

Depression, anxiety and long term conditions

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Depression and LTCs

- People with LTCs are twice as likely than other adults to suffer from depression
 - 20% in diabetes/coronary heart disease (CHD)
 - More common among COPD patients than other LTCs
- In presence of LTCs depression linked with:
 - Poorer self-care and higher use of healthcare resources
 - Disengagement from protective lifestyle and behavioural changes (e.g. exercise)
 - Poorer adherence to medical treatments
 - Increased mortality/morbidity
 - Worse HRQOL

Anxiety and LTCs

- Depression and anxiety frequently co-occur
 - More than 75% of patients diagnosed with depression in primary care are also suffering from an anxiety disorder
- People with an LTC are 2-3 times as likely as other adults to suffer from anxiety
 - 14% GAD in diabetes; 40% with elevated anxiety symptoms
 - 24% GAD in CHD

Psychological problems in diabetes

- 41% of people with diabetes will suffer with poor psychological well-being
- Increased rates of depression (~28%) and anxiety
- Depression often undetected in both primary and specialist care.

Barriers to management of depression

- Patients and practitioners both engaged in attributional styles that normalised distress in the presence of LTCs
- QOF led to highly performance managed and time-limited environment in primary care
 - Fosters disposal through screening
 - Militates against patient centred discussions about depression
- Opportunities to reach shared understanding about depression in patients with LTCs
 - Language/communication problems (e.g. with BME patients)
 - Absence of shared conceptual models
 - Focus on less contested activity – physical health

BMC Family Practice 2011;12:10

Seeking treatment: co-morbid physical illness

- “I refused to go to the doctor. I thought it was self-inflicted. If it’s self inflicted, why bother anyone?”
- “I don’t think that would help, you’ve got to sort your own way out of it, anyway, at the end of the day....I think you’ve got to work your way through it yourself”

Patients with co-morbid depression and Chronic Obstructive Pulmonary Disease

- *(Ellison et al 2012 in press.)*

Seeking treatment: co-morbid physical illness

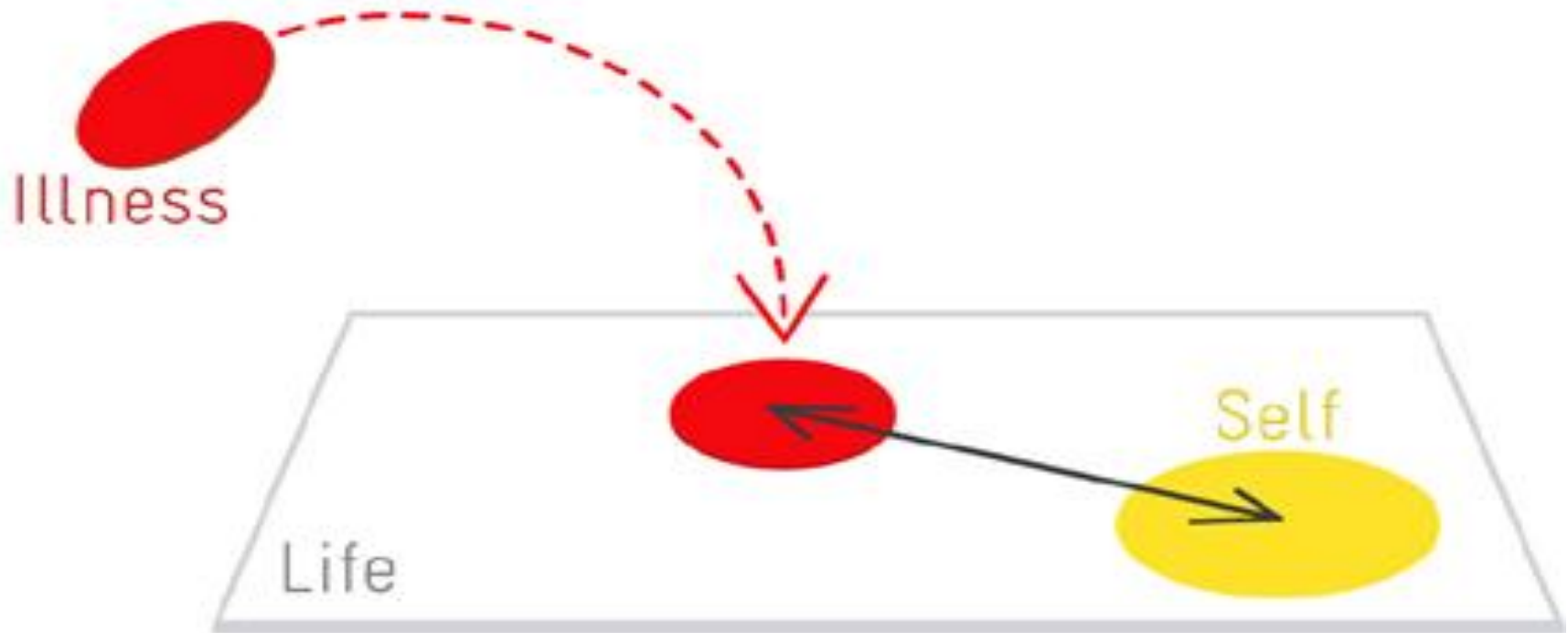
- “...if I do go to see him [the GP], it’s usually about something else and I don’t really think to say anything about it [the depression]...because it is not something that is happening continually...it is something that happens now and again and you just get low with it...to be honest I’ve not really told him [the GP] you know. [Female patient with depression, Coronary Heart Disease and diabetes]

