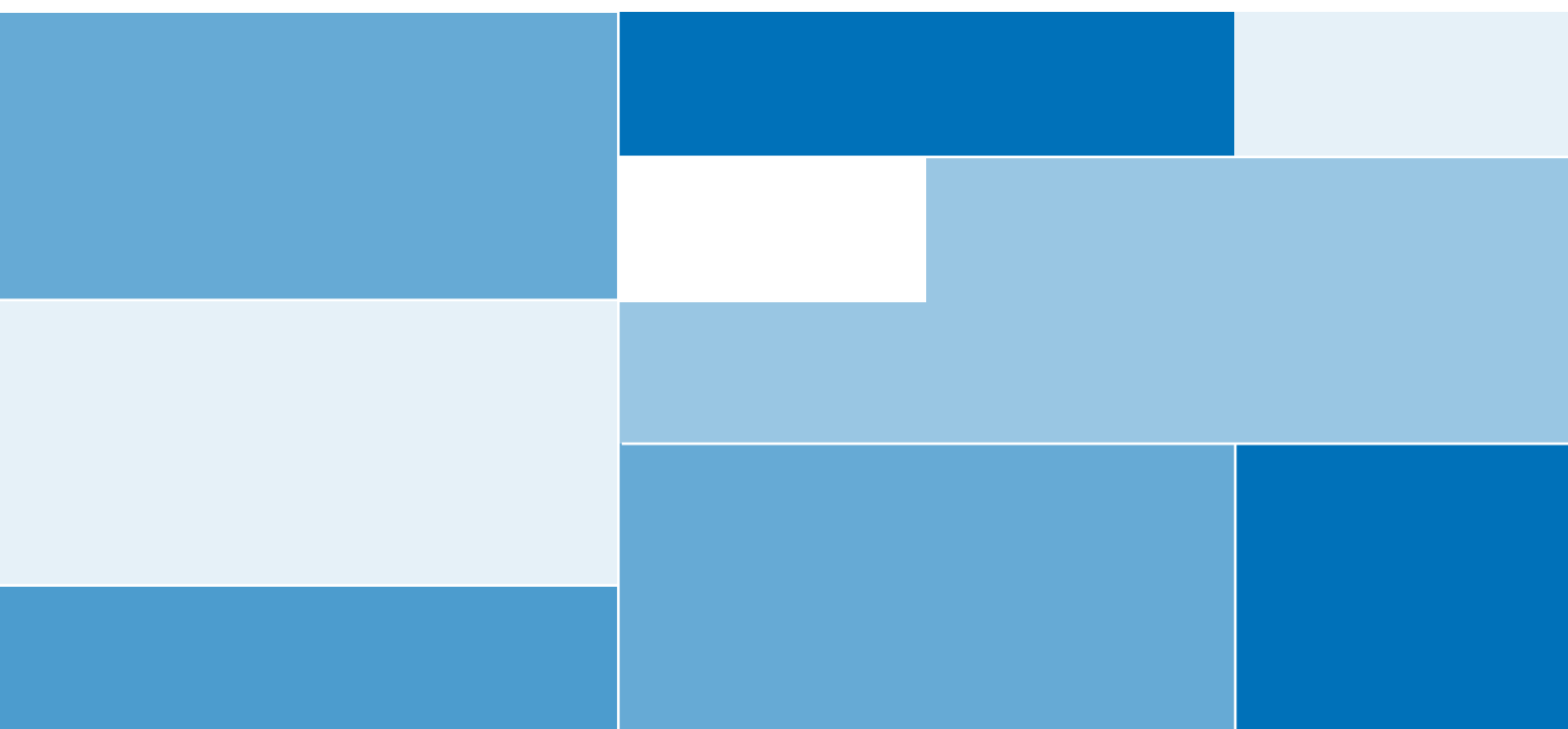


Long-term conditions positive practice guide



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Background

1. Chronic physical illness can have a life-changing effect on an individual's wellbeing, functional capability and quality of life. Depression and/or anxiety disorders (as either a cause or a consequence of the physical illness) may exacerbate the perceived severity of the physical symptoms and add to the person's distress.
2. Co-morbidity of depression and anxiety disorders with long-term conditions (LTCs) results in increased use of other healthcare services and increased physical healthcare costs.
3. Patients often present with physical symptoms, when in fact they are suffering from an underlying common mental health condition such as depression and/or anxiety disorder. Evidence suggests that 69% of people experiencing depression in primary care initially present with physical symptoms (Simon et al 1999), and 25% of people attending hospital emergency departments with acute chest pain actually have panic disorder (Huffman and Pollock 2003).
4. Delay in the accurate diagnosis, and therefore in the treatment, of depression and anxiety disorders results in unnecessary suffering, investigations and health service cost.

Benefits of psychological therapies for people with long-term conditions

5. Most analysis of the cost of long-term physical health conditions has come from the USA or Europe, where it has been possible to draw data from insurance records. However, there is no reason to believe that the prevalence of depression and anxiety as a co-morbid condition with long-term physical illness is any less in the UK.
6. Barksy, Orav and Bates (2005) calculated that 16% of total US healthcare spending was attributable to physical symptoms or disease co-existing with mental health disorders. Applying their estimation of 16% to the UK, it has been estimated that £8,483 million will be spent on somatisation in the UK during 2008/09.¹

