Health in mind and body: bridging the gap

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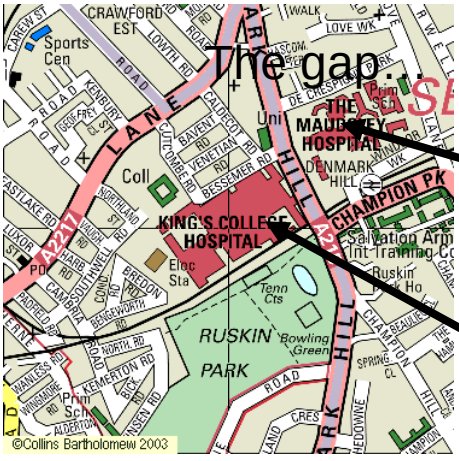
The Gap.....



Why the gap matters

•People with mental disorders have 5-10 years lower life expectancy than the rest of the population;

•If you have depression after a heart attack you are up to 3 times more likely to die in the next year;

•The commonest cause of maternal mortality after childbirth is suicide;

•20% of Accident and Emergency Department admissions associated with alcohol abuse/dependence;

•-70% of "frequent attenders" or "high users" of secondary care services have mental health disorders

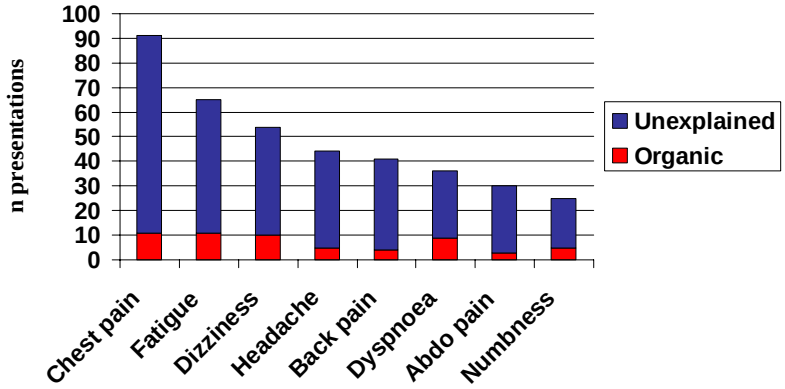
•50% of all new hospital outpatients have physical symptoms unaccounted for by physical disease.

Illness is not the same as disease

		Illness – the patient experience	
		Sick	Well
Disease according to medical science	Present	Medically explained illness	Prodrome /screening
	Absent	Medically unexplained	Healthy

Symptoms in US primary care

Kroenke and Mangelsdorff, 1989

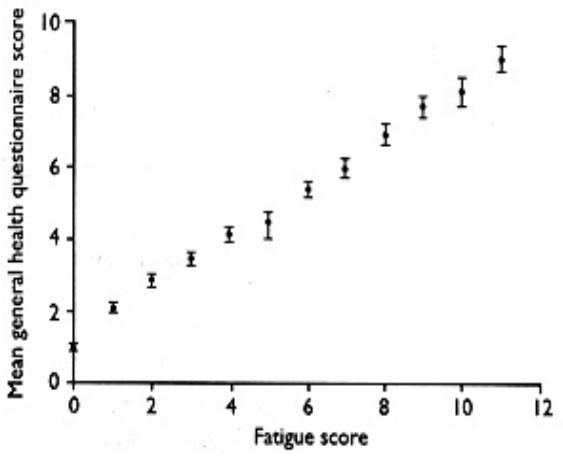


Prevalence of unexplained symptoms in 600 consecutive new attendees to medical clinics at King's College Hospital

Clinic	Prevalence
Chest	59%
Cardiology	56%
Gastroenterology	60%)
Rheumatology	58%
Neurology	55%
Dental	49%
Gynaecology	57%
Total	**56%**

Nimnuan and Wessely, 2000

Association between fatigue and psychological distress in a population based sample



