



The Living Better Project

**Addressing Mental Health and
Mental Well-being in People
Living with Diabetes and/or
Coronary Heart Disease (CHD)**

**South East Glasgow CHCP
Focus Group Findings (Draft)**

November 2009

1.0 South East Glasgow CHCP

Areas covered by the South East Glasgow CHCP include Carmunnock, Castlemilk, Cathcart, Croftfoot, Dumbreck, Gorbals, Govanhill, King's Park, Langside, Laurieston, Mount Florida, Oatlands, Pollokshields, Queen's Park, Shawlands, Simshill, Strathbungo and Toryglen. Data from the 2001 census indicates that the area has a population of approximately 101,476 but the 2004 estimate gives a total of approximately 113,695 and it is acknowledged that there has been a significant incoming population over recent years both in terms of asylum seekers and refugees but also in respect of nationals from the new European accession states. There are currently 30,842 people (30%), within this CHCP, who have registered with a long term condition (LTC).

In its 2006-2007 Annual Developmental Plan, the CHCP noted that key issues to note for the South East were:

- The age profile of the population is similar to that of the rest of Glasgow with 21% aged between 0 and 17, 65% between 18 and 64 and just over 14% aged 65 years and older
- In terms of ethnicity breakdown the South East has the highest proportion in Greater Glasgow with 11.6% of people in the South East coming from a Black and Minority Ethnic background, this is also the largest Black and Minority Ethnic community in the whole of Scotland (this will be addressed in greater detail in the next version of the report which will focus specifically on the focus group findings from the 4 South Asian focus groups that took place last month and will have a literature review on diabetes and CHD in the South Asian communities in Scotland and the UK).
- Over 24,000 (23.8% of the population) people live in neighbourhoods, which are categorised as being the most deprived in Scotland. This is below that for the whole of Glasgow which is 32%.

Health Profile

According to recent statistics, South East Glasgow has the one of the lowest life expectancy rates in the West of Scotland, with both South East Glasgow and Greater Shawlands well below the Scottish average. Life expectancy is one of the key indicators of health status.

The 2006-2007 report also noted that the above figures, however, mask some of the key health issues in the South East. As noted earlier, the South East has a diverse population, which is not adequately reflected on the overall health statistics for the area. For example, male life expectancy for a man living in the Gorbals is 62.5, compared with 70.7 for a man living in Battlefield.

1.1: Long Term Conditions: General Background

A long term condition (LTC) is a condition that requires long-term medical care, limits what one can do, and is likely to last longer than one year. Examples include epilepsy, diabetes and chronic obstructive pulmonary disease (COPD). In their 2007 report '*Managing Long Term Conditions*', Audit Scotland reported that people with a long term condition account for 80% of all GP consultations, are twice as likely to be admitted to hospital as those without one; account for over 60% of hospital bed days and stay in hospital disproportionately longer. In 2005 the CASS City of London Business School estimated that managing chronic disease and the loss in earnings

that resulted from people living with them totalled £12 billion a year. With the percentage of the UK wide population of those over 50 set to increase by 30% by 2025, they estimated this bill will increase to a minimum of £15.6 billion over the next two decades.

The real cost of long term conditions however are the physical and emotional impact they have on people.

The World Health Organisation has stated that managing long-term conditions (LTCs) is the biggest challenge facing healthcare systems worldwide, given that over 60% of all deaths are attributable to them and limiting effect they can have on a person's lifestyle, opportunities, outlook and potential. Scotland is no exception to this challenge given the actual and projected numbers of people living with at least one long term condition. The Audit Scotland report noted that around one million people have a long term condition and nearly a third of households contain at least one person with a long term condition.

1.1.2 Emotional Consequences of Living with Chronic Physical Illness

It is well established that depression is highly prevalent in people with chronic physical illness, and should be treated. Up to 33% of patients develop depression after a myocardial infarction [1] and meta-analysis has shown that depression is associated with a doubling of mortality in CHD [2]. It is estimated that one in three patients with heart failure and one in five patients with CHD experience depression [3]. Depression is also found in 30% of cases of diabetes [4]. Such 'co-morbidity' of physical and mental health problems are exacerbated by socio-economic deprivation such as exists in certain areas of Scotland [5, 6]. A result of this recognised prevalence is that the revised Quality and Outcomes Framework (QOF) of the GMS contract incorporates case finding for these groups [7]. Screening for depression in patients with diabetes and Chronic Heart Disease was added to the QOF in 2006.

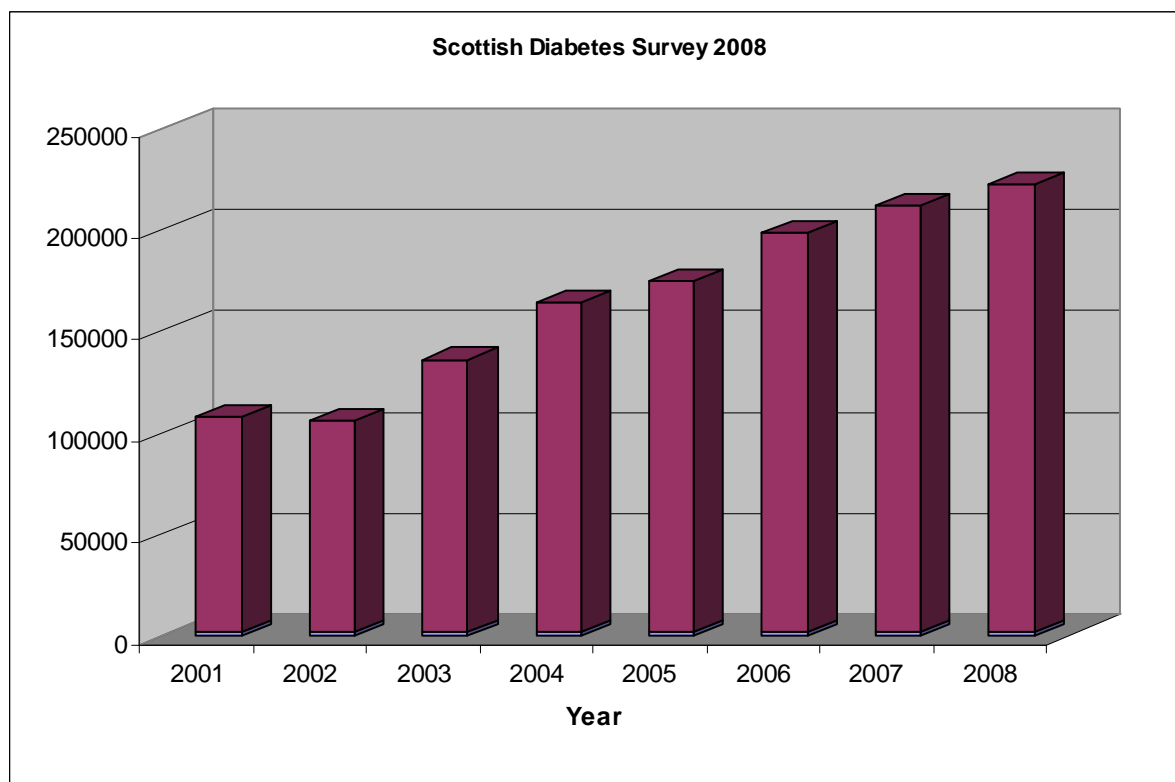
Recognition of significant psychological distress is an important function of general practice, and depression and anxiety together form the most common reason for patients consulting a GP in Scotland. Approximately 50% of patients with such mental health problems remain undiagnosed and un-treated [8-10]. In deprived areas, the prevalence of mental illness is higher, and the detection rate lower than in more affluent areas [11]. A recent study on depression in Scotland found that around half of patients with significant symptoms were not identified by their GP as suffering from a depressive disorder (11b). Given the higher demands placed on GPs by patients with chronic physical illness together with the significant time constraints GPs face, it seems likely that depression in patients with chronic illness is massively under-diagnosed (hence the rationale for the QOF points), and this is likely to be exacerbated by deprivation.

1.2 Diabetes Prevalence in Scotland

There were 219,963 people with known diabetes in Scotland recorded on local diabetes registers at the end of 2008, which represents 4.3% of the population. In the 2007 diabetes survey, 209,706 people (4.1%) were reported. It is estimated that there may be as many as half a million people in Scotland with diabetes within the next ten years [12a]. Diabetes UK estimates that 620,000 people in Scotland - about one in 10 of the population - could have pre-diabetes but are undiagnosed.

As the chart below indicates, the reported prevalence of diabetes has increased in Scotland. People with diabetes not only have to live with the physical issues of being diabetic, they have higher risk of eye disease, renal failure and cardiovascular

disease than people without diabetes. They are also at greater risk of developing depression and/or anxiety.