1 Source: Michael Parsonage, economist for the Sainsbury Centre for Mental Health. This figure is based on total NHS planned revenue expenditure in 2008/09 of £92,642 million. Using DH information on age-specific spending, it can be estimated that the 16–75 age group accounts for 57.23% of this total, i.e. £53,019 million.

Mechanisms of co-morbidity

7. Depression and/or anxiety disorders may decrease adherence to medical treatment; increase unhealthy behaviour such as smoking, substance misuse, and poor diet; and lead to poorer outcomes for those suffering with chronic diseases.
8. Mental health commissioners are encouraged to work closely with commissioners who have responsibilities for relevant physical health services. More integrated commissioning will ensure that better links are made between IAPT services, and physical health services, to ensure continuity of care and effective referral pathways for people with co-morbid physical and mental health problems.
9. The physical illnesses described below are not an exhaustive list, and many others can be identified where treatment of depression and anxiety disorders would be beneficial to the person with a co-morbid LTC.

Cardiovascular disease

10. People who have suffered a heart attack have a 30% chance of developing depression (Davies et al 2004). Those with cardiac problems are three times more likely to die of these causes if they also suffer from depression than if they do not (Frasure-Smith et al 1999).
11. Research has shown that people with heart disease are more likely to suffer from depression, and people with depression are at greater risk of developing heart disease (Nemeroff 2000).
12. NICE-approved psychological therapies have been shown to improve the psychological, symptomatic and functional status of patients newly diagnosed with angina (Lewin, R.J.P. et al 2002). They have also been shown to reduce hospital admissions in refractory angina patients (Moore, R.K.G. et al 2007). It has been estimated that 40% of admissions and half of revascularisations can be avoided by providing a NICE-approved psychological therapy to those suffering with angina (Chester). IAPT workers would be very well placed to supervise and deliver such a programme.