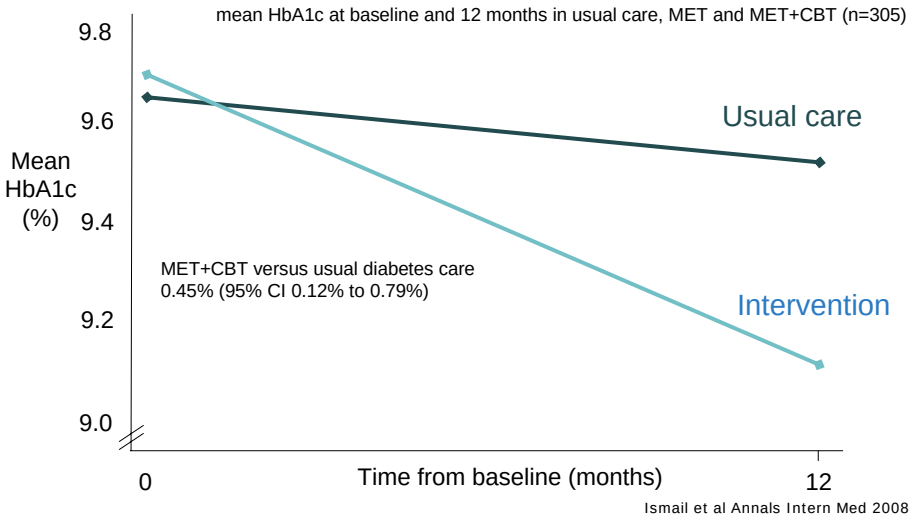
Pawlikowska et al, BMJ 1994

Physical symptoms are a an ESR/CRP for psychological distress

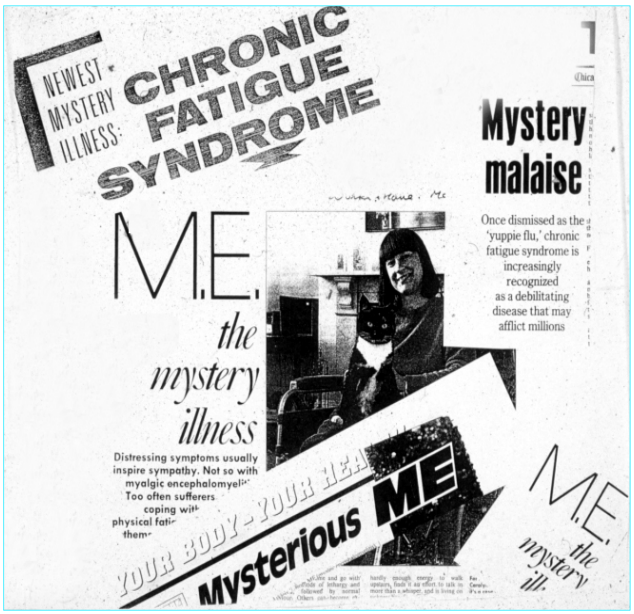
Symptom Counts	No. of Patients	Mood or Anxiety
0-1	**106**	**4%**
2-3	**131**	**18%**
4-5	**129**	**31%**
6-8	**96**	**52%**
9+	**37**	**78%**

So what?

RCT in type 1 diabetes



Ismail et al Annals Intern Med 2008



CFS: What do we know?

- **Predisposition by genes and/or previous depression;**
- **Precipitated by various insults – especially infection (Glandular fever, meningitis etc), toxins, life events**
- **Perpetuated by behavioural and psychological factors;**
- **No evidence for chronic infection, "Yuppie Flu", hysteria, personality, contagious etc. etc.**

- What doesn't work – antidepressants, anti viral agents, immune modulators, diets, allergy treatments, vitamins, being told to pull yourself together etc. etc.

- What might work - understanding what you think about your illness and what you do about it.

The slow pace of translation

Wessely S, David A, Butler S, Chalder T. (1989). The management of chronic postviral fatigue syndrome. *J Royal College of General Practitioners* , 39, 26-29

Butler S, Chalder T, Ron M, Wessely S. (1991) Cognitive behaviour therapy in chronic fatigue syndrome. *J Neurol Neurosurgery and Psychiatry,* 54, 153-158

Bonner D, Butler S, Chalder T, Ron M, Wessely S. (1994) A follow up study of chronic fatigue syndrome. *J Neurol Neurosurgery and Psychiatry,* 57, 617-621.

