Conditions

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In the last decade, there has been increased recognition of the link between mental health conditions and physical disorders. This nexus has had particular implications for women diagnosed with a psychiatric illness and receiving public sector mental health services. The purpose of this article is to summarize 4 core health-related concerns that women with psychiatric conditions present to mental health providers. They include psychosocial/personal history, medication-induced weight gain, pregnancy, and substance use. The article then defines and describes health promotion strategies (e.g., Wellness Recovery Action Plan, Fitness Program, Health Education, and Gender-Specific Treatment Groups) and model programs within the context of brief treatment. Finally, the article reviews barriers to implementation of strategies (e.g., fiscal, clinical, and training) and concludes with recommendations for organizational shift to a health promotion philosophy and brief treatment. [Brief Treatment and Crisis Intervention 7:161–175 (2007)]

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Although both men and women with mental illness face medical challenges greater than those without mental illness (Goldman, 1999, 2000; Perese & Perese, 2003), it appears that women have unique experiences, risks and needs that must be considered when a clinician and client develop treatment strategies. For example, women who experience severe and persistent mental illness suffer from increased rates of multiple or co-morbid medical problems due to history of trauma (e.g., sexual abuse, domestic violence), barriers to treatment of physical illness (e.g., poverty, lack of insurance; misdiagnosis, or under diagnosis), lifestyle choices (e.g., high smoking prevalence and substance misuse), effects of medications (e.g., obesity and diabetes mellitus related to certain psychiatric medications), and consequences of the illness itself (e.g., neglect of personal care). Additionally, quality of life and indices of psychopathology are both adversely affected by the burden of medical illness (Brady, 1989; Cook, 1998; Dickerson, Pater, & Origoni, 2002; Dixon, Delahanty, Fischer & Lehman, 1999; Dixon, Kreyenbuhl, Dickerson, Donner, Brown, Wolheiter, Postrado, Goldberg Fang, Marano & Mersias 2004; Meyer & Nasrallah, 2003).

From the service delivery end, mental health clinicians are experiencing an unprecedented
increase in complex psychiatric cases in which women with serious medical, substance use, and social issues challenge the effectiveness of traditional, office-based approaches to mental health care. As a consequence of these multiple issues, clinicians and women clients are beginning to explore intervention strategies that embrace notions of wellness, partnership, quality of life, and recovery. One such strategy emerges from the field of public health and is known as health promotion.

What is Health Promotion?

A general definition of health promotion is any planned approach that can be educational (e.g., philosophical shift), political (e.g., policy reform), organizational (e.g., integrated practice model), and supports the actions and conditions of living conducive to the health of individuals, groups, and communities (Green & Kreuter, 1991). However, health promotion can also be described as a philosophy and a strategy.

As a philosophy, health promotion is based on the belief that individuals should be supported in their efforts to exert control over the determinants of their health (Green & Kreuter, 2005; O’Donnel, 1989). It offers practitioners a philosophical shift from an orientation based on illness and deficits to one of health and wellness. Overall, health promotion is considered both the art and science of helping people identify areas of personal and environmental change as they move toward their goals of optimal health (Green & Kreuter, 2005).

As a strategy, health promotion can be described as an integrated practice model that uses a variety of individual and community strategies. Examples of individual health promotion strategies include developing personal growth skills, learning self-care management, and emphasizing positive outcomes that are oriented toward well-being and empowerment. Examples of community health promotion strategies include creating supportive environments and strengthening social empowerment through community action (Raeburn & Rootman, 1996). With these definitions in mind, let us review the research on women’s health and mental health and how health promotion strategies can be applied as brief treatment approaches.

Clinical Concerns

There are four areas of clinical concern that clinicians need to be aware of when providing mental health services to women. These are psychosocial/personal history, medication-induced weight gain, pregnancy, and substance use with complications of HIV/AIDS.

