THE LIVING BETTER PROJECT: ADDRESSING MENTAL HEALTH and MENTAL WELL- BEING in PEOPLE WITH CHD and/or DIABETES & COPD – FINDINGS FROM FOCUS GROUPS

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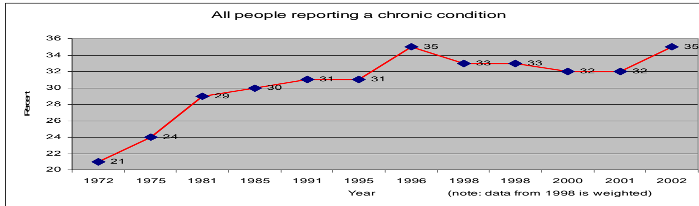
1. BACKGROUND

1.1 DRIVERS FOR CHANGE: THE INCREASE IN LONG TERM CONDITIONS (LTCs) in SCOTLAND

GRAPH 1 – The Rising Number of LTCs in Scotland 1972-2002 (source ISD)



- Whilst LTCs are most prominent in older people they are increasing in all age groups in Scotland, and are higher in people living in areas of high deprivation and people from Black and Minority Ethnic Communities (1).
- The WORLD HEALTH ORGANISATION has stated that managing long-term conditions is the biggest challenge facing healthcare systems worldwide, given that over 60% of all deaths attributable to them, and that they can limit a person's lifestyle, opportunities and potential.

1.2 NHS SCOTLAND'S STRATEGIC POLICY RESPONSES

- In 2005-2006 following the publication of the 'Kerr Report' and 'Delivering for Health' health policy in Scotland identified a number of key 'Principles of Good Long Term Conditions Management'. These included:

- Focus on the whole person – take a more holistic approach
- Primary Care is the key – Improve co-ordination in Primary Care
- Use good information systems and management
- Review care using evidence based protocols and guidelines
- Involve community and voluntary resources
- A well-trained workforce is a re-skilled workforce
- Community Health Partnerships (CHPs) offer significant opportunities for providing systematic integrated care - and need support

2. MENTAL HEALTH, MENTAL WELL-BEING and LTCs: WHY THEY MUST BE ADDRESSED COLLECTIVELY

- Research has established that people living with an LTC are at greater risk of developing mental health problems with approximately 30% developing depression and/or anxiety which can negatively affect management and outcomes of LTCs (1, 2, 3).
- Despite the above association being known for some time, organisations like Long Term Conditions Alliance Scotland (LTCAS) point out that the mental health needs of people with LTCs are still not being adequately addressed.
- Recognition of psychological distress is an important feature of general practice but recent research in Scotland has found that around half of patients with significant symptoms were not identified by their GP as suffering from a depressive disorder (4)

3. THE LIVING BETTER PROJECT'S FOCUS GROUPS

- Working with 5 CHPs and 10 GP practices across rural and urban Scotland, patients with diabetes and/or CHD & COPD have been/will be randomly selected from Diabetes, CHD and COPD registers. To date 24 focus groups, 17 with patients (involving over 130 people) and 7 with health professionals (involving over 50 health care staff working with these patients) have been conducted to discuss mental health and well-being issues and how these could be better addressed collectively by primary care health services. A further 4 focus groups have been/are being planned.

References: *(1) Scottish Executive Social Research (2007) 'Characteristics of adults in Scotland with long term health conditions'; (2) Barth J, et al, (2004) Depression as a Risk Factor for Mortality in Patients With Coronary Heart Disease: A Meta-analysis. Psychosomatic Medicine,;**66**:802-813; (3) Lin EHB, (2006) Effects of enhanced depression treatment on diabetes self-care. Ann Fam Med 2006;**4**:46-53; (4) Cameron S, Lawton, K, Reid, C (2009) Appropriateness of antidepressant prescribing: An observational study in a Scottish primary care setting British Journal of General Practice. September, 2009.*

3. SUMMARY of KEY FINDINGS FROM PATIENT FOCUS GROUPS

- Whilst the impact of illness differs across the 3 conditions all patients spoke of *'frustration', 'isolation', 'fear', 'strain of lifestyle re-adjustments', 'feelings of stress in lead up to and* (if not good news) *after the annual or 6 monthly review', 'strains in family and other personal relationships'.*
- When the discussion turned to what types of support would help to prevent or lessen the extent of these feelings, a consistency of findings emerged from the 3 different patient focus groups in that low level forms of social support were most commonly mentioned. These included;

  'a person/s to confide in' (this included both healthcare and non-healthcare staff), *'sharing experiences with someone with same condition', 'support classes', 'telephone support', 'exercise classes', 'dietary classes*'.
- When asked why these types of support would be helpful, typical responses included; *'occupies the mind with something else', ' gets me out of the house', 'good to talk with someone who really understands what I'm experiencing', 'the chance to honestly express how I feel*'.
- People with CHD and COPD especially spoke of benefits of exercise classes to physical and mental well-being with typical comments including *' the people there are all in same boat, it wasn't only exercise – a cup of tea and a chat, there is a good social side'.*

4. SUMMARY of KEY FINDINGS FROM HEALTH PROFESSIONAL FOCUS GROUPS

- The Quality Outcomes Framework (QOF) mental health questions and pre-questions are too basic/crude and some professionals feel awkward asking them, both with patients they know and don't know well.
- After using HADS or PHQ 9 as part of the QOF, if patient scores showed depression/risk of depression, many nurses said the scores were passed on - but they often did not know what happened next.
- Greater role for voluntary sector groups, e.g. Diabetes UK, Chest Heart Stroke and Depression Alliance Scotland in planning and delivering CHD and diabetes services in primary care.
- Greater integration of appropriate community health, voluntary and social care services, especially between CHPs, GP practices and social services.
- Practice and CHD/Diabetes/COPD specialist nurses expressed a desire for more mental health and mental well-being awareness training.
- Greater promotion of mental well-being in CHD, diabetes and COPD care.

Estimated No. of Primary Care Consultations for Patients with CHD, Diabetes and COPD in Scotland in 2007/08 - 1,270,996 (Source: Practice Team Information, ISD Scotland March 2009).

5. INITIAL CONCLUSIONS FROM FOCUS GROUPS

- As the above chart shows more and more consultations in primary care involving people with CHD and/or diabetes & COPD are with practice nurses. Greater mental health and mental well-being awareness training should be provided to these nurses. This would improve the prevention, assessment, and treatment of depression and/or anxiety as well as promote mental well-being in these patients.
- Social support is a non-complex, low cost intervention. It has the potential to bring significant benefit to these patients. Greater consideration of this important aspect of mental health and well-being, during prevention, screening, assessment and treatment must be increasingly considered for patients with CHD and/or diabetes & COPD.