

A Strategy for Improving the Mental Health and Well-being of Adults with  
Long Term Physical Health Conditions in the Community

A consultation paper for Manchester

**Teresa Czajka**  
**Mental Health Promotion Specialist**  
**NHS Manchester**  
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## **SUMMARY**

Living with long term illness can lead to poor mental health which can result in;

- increased rates of morbidity and mortality
- reduced rate of recovery and poorer functioning
- poor health choices and behaviours
- reduced quality of life
- increased costs to health and social care.

The prevention and improved management of mental health problems and psychological distress can deliver some significant health and service improvements and reduce demand for a range of specialist and acute services.

***Good mental health and well-being can protect physical health and supports the recovery process.***

This paper aims to highlight this as an important area of work and engage relevant stakeholders in discussions on how this can be taken forward.

# A Strategy for Improving the Mental Health and Wellbeing of Adults with Long Term Physical Health Conditions in the Community

## Purpose of this Paper

This is a strategy for discussion and consultation. Its aims are;

- To direct planning for action to improve mental health for this population
- To encourage and support joint action between agencies
- To raise awareness of the nature of mental ill health for this population and of appropriate responses based on evidence of effectiveness and good practice.
- To support the relevant aspects of the Manchester Mental Health and Wellbeing Joint Commissioning Strategy and the Manchester Public Mental Health and Wellbeing Strategy (see appendix 5 for further strategic and policy links)

## Background

***The influence of poor mental health and wellbeing and in particular depression is increasingly recognised as a pivotal factor in determining the quality of life and recovery outcomes for people with long-term physical health conditions.***

- A long term physical health condition can be defined as a one which cannot be cured but can be controlled by medication or other therapies. These include conditions such as diabetes, epilepsy, coronary heart disease.
- There are approximately 17.5 Million people living with a long term condition in the UK.
- In Manchester approximately 32% of people were reported to have a long standing illness or disability (Manchester Residents Survey 2007)
- Three out of five of people living with a long term condition are aged 60 and over.
- Numbers of people living with long term conditions are expected to rise by 23% in the next 25 years
- Depression is the most common condition e.g. in people with coronary heart disease – up to 33% of patients experience depression after a heart attack (Davies et al) and people with diabetes have a 24% lifetime prevalence of depression: a rate three times higher than the general population (Goldney et al 2004)
- Yet an estimated 35% of people with depression and 51% with anxiety disorders are not receiving treatment (Crone et al 2008).

Physical health and mental health are closely linked. Poor mental wellbeing and mental health problems are more common amongst people living with long term physical health conditions than those in good health. Manchester has a high incidence of poor mental health generally, however rates of depression and/or anxiety in those living with chronic illness tend to be higher.

## **The Impact of Mental Health Problems**

Living with long a term physical health conditions and experiencing mental health problems can have an impact on the following areas:

- Psychological, social, familial and vocational aspects of an individual's life
- Ability to self care and manage condition successfully
- Delay recovery and return to optimal level of functioning
- Poorer adherence to treatment regimes and rehabilitation programmes
- Increased levels of morbidity and mortality - often due to the increase in health risk behaviours as a consequence of psychological distress.
- Prolonged stress affects immunity making illness more likely – risk factor in aetiology of health problems such as coronary heart disease and diabetes.
- Increased use of health and social care services, consequently incurring more costs. This may be as high as 50% more.
- Decreased quality of life and low sense of mental wellbeing.

*Investment in improving the mental health of people with long-term conditions, particularly in the identification and treatment of depression and anxiety should lead to financial savings in unscheduled and scheduled care services (Sharpe et al 2008)*

*“Treating depression in physical illness is important not only to optimise mental health but also improve the outcome of the physical illness itself” (Dickens 2002).*

## **Barriers to Detection, Care and Treatment of Mental Health Problems**

Although rates of detecting depression are improving since the introduction of the case finding of depression in people with Diabetes and Coronary Heart Disease in primary care (Quality and Outcomes Framework Contract 2006) the mental health needs of people with long-term conditions are still often undetected and inadequately treated; at cost to the individual, their family, health and social care services, the economy and society in general (Layard 2004).

There are a number of barriers which affect the care and treatment of those with psychological and physical health needs, including;

- Focus is often on physical health needs rather than psychological needs and the impact of living with a long term condition.
- Misconception and belief that depression is a natural consequence of illness and later life by public and health professionals.
- Poor recognition of mental health issues by public and health professionals. Older people experience the highest incidences of physical illness yet common mental health problems in this group are often unidentified and least likely to be offered the range of treatment options available. Delay in diagnosis and treatment leads to unnecessary suffering, investigation and cost to health/social services.
- Difficulty in identification of problems due to overlapping physical and mental health symptoms and atypical presentations.
- The stigma around mental health and its treatment often prevents people discussing psychological needs or accepting treatment.
- Psychological needs not being addressed at crucial times when support is required e.g. at point of diagnosis of health condition and end of life.

