Victoria Medical Centre

BEATING THE WINTER BLUES

VMC PPG AUTUMN EVENT, 20 October 2011

The meeting was attended by 32 people, and the speakers were:

- **Dr. Clair Pollard**, clinical psychologist,
- **Dr. Sarah Ketteley**, clinical psychiatrist,
- **Liz Greenway**, psychotherapist and counsellor
- **Juliana Moro**, psychological wellbeing practitioner, from Westminster Improving Access to Psychological Therapies (IAPT) team.
- Present in the audience was **Baffor Ababio**, representing **Westminster Mind**.

The meeting was opened by Margaret McKinlay who welcomed the audience and speakers and introduced Mary Orr, editor of the VMC PPG Newsletter.

VMC practice manager, Aziz Pandor, gave a short talk about the data gathering exercise that the practice and the PPG are currently engaged in, designed to ensure that we as complete a database as possible.

The first presenter was Sarah Ketteley on 'What is depression?'

The difference between 'being down' and depression is a matter of degree. 15% of adults will experience depression in their lifetime. 25% of patients with two or more chronic physical problems have depression.

Depression is the third most common reason for a GP consultation.

There are approximately 1.2m people living with depression in England today costing up to £1.7bn per year (70% medication, 30% other services) increasing to £7.5bn given the associated additional costs.

Two thirds of all suicides have a diagnosis of depression. Mild depression increases the risk of suicide fourfold, severe depression twentyfold.

The risk factors for depression include genetic/family factors, gender (women suffer more than men), adverse childhood experience e.g. abuse, personality, social circumstances. Life events (e.g. bereavement) may trigger vulnerability to a depressive response.

Very important contributory factors are: not having a confiding relationship with another person, having three or more children under 14 years at home, having no paid employment. Protective factors are having confiding relationships, friendships and marriage (more protective for men than women.)

The components of depression are: emotional – how do I feel?: cognitive – how do I think?: physical – e.g. disturbed sleep patterns and appetite: behavioural/functional – feeling of numbness, inability to think, no appetite for food. The symptoms include a depressed mood, loss of interest and enjoyment of life, reduced energy, increased fatigue, diminished levels of activity. Patients commonly suffer reduced concentration and attention, reduced self-esteem and confidence, feelings of guilt and worthlessness, a bleak and pessimistic view of the future, thoughts of self-harm or suicide, disturbed sleep patterns and diminished appetite for food.

A diagnosis of depression is made if the symptoms persist for more than two weeks. Four clinical categories influence the treatment choices. Is the depression mild, moderate, severe without psychotic symptoms, or severe with psychotic symptoms? Mild depression is always considered serious because it affects patients' functioning.

Depression is common, it can be recognised and can be treated.

At this point, questions were invited.

- **Are the elderly more vulnerable?** No, 30-65 is the most vulnerable age group, people learn to cope better as they age.
- **Is depression an extension of sadness?** very difficult to decide. Life events can make us sad. Sadness is transitory but prolonged sadness may lead to depression if the patient is vulnerable.
- **Is depression an illness?** Yes. Real chemical changes take place in nerve receptors in the brain. Also real biological functioning changes occur leading to not just a sense of loss outside of oneself but of loss of part of oneself.
- **What is the best treatment?** This is discussed later in the note.
- **How common is depression amongst the disabled?** Don't know, don't have the figures but the two are likely to feed each other.
- **Why do more women than men suffer depression?** Genetics possibly, also the different gender roles but women have better protection mechanisms and are more likely than men to ask for help. We know that babies of anxious pregnant women are more likely to develop emotional problems.

- **Is there a distinction between depression and melancholia?** Without treatment, depressions tend to resolve in about six months. Melancholia is a persistent low mood.

The next presentation, 'Managing Depression', was given jointly by Clair Pollard, Juliana Moro, and Liz Greenway.