CBT-based education reduces bed use and heart attacks

“Chronic refractory angina is an increasingly prevalent, complex chronic pain condition, which results in frequent hospitalisation for chest pain. We have previously shown that a novel outpatient cognitive-behavioral chronic disease management program (CB-CDMP) improves angina status and quality of life in such patients. In the present study of 271 chronic refractory angina patients enrolled in our CB-CDMP, total hospital admissions were reduced from 2.40 admissions per patient per year to 1.78 admissions per patient per year ($P < 0.001$). The rising trend of total hospital bed day occupancy prior to enrolment fell from 15.48 days per patient per year to a stable 10.34 days per patient per year ($P < 0.001$). There were 32 recorded myocardial infarctions prior to enrolment compared to eight in the year following enrolment (14% vs 2.3%, $P < 0.001$) and overall mortality was lower than comparable groups treated with surgery. This study shows that educating patients and demystifying angina using a brief outpatient CB-CDMP produces an immediate and sustained reduction in hospital admission costs that represents a major potential healthcare saving. This benefit accrues in addition to the known effects of CB-CDMP on symptoms and quality of life. These data suggest that a CB-CDMP approach to symptom palliation represents a low cost alternative to palliative revascularisation.”

Reprinted from *Journal of Pain and Symptom Management*, Volume 33, Issue 3, Pages 310–316: ‘A Brief Cognitive-Behavioral Intervention Reduces Hospital Admissions in Refractory Angina Patients’, Moore, R., Groves, D., Bridson, J., Grayson, A., Wong, H., Leach, A., Lewin, R. and Chester, M. (2007), with permission from Elsevier.

Diabetes

13. Depression is common among people who suffer from diabetes. It has been estimated that almost a quarter (25%) of people with diabetes also experience depression, with people with diabetes being two to three times more likely to suffer from depression than the general population.²

2 Boehm, G., Racoosin, J., Laughren, T. and Kate, R. (2004) Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes: Response to consensus statement. *Diabetes Care*, 27(8), 2088.

14. Furthermore, those with co-morbid depression and diabetes typically have:
 - poorer health outcomes;
 - more severe perceived symptoms;
 - poorer self-care;
 - increased health service utilisation; and
 - an estimated healthcare spending increase of 50% to 75% (Simon 2005).

The importance of links to physical health services: Salford IAPT Pathfinder

The Salford Pathfinder has explored the needs of people with type 1 diabetes who are also experiencing depression and/or anxiety disorders, by developing a suitable care pathway into the IAPT service. The service, which provides a sessional input to the community diabetes clinic, has been set up in collaboration with the PCT diabetes specialist team and with the support of the consultant diabetologist and the Salford Diabetes Forum.

All 1,000 people on the type 1 diabetes register have been sent a copy of the Diabetes UK booklet on diabetes and depression, a PHQ-9 and GAD-7 and an invitation from the consultant diabetologist to return the forms if they would like to discuss the contents of the booklet in the clinic. To date there has been a 20% response rate, with direction into the IAPT service for people with moderate to severe symptoms and joint management of problems between services.

Additionally, staff who manage people with diabetes have been trained to screen and identify common mental health problems such as depression and anxiety, and refer those patients to providers of psychological therapies.

Chronic obstructive pulmonary disease

15. Chronic obstructive pulmonary disease (COPD) is a progressive disease characterised by irreversible obstruction of the airways. It covers the diagnostic labels of chronic bronchitis, emphysema and some cases of chronic asthma.
16. COPD accounts for as many as one in eight medical admissions. Emergency admissions are also common, owing to a combination of acute exacerbations and increased incidence of panic attacks.

17. It is estimated that up to 51% people suffering with COPD have clinically significant symptoms of depression and/or anxiety disorder; similarly, prevalence of panic disorder is markedly higher in patients who have COPD, with up to 67% experiencing panic disorder. Avoidance of experiencing symptoms is associated with increased disability; this is amenable to psychological therapy.

Importance of good relationships with other health professionals: Hertfordshire IAPT Pathfinder

Watford PCT consulted its local practice based commissioning group 'Watcom' to develop the IAPT service for patients with COPD. The Pathfinder worked closely with a number of GP surgeries which served a population of 32,000 and together had 457 COPD sufferers on their registers.

A brief training programme was developed for high- and low-intensity workers, with a specialist respiratory nurse who explained the important physical issues around COPD and the way in which breathlessness and consequent reduced activity have significant physical and psychological consequences.