- The housebound or those severely debilitated by their condition are often unable to travel to access services. Ideally services should be local, flexible to need, accessible and person centred.

## **Effective interventions**

More research needs to be done in this area but the following interventions are likely to result in improvements in mental health and wellbeing.

- Routine and systematic identification of psychological needs in health and social care service provision ensuring psychological needs and mental health problems particularly depression are recognised. All care pathways should have a mental health component with an emphasis on person centeredness, recovery and early intervention.
- Patients often report having no one to discuss fears and concerns with when they need it most. Increasing the knowledge, skills and confidence of frontline staff through mental health training could improve support provided by non mental health trained staff.
- Effective management of depression (recent NICE guidelines for depression in adults with chronic physical health problems 2009) and other mental health problems. Information and timely access to a range of support and treatment options. This can include specialist mental health services (including supported self help through to access to psychological therapy services which can help with adjustment to diagnosis or more complex difficulties), case management, condition specific support groups/charities, condition management programmes e.g. Expert Patient Programme.
- For the most vulnerable, making use of collaborative care where there is evidence that there is a physical and mental co-morbidity and where a mental health problem has not improved following initial treatment. Closer and improved partnership working, communication and shared care delivery methods between health, social care and voluntary providers at primary, secondary and acute levels, including specialist mental health services, are recommended to ensure physical, mental and social needs are addressed.

## **Recommendations**

### **1. Develop an increased shared awareness.**

- All organisations involved in the care of individuals with long term illness to recognise the fundamental part psychological factors play in the aetiology and management of conditions and be aware of interventions that support mental wellbeing.
- Patients and their carers should have access to information and education about the psychological and physical aspects of their illness.
- Provide public information that increases general awareness about the association between poor mental health and long term physical health conditions. Patient and public information should be orientated towards reducing the stigma of mental ill health. (N.B. An information booklet and poster on this subject is already published and distributed)

### **2. Improve identification of mental health problems by health and social care services**

- Incorporate identification of emotional/ mental health problems into assessments and protocols for the diagnosis and management of long term conditions.
- Ensure that assessments include risk assessment relevant to psychological factors, e.g. risk of suicide or self neglect.
- Develop the use of assessments that are able to detect the impact of broader psychological wellbeing as well as specific mental health conditions.

- Learn from current practice where holistic assessment is already practised and ensure a consistent approach across services.
- Develop skills of frontline staff to identify and respond to emotional distress and mental health problems.

### **3. Improve access to specialist mental health services**

- Ensure that health and social care staff are equipped with knowledge of referral pathways to specialist mental health services and are able to liaise with them concerning continuing care of individuals.
- Open referral routes and timely treatment.
- Ensure that specialist mental health services are equipped to provide appropriate services to people with long term conditions (whilst removing barriers to access) including therapeutic skills, knowledge of impacts of illness and flexibility in delivery of interventions if mobility is impaired e.g. home visits, telephone and carer support.
- Promote awareness of the range of mental health services relevant for people from diverse communities and people with a variety of particular health care needs. Many such services are in the voluntary and independent sector.
- Provide public information to improve access to appropriate services.
- Develop increased collaboration and joint approaches between specialist mental health services and those providing support to people with chronic conditions i.e. Case management.
- Ensure appropriate health and social care services for people with severe and long term mental health problems (e.g. those on general practice SMI registers and/or the Care Programme Approach) who also have chronic physical health conditions. (*See also Manchester Supporting Health Programme for people with severe mental health problems and for people with dementia and their carers.*)

### **4. Improved systems of working across disciplines and organisations**

- Develop increased collaboration and joint approaches between services providing for chronic health care and specialist mental health services.
- Joined up care through improved clear care pathways, partnership working and communication at all levels primary, secondary and acute settings.

### **5. Increase the availability of direct emotional support from health and social care services and other services with direct contact e.g. supported housing.**

- Many services may have direct contact with people who have long term health problems and are likely to experience emotional distress and mental health problems. These front line staff may be able to provide emotional and problem solving support to individuals and this role may be enhanced through appropriate mental health training.