The increase in reported prevalence is thought to depend on a number of factors, which include:

- an increase in the rate of type 2 diabetes, associated with rising levels of people being overweight and obese
- demographic change – the risk of developing diabetes increases with age and growing numbers of older people in Scotland’s population results in higher numbers of people with diabetes
- changes in the definition of diabetes, with the diagnosis made at a lower level of fasting plasma glucose
- better survival of people with diabetes because of improved control of blood glucose, blood pressure and cholesterol level
- improved recording of diabetes on GP computer systems
- improved detection of diabetes in people with type 2 diabetes, many of whom have no symptoms

(Scottish Diabetes Survey, 2008)

As the table below shows, nearly 30% of people diagnosed as having diabetes have lived with the condition for 10 years or more.

<i>Less than 1</i>	<i>18,727</i>	<i>8.6%</i>
<i>1-4</i>	<i>69,412</i>	<i>31.8%</i>
<i>5-9</i>	<i>65,921</i>	<i>30.2%</i>
<i>10-14</i>	<i>30,073</i>	<i>13.8%</i>
<i>15-19</i>	<i>15,905</i>	<i>7.3%</i>
<i>20-24</i>	<i>7,738</i>	<i>3.5%</i>
<i>25-29</i>	<i>4,325</i>	<i>2.0%</i>
<i>30-34</i>	<i>2,409</i>	<i>1.1%</i>
<i>35-39</i>	<i>1,600</i>	<i>0.7%</i>
<i>40-44</i>	<i>888</i>	<i>0.4%</i>
<i>45-49</i>	<i>539</i>	<i>0.2%</i>
<i>More than 50</i>	<i>572</i>	<i>0.3%</i>

Source: Scottish Diabetes Survey, 2008

The Diabetes Action Plan for the Scottish Diabetes Framework [12b] included aims to “*improve access to psychological and emotional support for people with diabetes in all parts of Scotland*” within its 9 key promises. This includes aims to improve the identification of depression and anxiety among those who care for people with diabetes. The inclusion of aims around psychological support has been welcomed by Diabetes UK as consultation with their members has highlighted psychological needs as is a key concern due to a perceived lack of in-put from health services in relation to psychological needs. One review indicated that treating depression can improve glycemic control [16]. Collaborative stepped care, including the use of enhanced education and support, antidepressants or problem solving delivered in primary care for patients with diabetes and depression was shown to reduce depression severity, increase patient rated improvement and increase patient satisfaction with care [17, 18].

1.3 Coronary Heart Disease (CHD) in Scotland

On 24th November 2009, the Information and Statistics Division of NHS Scotland reported that;

In the 10-year period between 1999/00 and 2008/09, the rate per 100,000 population of incident cases of CHD (standardised by age and sex) has fallen by 27.6% (from 405.6 to 293.5 per 100,000 population).

Between 2007/08 and 2008/09 the incidence rate for CHD (total number of people diagnosed with CHD per 100,000 population, standardised by age and sex) decreased by 5.6%. (from 310.9 cases per 100,000 population for 2007/08 to 293.5 cases per 100,000 population in 2008/09).

CHD incidence is related to age - the rate for under 75s in 2008/09 is 218.0 per 100,000 and for over 75s for the same period 2107.2 per 100,000. Coronary heart disease incidence rates are consistently higher for males than females across all age groups

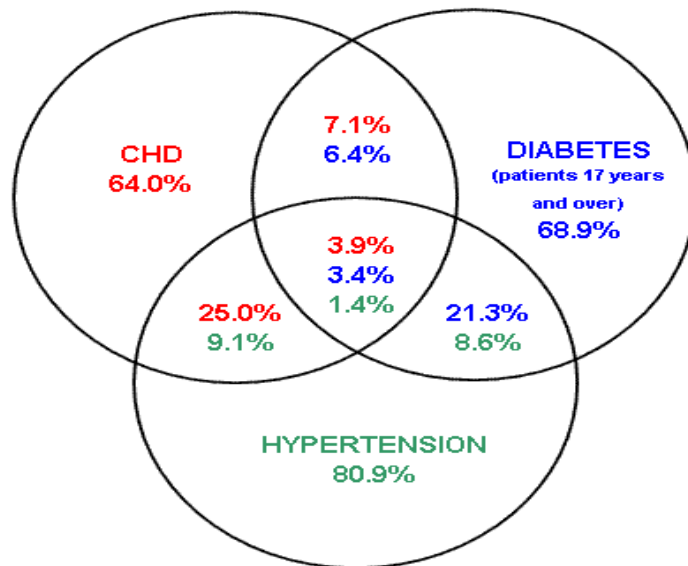
Whilst mortality rates for CHD in Scotland have declined in recent years, Coronary Heart Disease remains the leading causes of death in Scotland. Around one fifth (19%) of premature deaths in men and more than one fifth of premature deaths in women are caused by CHD. Approximately 140,000 people in Scotland have had a heart attack; 260,000 people are suffering or have suffered from Angina (the commonest form of CHD). Scotland has one of the highest death rates from CHD in the western world. This has been attributed to high rates of smoking, poor diet and

deprivation. It is estimated that 14.9% of Scottish men and 14.5% of Scottish women are living with some kind of cardiovascular disorder. It is estimated that 82,000 patients with CHD and 24,700 patients with stroke or transient heart attack visit their GP each year. The prevalence of all conditions increases markedly with age. [13a, 13b]. The estimated prevalence of CHD based on admission to hospital is 3.6% of the Scottish population. CHD prevalence is higher in males (4.6%) than in females (2.7%) and is strongly associated to age. It is estimated that 16% of the Scottish population aged 75 years and over are living with CHD (14a) In some Scottish CHPs over a quarter of men aged 75 years and over have CHD. The effect of deprivation on prevalence amongst the younger population can be seen in the 45-64 age group. The prevalence rate in males aged 45-64 in East Glasgow (9.1%) is almost twice that of the rate in Aberdeenshire CHP (4.7%). For females aged 45-64 the prevalence rate in North Glasgow CHP (4.4%) is almost three times that in Shetland CHP (1.5%) [14a].

There is emerging evidence that treating depression improves morbidity and mortality in relation to CHD, which may be due to improved compliance for cardiac medication [14b]. Pharmacological treatment for people with CHD and depression can be complicated as some antidepressants have cardiac side effects, and herbal supplements (such as St. John's Wort) can interact dangerously with cardiac drugs [15]. Hence it is recognised that management can be clinically complicated and that there is a gap in best practice for treating depression in CHD patients, and in general studies support the use of multidisciplinary approaches in providing care [14, 15].

The Overlap between Diabetes and Coronary Heart Disease and Hypertension

Relative proportions of patients consulting a GP or practice nurse for CHD, diabetes and/or hypertension; 2007/08 (a,b).



(a) Based on 47 PTI practices that submitted complete GP and practice nurse data for the year ending 31 March 2008.

(b) opulation source: Community Health Index (CHI) record, as at 30 September 2007.

The challenge to prevent long term conditions occurring in the first place is a central part of health and social care policy in Scotland. At the same time, government and various health, social care and voluntary sector organisations are increasingly identifying and addressing mental health and wellbeing as vital components in the

management of long term conditions in general, and diabetes and/or CHD in particular.

2.0 Addressing the Challenge of Long Term Conditions: The Policy Context

The way health and social care is being planned and delivered in Scotland is changing. To address the challenge of growing numbers of people with chronic illnesses, health and social care organisations have been directed by the Scottish Government to work together in partnership with each other, with the voluntary sector and with patients and carers (19). On a wider level, under current Scottish Government health policy, Health Boards and Local Authorities are assessed on their levels of partnership working and are seen to be progressive if they deliver community partnership working; fair, equitable and accessible services for service users; put patients and carers at the centre; provide services that are as local as possible; and test out new ways of delivering integrated services in the community (19).

Alongside the recent progress and improvements made with managing long term conditions, greater responsibility for self-care and supportive care is now on people living with diabetes and/or CHD and their families and carers. Increasing responsibility is also being placed on community based health and social care organisations and the voluntary sector to provide and facilitate community based treatments and support for people with diabetes and/or CHD.

