



Referral for psychological therapy of people with long term conditions improves adherence to antidepressants and reduces emergency department attendance: Controlled before and after study



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ABSTRACT

Background: Referral to psychological therapies is recommended for people with common mental health problems (CMHP) however its impact on healthcare utilisation in people with long term conditions (LTCs) is not known.

Method: Routinely collected primary care, psychological therapy clinic and hospital data were extracted for the registered population of 20 practices ($N = 121199$). These data were linked using the SAPREL (Secure and Private Record Linkage) method. We linked the 1118 people referred to psychological therapies with 6711 controls, matched for age, gender and practice. We compared utilisation of healthcare resources by people with LTCs, 6 months before and after referral, and conducted a controlled before and after study to compare health utilisation with controls. We made the assumption that collection of a greater number of repeat prescriptions for antidepressants was associated with greater adherence.

Results: Overall 21.8% of people with an LTC had CMHP vs. 18.8% without ($p < 0.001$). People with LTCs before referral were more likely to use health care resources (2-tailed t -test $p < 0.001$). Cases with LTCs showed referral to the psychological therapies clinic was associated with increased antidepressant medication prescribing (mean differences 0.62, $p < 0.001$) and less use of emergency department than controls (mean difference -0.21 , $p = 0.003$).

Conclusions: Referral to improved access to psychological therapies (IAPT) services appears of value to people with LTC. It is associated with the issue of a greater number of prescriptions for anti-depressant medicines and less use of emergency services. Further studies are needed to explore bed occupancy and outpatient attendance.

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Introduction

Long term conditions (LTCs) are common and an increasing proportion of the burden of disease (Lopez, Mathers, Ezzati, Jamison, Murray, 2006; Mathers, Boerma, & Ma Fat, 2009). People with LTCs have a higher prevalence of common mental health problems (CMHP), principally depression and anxiety (Patten, 2001; Patten et al., 2008; Shen, Sambamoorthi, & Rust, 2008). People with chronic physical conditions and mental illness are more likely to use emergency services and have higher total, outpatient, and pharmaceutical expenditures than those without mental illness (Shen et al., 2008).

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A variety of case-management models are proposed for people with long term conditions (Drennan & Goodman, 2004); and managing both mental and physical health is important (Harkness et al., 2010; Lempp et al., 2009). The principles of care described within the “Chronic care model” (Bodenheimer, Wagner, & Grumbach, 2002a) appear to be associated with improved clinical outcomes in both physical and mental health (Bodenheimer, Wagner, & Grumbach, 2002b; Tsai, Morton, Mangione, & Keeler, 2005). In the UK the number of people with LTCs is increasing and these people make greater use of the health service (Wilson, Buck, & Ham, 2005). Recent policy developments propose the greater use of mental health services in the long term care of people with LTCs (Lau, 2005). However, the focus at health service level has been on improved case management by experienced nurses (“community matrons”) and the use of risk scores to attempt to identify those at highest risk of readmission (Hall, Kulendran, Sadek, Green, & de Lusignan, 2011).

Improving Access to Psychological Therapies (IAPT), principally the provision of brief interventions and access to cognitive behavioural therapy, has been provided by the NHS in England (Clark et al., 2009); and we have shown that referral to these services is associated with a reduction in health care utilisation; people referred to IAPT are issued fewer sick certificates, have fewer admissions to hospital, bed-days, and emergency department attendances (de Lusignan, Chan, Parry, Dent-Brown, & Kendrick, 2011).

We carried out this study to explore whether referral of people with LTCs to a psychological therapies service was associated with a change in health service utilisation or adherence to antidepressant therapy. The principal comparison in the paper is a controlled before and after comparison of those with LTCs exposed to IAPT compared with those with LTCs who are not.

Method

Overview

We carried out anonymous linkage of general practice, hospital and psychological therapy service data. We report the prevalence of LTCs; and the proportion of people with CMHP who have an LTC.