– *(Coventry et al 2011).*

Understanding the perception of 'self'

The more the illness maps onto the individual's sense of self the less he or she feels in control of the diabetes.

PRISM (Pictorial Representation of Illness and Self Measure)



Self-Illness Separation (SIS)

Need for a narrative view

- We need to understand that there may be a change over time in way illness perceived
- ***Where are they now, where have they been and where do they want to be?***

– *Gask et al Chronic Illness (2011)*

Helping the patient- and us- to make sense of the illness

Need to understand the patients' ideas, concerns, fears, expectations and hopes about their health and illness

Not just about 'education'

We need to talk about.....

- Impact on emotions, life, social functioning and relationships
- Symbolic meanings of illness(es) for that person
- Perceived stressors, barriers, risks and other potential challenges to moving forwards towards empowerment
- Fears and worries about future
- Coping strategies employed to manage selves
- Sources of support and how they engage with them

Psychological therapies for depression in diabetes

- Patients with diabetes have elevated rates of mental health problems such as depression
- Systematic review of 49 treatment comparisons found:
 - Psychosocial interventions were associated with modest improvements in HbA1c (SMD= -0.29, 95% CI -0.37 to -0.21)
 - Smaller improvements in mental health (SMD= -0.16, 95% CI -0.25 to -0.07)
- Interventions including both a lifestyle and a mental health component were significantly more effective than lifestyle interventions alone in improving mental health.

Diabetes Care 2010; 33:926–930

Psychological therapies for depression in CHD

- Effects of psychological interventions on depression among CHD patients are very mixed
- Unclear which psychological treatments are most effective for depression in this group.
- 58 independent treatment comparisons were identified
- No individual treatment component significantly improved depression
 - effects were largest in magnitude for CBT (SMD=0.12, $p=0.22$)
 - and problem solving (SMD=0.19, $p=0.20$)

CBT for depression in COPD

- Limited evidence for treating depression with CBT
 - Large trial (n=238) in US showed that group CBT was not superior to COPD education
 - Short follow-up (8-weeks)
 - CBT not sufficiently tailored
 - Education group received some active ingredients
- (Psychol Med 2001;31:717-723)