In light of this, meeting the challenges of living with long term conditions has become a major policy priority for NHS Scotland and its partnership agencies. Following the publication of the Kerr Report in 2005, *'Building a Health Service Fit for the Future'*, the Scottish Executive responded by producing *'Delivering for Health'*, a statement on the future plans for healthcare in Scotland. The model of care proposed within *'Delivering for Health'* (21) was based on the principle of integration, with patients and carers playing a central role in decisions about their care. Both policy documents underlined the need, if services are to be improved, of developing partnership working between the NHS, other public sector and voluntary organisations. This requires; (i) developing efficient partnership working between health, social care and voluntary sector organisations, with patients and carers at the centre of such partnerships and (ii) the need for a 'whole systems' approach to providing services, with each partner linking together to form one 'whole system' of care, again with patients and carers at the centre.

In October 2007, the new Scottish government launched their health policy action plan *'Better Health, Better Care'*. The proposals focused on the evolution of existing health policy as opposed to any radical departure from fundamentals contained in the Kerr report and *'Delivering for Health'*. The new and developing model of healthcare delivery in the NHS is through multi-professional teams crossing traditional professional, geographical and organisational boundaries. One example of this is the development of Managed Clinical Networks (MCNs) where the emphasis is on cross-boundary working to ensure equality of care and outcomes. Managed Clinical Networks deliver diabetes and CHD services across different sections of Scotland. They are important in the context of delivering information to people affected by diabetes and/or CHD as *'they lead to clearer information for patients and carers'* (19). Strongly linked with the Managed Clinical Networks of care is the centrality of the patient journey. This concept sees patient care as a combination of services involving health promotion, preventative care and follow-up care and support in the community from a range of health, social care and voluntary sector organisations working together. To address the challenge of managing long term conditions in Scotland requires a culture of trust and co-operation between different organisations. An

important driver for achieving greater partnership working, greater patient and carer involvement, and ensuring effective delivery of quality healthcare are the Community Health Partnerships that operate in every Health Board area of Scotland. A key role of CHP's is in developing systems of care for the management of chronic illnesses in the community, and supporting the increasing number of patients with more than one long term condition at home and in community settings (19).

It is becoming increasingly recognised therefore that peoples' physical and mental health and well being are not separate entities and must be intrinsically linked. Living with a long term condition and experiencing mental ill-health can be costly to the individual, their family and community and can result in a considerable loss of human potential and resources. It doesn't have to continue like this. Research on diabetes and depression, for example, has shown that social support (an important aspect of positive mental well being) can have a helpful affect on patient self-care and diabetes outcomes (39); and in people with coronary heart disease, effective treatment for depression has been shown to enhance quality of life and to improve physical, social and emotional functioning (43).

Yet, in autumn 2007, after reviewing the management of long term conditions across Scotland, Audit Scotland published a report in which they stated '*people with more than one long-term condition are less likely to be receiving joined-up care across all the services they receive*' (p.40). Their report recommended improved partnership working at primary care level between health, social and voluntary care providers in order to integrate services for people with LTCs. The report also recommended that Community Health Partnerships (CHPs) should have a key role in co-ordinating this.

2.1 The Evidence - Shaping Policy – Shaping the Living Better Project's Goals

Overall the evidence from numerous studies on people with diabetes and/or CHD and people with long term conditions generally, points to these conditions having a negative impact on mental health and wellbeing and demonstrates the increased likelihood of them experiencing depression and/or anxiety. The evidence also indicates there can be significant benefits obtained by improving best mental health practice in relation to these patient groups and that holistic, collaborative and integrated approaches in primary care offer the most promising mechanism for quality improvement for these patients. In this project we aim to draw on best practice in depression management as outlined in NICE guidelines and on evidence-based guidelines developed by the Scottish Executive Health Department as part of the national Mental Health Delivery Plan (2006). The Living Better project will also draw on policy developments as outlined in '*Towards a Mentally Flourishing Scotland*', (2009) which recognises importance of physical health to mental health, '*Better Health, Better Care*' (2007) which identified the need to make holistic care for long term conditions more consistent and widespread across Scotland and '*Gaun Yersel: The Self Management Strategy for Long Term Conditions in Scotland*' (2008) which identified emotional wellbeing as a key component of self management for long term conditions.

2.2 The Living Better Project – Basic Goal

The basic goal of the Living Better project is to build on the existing research evidence outlined above through focus groups with people with diabetes and/or CHD and health, social care and voluntary sector staff working with these patients. We will then link this evidence base to recent Scottish health policy in general and policy on mental health and wellbeing and long term conditions in particular. We will then sit down with key stakeholders in the 5 CHP sites and develop specific proposals and plans to improve the way in which local health, social and voluntary care services address the mental health and wellbeing of people living with diabetes and/or CHD.

3.0 The Living Better Project

The Living Better project is a three year, Scottish Government funded initiative, involving the Royal College of General Practitioners (Scotland), the University of Stirling, the Scottish Development Centre for Mental Health, Depression Alliance Scotland, the British Heart Foundation (Scotland), Chest Heart and Stroke (Scotland) and Diabetes UK (Scotland). The project aims to lead the development of improved mental health care for people with Coronary Heart Disease (CHD) and/or diabetes and Chronic Obstructive Pulmonary Disease (COPD) who, because of the acute and chronic strains of living with these conditions, are at significant risk of developing depression and/or anxiety disorders which can often go undiagnosed and untreated. The project is working with 5 Community Health Partnerships and 10 GP practices across Scotland to address mental health and wellbeing in people with long term conditions. In 4 CHP sites the project is focusing on diabetes and/or CHD and in 1 CHP site Chronic Obstructive Pulmonary Disease (COPD).

4.0 The Living Better Project's Research Questions in South East Glasgow

- (i) How does Living with diabetes and/or CHD affect People's Mental Health and Wellbeing
- (ii) What Type of Support do these people Want and Need to Address their mental health and wellbeing needs.
- (iii) Do Health Professionals Working with these Patients feel Suitably confident/trained to Address Mental Health and Wellbeing Issues in these Patients
- (iv) What has to be done at CHP and GP Practice Level to Develop Appropriate Support/s to Address These Patient's Mental health & Wellbeing.

5.0 The Research Process in South East Glasgow

To discuss how living with these long term conditions affects peoples' mental health and wellbeing patients with diabetes and/or CHD were selected from 2 GP practice registers and invited to attend four focus groups in their respective areas. Two focus groups involving health, social care and voluntary sector staff working with these patients were also organised.

6.0 Methods

1. Working with South East Glasgow Living Better reference groups consisting of appropriate health and social care staff working in diabetes and/or CHD and diabetes and/or CHD related care.
2. Patients with diabetes and/or CHD selected from diabetes and/or CHD registers.
3. 6 patient focus groups (involving approximately 60 people) were organised
4. One health professional and one Living Better Reference Group focus groups (involving over 12 professionals)
5. The research findings are reported back to the CHP Living Better reference group to help them develop appropriate plans to address the mental health and wellbeing needs of diabetes and/or CHD patients.

7.0 The Research in South East Glasgow

The focus groups discussed;

- (i) what it was like to live with diabetes and/or CHD;
- (ii) the emotional strains and mental health issues that arise and how they manifest themselves;
- (iii) the type of support systems these patients would like to see available to help them live with their condition and reduce the associated stresses;
- (iv) whether health, social care and voluntary sector professionals were aware of mental health and well-being issues in these patients and how confident they were in addressing these issues;
- (v) whether health, social care and voluntary sector professionals believed services at CHP level were equipped to address these issues and
- (vi) in the opinion of both patients and professionals, what changes should occur locally to address mental health and wellbeing of people with these conditions. The same questions and methods were used across all 5 participating CHP sites.

7.1 Analysis of Focus Group Data

Analysis of the data was thematic. Thematic content analysis is a validated and effective approach for answering questions about the most significant issues raised by a particular group of respondents and/or for identifying typical responses from interviews and focus groups (20).

8.0 Summary of Research Findings in South East Glasgow

8.1 Summary of Key Findings from Patient Focus Groups

Living with diabetes and/or CHD is both an Acute & Chronic Stress and Impacts on Patients in the Following Ways

- **Shock of being diagnosed with diabetes or being told will require heart surgery**
- **Financial pressures, especially during benefit assessment**
- **Strain on personal relationships**
- **Acute angina attack = acute stressor**
- **Socially Isolated in the house increases risk of feeling anxious/depressed**
- **Accessibility / Transport Problems**
- **Frustration at people who don't have the condition/s not understanding the effects of living with an LTC**
- **Reduced lifestyle options**
- **Strain of having to re-adjust lifestyle**
- **Difficulties of living with more than one LTC**
- **Strain of having to take numerous medications which can affect how feel emotionally**

8.1.2 Some Typical Focus Group Comments from People living with diabetes and/or CHD.

Patient 1- Commenting on being diagnosed as having diabetes

'It's a shock, absolutely...It takes you a long, long time to get... took me about a year to come to grips with it...it did. And then you think to yourself, you're sitting here feeling sorry for yourself, you know'.