Psychosocial/Personal History

More than half of women with severe mental illness report a history of childhood sexual abuse, and those with history of abuse have five times the rate of suicide, twice the rate of rape when compared with women who have psychiatric disorders who had not been abused as children (Miller, 1997; Miller & Finnerty, 1996). They also have double the rate of depression, twice as many gynecological problems, and generally seek care in primary settings for insomnia, gastrointestinal problems, chronic pain, and multiple problems. There are several explanations for these high rates: childhood sexual abuse frequently results in feelings of shame, lack of control, and difficulty trusting and relating to others (Brown & Jemmott, 2000; George, 2002; Perese & Perese, 2003). Additionally, women who have been abused may have difficulty accepting gynecological examinations that may trigger memories of abuse.

Early symptoms of mental illness may also have interfered with typical activities
associated with adolescence, such as dating and developing skills necessary for negotiating healthy relationships, including boundaries. Consequently, some women with a history of mental illness may frequently be in relationships that are abusive and exploitative. They are seen in mental health settings for depression and self-destructive behaviors, such as suicide attempts and domestic violence (Perese & Perese, 2003). Poverty is considered a risk factor that may lead some women with mental illness to trade sexual favors for food, a place to sleep and drugs. George (2002) noted that although these issues can explain some of the reasons why women have difficulty participating or engaging in health or mental health care, overall, women respond well to caregivers who treat them with respect and help them with problem solving. They often consider health and mental health care providers as an important source of support.

**Weight Gain and Psychopharmacology**

One measure of health status for adults and children is body weight. When people gain weight, they are at increased risk of developing diabetes mellitus, coronary artery disease, and endocrine disorders not to mention negative health and self-image consequences (Kawachi, 1999; Umbricht & Kane, 1996). The clinical picture becomes more complex when weight gain is a side effect of pharmaceutical treatment for a primary mental health condition. Perese and Perese (2003) noted that psychotropic medication is implicated in more than just weight gain for women and includes co-morbid conditions such as amenorrhea, sexual dysfunction, breast cancer, and osteoporosis.

While both men and women with schizophrenia have higher mortality rates and lower rates of health promoting behaviors than rates observed in the general population (Brown, 1997; Holmberg & Kane, 1999), suicide and obesity stand out as higher among women than men (Allison, Mentore, & Heo, 1999). Although studies are mixed regarding the prevalence of obesity in mental health populations (Elmslie, Mann, Silverstone, Williams & Romans 2001), weight gain associated with some pharmaceuticals has become an increasing concern among women with mental illness and their prescribers (Brady, 1989).

There is a well-established relationship between psychiatric medications, appetite control, metabolism, and weight (Vanina et al. 2002). For example, individuals who are taking psychopharmaceuticals have observed drug-induced changes in body weight of as much as 5% or roughly 22 lbs per year. Vanina et al. (2002) highlight key issues associated with weight changes and psychotropic medication use:

- Medications with sedative properties may alter metabolism, compounding the problem
- Patients who are receiving treatment often eat more as their appetite and well-being improve
- Many psychotropic medications produce weight gain that can be distressing and result in noncompliance with or discontinuation of treatment
- Weight gain is one of the most prominent difficulties associated with the use of certain psychotropic medications
- Drug associated weight gain does not regress easily
- Weight increases are gradual and are often linked to the patients personal characteristics and medication-response history
- Sometimes weight gain during pharmacotherapy can be a reflection of improvement in the clients mental status.

Additionally, the direction and extent of weight change also depends on the specific
drug, the dosage, and the duration of treatment, as discussed in the next section.

**Drug-Specific Weight Gain**

In addition to overall weight changes, certain psychiatric medications have been implicated in very large weight gains (Vanina et al. 2002). Vanina et al. have developed a consensus report on drug-induced weight changes associated with six categories of commonly used psychiatric medications: antipsychotic drugs, mood stabilizers, antidepressant drugs, antiparkinsonian drugs, psychostimulants, and other medications (e.g., buspirone). Of 69 significant papers reviewed, the authors rank ordered weight change from “loss” to “very large gain.” The medications most associated with very large weight gain emerged from three main groups: two antipsychotic drugs, chlorpromazine and clozapine, one mood stabilizer, valproate products, and one antidepressant drug, amitriptyline. Conversely, medications associated with weight loss were one antipsychotic drug, molindone; one mood stabilizer, topiramate; and three antidepressant drugs, isocarboxazid, bupropion, and nefazodone.