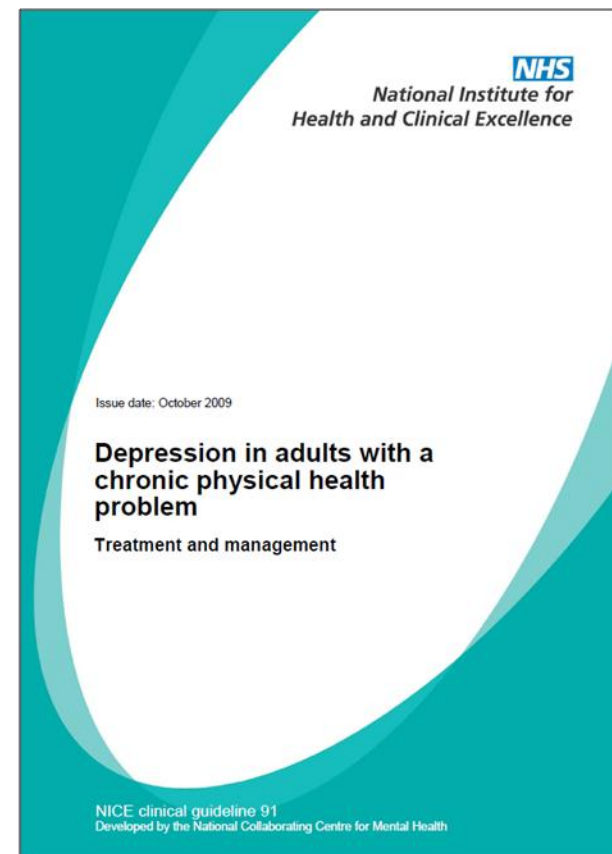
Antidepressants don't perform much better in CHD!

Study	Antidepressant used	Effect sizes
Strik et al	Fluoxetine	0.38
Glassman et al	Sertraline	0.20
Honig et al	Mirtazapine	0.35
Lesperance et al	Citalopram	0.33

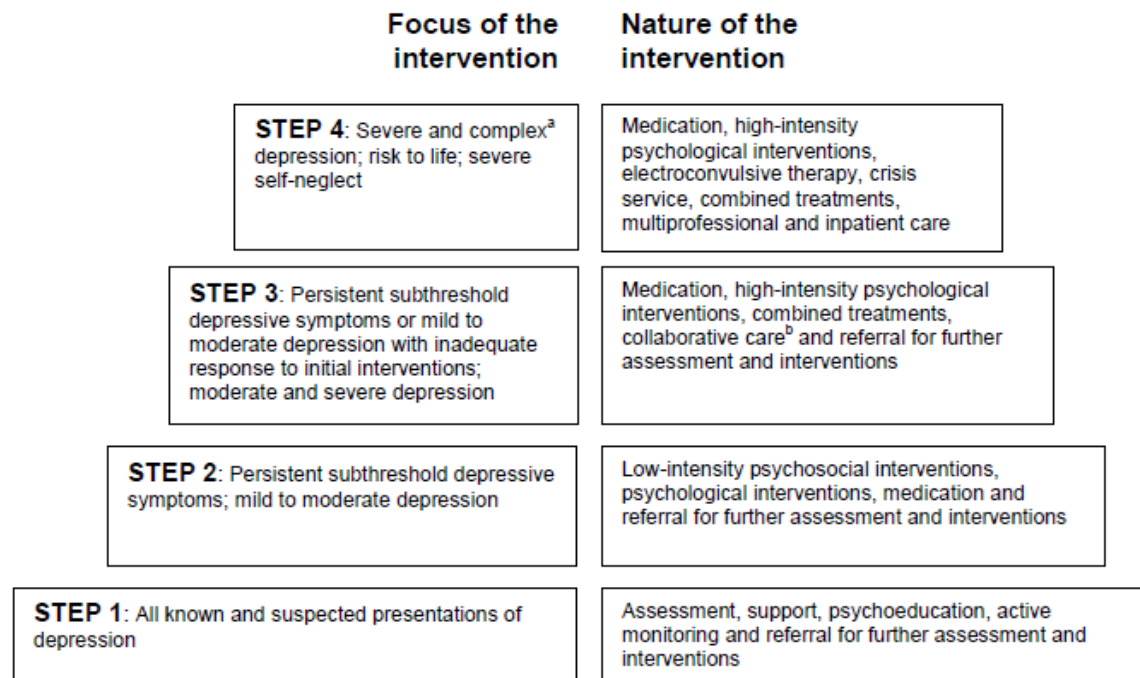
Thombs et al 2008

NICE Guideline

“**Collaborative care**, which should form part of a well-developed stepped-care programme, could be provided at the primary or secondary care level. The interventions, which involve all sectors of care, require a coordinated approach to mental and physical healthcare, as well as a dedicated coordinator of the intervention located in and receiving support from a multi-professional team, joint determination of the plan of care, and long-term coordination and follow-up.”