Patient 2 – Commenting on being told would require surgery

'The shock I got when they told me I had to have a by-pass, I nearly passed out when they told me that. They sent me to The Royal Infirmary for this angiogram first, and I was lying in bed getting over it and the doctor told me that. I didn't know what to do, you know, have an operation?'

Patient 3 - Financial Concerns

'And fighting with the Social all the time, no money.....totally stressed...I was about two months without any money'.

Patient 4 - Financial Concerns

'Well I'm having terrible problems with that (disability allowance) right now. You know the way you've got to renew it every so many years, mine's is up for renew and I got a letter back, they took everything off me. And you get all upset if you've got to face all these people its like being in a court. I'm waiting every day for a letter. So I'm fighting with them just now, so that's quite stressful'.

Patient 5 – Strain on Personal Relationships

'Just some days he's really not well and can't be bothered, so you're kind of walking on egg shells kind of thing. It's a case of go with the flow and let it pass, tomorrow he could be alright again, you know, so you learn to know when to stop and when to start so to speak'.

Patient 6 – Strain on Personal Relationships

"My family does, you know, my immediate family and they can tell when I'm not feeling right with the way I'm acting, if I'm snapping at them or something, you know. But maybe people outside don't understand, outside the family?"

Patient 8 – Chronic Strain of Living with the Condition

'And you get fed up taking so much medicine and tablets. Sometimes you feel like not taking them, then you'll say 'oh if I do that, something might happen?' you know what I mean, you do get fed up taking tablet. Its been stress for the last 18 years you know.I mean the stress is as bad as my illness....worse!'

Patient 9 – Chronic Strain of Living with the Condition

‘ Since last July/August I’ve been in and out of the hospital...we’ve a doctor on every floor Haematology, Cardiology, Urology...we’ve got a season ticket!’.

Patient 10 – The Benefits of Sharing Experiences with Fellow Patients

It does help talking with someone with same condition you can compare symptoms, what helps, they’re more understanding even than family. My wife says half of my problem is my illness is in my head.

8.2 Types of Support Patients Wanted/Needed to Help Ease the Stresses of Living with diabetes and/or CHD

Living Better asked people what type of support/s they would like to help cope with the emotional demands of living with diabetes and/or CHD. This is a summary of what people wanted.

- **Broad social support services – Levels 1 & 2, e.g., support classes (exercise, dietary, general talking) to share experiences exchange information and improve self care to ease the burden of living with diabetes and/or CHD.**
- **More time with health professionals particularly nurses**
- **Advice over benefits especially during appraisal**
- **Opportunity to confide in a person one to one, on telephone or face to face**
- **More frequent access to the Castlemilk stress centre services**
- **Alternative therapies available on NHS and/or cheaper**
- **Support classes such as dancing, swimming classes are good for mental well-being and mental health. They ‘take our mind of things’, ‘get us out the house’, ‘help forget about the condition’, ‘provide opportunity to share experiences’.**
- **Support groups as they have a beneficial social side**
- **Longer lasting follow up support after diagnosis/acute episode**
- **Having opportunity to talk with a person with the same condition one can share experiences with**

9.0 Key Findings from Health Professional and Reference Group Focus Groups

- Health professionals believed there has been significant progress in addressing mental health and well-being in people with long term conditions in SE Glasgow following the formation of the CHCP which has helped develop partnership working between health services and local authority services particularly through the work of STEPS.
- Whilst the introduction of the two QOF questions asking patients about their emotional feelings were seen as a step forward, a number of health professionals believed (i) they were a bit like a 'tick box exercise'; (ii) the questions were too basic; (iii) they came too late into the consultation especially with diabetes patients who required a lot of physical checks and (iii) patients would often reply 'fine' because of the stigma of mental illness.
- The stigma of mental illness remains a barrier to people seeking out help for their emotional distress when living with diabetes and/or CHD and LTCs generally.
- Some health professionals believed more work has to be done to raise awareness of mental health and LTCs among the general public not just in health professionals.
- Practice nurses lacked the time to tease out mental health issues with diabetes and/or CHD patients.
- Not all primary care staff working with people with diabetes and/or CHD (and LTCs generally) know about all of the services that are in the community that they could refer patients to.
- Services have to be delivered as locally as possible as patients unwilling to travel out-with their own areas. More detailed mapping exercises required.
- More support services for people with diabetes and/or CHD should be provided out-with clinical settings to foster a more holistic environment.
- Mental Health awareness training is required to give staff, especially nursing staff the confidence to address mental health issues in people with diabetes and/or CHD.
- Nurses aren't being asked to providing counselling for these patients, any advanced mental health role should involve self-help coaching and be protocol driven but not counselling or therapy.
- Need for greater clarity about what Living Better is expecting Nurses to do.
- Inability to work due to their physical health increases the burden on patients as it leads to social isolation
- There should be greater recognition of the emotional strains on carers of people who have LTCs and the fact that they need supported also.
- One to one telephone support and/or group support classes should be considered and/or made more widely available with input from health care support workers/paraprofessionals.

10.1 Some Typical Comments from Health Professional and Reference Group Focus Groups.

The Stigma of Mental Illness is a Barrier in Addressing Mental health and Wellbeing in these Patients

Health Professional 1

'I feel as well getting somebody to admit that they need help is one massive barrier. As you said earlier, 'it's always the other guy, it's never me', and getting people to the stage where they have to go and seek help and admit there's something wrong, especially if they are a typical Glasgow male'.

Health Professional 2

Certainly the individuals that I encounter there's a huge stigma accepting they have a mental health condition and it is frowned upon

The QOF Questions are like a 'Tick Box Exercise' and the Replies will be influenced by Time available and how the Questions are asked.

Health Professional 3

Sometimes the nurse goes 'how do you feel?' 'I'm okay', and that's it there. So the professional person thinks he or she said its okay, but that person might be holding quite a lot back and they just need a bit probing into, you know, 'what does okay mean to you?' 'what is okay?'. How to ask the question that's another one, you know, how do you put that question out there to the patient, the tone?

Health Professional 4

Time is always a barrier, so even if someone in the frontline has the skills to say 'so you're okay?' to see if they get anything coming back, they'll have to be aware that they've got ten other patients waiting in the waiting room, so it's just a kind of capacity of time issue...time is a big issue.

Health Professional 5

I think sometimes what they do is they would tell you what they think you want to hear... It's almost like it's contrived. And where we're talking about ten different things relating to their blood pressure, their eyes, their feet, 'by the way, are you feeling down?', it's not going to work properly. But how appropriate is that question, they're not appropriate at all?

Health Professional 6

Right, if you are a diabetic coming in for a review (1) you must have your blood pressure checked, you've got to keep an eye on your weight, got to check all your bloods. Have you got an up to date HBA1C? Have you got an up to date creatinine? Is your glomerular filtration rate been checked? ? Depending on what drugs they're on as well, we have to keep an eye, these are checked more often. You have to make sure they have been for their annual eye check, make sure they've had their feet checked so you can pass them onto the podiatrist and the retinal screening and all different things. And then at the very end you've got these two little questions about how they're feeling emotionally... 'aye, so you're fine, aye' tick, tick, tick...I don't think they are appropriate

Health Professional 8

Now we know from the research that Chris Williams did that a lot of nurses aren't asking the questions or don't feel confident in doing the training, also I've been asked to do training over in the North, so I presume it's relevant for over here too, again for nursing staff who aren't confident what they're doing. So is there potential for the work that Living Better does to focus on training around identification?

Need to Continually Map Services to Keep Track of What's Out There

Health Professional 1

There's also the issue about, as Kevin said, about relating the mapping, although there are different ways of doing things. And also no matter how many times we do our mapping or I've talked about keeping Glasgow online with the Glasgow health dot com stuff. I was recently at a community planning group where I talked about covering what we're talking about, and several people who are all key partner agencies, not in health and social work, but you know, key partner agencies in South East Glasgow, hadn't a clue what I was talking about, and I was actually quite taken aback. I was thinking 'this is a community planning forum, surely you would know X, Y and Z, and they didn't know.' So even the people who's job it is to plan across the communities weren't aware of different projects. I think there is a real lack of knowledge, a serious lack of knowledge about what is used within the communities, within say for example, Pollokshields and Govanhill.

Greater mental health role for Nurses should involve self-help coaching and be protocol driven but not counselling or therapy.

Health Professional 9

I just think there's another point that we haven't really picked up and that's about we presume a GP, practice nurse can just do a little bit of counselling with a patient, and I think that's based on a complete fallacy, because counselling's quite a specific skill. And people can't just automatically do it. but it's an absolute fallacy to presume that they can do that. Counselling's a very specific way of communicating with someone and clearly you haven't been trained in doing it...And it takes time, more than ten minutes with a patient.