There are several self-help options to try before seeking professional help:

- Strictly regulate your bedtime and waking time, using an alarm if necessary. Do not nap during the day. 5 hours' good sleep is better than 8 hours' disturbed sleep. Do not use your bedroom for activities other than sleep.
- Reduce your caffeine [coffee/tea] and nicotine [tobacco products] (stimulants) and alcohol (depressant) intake. Certainly take none of these less than four hours before bedtime.
- Eat healthily, never miss breakfast. There is good evidence that omega 3/6 oils (in oily fish – also available as capsules) are beneficial.
- Be physically active in the day. Walking is especially good. Body image improves, mood enhancing hormones (endorphins) are generated, anxiety is reduced, better sleep is achieved. Also increased vitamin D from exposure to sunlight. Exercise on prescription – a low cost exercise programme at Queen Mother Sports Centre – is available from GP.
- Seek support from those around us. One in four suffers depression at some time.
- Do more! If you give up doing things outside the home, the less you feel like doing. Do something that gives you pleasure. Look for small achievements day to day. Do something even when you don't feel like doing anything.
- Other self-help: Books on prescription – free long loans at local library of evidence-based books – GP issues prescription. On-line website 'Living Life to the Full.' A Cognitive Behavioural Therapy (CBT) programme. www.llttf.com

Other ideas which might have more specific relevance to someone experiencing depression or mental ill-health, are:

- Doing voluntary work/befriending
- taking an educational/training course
- seeking employment

- going on a retirement preparation course
- assertiveness training
- seeking financial advice
- learning meditation techniques
- investigating alternative therapies

If more help is needed what happens next? NICE guidelines, (the National Institute for Health Care Excellence), guidelines suggest psychological therapy alone for mild depression and psychotherapy with medication for moderate to severe depression.

The therapies are based on a stepped care model with the least intrusive and evidence-based most effective treatment offered first.

If this is not effective a more powerful technique/medication will be used. Low intensity therapy starts with guided self-help (coaching) moving to CBT and then to counselling with short term psychodynamic therapy.

CBT is a NICE recommended treatment with a strong evidence-based record of effectiveness but not appropriate or effective for all patients. But, when it works, it is as effective as antidepressants in mild to moderate cases.

CBT focuses on the relationship between thoughts, feelings and bodily sensation with the aim of changing the thought patterns. The patient is given homework assignments between appointments.

Psychotherapy and counselling involve interpersonal dialogue providing a place to pause and make meaning of life events and situations. They provide the patient with an empathetic and listening ear.

At this stage of the presentation a helpful summary of an actual case was presented which provided evidence of the real and beneficial effects of therapy.

At this stage questions were invited of which there was only one.

- **Was the patient in the case study receiving high intensity treatment?** Yes, both CBT and counselling over ten sessions.

The meeting was rounded off with a summary of the services provided by VMC:

- An incoming patient might see a practice nurse if not a GP, and the first action is the completion of an assessment questionnaire.

- Depending on the needs identified the patient might be referred to the Westminster IAPT team for CBT or be encouraged to take the self-help path in 20 minute coaching sessions (especially for mild depression, panic attacks and generalised anxiety disorder.)
- Another path is to take part in workshops at the Westminster Centre for Psychological Wellbeing (for instance for sleep disorders and training in assertiveness skills.)
- The next level up might be up to 20 weekly sessions of CBT (12 – 16 are usually sufficient.) This treatment is available for depression, post traumatic stress syndrome, obsessive compulsive disorder and phobias.
- A patient can be referred to IAPT either by a GP or they can self-refer. Counselling at VMC is offered on the basis of nurse or GP referral. The sessions last 50 minutes and 2 – 10 sessions are normal. Longer term counselling is available at a local hospital.
- More serious depression and other mental problems will require contact with the VMC Community Psychiatric Nurse. Antidepressants might be prescribed. In severe cases of depression (which often recurs) working with the patient when the patient is well is important to improve the patient's awareness of what is likely to help them stay well.

Questions were then taken.

- **How long might one have to wait for treatment?**
  - There is a maximum two week wait for the initial assessment.
  - If self-help is suggested then it can begin immediately, for CBT there would be a 6-8 week wait.
  - For counselling there is a 4-6 week wait for first assessment.
  - For secondary level hospital services the wait is 2-4 weeks.
- **Are foreign language services available for patients with poor English?**
  - Yes. If necessary an interpreter is used. Language is not a bar to treatment.

The meeting ended with a vote of thanks to the speakers from the chair.

Andrew Brown, 23 October 2011