Mental and Physical Wellbeing: A shared agenda

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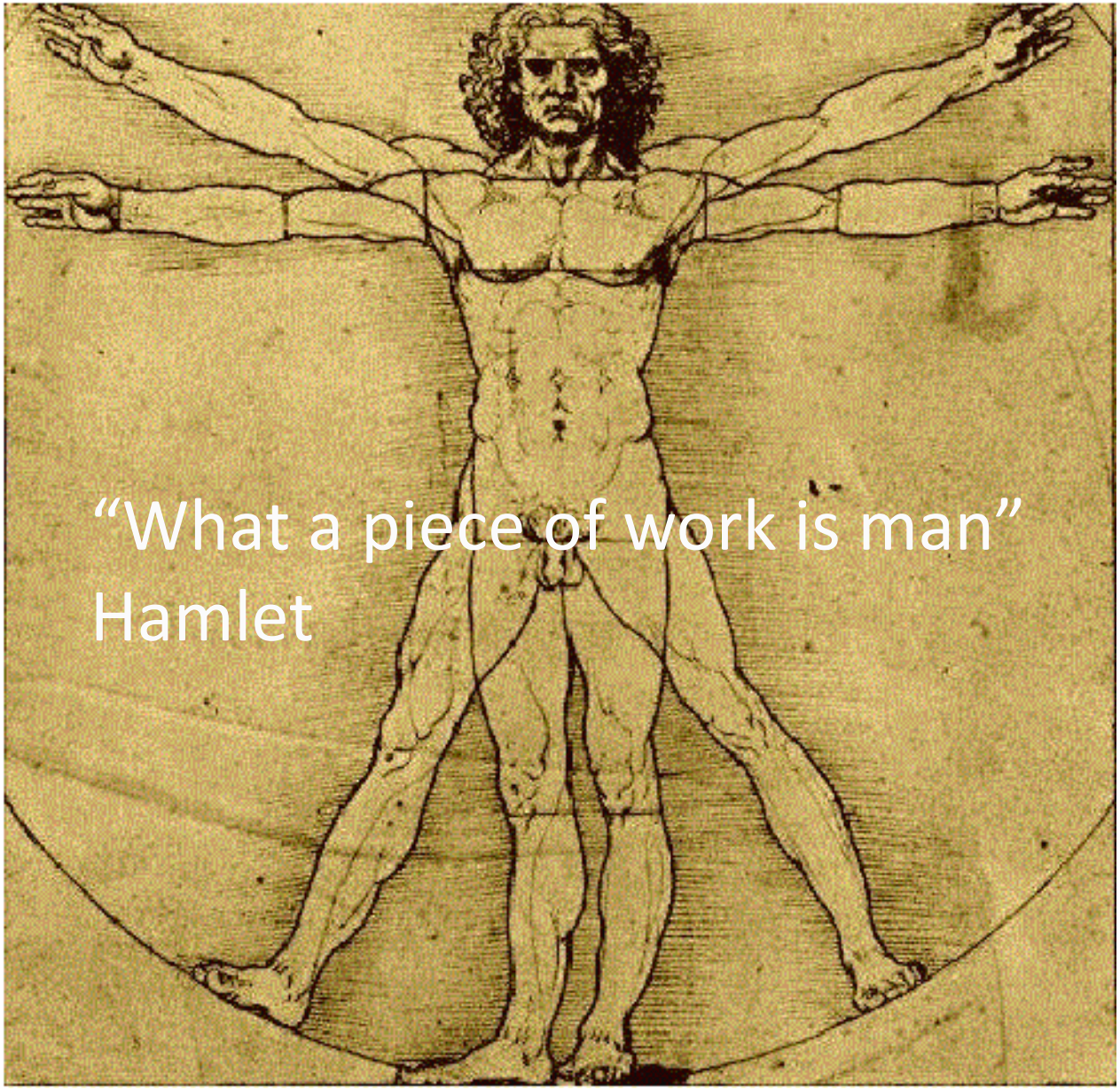