Health Professional 10

Yes, I agree with that. What I feel that I can do is when I'm accessing hard to reach, high risk vulnerable individuals, is pick up signs and really then link in, that's my issue is linking in to other services out there that can help the patient, diagnosing & linking in.

Health Professional 9

As far as training is concerned I'd go for motivational interviewing because I don't think frontline staff, there's no point teaching them about counselling because they don't have time to deliver it anyway, but if they had more motivational interviewing techniques... It might be easier for them to address the mental health issues?

Not Just the QOF Questions and how they are asked but where they are asked

Health Professional 9

I think at times doing healthcare clinics in non-healthcare settings is one of the ways because it's an environment they're comfortable in and they should come to that..... I think that's one of the advantages of the Castlemilk Stress Centre, they do feel safe, they do feel that we're not judging them, we're not a statutory service if you like, you know, we're not going to send them to social work or whatever. Also they have much more time, 45 minutes which your never going to get with a GP or Nurse so we should give that some thought, looking at where we actually talk to people about their feelings.

Carers of People with Diabetes and/or CHD Also Need Supported

Health Professional 12

One of the things we do would be refer the carer along to the stress centre or to make sure that we do the STEPS programme. We also have a programme called Personal Effectiveness which is looking at the person themselves and realising that you're a person first, you're an individual

before you're a carer or a wife or a mum, that you have needs as well. The other thing is, what happens to the person you're caring for if something happens to you? So it's things like maybe making sure that homecare goes in because homecare can do the injections in the morning and homecare can help them to get ready in the morning and it gives you time, if you're a diabetic, to get up and have your breakfast and take your own medication, while somebody's looking after the person you care for.

Another thing we do is some of our carers have a kind of problems because they're looking after their husband who has got dementia, but how do you go to the hospital and take him with you because the family's all working? So one of the things we can do is maybe use our Short Breaks Projects to allow someone to sit with the husband to let her go to her medical appointments that she needs to attend. Another thing is, first of all we need to ask the carer what's the barriers, you know, it can be something really silly to us, but to them it's a mountain. But staff have to know about these services.

Conclusions from Focus Group Findings and Recommendations

- **Nurses, AHP and health support workers, in collaboration with social and voluntary sector colleagues, have a vital role to play in addressing the mental health and wellbeing needs of patients living with diabetes and/or CHD.**
- **Greater mental health and mental well-being awareness training should be provided to nurses, AHP and health support staff working with diabetes and/or CHD patients.**
-
- **Routine Mapping & Improved signposting of existing health, social care and voluntary sector services is needed to address mental health and wellbeing issues in people with diabetes and/or CHD.**
- **Build on existing positive Partnership working already established with local council and voluntary sector services to address access/transport issues, provide easily accessible financial/benefits advice, and accessible and affordable exercise/leisure facilities and other social support needs of people living with diabetes and/or CHD.**
- **Social support services are non-complex and low cost interventions that have the potential to bring significant benefits to these patients.**
- **Greater recognition of the benefits of developing appropriate social support services as highlighted in the report should be discussed and planned by East Dunbartonshire Living Better reference group.**

11.0 Conclusions from Focus Group Findings and Recommendations

- **Nurses, AHP and health support workers, in collaboration with social and voluntary sector colleagues, have a vital role to play in addressing the mental health and wellbeing needs of patients living with diabetes and/or CHD.**
- **Greater mental health and mental well-being awareness training should be provided to nurses, AHP and health support staff working with diabetes and/or CHD patients.**
- **Improved signposting of existing health, social care and voluntary sector services is needed to address mental health and wellbeing issues in people with diabetes and/or CHD**
- **Build on existing Partnership working with local council and voluntary sector services to address access/transport issues, provide easily accessible financial/benefits advice, and accessible and affordable exercise/leisure facilities and other social support needs of people living with diabetes and/or CHD**
- **Social support services are non-complex and low cost interventions that have the potential to bring significant benefits to these patients.**
- **Greater recognition of the benefits of developing appropriate social support services as highlighted in the report should be discussed and planned by East Dunbartonshire Living Better reference group.**

12.0 Some Comments and Observation from Initial Analysis of Focus Group Data: Locating the Data in the Literature

13.1 Social Support and Mental Health and Wellbeing

The concept of social support is very broadly defined one but for the purposes of this preliminary report, the essential component of support focuses on the significance of human relationships and some form of helping element. Pearlin et al (1981) described social support as '*access to and use of individuals, groups or organizations in dealing with life's vicissitudes*' (26). Support can be in the form of meaningful social contacts, available confidant/s, or human companionship (27). As noted earlier, support is important to people affected by chronic illnesses as the stresses of living with them can increase their vulnerability to depression and anxiety (27). When considering the impact of chronic illness, both as an acute and chronic life event, one has to take into account the tensions that people experience as they negotiate specific symptoms, potential and actual changes to valued social roles and positive identities, and disruption to daily lifestyle. General studies show that social support may benefit mental health directly and indirectly, as a mediator, suppressor, and moderator or stress-buffer. For example, perceived emotional support refers to beliefs that one is valued, cared for, and loved, and these beliefs tend to promote mental health (27b). Like other psychosocial resources, social support may also benefit mental health by altering stress appraisals and promoting alternative or healthy coping strategies in the face of stress or burden (27c).

Three or four categories of social support can be distinguished: **emotional support** (warmth and nurturance expressing commitment, reassuring the person that he or she is a valuable individual who is cared for, including approval or appreciation for the patient's situation and behaviour), **appraisal support** (helping a person understand a stressful event better and what resources and coping strategies may be mastered to deal with it) or **informational support** (giving advice and information), **and tangible assistance or practical- instrumental support** (material or other practical help such as services, financial assistance, or goods). This can be in the form of one to one confiding relationships, confiding in group situations, sharing experiences and exchanging information and/or receiving assistance to address a specific stressor (39)

13.1.2. Chronic Illness, Stress, Depression, and Social Support: Why they are Inter-related and Important in the Context of the Living Better Project

Living with a chronic illness and experiencing mental ill-health can be costly to the individual, their family and community and society generally. Chronic illness can have a devastating impact on social, family and occupational functioning. It is commonly associated with disability, pain, mood disturbance and fear of death. Developing a chronic illness may cause a period of adjustment or disruption, promoting feelings of worthlessness or hopelessness that may fuel depressive symptoms (32, 33). Consequently, chronic illness has been considered a chronic stressor that is persistent and associated with negatively impacting on a person's mental health and well-being (34). As a chronic stressor, chronic illness produces limitation in the ability to perform social roles and may interfere with social interaction especially for older individuals whose chronic illness can be more debilitating (34). This can have negative psychological consequences to the individual which may endure over time. At the same time, it may threaten an individual's ability to live alone and decrease a sense of independence or that person's sense of 'feeling in control', which is known to be particularly important for continued psychological well-being (35, 36)

Following the research of Brown and Harrison on depression in different parts of the UK their book '*The Social Origins of Depression*' was published in 1978. This highlighted the importance of social support, to a person's mental health and mental well-being. Research on depression and anxiety over the last 25-30 years has shown a consistent association between acute and chronic life events (e.g., in the context of the Living Better project a heart attack or major heart surgery or a diagnosis of diabetes and/or CHD and the accumulated strain of living with the condition over time) and an increased risk of developing depression and/or anxiety (28, 29). The same and similar research has also shown that the presence of social support can not only act as a 'buffer' to stressful live events thus reducing risk of developing depression and/or anxiety conditions, but is also helpful to an individual's general mental well-being and also can be a positive factor in the management of depression and/or anxiety (30, 31). Flowing from the work of Brown and Harris, a conceptual outline of the stress process was developed by Pearlin et al in 1981, which contained three central elements: sources, mediators, and outcomes. Pearlin et al (1981) put forward a framework which suggested that stress may impact on an individual either directly as an acute severe life event or as a chronic strain over time. Central to this framework was the buffering/protective role of mediator's notably social support in limiting the negative impact of acute and/or chronic stressors to a person's mental health and mental well-being (26).

Approximately three decades after the publication of '*The Social Origins of Depression*', the World Health Organisation published '*Social Determinants of Health: The Solid Facts*'. This report emphasised the importance of social support as

an important social determinant of health generally and an especially important factor in positive mental health and wellbeing (56). The report noted that:

Social support and good social relations make an important contribution to health. Social support helps give people the emotional and practical resources they need. Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued. This has a powerful protective effect on health. Supportive relationships may also encourage healthier behaviour patterns.