It is theorized that the mechanisms responsible for neuroleptic-associated weight gain with the use of antipsychotics is related to the blockage of certain cortical receptor sites (e.g., anticholinergic, serotonergic and histaminergic) connected to appetite stimulation. These mechanisms will be different for each medication. In one study, patients who were treated with chlorpromazine increased their food consumption and gained an average of 10 pounds during the course of 3 months of therapy (Allison, Mentore, & Heo, 1999). Ironically, while new antipsychotic drugs are associated with fewer neurological side effects, they are known to increase weight gain, which may adversely affect glucose metabolism and have a diabetogenic influence. Of the mood stabilizers, valproate acid and its derivatives are associated with significant weight gain.

Overall, weight gain can be explained by increased food intake, decreased energy expenditure, low physical activity, reduction of thermogenesis, and greater availability of long-chain fatty acids. Antidepressants can enhance appetite, cause dry mouth, and induce a craving for carbohydrates and sweets—all of which can lead to increased risk for periodontal disease, dental caries, and excessive consumption of high-caloric beverages and food (Keene, Galasko, & Land, 2003).

**Pregnancy**

For women with schizophrenia, pregnancy carries a unique set of risks as well as options. Miller (1997) provides a comprehensive review of the research on pregnancy in women with schizophrenia. Research suggests that women diagnosed with schizophrenia, when compared to controls, were at increased risk of pregnancy due to reported higher rates of coerced or forced sex, higher rates of HIV-risk behavior (e.g., needle sharing or not insisting that partners use condoms), and limited knowledge about contraception, basic physiology, and anatomy.

Although women with schizophrenia averaged the same number of pregnancies as others who were not mentally ill, a greater percentage of the pregnancies were unplanned and unwanted. Additionally, several studies found that women with schizophrenia were less likely to receive prenatal care than women who are not mentally ill, and when prenatal care is offered, psychiatric symptoms are often underreported, partly due to fear of potential custody loss. Psychosis or psychotic denial may also contribute to underreporting due to delayed recognition of pregnancy, misinterpretation of somatic or bodily changes, failure to recognize
labor, attempts at premature self-delivery, and precipitous delivery (Miller, 1997). Compounding all these health risks is the challenge of finding agencies that will support the care of women with schizophrenia who are pregnant. Shelter or residential facilities may refuse admission to pregnant mentally ill women for a number of reasons, including concern for liability associated with obstetric complications, premature labor, or the risk of other residents harming a pregnant woman. When shelter or brief inpatient services are acquired, treatment policies may focus on consent to an abortion, custody issues, and medication management rather than counseling, nutrition education, or family planning and support (Miller & Finnerty, 1996; Nicholson & Henry, 2003).

For women with schizophrenia who are successfully managing their illness with medications, a pregnancy impacts their ability to continue their pharmacotherapy. While the concern is focused on the potential effects of the medication on the fetus, withdrawing medication for the mother will likely precipitate a relapse during the pregnancy itself. The consequences of relapse may, in turn, lead to an acute psychosis that is likely to adversely affect nutrition, self-care, and ability to access or utilize prenatal care. It has been estimated that 65% of women with schizophrenia who do not maintain medication will relapse during pregnancy (Casiano & Hawkins, 1987). Overall, high rates of obstetric complications and untreated psychosis increases the health and mental health risks for women with schizophrenia who are pregnant.

Other findings by Miller (1997) indicated that rates of obstetric complications are higher among women with schizophrenia than in the general population. This seems due to risk factors associated with low socioeconomic status and substance use. While rates of substance abuse are high among mental health populations in general, one study found that 78.1% of a sample of women with schizophrenia acknowledged substance abuse during pregnancies (Miller & Finnerty, 1996).