### **6. Promote self management**

- There is an increasing range of evidence for the benefits of self management approaches to chronic ill health and related psychological aspects. These should be promoted directly to people with long term health problems and their carers, to health and social care services and other organisations with direct contact.
- Resources and training to support self management and its promotion should be made available.
- Ensure access to supported self management, e.g. Expert Patient Programme, self help groups.
- Matching care to need through personalisation and reablement, increasing potential for independence, improving health, quality of life and sense of wellbeing.

## **7. Carers**

- Ensure psychological needs of unpaid carers are addressed through carer's assessment. Support should be made available from the onset of a condition.
- Information and support for carers in helping to manage mental health problems of those they care for.

## **8. Increase access to other options for improving mental health**

- Promote awareness for people with chronic health problems, their carers and amongst health and social care services of the wider range of options that may promote better mental health and wellbeing for individuals, e.g. increase social contact, encourage purposeful/creative activity, to increase physical activity, improved diet etc.
- Map those organisations providing helpful activities that are most appropriate to this population. Promote their availability and consider appropriate support to enhance their capacity to support this population.
- Greater collaboration between health and employment initiatives – Pathways to Work (condition management programmes)

## **9. Service user and carer engagement**

- Ensure that people experiencing chronic health problems and their carers are involved in the design and delivery of available services making use of mechanisms available e.g. Talking Health.
- Ensure that appropriate methods for gauging user and carer satisfaction with services are sensitive to those aspects of provision relevant to mental health.

## **10. Measuring and monitoring mental health improvement**

- Design a methodology for monitoring and evaluation of the effectiveness of action to attend to the psychological aspects of chronic physical illnesses and to mental health problems experienced by people with chronic health problems and their carers.
- Design a methodology to assess the impact of effective action on overall service use, including hospital services and the contribution to the reduction of health inequalities in Manchester.

## Appendix 1

### EXTENT OF THE PROBLEM - PREVALENCE OF CO- MORBIDITY

Prevalence rates vary depending on research study. However most agree that there are high incidences of common mental health problems such as depression and anxiety in people living with long term conditions.

- Depression is twice as prevalent in people with diabetes compared to the general population (Anderson et al 2001)
- 24-31% are clinically anxious after suffering a heart attack (Denollet & Brusaert 2000)
- 40% of people living with Chronic Obstructive Pulmonary Disease experience depression and 36% anxiety (Yohannes et al 2001)
- Depression may be as high as 61% in people who have suffered a stroke (Stenager et al 1998)
- Psychological disorders are between 5 -10 times more common in people with epilepsy compared to general population (Barry et al 2008)

#### Local data – prevalence (South Manchester locality data)

There is a strong relationship between depression and anxiety and many long term conditions. Anxiety symptoms can lead to repeated and frequent hospital admissions which are distressing both for individual and costly for the NHS. An audit of Active Case Management South Team (2006), who provide support for people with long term conditions indicated that 30% of their case load have some form of mental health problem with 19% having some form of common mental health problem - 5 % have anxiety, 14 % depression, 8 % dementia, 2 % severe and enduring mental illness.

The South Manchester COPD team (2006) reported that 43 % of their patients had suffered significant levels of anxiety and 44 % experienced significant depression.

Local service estimate is that approximately 40% of people attending Manchester Expert Patient Programme courses are experiencing some form of mental health problem.

#### South Manchester locality – co-morbidity rates 2006

Table 1 indicates the percentage of people with specific conditions with common mental health problems e.g. anxiety and depressive disorders or both. (Mental health problem diagnosed after medical condition diagnosed). Although unable to infer causality i.e. that having a long term condition directly caused the mental health problem the data gives some indication as to prevalence of people in south Manchester having experienced both common mental health problems alongside a long term condition. In addition, it is believed that many more people have not been identified or undiagnosed and therefore do not appear in the data. If we accept (from research) that psychological problems in many people with long term illness go undetected then the data will represent some and not all of the people who could be living with a mental and physical health problem.

Table 1 Numbers of patients with specific physical health conditions and common mental health problem in South Manchester GP practice population (2006)

<b>Chronic Condition</b>	<b>% with co morbidity (anxiety, depression or both)</b>
<b>Asthma</b>	<b>12 %</b>
<b>Arthritis</b>	<b>11 %</b>
<b>Cancer</b>	<b>13.7 %</b>
<b>Coronary Heart Disease</b>	<b>12 %</b>
<b>Chronic Obstructive Pulmonary Disease</b>	<b>17.2%</b>
<b>Cerebrovascular / stroke</b>	<b>13 %</b>
<b>Diabetes</b>	<b>10 %</b>
<b>Epilepsy</b>	<b>16.6 %</b>
<b>Intestinal Disorders</b>	<b>22.7%</b>
<b>Multiple Sclerosis</b>	<b>25.3 %</b>
<b>Parkinson's Disease</b>	<b>9.1 %</b>
<b>Skin disorders e.g. eczema</b>	<b>15.3 %</b>
<b>Endocrine disorders e.g. thyroid problem</b>	<b>13 %</b>

## **Appendix 2**

### **THE IMPACT OF LIVING WITH PHYSICAL AND MENTAL HEALTH PROBLEMS (CO- MORBIDITY)**

#### Cost Implications

Co-morbidity has significant implications for disease management, health and social care costs, recovery and quality of life. Mental health problems are drivers of the recovery process (Michie et al 2005).