Deale A, Chalder T, Marks I, Wessely S. A randomised controlled trial of cognitive behaviour therapy for chronic fatigue syndrome. Am J Psychiatry 1997; 154:408-414.

Deale A, Chalder T, Hussain K, Wessely S. Long term outcome of cognitive behaviour therapy versus relaxation therapy for chronic fatigue syndrome: a 5 year follow-up study. Am J Psychiatry 2001: 158: 2038-2042

Comparison of adaptive pacing therapy, cognitive behaviour therapy, graded exercise therapy, and specialist medical care for chronic fatigue syndrome (PACE): a randomised trial

P D White, K A Goldsmith, A L Johnson, L Potts, R Walwyn, J C DeCesare, H L Baber, M Burgess, L V Clark, D L Cox, J Bavinton, B J Angus, G Murphy, M Murphy, H O'Dowd, D Wilks, P McCrone, T Chalder*, M Sharpe*, on behalf of the PACE trial management group†

Summary

Background Trial findings show cognitive behaviour therapy (CBT) and graded exercise therapy (GET) can be effective treatments for chronic fatigue syndrome, but patients' organisations have reported that these treatments can be harmful and favour pacing and specialist health care. We aimed to assess effectiveness and safety of all four treatments.

Methods In our parallel-group randomised trial, patients meeting Oxford criteria for chronic fatigue syndrome were recruited from six secondary-care clinics in the UK and randomly allocated by computer-generated sequence to receive specialist medical care (SMC) alone or with adaptive pacing therapy (APT), CBT, or GET. Primary outcomes were fatigue (measured by Chalder fatigue questionnaire score) and physical function (measured by short form-36 subscale score) up to 52 weeks after randomisation, and safety was assessed primarily by recording all serious adverse events, including serious adverse reactions to trial treatments. Primary outcomes were rated by participants, who were necessarily unmasked to treatment assignment; the statistician was masked to treatment assignment for the analysis of primary

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Therapies

- Adaptive Pacing Therapy (APT)
- Cognitive Behaviour Therapy (CBT)
- Graded Exercise Therapy (GET)
- Standard Medical Care (SMC)

Differences between therapies

"Pacing" - adapting to illness, "Living within your limits"

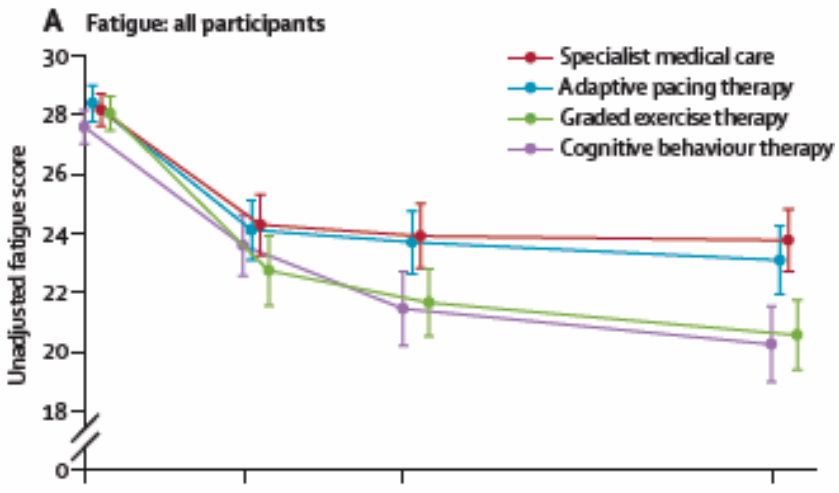
CBT and GET: behavioural activation / graded exposure

CBT also addresses thoughts and feelings

Standard medical care – general support

Trial

- Funded by MRC, DH, DWP, Scottish Office
- 641 successfully randomised
- Treatment fidelity maintained throughout
- 95% follow up at one year