### Substance Use with Complications of HIV/AIDS

The role of mental illness, medical illness, and substance use in the lives of women presents a complex clinical picture. For example, in a large, cross-sectional prevalence study of 26,332 Medicaid recipients in which half (n = 11,185) were noted to have been treated for a severe mental illness, three key findings emerged: (a) co-morbid substance use increased risk for multiple medical disorders, (b) those with a psychotic disorder had two or more medical disorders, and (c) their was a significantly higher age- and gender-adjusted risk of key medical disorders compared with Medicaid beneficiaries who were not treated for severe mental illness. (Dickey, Normand, Weiss, Drake, & Azeni, 2002.)

Although prevalence data for men and women indicate that 41–65% of individuals with a lifetime substance-abuse disorder also have a lifetime history of at least one mental disorder (Kessler et al. 1996), the research is even more bleak for women. Research from the Center of Substance Abuse and Treatment (Sacks & Ries, 2005) report that, when compared with the general population, 30% of women with mental illness have coexisting substance-abuse problems and are at increased risk of HIV/AIDS with rates of 5% in comparison to 0.17% among the general population. Additional factors that increased the risk for infectious diseases (e.g., HIV) was life style practices that included multiple sexual partners, unprotected sexual activity or shared needle use, a history of intravenous drug use, and a diagnosis of depression, which was shown to independently predict seropositivity (Perese & Perese, 2003).
Blank, Mandell, Aiken, and Hadley (2002) report that the rates of HIV infection are significantly elevated among persons with serious mental illness. Using a cross-sectional study of Medicaid claims data and welfare recipient files for persons aged 18 years or older, the authors estimated the treated period prevalence of HIV infection among the Medicaid population and the rate of HIV among persons with serious mental illness. They found that the treated period prevalence of HIV infection was 0.6% among Medicaid recipients who did not have a diagnosis of a serious mental illness and 1.8% among those who did.

The good news is that contrary to popular belief, there is no evidence that adherence to treatment for HIV infection is poorer among persons with serious mental illness than in the general population (Blank, Mandell, Aiken, & Hadley, 2002). However, if professional bias enters into the clinical picture and providers think that women with serious mental illness are less likely to adhere to treatment, they may be less likely to prescribe a state-of-the-art treatment regime (i.e., highly active antiretroviral therapy combined with gender-specific support groups) for these clients than for women who do not have serious mental illness.

**Health Promotion Strategies as Brief Treatment**

Green and Kreuter (1999) identify nine personal health promotion practices that are associated with physical and mental health and are cumulative in their effect. Each may be seen as goals of brief treatment. They are sleeping 7–8 hours daily, eating breakfast most days, rarely or never eating between meals, being at or near the recommended height-adjusted weight, being a nonsmoker, using alcohol moderately, participating in physical activity, and having social support and association memberships (p.126). Yet, these are practices that are frequently compromised in the lives of women with mental health conditions.

Overall, the data on positive health promotion practices or lifestyle lend credibility that at least 50% of all co-morbidity can be modified by brief treatment to promote healthy behaviors. However, research also suggests that although knowledge itself is necessary, simply dispensing information has not shown to influence risk behavior levels (Wainberg, Cournos, McKinnon, & Berkman, 2003). For health promotion strategies to be effective in the lives of women with mental illness and co-morbid health conditions, they need to be relevant, meaningful, sustainable, and brief.

This section will describe four health promotion strategies that address the clinical concerns described earlier. These strategies are, respectively, Wellness Recovery Action Plan (WRAP), Fitness Program, Health Education, and Gender Specific Treatment Groups. Each may be delivered in a time-limited or brief treatment format. For an overview of these strategies, see Figure 1.