The NICE stepped care model



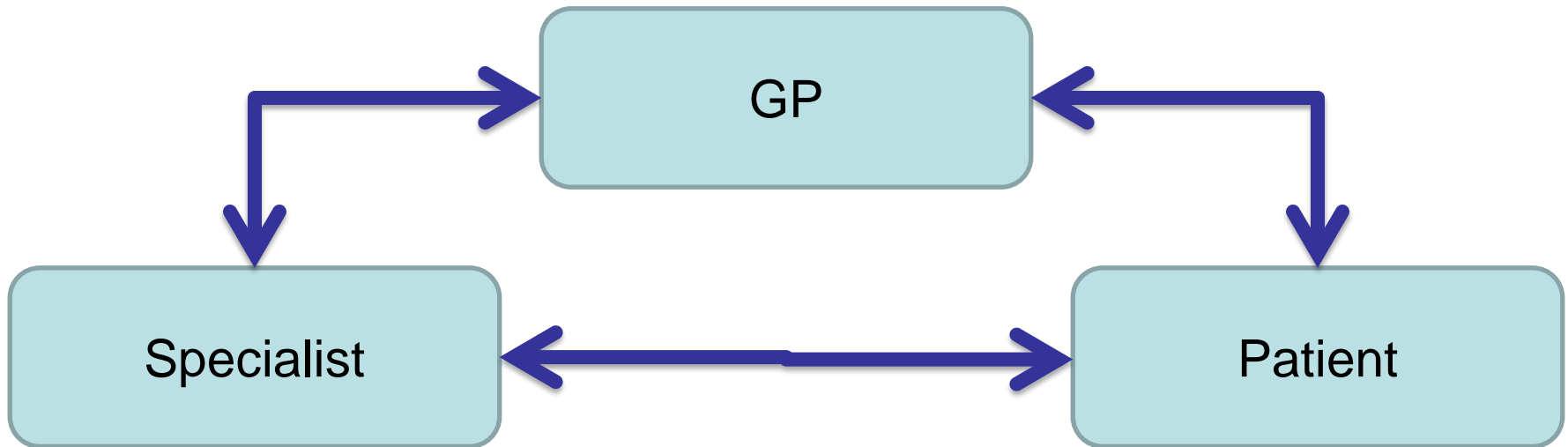
Collaborative care/disease management programmes

- Evidence for improved outcomes (TEAMCARE- both depression and diabetes)
- Decreased mortality in older people with diabetes if active programme of treatment of depression is instituted ('PROSPECT' study) .
- Reduced costs in longer term?