Despite numerous reminders and enquiries to the pilot surgeries, the COPD IAPT service did not receive its first referral until four months into the project. Surprisingly, the referral did not come from one of the pilot surgeries.

Hertfordshire Pathfinder involved an additional surgery with an active COPD-oriented specialist respiratory nurse. A good relationship was developed with the nurse, meaning that this surgery was immediately successful in generating appropriate referrals; as a result, the IAPT service received a good number of referrals. Hertfordshire Pathfinder then contacted a number of other respiratory nurses to establish a good referral route.

The Pathfinder has successfully illustrated the importance of ensuring good relationships with other health professionals as well as GPs.

Chronic pain

18. Chronic pain can be caused by disease or be a physical symptom of an illness, or it may be medically unexplained. It is estimated that 21.5% of the general population experience chronic pain.³ A significant proportion of these people will be distressed and will frequently seek healthcare including:

3 Gureje, O., von Korff, M., Simon, G. and Gater, R. (1998) Persistent Pain and Well-being: A World Health Organization Study in Primary Care. *Journal of the American Medical Association*, 280(2), 147–151.

- increased primary care consultations;
 - increased analgesic use;
 - increased referrals to secondary care;
 - increased healthcare spending to investigate the cause of pain; and
 - increased surgical interventions.
19. The direct cost of chronic pain to the healthcare system in the UK is estimated to be £1.6 billion, with a further £10.6 billion in informal care costs. Back pain is the second most common reason for absence from work in the UK, and an estimated £3.8 billion is paid annually in disability benefits for pain-associated conditions.
20. Between 30% and 45% of patients attending chronic pain clinics are estimated to be clinically depressed.⁴ Patients with chronic pain are also likely to have a high degree of health anxiety about their pain.
21. Several systematic reviews have shown NICE-approved psychological therapies to be an effective treatment for chronic pain, with multidimensional reductions in distress and disability as well as changes in work status and healthcare-seeking behaviour.
22. A biopsychosocial approach is recommended in a multidisciplinary comprehensive pain programme. Clinical improvements have been shown to be maintained over long periods, including a greater likelihood of remaining in paid employment. One study showed that treatment gains were maintained after 13 years on all dimensions including mood, pain intensity and interference with daily life.
23. Comparisons between psychological therapies and medical and surgical treatments are favourable. A comparison of spinal fusion and a multidisciplinary pain management programme showed the same benefits at one-year follow-up, but the costs of surgery were £7,830 per person compared with £4,526 for the rehabilitation group. A recent comprehensive review of all studies reporting treatment outcomes for patients with chronic pain concluded that comprehensive pain programmes offer the most efficacious and cost-effective treatment, relative to a host of conventional medical treatments. Furthermore, some widely used medical procedures for chronic pain have yet to demonstrate efficacy and contribute to physician

4 Banks, S. and Kerns, R. (1996) Explaining high rates of depression in chronic pain: a diathesis-stress framework. *Psychological Bulletin*, 199(1), 95–110

dependency or cause iatrogenic problems such as the development of hyperalgesia in long-term opiate use.

24. The opportunity presented to pain services by IAPT is clear. Commissioners need to ensure that delivery of IAPT integrates with and augments current pain services.

Sickle-cell disease

25. Sickle-cell disease is an inherited condition, primarily affecting the African and Caribbean populations, in which a different structure of haemoglobin causes frequent painful 'crises' owing to 'sickling' (a change in shape from rounded to sickle shape) of red blood cells. These crises can lead to conditions such as ulcers, bone necrosis and stroke, and are associated with marked shortening of life expectancy.
26. Unsurprisingly, sickle-cell disease has psychological consequences, with sufferers at risk of developing anxiety, depression and a dependent style of coping which comes to dominate their lives in and out of hospital.
27. Cost evaluation undertaken in the London boroughs of Lambeth, Southwark and Lewisham estimated that the annual cost of hospital admissions for sickle-cell crises during 1995 was £2.5 million (Streetly 1995).
28. Psychological therapies have been shown to be effective for people suffering from sickle-cell disease, and are considered an important supportive strategy for enabling patients with chronic pain to adopt a normal lifestyle (Turk et al 1986). Such therapies significantly reduce emotional distress and improve positive coping strategies and perceptions of internal control.