**Wellness Recovery Action Plan**

WRAP (Copeland, 2002) is a manualized, self-management program whose goals are to help participants acquire new skills and information to better manage troubling symptoms, reduce personal risk factors, and achieve higher levels of health, wellness, and functioning. Participants identify internal and external resources for facilitating mental health recovery and promoting health. These resources are then utilized as “tools” to create an individualized plan for successful living. Individuals are guided to develop a personal Wellness Tool Box consisting of safe, free, or low-cost self-management strategies such as healthy diet, exercise, medication, vitamin schedule, and pursuit of adult life roles. Offered in either an individual or group or
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Figure 1
Clinical concerns and health promotion strategies for women with mental illness and co-morbid health conditions.
classroom format, WRAP is structured around five sections. The content of each section is described below:

Section 1: Daily Maintenance List—describe when you are feeling all right, things you do to keep yourself feeling all right and things you need to do to keep on track

Section 2: Triggers—describe external events or circumstances that, if they happen, may produce serious symptoms—like not taking the correct dosage of medication

Section 3: Early Warning Signs—list early warning signs that you recognize as potentially indicating future trouble

Section 4: When Things Break Down—list symptoms, what they mean to you and what you want done

Section 5: Crisis Planning—write down a plan for yourself and others if you are in a situation where others need to intervene; list medications you are currently taking and those that might help in crisis and those that should be avoided. WRAP can be offered as a brief treatment intervention using a single or multi-session workshop format.

Model Program

One program that has fully incorporated the WRAP model is Boston University’s Center for Psychiatric Rehabilitation—Rehabilitation and Recovery Services. WRAP content is integrated into the program in either a one-to-one or classroom-based format. The program is open to persons who have had psychiatric experiences; participants enroll in courses that they identify as supporting and facilitating their recovery process. For example, one entire Curriculum Model is entitled “Wellness.” Course topics include: Coping with Stress, Personal Fitness, Healthy Lifestyles for Women, Inharmony Hatha Yoga, Building Your WRAP (as described above), Meditation, WuStyle Tai Chi I and II, and Fruits and Vegetables (Hutchinson, 2005; Richardson et al. 2005).

Fitness Program

Exercise is emerging as a recognized health promotion strategy for addressing medication-induced weight gain. By way of example, a national consensus panel on Antipsychotic, Obesity and Diabetes (Consensus Report, 2004) recommended physical activity and nutritional counseling for overweight clients taking antipsychotic medications. Richardson et al. (2005) found that the most effective fitness programs were those that tailored interventions to specific populations (e.g., women) and or individual’s age, gender, socioeconomic status, cultural background, health status, barriers, and fitness level; used motivational messages in printed form; provided physician prescribed “exercise prescriptions” (e.g., walk around block two times a week); focused on moderate-intensity activities (e.g., walking); and used principles of behavior modification (e.g., goal setting, self-monitoring, social support, and shaping).

Prior to beginning a fitness program for medication-induced weight gain, clinicians and clients can explore together the following health matters: (a) assess whether the client has gained or lost weight, the extent of the weight change (e.g., a few pounds or a lot), timing of the change (e.g., rapid, gradual, seasonal, holiday), any associations with illness or smoking history and life time patterns, (b) consider switching to a medication that is less likely to cause weight gain before clinically significant gains occur, and (c) explore treatment options (e.g., fitness program) based on the severity of the weight problem, the emotional impact of the problem and the clients somatic or mental status (Vanina et al. 2002). As a time-limited, health promotion strategy, physical
activity interventions have the benefit of being low cost, valued, accessible, wellness oriented, flexible, normalizing, and easily adopted into existing mental health programs or primary care settings (Richardson et al. 2005).

Model Program

A Fitness Class is one of many wellness-oriented classes offered through the Recovery Center at the Center for Psychiatric Rehabilitation, Boston, MA, and serves as a model for programs striving to incorporate physical fitness health activities into traditional mental health care. While the emphasis is on total health, clients learn about physiology and self-care issues specific to medication-induced weight gain. Based on the notion that weight changes have a powerful impact on medication adherence, body image, and health, the central aim of a fitness class is to provide a structured and supportive environment for exercising and fitness training. Clients work with their recovery advisor to develop individualized fitness goals and create wellness plans. The setting also provides an opportunity for socializing, mutual support, and education, particularly as students receive guidance for understanding and managing weight changes associated with the use of psychotropic medications.