Our cases are people exposed to IAPT ($n = 1118$) of whom 118 had an LTC and 932 did not; our controls were age, gender, practice matched with an approximate ratio of 6:1. Of the controls ($n = 6711$) 1155 had an LTC and 5556 did not (Fig. 1). The controls were identified from the total number of people with LTCs

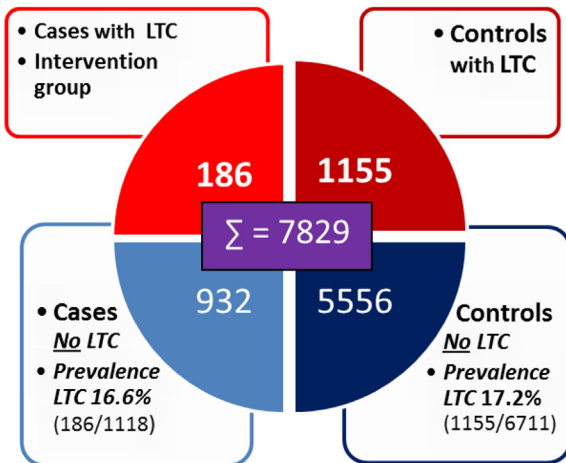


Fig. 1. Cases and controls, with and without long term conditions (LTC). Cases have been exposed to psychological therapies (IAPT).

($n = 23,1310$) or from the wider practice population without LTCs ($n = 98,068$).

We report the utilisation of health care resources by those with and without LTCs; and healthcare consumption before and after referral to IAPT. Finally, we make a controlled before and after comparison of the people with LTC and CMP ($n = 118$) and the controls with LTCs ($n = 1115$).

Sample

The study used linked primary care, psychological therapy and hospital datasets linked using our Secure and Private Record Linkage (SAPREL) method (de Lusignan, Navarro, et al., 2011). This novel method uses fuzzy-logic to link records without the researcher knowing the identity of the linked cases. Routinely collected primary care, psychological therapy clinic and hospital data were extracted for the registered population of 20 practices situated in two sites – one in East London, the other in a northern city ($N = 121,199$ registered patients) as part of a National Institute for Health Research evaluation of IAPT demonstration sites (Parry et al., 2011). We collected the following data from practices: basic demographic, mental health problems, sick-certificate issue, antidepressant prescription and LTC data (Fig. 2). We extracted coded data for the study variables along with the related date, and where

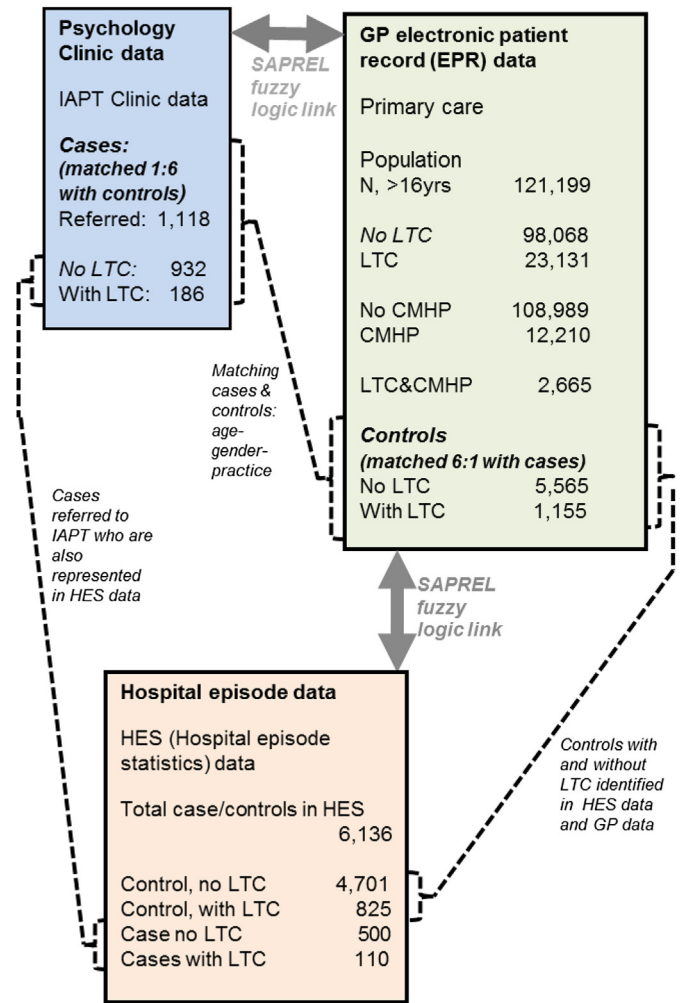


Fig. 2. People referred to psychology clinic ($n = 1118$), Population recorded on GP electronic patient record (EPR) system ($N = 121,199$), and control group ($n = 6720$), and number of cases and controls with Hospital episode data ($n=6136$).

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