Rheumatoid arthritis

29. As with other LTCs, there is an increased prevalence of depression among people with rheumatoid arthritis (RA).
30. Sharpe et al (2008) reported on a five-year follow-up of patients with RA who had been given NICE-approved psychological therapies early in the course of their illness. The outcome was significantly less use of healthcare resources during the following five years, with significant reductions in admissions, injections, referral for physiotherapy and total healthcare costs.

Stroke

31. The prevalence of post-stroke depression has been estimated to be as high as 61%. Additionally, research has shown that middle-aged men are three times more likely to suffer a stroke if they are depressed (May 2002).
32. If left untreated, depression following a stroke is likely to have a negative impact on functioning outcomes that will affect daily living activities and quality of life.
33. Effective treatment for depression in people who have suffered a stroke has been shown to:
 - enhance the patient's quality of life;
 - improve physical functioning;
 - improve emotional functioning; and
 - improve social functioning.

Removing barriers to access

34. People experiencing LTCs often face a number of barriers to accessing psychological therapies that can treat the co-morbid depression and/or anxiety disorders they may be experiencing.
35. General practitioners (GPs) and other healthcare professionals may also prevent people who are experiencing psychological co-morbidities with LTCs from accessing services that provide psychological therapies. GPs and other healthcare professionals may:
 - have time constraints in their surgeries which may prevent them from diagnosing mental health problems effectively;
 - recognise the symptoms of depression or anxiety but fail to recognise that they can be effectively treated by psychological therapies or other treatments;
 - believe that mental health problems are attributable to the patient's reactions to their physical health condition, meaning that they do not consider the patient suitable for treatment;
 - believe that identifying, investigating and treating physical health problems are a higher priority than treating mental health problems; and

- not have an appropriate psychological therapy service to which the patient can be referred.
36. People experiencing LTCs may prevent themselves from receiving psychological therapies by:
- believing that they only have physical health problems and not recognising that they are suffering from depression or anxiety disorders at all;
 - not understanding the links between LTCs and depression and anxiety disorders;
 - having physical health problems or chronic pain that distract them (and the GP) from any mental health problems;
 - refusing to accept that they have depression and/or anxiety disorders; and
 - having physical health problems that restrict their access to attend psychological therapy services.

Engagement

37. Proper and effective engagement with people experiencing LTCs is essential if their needs are to be met. This can be addressed by:
- monitoring uptake of IAPT services by people with LTCs;
 - identifying successful and unsuccessful referral pathways; and
 - designing IAPT services with the involvement of service users who have or have had LTCs.
38. GPs have an important role in ensuring that people experiencing LTCs engage with IAPT services. GPs are usually the first point of contact for people with physical illness, and they may need to sensitively prepare patients for psychological therapies by explaining how depression or anxiety disorders may be linked to physical problems. Commissioners need to ensure that GPs are engaged with the IAPT service and understand the benefits of referring their patients to IAPT services.
39. Engagement with other health professionals is particularly important for people experiencing LTCs. Other health professionals, such as specialist respiratory nurses, may be better placed to identify the existence of depression and anxiety and could provide an important referral route to the IAPT service while any physical health needs are also being addressed.

40. The venue or location of an IAPT service should be considered when looking to break down barriers for individuals experiencing LTCs. With many patients believing that their symptoms are entirely physical problems, a service that is located or embedded in a physical health framework – i.e. within a pain clinic, a clinical assessment service or an intermediate clinical assessment team for musculoskeletal problems – may encourage engagement. IAPT services located within physical health services are useful to ensure that both the physical and the mental health problems of the person are being addressed simultaneously.

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