People who get less social and emotional support from others are more likely to experience less well-being, more depression, and higher levels of disability from chronic diseases (56: p.22).

13.2 The Importance of Social Support to People with Chronic Illness

As noted above, the concept of social support has a number of forms and can involve the provision of confiding support, emotional comforting or being part of a social group with the opportunity to access confiding support and/or shared understanding all of which can act as a buffer to the stresses of everyday life and/or in the context of Living Better, can 'buffer' the stresses of living with a chronic illness. It can range from one to one confiding support from an individual a person feels comfortable about discussing their innermost thoughts and feelings with, support from a social network of people a person feels they have something in common with, and the exchange of information and advice designed to answer important issues in that person's life. The outcome of such interaction is beneficial to the person seeking that support either emotionally through reducing distress and/or improving a person's emotional outlook or by providing a buffer to day - to- day pressures which helps them with day-to-day living, or all three (37).

This support is often needed because of the psychosocial impact of a diagnosis of diabetes and/or CHD. For the purposes of this report, the term psychosocial relates to the psychological and social aspects of peoples' lives. It covers how a person thinks about themselves and their situation, how they feel emotionally and the daily practical aspects of their lives from personal relationships through to day-to-day economic issues such as employment and managing finances and one's social and personal networks. When a person receives a diagnosis of diabetes and/or CHD, all these areas are affected, not just their own but their family's too.

Despite this recognition, psychosocial aspects can often be missed by healthcare specialists, especially at the beginning of a person's treatment. For example, a study by Farrell et al. (2005) identifying the concerns of 33 women undergoing chemotherapy in Northwest England found that experienced nurses could not identify the majority of patients' concerns and were biased towards physical and treatment related issues. The researchers concluded that their study provided clear evidence for the importance of a continued focus on psychosocial aspects of care during the preparation of staff for clinical roles with patients diagnosed with chronic illnesses. They also believed their findings highlighted the need for preparation in listening and responding to non-medical, psychosocial concerns which touch on aspects of care with which health care professionals may feel less familiar and comfortable (38).

In the context of what type of support patients in Scotland with diabetes and/or CHD said they wanted, this came in a number of different forms. It can be a group form of support such as a diabetes and/or CHD support group, where people affected by the condition share experiences with each other, a more individual one-to-one type of

support of sharing or confiding, rapid access to locally available general informational/educational services.

These different support forms are usually targeted to one of three points on the illness trajectory: diagnosis/pre-treatment, immediately post-treatment or during extended treatment. Certain types of supportive interventions for people affected by diabetes and/or CHD have been shown to be more effective at one or more of these time periods.

13.3 The Importance of Psychosocial & Social Support to Patients with Diabetes and/or CHD

The British Lung Foundation Scotland has noted that in people with mild to moderate diabetes and/or CHD, psychosocial and social support are effective in helping diabetes and/or CHD patients live with their condition (2). Diabetes and/or CHD patients with breathlessness can often avoid exercise and become unfit and demotivated. They can become anxious, depressed and socially isolated. Pulmonary rehabilitation addresses all these issues (Diagnosis and management of chronic obstructive pulmonary disease in primary care: A guide for those working in primary care (2007). Gore (2000) noted that social support was often lacking for diabetes and/or CHD patients in community but that where social support was provided it made a positive difference to diabetes and/or CHD patients' psychological well-being.

A key feature when considering the psychological impact of diabetes and/or CHD is that there is no cure and therefore interventions are designed to minimize the worsening of the disease process, assist the patient to regain the best quality of life attainable and to prevent the secondary effects of chronic disease such as depression and social isolation. Scott (2004) noted that people with diabetes and/or CHD have to cope with highly changeable and distressing symptoms and that they manage their condition much more effectively when they feel that there is someone whom they can contact for healthcare advice and support.

When Young et al (1999) conducted a project to determine whether persons who declined participation in, or failed to complete, a diabetes and/or CHD rehabilitation programme they aimed to find out whether there were significant differences in terms of socio-demographics, physiological parameters or psychological factors, from those who completed the rehabilitation programme. They found that a substantial proportion of eligible subjects who did not participate in a diabetes and/or CHD rehabilitation programme were not more physiologically impaired, but were more likely to be: socially isolated, lack chronic obstructive pulmonary disease-related social support, still be smoking and be less compliant with other healthcare activities. The researchers concluded that identification of one or more of these factors reliably allows prediction for non-adherence to a rehabilitation programme.

After reviewing the treatment options for addressing depression in people living with diabetes and/or CHD, Alexopoulos et al (2008) suggest that pharmacotherapy, psychotherapy, and interventions aimed to increase treatment adherence can be helpful in depressed DIABETES AND/OR CHD patients. However, administered alone, each approach offers limited long-term benefits in reducing depression and disability. Many diabetes and/or CHD patients will be offered antidepressants as a result of the impact of the illness to their emotional state of mind. This offer is often refused and patient reluctance to receive antidepressants further reduces their impact. One study showed that 72% of depressed elderly diabetes and/or CHD patients refused antidepressants, and only 50% of those agreeing to treatment completed a trial of fluoxetine (Yohannes et al., 2001). Alexopoulos et al (2008)

argue that limited efficacy and poor acceptance of anti-depressants in patients with DIABETES AND/OR CHD suggests that psychosocial interventions may play an important role in the treatment of these patients.

13.3.1 Economic Benefits of Social Support to the Wider Healthcare System

When discussing new ways and directions of tackling the growth of chronic illness in modern society, Walker et al (2003) estimated that effective psychosocial support services lower general health service use by between 7% and 17% among people with chronic illness (41).

Other reviews on the benefits of providing psychosocial support also point to cost savings for the wider healthcare system. Carlson & Bultz (2003) reviewed the literature detailing the extent of psychological distress in cancer patients (increasingly being treated today as a long term condition), the staffing needed to treat such levels of distress, and the effectiveness and value of psychosocial treatments for cancer patients were assessed. From their review they concluded that providing psychosocial support for people affected by long term conditions:

shows large savings in medical billing through the treatment of emotional problems, including anxiety and depression, resulting in fewer visits to GPs and specialists alike. Although there is very little research on psychosocial oncology to date, studies seem to support the general findings in other (LTC) groups of fewer visits to primary care physicians after receiving efficacious psychosocial treatment. Clearly, the time has arrived to promote a compassionate model for treating patients' physical and emotional needs as a vital part of our healthcare systems (42).

14.0 Some Observations and Preliminary Conclusions based on Focus Group Findings and Literature Review

Recent research in Scotland has shown that people living with chronic illness are at greater risk of developing mental health problems than those without such illnesses; 30% of those with limiting long term conditions scored 4 or more on the General Health Questionnaire (GHQ) rating (indicating potential mental ill health), compared with only 9% of other adults (44).

In Scotland for the financial year 2007/2008, the number of consultations with a GP or nurse at least once in primary care for a patient with diabetes and/or CHD totalled over 200,000(45). Despite this association being known for some time, organisations like Long Term Conditions Alliance Scotland (LTCAS), as recently as 2007, pointed out that the mental health needs of people with chronic illnesses such as diabetes and/orCHD are still not being adequately addressed (49).

Recognition of psychological distress is an important function of General Practice, yet approximately 50% of patients experiencing mental health problems can remain undiagnosed and un-treated (50, 51, 52). Social support comes in various forms including individual one to one confiding with a health professional or an individual or individuals who may have the same chronic illness and provide shared understanding. It can also take the form of group classes such as exercise classes or general groups not related to health per se. Compared to other treatments and interventions, providing social support is a non-complex, low cost intervention. Research has consistently shown it has the potential to bring significant benefit to patients with chronic illnesses such as diabetes and/or CHD. It is therefore vital that greater consideration of this important aspect of mental health and well-being, during

screening, assessment and treatment must be increasingly considered in patients with diabetes and/or CHD.

Following the focus group findings and literature review contained in this report, the next steps for the Living Better reference group in South East Glasgow will be to discuss what to do with this data in terms of linking it to re-assessing services for people with diabetes and/or CHD locally.

15.0 Quality Outcomes Framework (QOF) Questions are a Step Forward – But More Needs Done to Sensitively Address Mental Health issues in People with Chronic Illness

Statistics from ISD NHS Scotland show that in the financial year 2007/2008 most diabetes and/or CHD consultations' in primary care were with nurses (see Appendices 1 & 2). Nursing staff we spoke with in Scotland were aware of their client's mood being low or lower and thus they became conscious of their mental health needs, but usually only if they knew them quite well. A telling comment from staff in South East Glasgow working with people who have diabetes and/or CHD (and elsewhere in Scotland from health professionals working in diabetes and/or CHD care) regarding the QOF questions (*During the last month, have you often been bothered by feeling down, depressed or hopeless? During the last month, have you often been bothered by having little interest or pleasure in doing things?*) was that whilst they asked patients these questions, and if necessary followed this up by using PHQ 9 or HADS, they were often unsure what happened to the patient afterwards. For some, the process felt like a purely operational exercise which they believed was not sufficient in 'getting to grips' with addressing the emotional and social complexities that people with diabetes and/or CHD often experience.