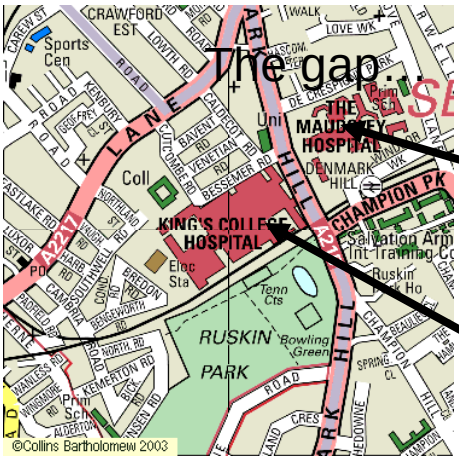
Safety

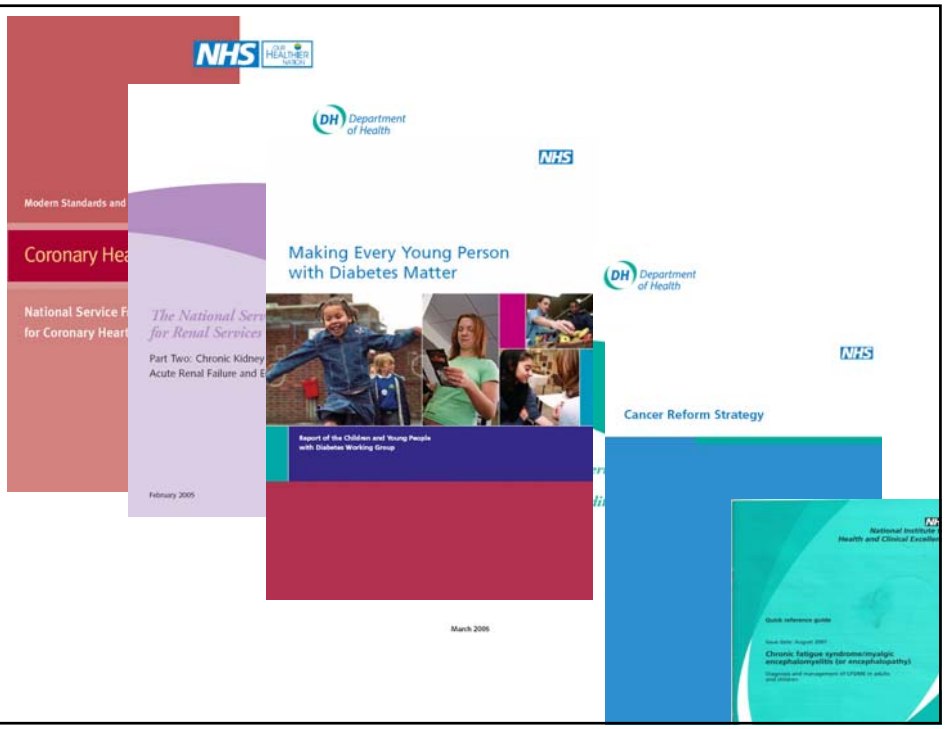
Measured 5 ways

% with events

	SMC	APT	GET	CBT
Serious adverse reactions	**1**	**1**	**1**	**2**
Serious deterioration	**9**	**8**	**6**	**9**

The Gap.....


The gap...
CRAWFORD EST
Sports Cen
THE MAUDSLEY HOSPITAL
DENMARK HILL
KING'S COLLEGE HOSPITAL
CHAMPION PK
RUSKIN PARK
Bowling Green
Tenn Cts
Elec Sta
©Collins Bartholomew 2003


NHS
Department of Health
Modern Standards and
Coronary Hea
National Service F
for Coronary Heart
Making Every Young Person with Diabetes Matter
Report of the Children and Young People with Diabetes Working Group
March 2006
Cancer Reform Strategy
Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy)

Why the gap exists

Separate commissioning of mental health and physical healthcare services

Separate NHS trusts provide physical and mental healthcare

Separate training for mental vs physical healthcare professionals

Increasing sub-specialisation within medicine

Separate classifications for psychiatric and neurological disorders

Stigmatisation of mental disorders and mental health providers – in population as a whole and by other healthcare professionals

Closing the Gap

- GP led commissioning
- Academic Health Sciences as examples of good practice
- Shifts in the medical student curriculum
- More reciprocity – improved psychological care for those with medical disorders, improved medical care for those with psychiatric disorder, improved both for those in between
- Increasing acceptance of the importance of mental health in physical healthcare settings for delivering patient centred outcomes -