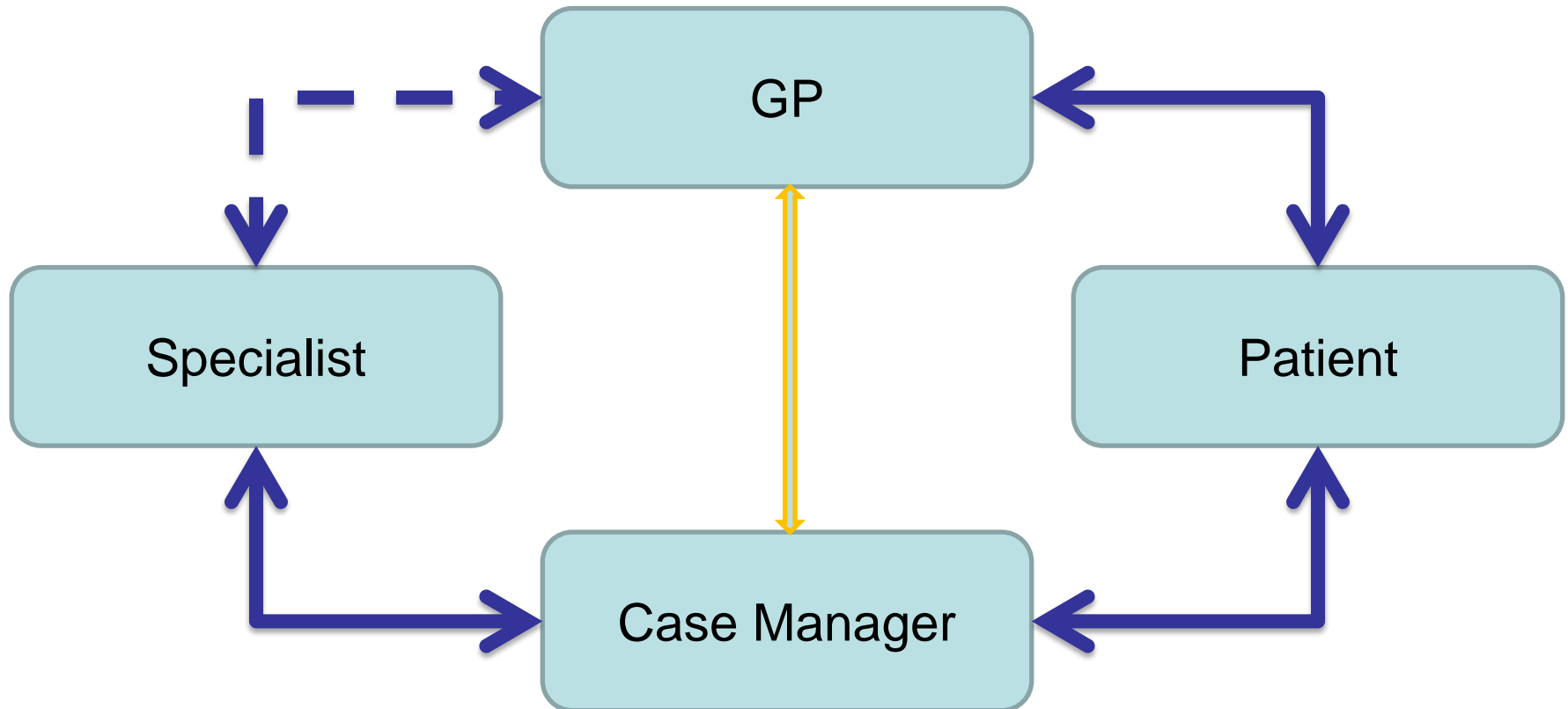
Core components of collaborative care

- **Multi-professional approach to patient care** provided by a case manager working with the GP under regular supervision from specialist mental health clinician(s).
- **A structured management plan** of medication support and brief psychological therapy.
- **Scheduled patient follow-ups** on one or more occasion (face to face or remotely).
- **Enhanced inter-professional communication** between the multi-professional team who share responsibility for the care of the depressed patient (e.g. team meetings, case conferences, supervision).

Usual care relationships



Collaborative care relationships



Case manager role

- Collaborative care models are based on changes in roles
 - Primary care providers
 - Specialists such as psychiatrists (and high intensity psychological therapists/supervisors)
- Introduction of a new role – the case manager
- Major innovation that can involve
 - Assessment
 - Behaviour change support
 - Clinical management
 - On-going follow-up and care co-ordination



COINCIDE

Collaborative Interventions for Circulation and Depression

- **Cumbrian pilot:**
 - Design and deliver training for IAPT PWP workforce to support depression in LTCs
 - 1 day workshop for practice nurses
 - Acceptability and feasibility evaluation
- **CLAHRC/IAPT in the North West**
 - 3 waves of training PWPs/engaging practices across North West
 - Started trial – January 2012
 - 6-9 follow-up and evaluation
- <http://www.coincidehealth.org>

Any questions?

<http://www.coincidehealth.org>

<http://www.rcpsych.ac.uk/improvingpmh>