Addressing depression and anxiety is a complex process. Teasing out emotional distress is a skilful process and whilst the QOF questions represent progress in addressing the issue of mental health and wellbeing in people with long term conditions, they are only one aspect of the equation. As highlighted earlier, as many as 50% of people with depression/anxiety in primary care can be undiagnosed, even after completion of HADS/PHQ9 scores.

16.0 Nurses, AHP Staff, Health care Support Workers and Social Care Staff have a Key Role in Addressing Mental Health & Wellbeing in Diabetes and/or CHD Patients

With at least 80% of patients with depression being treated entirely in primary care practice and specialist nurses are already seeing these patients for a variety of other reasons (59, 60). As noted earlier however undiagnosed depression remains a problem in primary care with approximately 50% undetected (stigma remains a problem) [11b, 60]. A key finding of Living Better focus groups is that for practice and specialist nurses to feel confident and competent in taking a more active role in detecting and treating depression, vital they have access to evidence-based training, mentoring and supervision. It has been found that, with effective training, Practice & Specialist Nurses can achieve excellent patient outcomes working with GPs in assessing and managing depression (60, 61, 62).

In the February 2009 special edition on depression the British Journal of General Practice editorial '*Managing Depression in Primary Care*', noted

"Evidence suggests collaborative models of care may be most effective here using a multi-professional approach to patient care involving a GP and a case manager (a professional or paraprofessional providing regular contacts with the patient about medication or psychosocial support)...Balint's idea of 'Dr is the drug' needs to be

enhanced and broadened to include the whole health care team....and non statutory services”.

A 2007 issue of Practice Nurse (63) carried an article on training practice nurses in mental health & wellbeing which concluded;

“Greater Integration will enable nurses to offer improved, fully holistic, individualized care to their patients by working with them to achieve improved wellbeing..... nurses can also encourage patients to engage with community activities that can impact positively on their mental health....

Practice Nurses can, with training, take on an enhanced mental health role (it has been) illustrated that the wellbeing agenda, which is currently so high in our government’s health priorities, can be embraced by practice nurses who will find that, with targeted training, they can better support patients to achieve a sense of increased purpose, meaning and fulfilment in their lives” (16: p. 227).

17.0 New National Institute for Clinical Excellence (NICE) Guidelines Underline Key Role of Nurses in Addressing Mental Health & Wellbeing in People with Chronic Illness

Last month the *International Journal of Nursing Studies* contained an editorial on the new NICE guidelines on managing depression in people with chronic conditions published on 31st October. The editorial was aimed specifically at nurses and midwives. In the section ‘Implications for Nurses’ the editorial notes

Nurses play a key role in the detection and the management of depression. Practice and district nurses, and nurses working in general hospital and intermediate care settings are particularly likely to be caring for people who are experiencing chronic physical health problems..... these individuals have increased vulnerability to depression, and the combination of mental and physical problems has clear and marked effects on quality of life, functional disability, and disease course. Nurses – who play a central role in all aspects of the care of these patients – there is a crucial opportunity to identify and assist in the management of depression.

This work requires knowledge of the presentation and evidence-based management of depression, and skills in assessment and interventions that will promote appropriate adaptive responses and concordance with treatment plans. Working with people with chronic physical illness, and their families and carers necessitates a central focus on patient and carer education and the promotion of self-management approaches; and where depression is a part of the clinical picture this guiding principal of care remains of key importance and will require additional knowledge and skill on the part of health professionals.

Practice innovations in a number of countries have highlighted the role of nurses in primary care within a collaborative system

of care, and this new NICE guidance gives added impetus and direction to these developments based on rigorous evidence review. (page 1414).

18.0 The Importance of Partnership Working in Addressing Mental Health and Wellbeing in People with diabetes and/or CHD

In addition to training nursing, AHP and health support staff in primary care to address mental health and wellbeing in people with diabetes and/or CHD, equally important is the need to develop effective partnerships with local authority staff and services. Areas such as transport, financial and benefits advice, and exercise facilities are all under the auspices of local authorities. Given the importance of these issues to people with LTCs, effective working to address mental health and wellbeing in these patients will therefore be partly dependent on good partnership working between CHPs, the voluntary sector and local authorities.

Long Term Conditions Alliance Scotland and the Scottish Government have highlighted the importance of partnership working to address mental health and wellbeing in people with long term conditions with the launch of the Self Management Fund. This was a key recommendation of 'Gaug Yersel' - The Self Management Strategy for Scotland' published in 2008.

The Self Management Strategy is informed by the lived experiences of people with long term conditions very much like those who participated in the Living Better focus groups held throughout Scotland. The Strategy calls for:

- People to have more access to high quality information about their condition and its impact on their life.
- People to have more access to support including peer support.
- Increased provision of emotional and mental health support for people with long term physical conditions.
- A change in culture so that people - those receiving and those delivering services - have the confidence and capacity to work together as partners.
- Better partnerships working by NHS, voluntary sector and local authorities.

19.0 An Example of Partnership Working to Address the Financial Concerns in People Living with a Long Term Condition

A practical example of the importance and benefit of effective partnership working was seen in August this year with the '*Extension of the Macmillan Tayside Welfare Benefits Project*', initially a project aimed at providing benefits advice to people affected by cancer (increasingly being treated as a long term condition). Following discussion between Macmillan Cancer Support; Dundee City Council, Angus Council; and Perth and Kinross Council a joint working arrangement has been proposed to augment the Tayside Welfare Benefits Project into long term conditions. In parallel to the development of cancer specific services this will be designed and delivered through a partnership between the relevant clinical teams and the advice professionals with the Macmillan Tayside Benefits Project. In turn it will pilot the value and impact of integrated benefits and financial advice for people and their families who are dealing with the social/economic impact of living with a long term condition.

Home visiting and direct advice in clinical settings will be used to deliver an effective service to both cancer and long term conditions patients and their families. The project will also provide a 'gateway' into established specialist welfare benefits advice, money advice and information services provided by Angus Council, Dundee

City Council and Perth and Kinross Council. Initiatives such as this represent the way forward in developing collaborative, 'joined up', holistic support systems for people with long term conditions.

20.0 Living Better and Learning from other Scottish Wide Initiatives

It is important to note that given existent time pressures on GP and nursing staff, consideration for such training to be rolled out to other primary care healthcare staff as is the case with the Scottish Government's '*Keep Well*' initiated being led by Health Scotland should be considered. This initiative is developing the role of health care support workers (HCSWs) for delivery of anticipatory care. Health Care Support workers have been an integral part of Keep Well anticipatory care delivery undertaking a range of roles and responsibilities which were traditionally undertaken by the qualified nursing staff within Keep Well anticipatory care settings. It has been generally believed that there is a need to develop the role of healthcare support workers, to confidently deal with the enhanced expectations of their roles and to provide safe and effective services to patients in primary care (57). This is especially relevant given the recently published '*Nurses' Employment and Morale Scotland 2009 Survey*' which was released in October and showed that over half of nurses (52%) said they were too busy to provide the standard of care they would like and 51% saying that there are not sufficient staff to meet patient needs.

The role of anticipatory care is central to both the prevention and management of long term conditions and is therefore an important area for Living Better. Changing service provision does not automatically result in corresponding changes in health seeking behaviours by patients and as research around this area has suggested, patient preferences for care delivery may be in conflict with the current reform agenda focussing on anticipatory care provision. Efforts to reform long term conditions' care may falter unless this is addressed (58). Nevertheless, developments across Scotland, England, Australia and the USA point to a growing recognition that traditional health/social care service provision is not addressing mental health issues in people with long term conditions in the required manner.

21.0 Partnership Working is Essential: The Need for Joint Action Planning and Collaborative Working

If future systems of care are to be effectively equipped and operational in addressing the mental health needs and mental well-being of people with diabetes and/or CHD - greater consideration on how to improve the mental health awareness, knowledge, and skills of specialist & primary care nurses, AHP staff and wider primary care staff in general working with this client group is vital.

Equally important is the need for primary care staff and their partners in social services and the voluntary sector to sit down together and draw up joint action plans for addressing the mental health and wellbeing of people with long term conditions. The importance of this was highlighted by patients in our focus groups when they spoke powerfully about how difficulties in accessing transport, information on benefits advice, and access to leisure services made living with their long term condition more stressful.