Based on an adult education model, the fitness class or exercise program consists of three supervised, 45-min exercise sessions each week for 20 weeks. Sessions are held in a university fitness room and participants can utilize stationary bicycles, stair-climbing machines, and treadmills. They are offered instruction on measuring their heart rates, strategies for warm-up, and cool-down periods. Preliminary findings from this program indicate that participants showed statistically significant improvements in their cardiovascular fitness and psychological fitness, such as self-esteem, quality of life, mood, and depression (Hutchinson, 2005).

Health Education

Incorporating women’s health and family planning into traditional mental health care delivery systems has many benefits. These include enhancing the physical and mental well-being of women with mental illness who are in their childbearing years, pregnant, or currently parenting. Women can be assisted in exploring sexual relationships and strategies to reduce unplanned pregnancies. Miller (1997) advocates for a multipronged health promotion approach to support women with mental illness who are pregnant or at risk of pregnancy due to lifestyle or educational needs. Examples of health promotion strategies that specialize in health content that is specific to personal health and family planning are classes on Family Planning and Women’s Health, active consultation with ob–gyn physician and nurse practitioners, access to day care, and enrolling client in women’s health and wellness center.

For women who are pregnant and taking psychiatric medications, the benefit of addressing a client’s pregnancy with a health promotion strategy is that a health-oriented approach helps reduce the stress, guilt, and fear of the pregnancy—regardless of whether a pregnancy was planned or unplanned. It also provides an opportunity for the pregnant woman to explore support systems, medication options, and life planning with case managers who are already familiar with her life. Although critics would claim that agency mental health staff does not have the time or expertise to provide such education, they should be reminded that their women clients are already experiencing these issues and will need their assistance regardless of the agency’s preparedness. Mental health agencies can tap into in-house nurses or nurse practitioners to provide these trainings or local public health nurses or student interns from nursing programs. As Miller (1997) states
mental health practice that considers sexuality, reproduction, and parenting can be highly effective in lessening risks for women with schizophrenia who are pregnant and soon to be parenting” (p. 631). Health education programs are, by design, usually short term and time limited. Women who participate in health and family planning programs typically participate in sessions that are relevant to their specific concerns and interests.

**Model Program**

One program that has obtained success in working with mothers considered “at risk” is the Nurse–Family Partnership Program. This program began as a research project in rural New York in the late 1970s and now operates programs in 22 states. The program was developed for first-time, low-income expectant mothers who were at risk for substance use and abuse. Additionally, other factors were targeted, such as behaviors that influence family poverty, school dropout, failure to find work, subsequent pregnancies, and poor maternal and infant outcomes. (Kitzman et al. 2000.) Most Nurse–Family Partnerships are funded through special projects or through state and federal appropriations (e.g., National Center for Children, Families and Communities). A key feature of the program is that it is administered by licensed nurses, whereas nonnursing or paraprofessional staffs have been found to be ineffective (Olds et al. 2002). Two central goals of the program are to improve pregnancy outcomes by helping mothers adopt healthy behaviors and improve families’ economic self-sufficiency. A nurse visits the homes of high-risk women when pregnancy begins and continues for the first year of the child’s life. Home visit protocols are in place and are designed to assist women learn new health-oriented behaviors (e.g., nutrition) and to responsibly care for their children. Recent research by Kitzman et al. (2000) found that the program increased employment by 83% and reduced maternal substance abuse by 25% and abuse of children by mothers by 80%.

**Gender-Specific Treatment: Women and Substance Use**

In order to deal with the diversity of co-morbid issues that women with mental health and substance-abuse conditions experience, health promotion strategies should emphasize gender-specific treatment. This recommendation is based on the knowledge that most therapeutic community programs for the treatment of substance abuse are typically tailored to men. The clinical approaches are often confrontational with little regard given to the needs of family and children. Bride and Real (2003) summarize the following benefits of gender-specific treatment services for women:

1) Provide women with an opportunity to concentrate on their own needs and desires away from their traditional concerns of social approval and the welfare of others
2) Offer safe environments to discuss topics that they might not discuss in mixed gender settings
3) Are more likely to provide services specific to needs of women
4) Tend to be more supportive, less confrontational, grounded in women’s experiences, and focus on empowerment and women’s strengths

Components of gender-specific health promotion strategies incorporate a broad range of activities that includes therapists and nurses collaborating closely with outside care-giving agencies and assisting clients in linking their medical services, which may include HIV/AIDS conditions, to ongoing mental health
and substance-abuse services. The needs of women who experience co-occurring mental illness and substance abuse complicated by health conditions generally require a long-term, flexible, integrated care model. However, many aspects of gender-specific treatment can be delivered in a brief treatment format, such as time-limited, women-only groups, and or counseling. These services are typically provided by female therapists in conjunction with nurse practitioners (Copeland, Hall, Didcott, & Biggs, 1993).