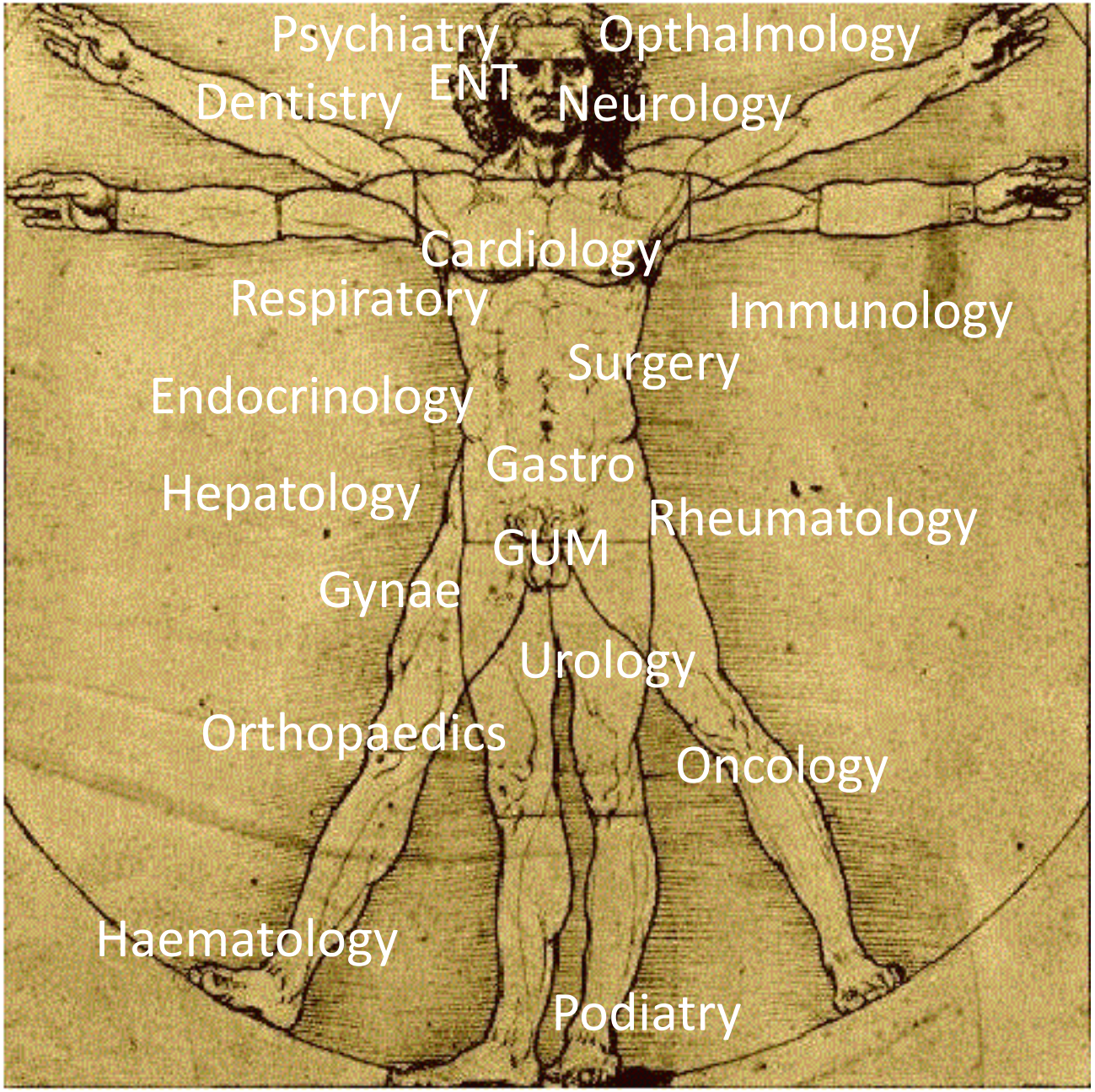
Challenge: How your project will improve patient's mental and psychological wellbeing as well as their physical health.