Research indicates that people with long term conditions and co morbid common mental health problems are more likely to;

- Have more frequent and lengthy hospital inpatient admissions and increased health care service use/costs (Egede et al 2002). Depression appears to be associated with a 50% increase in costs of long term medical care (Katon 2003). This is often due to effects of depression on health behaviours such as smoking, poor diet, lack of exercise and poor adherence with medication and treatment regimes such as rehabilitation programmes. People who don't attend rehabilitation often have poorer mental health. The un-rehabilitated patient can cost £64,000 more over a lifetime than a rehabilitated patient.
- Unrecognised and untreated mental health problems can result in repeated presentations for hospital admission at significant financial and emotional cost to the individual. 25% of people attending A&E departments with acute chest pain have panic disorder (Huffman & Pollack 2003)
- Have reduced ability to self care and manage the condition (Whiting et al 2006)
- Have the worst health status - compared to having depression alone and any chronic condition without depression (Moussavi et al 2007)

- Have an increased risk of mortality. Patients with depression following heart attack had increased risk of further cardiac arrest and death at one year compared to non depressed group (Ahern 1990).
- Be at greater risk of suicide in later life (Mackenzie et al 1987). People over the age of 65 are more successful at taking their own lives than any other age group. The perceived burden of physical illness can lead to increased risk of suicide (Beeston 2006)
- Have more days off sick if in employment (Druss et al 2000), or delayed return to work (Egede 2004). Be unemployed, which is likely to result in further deterioration in mental health and wellbeing.

In Manchester mental health disorders are by far the most common conditions experienced by people claiming either incapacity benefit or Severe Disablement Allowance. Mental disorders account for 49.2% of IB/SDA claims in Manchester (Source Incapacity Benefit/Severe Disablement Allowance Claimants May 2007). 10 Million working days in the UK were lost in 2005/6 due to depression, stress and anxiety (Oxford Economics 2007) People with long term illness often wish to return to employment but often experience obstacles to doing so and often experience discrimination on both physical and mental health grounds. Savings are likely to be made if those currently not receiving services are treated and supported e.g. increased numbers back in employment.

### **Appendix 3 Evidence of benefits/outcomes**

The emotional and psychological needs of people with long term conditions are not always deemed as important as physical care and disease management is often the priority.

Improved treatment and responses to mental health problems in people with long term physical health conditions should lead to:

- Reduced use of general practice, emergency and acute/inpatient services health and social care services resulting in improved cost implications for health and social care (Katon 2003). Reduction in hospital admissions (Moore et al 2007) found that a programme of CBT based education for patients with angina reduced bed use by 40% and heart attacks). Patients with COPD make up the largest group of “frequent flyers” of which 25% have significant levels of anxiety. 40% of admissions could be prevented by providing psychological treatments to those that need them. The cost of treating co-morbid depression and diabetes can be up to 250% more.
- Improved self care. (Boyle et al 2004)
- Reduced suicide risk. Patients with debilitating COPD and depression increase risk of suicide in later life (Hung et al 2000).
- Reduced early mortality. The best predictor of death following a heart attack is presence of depression (Frasure-Smith et al 1993).
- Improved perceived quality of life (Burgess et al 2005)
- Improved rehabilitation and recovery outcomes.
- Increased numbers in employment and off benefits. The cost of lost employment is currently estimated at £26 billion.

### **Appendix 4 Effective interventions**

- All patients with depression and/or anxiety and adjustment difficulties in coming to terms with their condition should have timely access to different support options according to

NICE stepped care guidelines for depression and anxiety. This may be Self-help groups, literature, exercise on prescription schemes, Computerised CBT, through to case management for those with more complex needs.