**Model Program**

Project Assist is an example of a model health promotion program that works solely with women who are homeless, mentally ill, abusing substances, and have HIV/AIDS conditions. Project Assist is an eight bed, modified therapeutic community for chemically dependent homeless women with HIV/AIDS. The program is organizationally linked with St Jude’s Recovery Center, a private, nonprofit substance-abuse treatment agency located in Atlanta, Georgia (Bride & Real, 2003). Project Assist was developed with a new set of principles to address the unmet health, mental health, and substance-abuse needs of women. Based on the principles of mutual aid, recovery, and the therapeutic community, Project Assist provides a variety of health promotion interventions that are specific to the needs of women. Health promotion interventions include: HIV support, education and health services, groups on spirituality, meditation, psychoeducation, the 12-steps program, relationships, addiction, employment, and health education.

**Barriers and Recommendations for Care**

Practitioners of brief treatment who wish to offer these four health promotion strategies to their women clients will face a complex set of challenges. Three areas in particular are fiscal, clinical and training.

From a fiscal standpoint, insurance plans are increasingly using carve-out behavioral health plans that separate psychiatric care from health care. While some research has shown that carve-outs may in some ways ensure focused mental health care, the medical needs of women with psychiatric disabilities may not be met. Further, these carve-out models continue to perpetuate the mind–body dualism that is the antithesis of health promotion strategies, as well as run counter to progressive medical and mental health practices. Given the strong association between mental illness and medical co-morbidity, health administrators have hypothesized that adequate treatment of mental illness will lead to a reduction in medical expenditures (Olfson, Sing, & Schlesinger, 1999). In other words, if only more money could be allocated to treat mental disorders, their will be lower expenditures for medical care. Simon, VonKorff, and Barlow (1995) found just the opposite: medical care costs were actually higher, not lower, when adults with mental illness were properly treated. However, Jeste, Gladsoj, and Lindamer (1996) speculated that inadequate medical treatment, rather than a co-morbid condition, may explain some research findings that people with schizophrenia have more severe physical illnesses but not necessarily more so than the general population.

From a clinical standpoint, some women with mental illness may be reluctant to seek medical care due to previous negative clinical experiences with mainstream health providers. Integrating medical and mental health treatment may encourage greater continuity of care but may not improve communication between the primary care provider and the woman client who needs treatment for both the mental health and health condition. For example, research has found that people diagnosed with
schizophrenia are reported to have a high tolerance for pain and thus unlikely to report pain as a symptom. Women with mental illness are sometimes unwilling to seek medical help or when they do they frequently have difficulty describing their problems to a physician. Other clinical barriers can include inability on the part of the woman with mental illness to recognize or describe physical symptoms or because psychotic symptoms interfere with her ability to communicate with the physician. On the other hand, a physician may focus on the mental illness and miss symptoms related to the medical disorders (Dickey, Normand, Weiss, Drake, & Azeni, 2002).

From a training standpoint, most mental health professionals are not trained in the philosophy or practice of health promotion nor are they trained to identify medical problems. Without some form of specialized public health training, front line mental health workers and case managers may be overlooking potentially life-threatening health symptoms that their women clients are experiencing or are at risk. So even though an integrated medical and mental health system would encourage greater continuity of care and coordination of different health promotion strategies (Dickey, Normand, Weiss, Drake, & Azeni, 2002), much still needs to be done to both enhance the health education of the mental health provider and to improve communication between the practitioner and women clients who present with mental health and medical needs.