“What a piece of work is man”
Hamlet


Psychiatry
Opthalmology
ENT
Dentistry
Neurology
Cardiology
Respiratory
Immunology
Surgery
Endocrinology
Gastro
Hepatology
Rheumatology
GUM
Gynae
Urology
Orthopaedics
Oncology
Haematology
Podiatry

Why?

- Driven by the fact that there is now so much information that it is no longer possible to be expert in anything other than a small fraction of medicine
- However it has unfortunate consequences:
  - Lack of co-ordination of care
  - No-one has an overview of the patient leading potentially to misdiagnosis and mistreatment
  - It costs a fortune as we shuttle patients through multiple specialties
  - Polypharmacy is rife, particularly in older people. Everyone adds a drug but no-one takes any away
  - There are long delays as we send patients round different services
  - Patients spend hours travelling to and from appointments and it costs them a fortune
  - Patients spend large parts of their lives in hospitals, clinics and primary care

Last month I saw a patient who

- Had seen 13 different specialists in the past three months
- Plus the GP, the physiotherapist and a social worker
- And had declined to see a further 3 specialists
- Had 11 different diagnoses
- Had been prescribed at least 7 pharmaceutical products but had ended up using only 2 - perhaps fortunately

The patient was 23

When asked what they would do next the patient replied

"I think I am going to give up seeing doctors"

People come as a whole package and we split them up into bits

We are particularly poor at integrating the psychological and the physical

- The life expectancy of people with severe and enduring mental illness, most commonly schizophrenia and bipolar disorder is 20 years less than that of other people
  - Increased risk of suicide
  - More likely to smoke
  - More likely to develop Type II diabetes
  - Higher risk of cardiovascular disease
  - More likely to be obese
  - More likely to develop COPD

SHINE PROJECT

- Funded by the Health Foundation
- Technical support from the CLAHRC MPW theme
- Aims to improve the quality of physical healthcare in secondary care for those with SEMI
- Uses a service improvement methodology driven by the clinical team
- Co-production with service users is central

Elements

- Better integration of the assessment of physical health - the project has produced an integrated multidisciplinary assessment which reduced paperwork by >60%
- Clear action pathways for physical health problems including lifestyle issues
- Individual physical health plan for each patient including what changes in lifestyle are needed, where to get advice and help and what the effects of change will be

People with long term mental health conditions are more likely to be anxious and depressed

- Rates of anxiety and depression are elevated in most long term conditions. In heart failure, asthma, COPD, diabetes, cancer in remission and arthritis the prevalence of anxiety and depression is almost double that in the population. (usually around 40-50%)

- Those who are anxious and depressed:
  - Are less likely to be treatment adherent
  - Do less well on treatment
  - Use more healthcare resources
  - Are miserable

Intervening in mental health makes a difference

- For some LTCs the evidence base is currently poor the work has not yet been done- heart failure is an example
- However where there is a good evidence base improving psychological wellbeing leads to better physical health outcomes, lower costs and more appropriate use of healthcare system
- For instance psychological intervention in COPD reduces A&E attendances (Howard et al 2010)
- Anxiety and depression in Asthma are associated with reduced adherence to treatment and reduced QoL and treatment of these conditions is associated with reduced panic attacks anxiety, asthma symptoms, and increased quality of life

IAPT big data

- Increasing Access to Psychological Therapies is a national programme with services in every CCG area
- Offers psychological treatments to those with anxiety, depression and related common mental health problems
- Takes referrals from GPs, all health and social care professionals and takes patient self-referrals
- In its first three years it saw over a million patients
- It is a primary care focussed service and complements, but does not replace, clinical health psychology (psychologists embedded as part of secondary care teams) and liaison psychiatry

MPW has two interests

- The IAPT data is the single largest set of outcome data for psychological therapies in the world
- It is a naturalistic set, it shows what works and how well in everyday practice
- We are looking at what drives recovery in IAPT, why do some people get better, and others not? (Green et al BMJ Open 2015)
- We are setting up a platform across North West London, likely to extend to other services nationally, to look in the future at the impact of IAPT in LTCs