Changes around developing a more psychosocial, holistic, collaborative form of care will be required to address the projected growth in long term conditions in South East Glasgow in general and the mental health and wellbeing of people with diabetes and/or CHD in South East Glasgow in particular. Practice and specialist nurses, Allied Health Professionals and associated primary care staff have the potential to play an increasingly pivotal role in this area of health care – but crucially, this must be

developed in partnership with relevant local authority and voluntary care staff and associated services.

The Living Better project will produce its final report, conclusions and recommendations to the Scottish Government, pulling together the data from all 5 CHP sites, in an all Scottish context, in March 2011.

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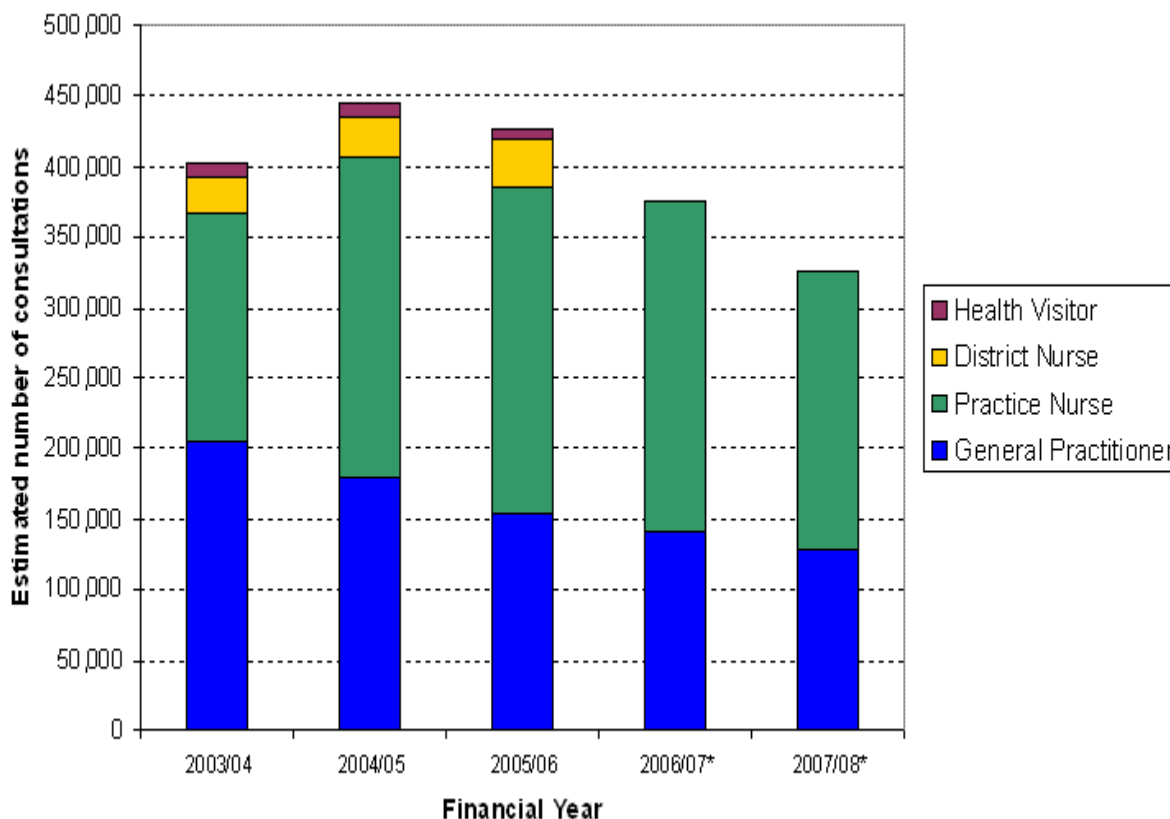
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Appendix 1

Coronary Heart Disease¹ - estimated number of consultations in Scotland in the financial years 2003/04 to 2007/08^{2,3} by staff discipline

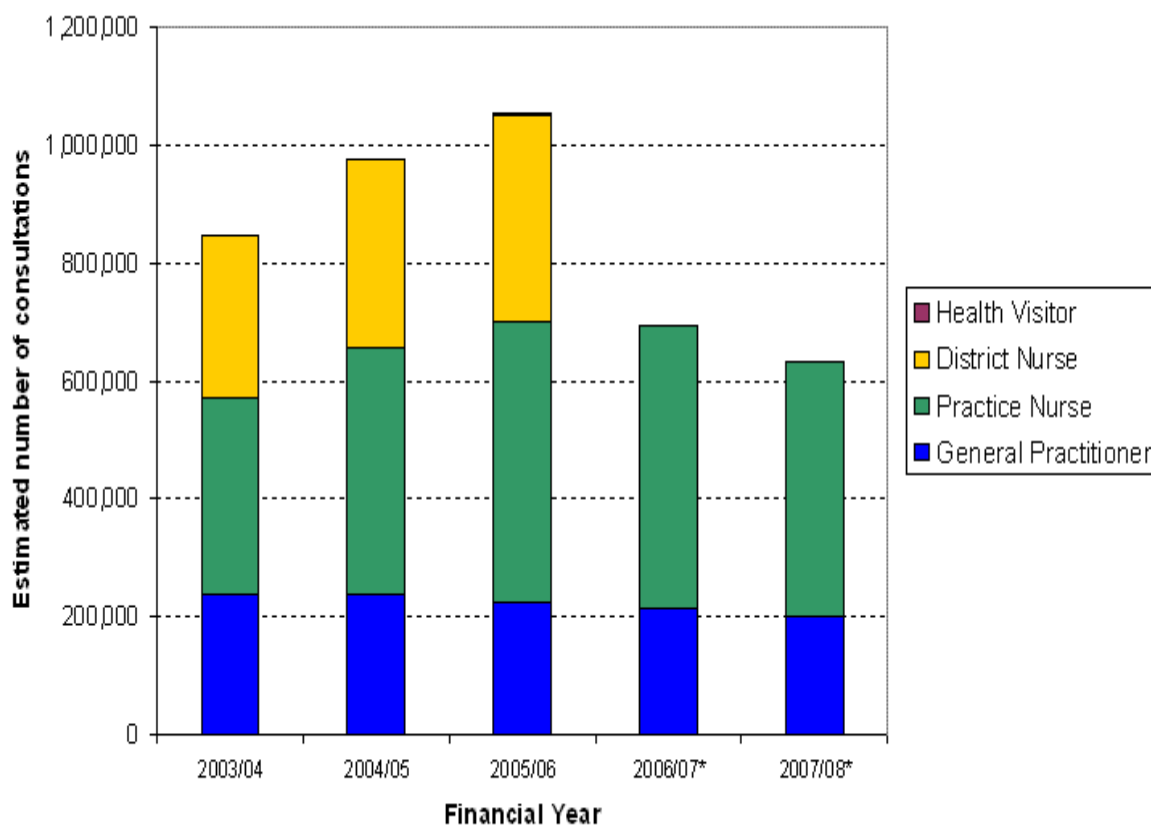


* Health visitor and district nurse data are not available from the financial year 2006/07 onwards. ¹ Based on ISD's [Read Code Grouping \(RCG\)](#) 'Angina', 'Acute myocardial infarction', 'Ischaemic heart diseases excluding angina & acute myocardial infarction' and 'CHD monitoring'. ² Based on 59, 53, 51, 49 and 47 PTI practices that submitted complete data for the years ending 31 March 2004, 2005, 2006, 2007 and 2008, respectively. Figures are standardised by age, gender and deprivation. ³ Population source: Community Health Index (CHI) record, as at 30 September 2003, 2004, 2005, 2006 and 2007.

Source: [Practice Team Information](#) (PTI), ISD Scotland (last updated 31 March 2009).

Appendix 2

Diabetes¹ - estimated number of consultations in Scotland in the financial years 2003/04 to 2007/08^{2,3} by staff discipline.



* Health visitor and district nurse data are not available from the financial year 2006/07 onwards. ¹ Based on ISD's [Read Code Grouping \(RCG\)](#) 'Diabetes'. ² Based on 59, 53, 51, 49 and 47 PTI practices that submitted complete data for the years ending 31 March 2004, 2005, 2006, 2007 and 2008, respectively. Figures are standardised by age, gender and deprivation. ³ Population source: Community Health Index (CHI) record, as at 30 September 2003, 2004, 2005, 2006 and 2007.

Source: [Practice Team Information](#) (PTI), ISD Scotland (last updated 31 March 2009).