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# The future treatment of depression in people with long term physical conditions in primary care – some reflections

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It is very likely in the future that the mainstay of treatment for depression will remain in the primary care setting, which includes general practice, primary care psychological services such as the national Improving Access to Psychological Therapies programme (IAPT) and a range of non-IAPT first line psychological or counselling services in the community. This article will describe how IAPT is progressing and expanding and current research aimed at improving our ability to personalize treatment for people with depression. The article will also consider how IAPT and general practice can tackle the increasing dilemma of managing depression and anxiety in people with long term physical conditions such as heart disease which is an inceasingly recognised priority area in the NHS.

When IAPT was first set up in 2008, the assumptions were made that with an estimated 6 million people nationally in need, by virtue of having depression and/or anxiety problems requiring National Institute of Health and Excellence (NICE) recommended treatments, that around 900,000 people would present to services, of whom 600,000 would complete a course of treatment and 300,000 (i.e. half) would be expected to recover and within that number, around 25,000 people would be able to move off sick pay and benefits. The plans for IAPT nationally are to see 15% of all people with depression and anxiety by 2015 and many services are on track to achieve this goal. Whilst this is an incredible achievement and something I never thought I would see in my professional lifetime, it does however also mean that only a proportion of people with depression/anxiety being seen in general practice can currently be referred for IAPT first line psychological treatment services and already articles in the general practice press over the last year or so have been reporting long waiting lists in some areas and wanting faster access and increased psychological treatment provision. It must also be acknowledged that many people do not want psychological treatment and prefer other approaches such as medication.

IAPT have recently reported the results from their first 3 years of operation in 2012 and these are impressive in public health terms. They have seen over 1 million people for treatment of whom 680,000 have completed treatment with more that 45% of people recovering and a significant improvement in 65% of people and more than 45,000 people moving off sick pay and benefits. Also, they have trained nearly 4000 new practitioners. Indeed so successful has this been that this area is one that the treasury and the opposition seem keen to continue funding and expand. IAPT services are expanding their role into providing depression and anxiety treatments for people with long term physical illnesses (LTCs) (such as heart disease, diabetes, chronic lung disease), people with medically unexplained symptoms (MUS) (such as fibromyalgia, chronic fatigue, irritable bowel syndrome), people with severe and enduring mental illness (such as schizophrenia, bipolar disorder) and children and young people.

There are currently 14 national Pathfinder pilot sites around the country to determine how best to expand first line psychological services for people with LTCs and MUS and the results are being independently evaluated by a team of researchers at the University of Surrey. These national Pathfinder sites are addressing a range of issues including; how to improve the skills needed by existing IAPT workers in seeing people with LTCs and MUS conditions and how to train clinical staff working in general practice (such as GPs and practice nurses) and hospital based physical health services (such as coronary rehabilitation services, pulmonary rehabilitation services) in psychological approaches that can be applied in their settings. Other examples of Pathfinder projects include introducing psychological approaches to diabetic patient groups and providing remote tele-health psychological advice to people with chronic obstructive airways disease living in remote rural settings.

At the Institute of Psychiatry and South London and Maudsley Foundation Trust, we want to understand why some people respond well to first line psychological services provided by IAPT and other people do not. For example, non response could be related to the complexity of someone’s psycho-social problems, so if someone has for example a history of childhood trauma contributing to chronic depression, they may need more complex psychological treatment than can be provided first line by an IAPT service. The PROMPT study (PRedictors of OutcoMe to Psychological Treatments) began in January 2014 and will be working with up to 600 people attending Southwark IAPT to identify a range of factors that may predict the lack of response to first line psychological treatment. All people attending Southwark IAPT who wish to be involved will receive a comprehensive assessment encompassing a range of psychological and social factors including childhood trauma and will provide blood and hair samples for a range of biological factors including cortisol which can now be measured in a small sample of hair. Once the process is established in Southwark we would wish to provide it in the other boroughs we serve (currently, Lambeth, Lewisham and Croydon). We currently have 12-15,000 people referred to our 4 IAPT services each year. Once we have a clear picture of contributory factors, we hope to be able to personalize treatment more than is currently possible so that people would be better able to be matched up to a more appropriate level of treatment for their personal circumstances and people needing more intensive treatment for more complex problems would be able to access second line psychological treatments at an earlier stage.

In early January 2014, the Department of Health published “Closing the Gap: Priorities for essential change in mental health” (www.gov.uk/dh). This has followed the Department of Health’s previous strategy “No Health Without Mental Health” and sets out 25 aspects of mental health care and support where government, health and social care leaders, academics and representative organisations need to focus. These priorities include the need for more and better integration of mental health care and physical healthcare at every level. The IAPT Pathfinders described above will contribute to this aim. In addition, the National Institute of Health Research has funded our team of multidisciplinary researchers at Kings College to develop more integrated and personalised care for people with coronary heart disease and depression in the UPBEAT programme. We have been working with over 800 patients with heart disease in 33 South London practices to understand the links between both conditions and how better to manage people with heart disease, depression and frequent angina and non anginal pain. We have been contacting our patients for up to 4 years to examine how depression (present in just under 1 in 5) and anxiety (present in 1 in 4) affected the outcome of their heart disease. Patients with depression at the outset reported more angina chest pain over the years than those without depression. We interviewed some patients with heart disease and depression in depth and they described having a very large range of psycho-social problems predominantly losses (e.g. loss of health, control, income, relationships, function, sexuality, gender roles etc). Many men felt that they had lost their traditional “breadwinner role” and this contributed to their depression. As a result we designed a new form of nurse administered personalised care for people with heart disease, chest pain and depression that encouraged patients to prioritise goals to achieve around reduction of chest pain, improved activity, better diet, anxiety reduction and a range of other areas contributing to their depression. Patients were contacted weekly or less by telephone for 10-15 minutes if appropriate by the nurse over 6 months to encourage their chosen goal attainment. This seemed feasible in that few patients dropped out and said they had become more effective at self management and whilst their depression only improved at the same rate as the comparison group who didn’t have nurse contact, the group who did have nurse contact were around half as likely to report chest pain at the end of the treatment and 6 months after treatment ended. These results suggest that it may be worth testing if a more personal approach by practice nurses tailored to the priorities of the patient, may prove beneficial in larger trials and whether such an approach could be beneficial in other physical disorders. Psychological wellbeing practitioners in IAPT may also prove able to apply some of the methods used by our nurses in UPBEAT.

Better integration of mental health care and physical health care as advocated by the Rt Hon Nick Clegg MP, Deputy Prime Minister and Norman Lamb MP, Minister of State for Care and Support, in “Closing the gap; priorities for essential change in mental health” will require a range of novel approaches within general practice and IAPT and hopefully the approaches described above will contribute to this.

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