Mental and Physical Wellbeing Theme USP*

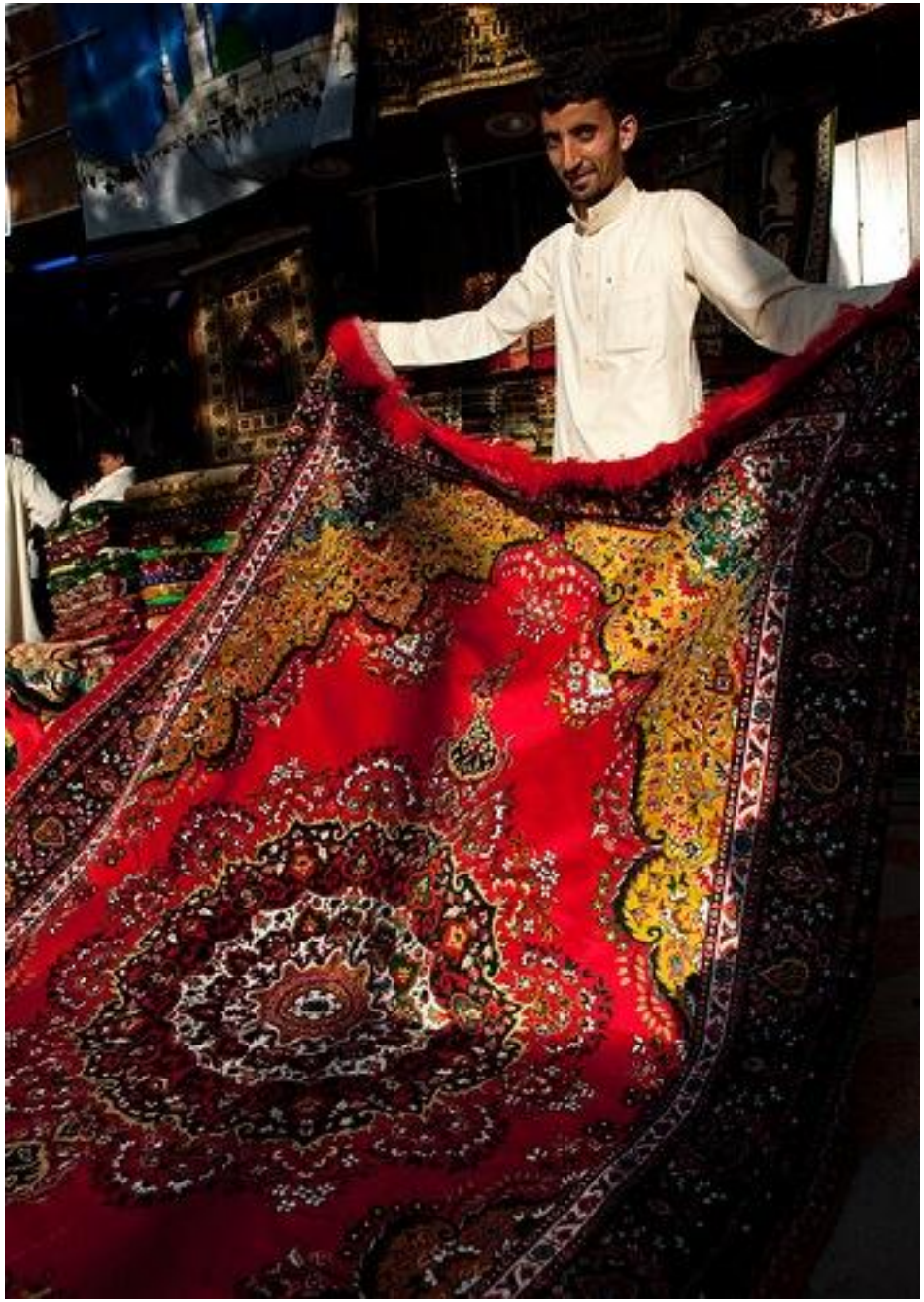
- Embedded in an improvement science setting in CLAHRC NW London
- Researching
  - The practicalities of how to include a more holistic approach in service improvement projects
  - Whether taking this approach will increase quality improvement projects chances of success.