- Psychological therapies particularly CBT are effective treatments for people with long term illness and have some impact on self management, adjustment and coping. It can have some impact on adherence and glycaemic control in diabetes (Surwit et al 2002). Referral to primary care mental health services should be offered routinely for those identified with problems.
- Raising awareness of the link between physical and mental health and how both impact on each other for health professional and public. This may reduce stigma, increasing awareness of signs and symptoms of depression / anxiety, sources of help and what treatments are available. This could benefit particularly older people of whom only approximately 1/3<sup>rd</sup> ever discuss symptoms of depression with their GP (Godfrey & Denby 2006)
- Investment in training. Many patients with long term conditions do not receive appropriate depression management <25% (Goodwin et al 2006) even though pharmacological and psychological interventions can be beneficial (Baldwin et al 2003). This suggests that more needs to be done to support people working with this group in their identification and management of patients with multiple/complex health problems. Training of staff to identify and manage depression in can improve patient outcomes and quality of life (Butler & Quayle (2007). Such training taking place within NHS Manchester should be evaluated to assess its success and subsequent changes to practice and patient outcomes.
- Prevention of mental health problems is equally important. How an individual is informed of their medical condition and support given at diagnosis can have a big impact on how the person adjusts to their condition. Accurate provision of information and options for support at times when it is needed is vital. Personalised care planning ensures people needs are assessed fully and provided with the information, skills and support to manage their own self care.
- There is evidence that psychological interventions can have some impact on self management, adjustment and coping. It can have some impact on adherence and glycaemic control in diabetes (Surwit et al 2002). Referral to primary care mental health services or voluntary agencies should be offered routinely for those identified with problems.
- Patients who receive psycho education and psychosocial support in rehabilitation and treatment plans show greater improvements in quality of life than those who received education and no ongoing support. Information and participation in local support groups e.g. City of Manchester Diabetes Group and national organisations such as Parkinson's Society can empower people to take more active role in management of their care and also reduce the psychosocial impact of the condition.
- The Expert patient's programme has made a small but positive impact on people's psychological wellbeing and condition management (Kennedy et al 2007) Voluntary attendance on Local Expert Patient Networks on completion of courses provide ongoing support on course completion. There should be more investment in this provision with many finding this low level support of great value.
- Although the detection and treatment of depression is of importance across all ages preventative measures at an individual and community level are also essential. Ensuring people have access to health promoting activities/schemes increasing activity and improving healthy lifestyles should promote successful and healthy ageing and also promote mental well-being. As mental health has a great effect on health behaviour health promotion activities should always look to incorporate mental health component e.g. effect of falls on mental health, smoking and stress etc. Health trainers are in an excellent position to support this work.
- The social impact of illness is important to acknowledge. Ensuring quality services and community interventions aimed at reducing social isolation and improving community

support can be beneficial (Allen 2008). Many older people live with preventable depression. More must be done to support wellbeing, social and local community participation.

## **Appendix 5**

### **Key local policy and national aims which are relevant to this area of work include:**

- Manchester Suicide Prevention Strategy. Suicide in later life is strongly associated with depression, physical illness or pain, living alone and feelings of guilt and hopelessness.
- Adult Social Care Prevention Strategy. Target prevention and early intervention to keep more people in better health.
- Manchester Mental Health & Wellbeing Strategy which aims to place more emphasis on promotion of mental health, prevention and early intervention.
- Manchester's Strategy for Ageing (2009-2012) A great place to grow older.
- Manchester Employment for Health - Pathways to work – condition management – programmes developed to support people with health conditions claiming incapacity benefit to return to work. Barriers to work exist with many employers unwilling to take on people with long term conditions resulting in feelings of worthlessness and risk of depression.
- "Your Health, your way - a guide to long term conditions and self care" (DoH 2008) how supporting self care enables people to manage their condition including any impact on their emotional life.
- National Service Framework for Older People (2004). Older people are more likely to suffer from long term illness which can lead to depression. Under detection is widespread.
- National Service Framework – Coronary Heart Disease (2000) Anxiety and depression is recognised as a risk factor for further morbidity. Management of psychological distress is an important component with cardiac rehabilitation programmes.
- National Service Framework – Diabetes (2001) Recognition that psychological support will help identify any emotional barriers that reduce ability to self care and manage condition.
- NICE guidelines for the management of COPD (NICE 2004a) recommend that in all patients in a stable condition presence of depression should be assessed.
- National Stroke Strategy (2007) – 1 in 3 develops depression after stroke (Hackett et al 2005) Screening and access to psychological support is important to improve outcome and recovery.
- NHS Cancer Plan (2000) highlights the importance of availability of psychological support throughout the care pathway.
- NSF for Long Term Conditions (2005) recognises the psychological and emotional effects of living with neurological conditions and the need for support to help people adjust to altered personal, familial and social circumstances.

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