**Recommendations**

Despite these barriers, much hope exists for the integration of health promotion strategies into mainstream mental health practice, particularly those settings that recognize the unique needs of women clients. To do so, however, requires a shift in organizational philosophy and practice. For example, one way that an organization can address fiscal issues is to advocate for insurance parity in the treatment of health and mental health conditions. This position is in-line with the health promotion philosophy that sees health and mental health as an integrated concept. Dickey Normand, Weiss, Drake, and Azeni (2002) take this argument further by recommending that (mental) health care organizations, rather than focusing on lowering medical expenditures, emphasize better medical treatment, not less. Better medical treatment could be achieved by integrating better medical treatment with mental health services, and mental health. While the result may not initially lower medical costs, integrated treatment may lead to early identification of medical illnesses among mental health clients, which in turn, may direct clients to health promotion strategies aimed at wellness and lifestyle changes. This philosophical shift has the potential to reduce co-morbidity that, in itself, is likely to be a cost savings.

Another area of organizational change can occur in the way that providers initially communicate and engage with women clients who present with medical and mental health issues. One of the defining hallmarks of the field of health promotion is its emphasis on a holistic, person-centered, empowerment-oriented approach to assessment and treatment. When medical providers and mental health practitioners listen to women clients with this philosophy in mind, the potential for miscommunication or under communication is lessened. To offset negative clinical encounters, better communication on the part of providers can result in openness on the part of women clients to participate in some of the evidence-based health promotion approaches associated with self-management techniques. These specialized tailored interventions might improve their understanding and self-management of certain types of co-morbid health conditions—like depression and diabetes.
Cross-training and pairing mental health workers with public health nurses is an excellent way to increase the skill set of traditionally trained mental health workers. Agencies that commit to interdisciplinary training and staffing (e.g., social workers, primary care physicians, nurses, psychiatrists, psychologists, nutritionists, fitness trainers) provide an important service to women clients who have multiple psychosocial, mental, and physical health needs. Scully (2004) reminds practitioners that “mental illnesses are medical illnesses, and the use of biological treatments such as medications involve multiple body systems beyond the central nervous system and require knowledge of biology, biochemistry, anatomy, and physiology” (p. 24). The mental health practitioner today needs to have an appreciation of the psychosocial lives of women clients as well as pharmokinetics (how the body handles a drug) and pharmacodynamics (the effects of a drug on the body). We are reminded that psychotropic medications affect many organ systems beside the brain, including the gastrointestinal, hepatic, renal, and circulatory systems.

Conclusion

The philosophy of health promotion is not a new concept. Beginning with Martial (AD, c.40-104), a first century Roman poet who stated “Life’s not just being alive, but being well” to the most recent endorsement by the New Freedom Commission on Mental Health (2003) that “mental health is key to overall physical health” (p. 21), the integration of health and mental health services has become, in a sense, recognized as “best practices.” Health promotion is one framework that helps unite these two arenas.

Health promotion strategies are also not a new or radical practice approach. Good mental health practice has always called for health promotion approaches—e.g., providing health education, organizing opportunities for fitness, conducting outreach, providing gender-sensitive services, arranging interagency coordination, and insuring that mental health staffs are cross-trained. Now the data are quite clear that clients want these types of interactions and consider them beneficial. As Sheridan and Radmacher (2003) wrote “a treatment cannot be effective if a client fails to utilize it, or its effectiveness may be reduced by actions taken by patients or by the failure of professionals to administer the treatment appropriately” (p. 5).

What is new about health promotion is the idea of formally embedding health promotion strategies as brief treatment interventions into mainstream mental health practice. The ultimate goal of this combined approach is best summed up by Green and Kreuter (1999): “Health promotion seeks to promote healthful conditions that improve the quality of life and health as seen through the eyes of those whose lives are affected. Though health promotion might have instrumental value in reducing risks for co-morbidity, its ultimate value lies in its contribution to quality of life.” (p. 54.) For women clients who believe there is more to treatment than just a plan and that wellness, empowerment, and quality of life can be the expectation rather than the exception, health promotion is one idea whose time has arrived.

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References