* Unique Selling Point

So one thing you could do in your project

- Is to assess patients for anxiety and depression
- This is too rarely done in healthcare
- It is quite straightforward
  - The standard measures, GAD and PHQ9 take a couple of minutes to complete and are self-completion
  - If that is too long there is a four item screen
  - It is straightforward to get help for the patient externally via IAPT
  - Or in some cases it is most effective to involve health psychologists as acute team members, which also gives access to behaviour change expertise

NIHR CLAHRC
Northwest London



If the NHS refused treatment to everyone who had contributed to their own misfortune we wouldn't have many patients

- They drank too much
- They took too little exercise
- They ran too much on hard roads and damaged their joints
- They have broken their leg and damaged their ligaments skiing
- They didn't cook the chicken thoroughly enough
- They ate the wrong things
- They fell off a ladder doing DIY
- They smoked, took drugs
- They took too many prescription medications
- They didn't take their medication

Nor of course would we be able to get treatment ourselves

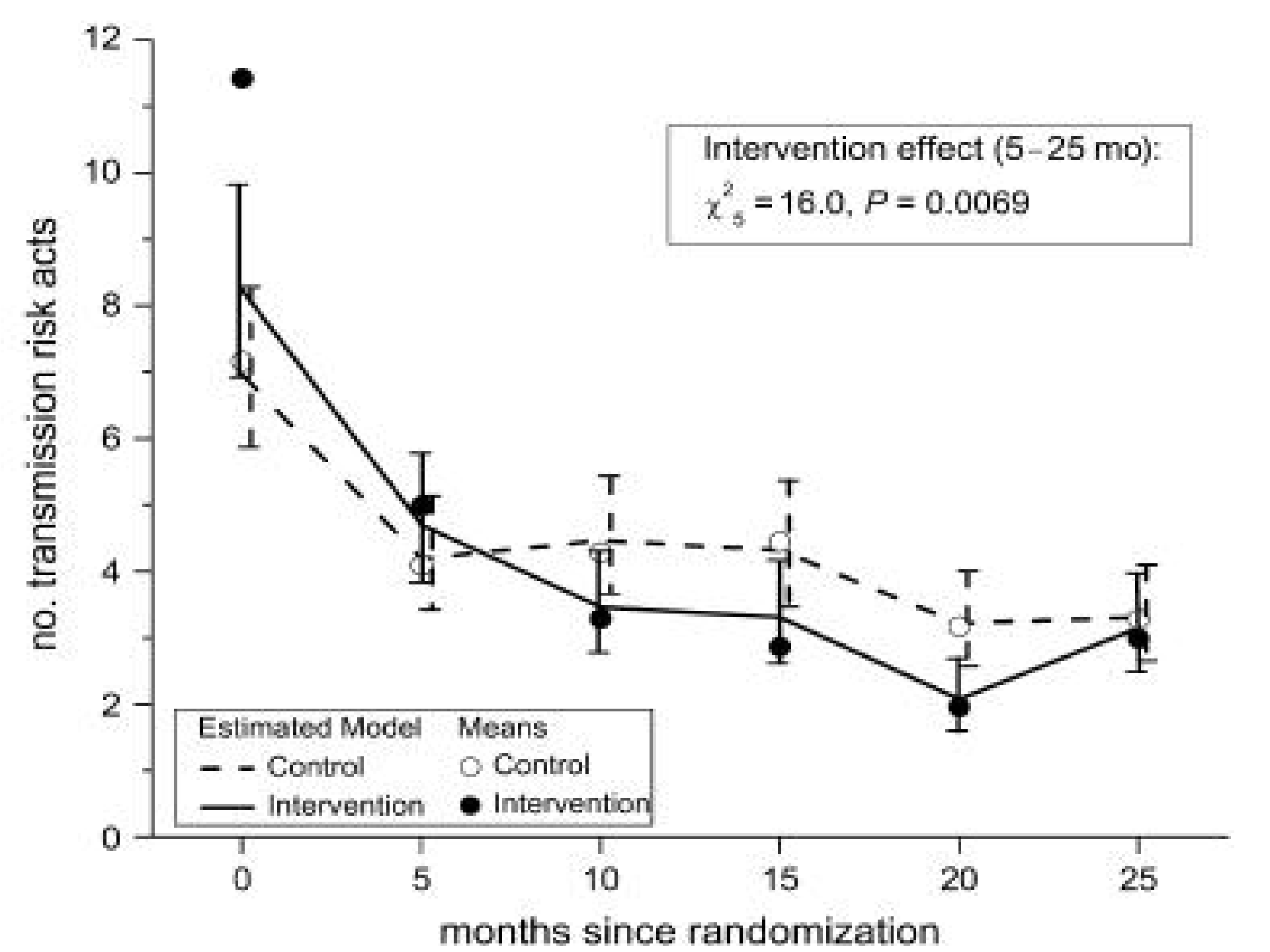

NON-
ALCO-
HOLIC
VODKA
NON-
ALCO-
HOLIC
NON-
ALCO-
HOLIC
NON-
ALCO
HOLI

Wherever we want people to change behaviour we have to ask

- How can I get change?
- How can that change be sustained?

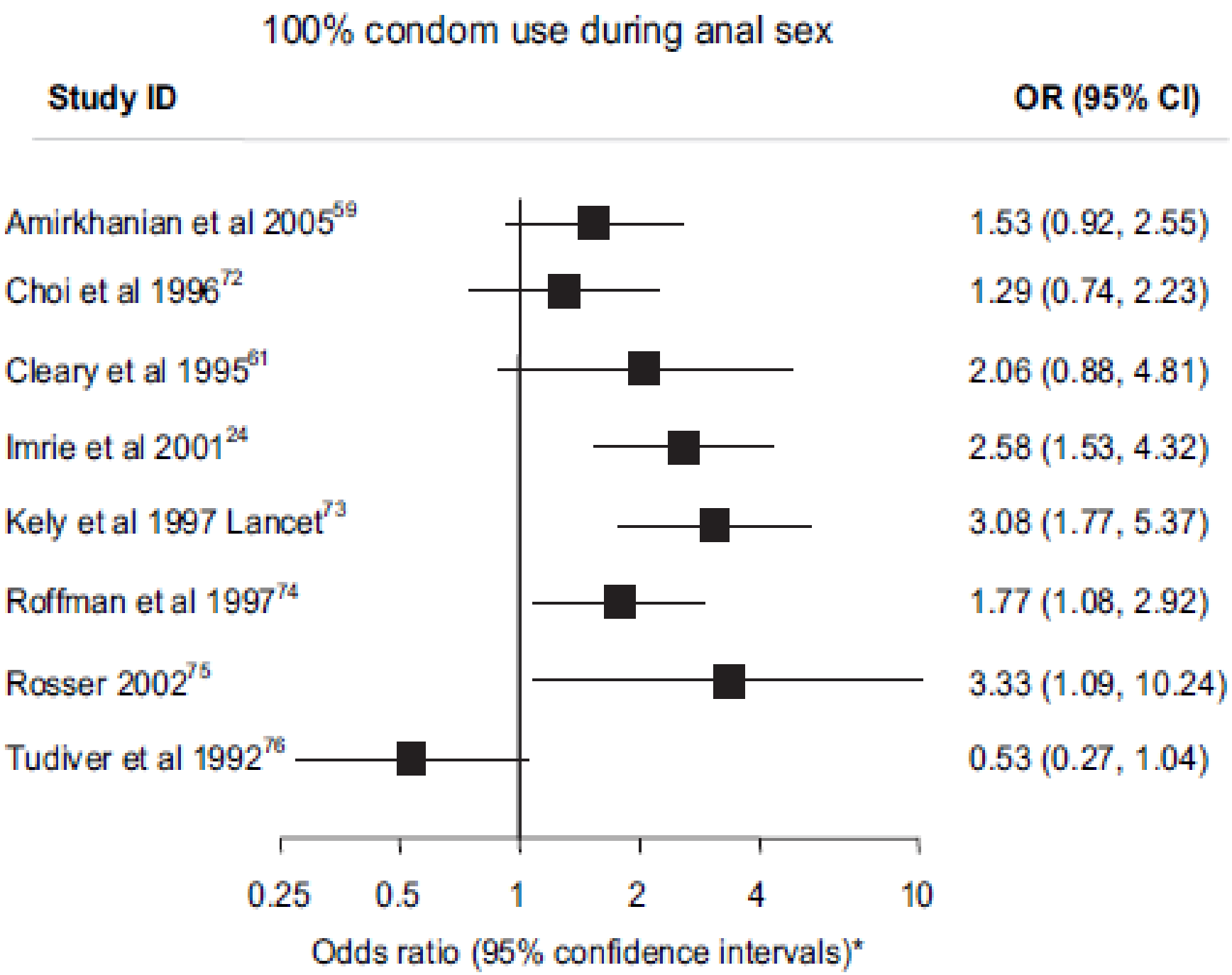
It is important to consider

- It is better to get someone to engage in moderate regular activity like walking the dog
- Than not going to the gym
- You have to accept that half a loaf is better than none
- The question is not “have we achieved everything we would have liked?” it is “is the patient better off than they were before?’


Intervention effect (5–25 mo):
$\chi^2_5 = 16.0$, $P = 0.0069$
Estimated Model
Control
Intervention
Means
Control
Intervention
no. transmission risk acts
months since randomization
0
2
4
6
8
10
12
0
5
10
15
20
25

People often assume that behaviour change will be automatic if we “educate” our patients

- Sometimes that is true but it is a rare individual who is not aware of what behaviour change they *should* make
- So lack of information can’t be the main issue
- It is important to think - and to ascertain with patients themselves - why they are not leading the lifestyle that would improve their health
- A lot is known about what works and does not work in behaviour change. It is important to draw on that literature rather than hope the patient will “see sense”


100% condom use during anal sex
Study ID
OR (95% CI)
Amirkhanian et al 2005[59]
1.53 (0.92, 2.55)
Choi et al 1996[72]
1.29 (0.74, 2.23)
Cleary et al 1995[61]
2.06 (0.88, 4.81)
Imrie et al 2001[24]
2.58 (1.53, 4.32)
Kely et al 1997 Lancet[73]
3.08 (1.77, 5.37)
Roffman et al 1997[74]
1.77 (1.08, 2.92)
Rosser 2002[75]
3.33 (1.09, 10.24)
Tudiver et al 1992[76]
0.53 (0.27, 1.04)
0.25
0.5
1
2
4
10
Odds ratio (95% confidence intervals)*

But we should not limit mental well-being only to the absence of mental health problems and behaviour change

Why do we bother to provide healthcare to people in the first place?

Various reasons

- We want to stop people dying (temporarily)
- We want to prevent them giving infectious diseases to other people
- We want a productive workforce
- We want to reduce suffering

The last of these is particularly interesting

- "Suffering" is a subjective - psychological - term
- At its heart is the proposition that we want to maximise enjoyment of life and being sick gets in the way of that
- Thomas Jefferson's first draft of the US constitution sums it up "We hold these truths to be sacred & undeniable; that all men are created equal & independent, that from that equal creation they derive rights inherent & inalienable, among which are the preservation of life, & liberty, & the pursuit of happiness"
- Psychological well-being is a central, perhaps the central, aim of the NHS and healthcare worldwide
- It is why we are here today

And it is, of course, why NICE uses QALYs

- Life has not just length, but it has quality as well
- And we ultimately judge that quality by how happy or unhappy we are
- It is possible to be terminally ill and still have a good quality of life
- It is not possible to be depressed and have a good quality of life

Which suggests

- It is prudent in any study to look at Quality of Life (QoL)
- A good assessment of quality of life should *include* subjective well-being as well as more direct measures of things one expects the intervention to change
- Not all QoL measures include subjective well-being. Some are intermediate measures of disability for instance scales looking at Activities of Daily Living
- It is usually straightforward either to choose a scale which does include life satisfaction or to add on a simple additional measure

So three ways you might achieve integration are:

- Identifying and treating mental health problems in patients with physical health problems
- Finding effective ways of getting and maintaining health behaviour change
- Measuring psychological well-being directly in your project

“The rest is silence” Hamlet