

LONG TERM CONDITION: Depression

Module: Community Care & Management of Longer-term Conditions

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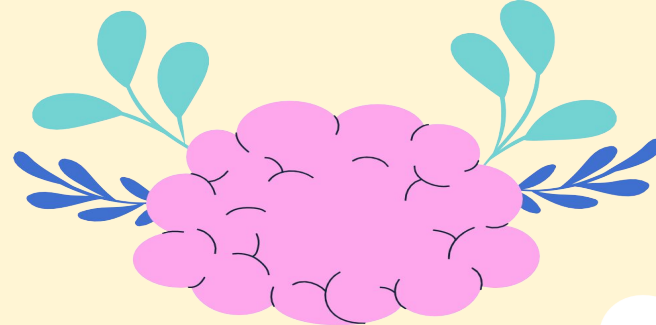
Lecturer: Muhammed Khan

NAME: BISMA AMIN

ID NUMBER: 2435002



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Y Drindod Dewi Sant
University of Wales
Trinity Saint David



INTRODUCTION

LTCs are health conditions that require long-term care and management, usually for most of a person's life. They are often characterized by complex symptom profiles, episodic healthcare use, and significant biopsychosocial consequences. Traditionally, single-disease-based healthcare systems, both in the UK and globally, have dominated health system organisation. Yet the growing modern experience of multimorbidity, chronic illness, and concurrent physical and mental health problems has exposed the limitations of this approach. Mental health LTCs, with depression as one example, represent important opportunities to consider integrated, person-centered, and multidisciplinary models of care.

Depression is increasingly recognized as a chronic, recurrent, and disabling mental health condition. Far from being an episodic disorder, evidence suggests that for many individuals, depression follows a long-term fluctuating course characterized by frequent relapses, residual symptoms, and risks of recurrence (Malhi & Mann, 2018). It significantly interacts with physical health, social functioning, and overall quality of life. Furthermore, depression contributes to inequalities in health outcomes and disproportionately affects people living in conditions of deprivation, those with chronic physical illness, and marginalized communities (Marmot, 2020).

The importance of depression as an LTC is evidenced by the NHS Long Term Plan 2019, with its priority on mental health transformation and integration across services. Depression holds deep personal, societal, and economic impacts, including wide-ranging effects on families, carers, workplaces, and community well-being (Centre for Mental Health, 2021).

This booklet critically examines depression as a long-term condition in the UK by discussing its clinical definition, prevalence, aetiology and risk factors, and the multifaceted impact on individuals and their families. It examines evidence-based treatment pathways available within the NHS, including psychological therapies, pharmacological treatments and multidisciplinary approaches. This booklet further discusses theoretical models-nationally and internationally-that inform best practice in managing depression. UK policy frameworks and political agendas that shape mental health services are examined, focusing on their implications for service delivery, equity and patient experience. Finally, it outlines recommendations for person-centred care, self-management and collaborative practice. This resource is intended for health and social care professionals whose role includes working with people with LTCs and who wish to enhance their evidence-based practice.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC6297343/>



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DEFINITION



Depression is clinically defined as a mood disorder characterised by persistent low mood, diminished interest or pleasure in activities, and accompanying cognitive, emotional and somatic symptoms lasting at least two weeks (American Psychiatric Association, 2013). The DSM-5 distinguishes between mild, moderate and severe depressive episodes, as well as chronic presentations such as dysthymia (persistent depressive disorder). The ICD-11 (WHO, 2023) similarly defines depression as a sustained disturbance in mood and affect that leads to significant impairment in personal, social, occupational or educational functioning.

Importantly, depression is not a single homogeneous disorder; it can present in a variety of subtypes, including:

- Major depressive disorder (MDD)
- Persistent depressive disorder (dysthymia)
- Seasonal affective disorder
- Perinatal Depression
- Depression with psychotic features
- Depressive symptoms secondary to physical LTCs

These diverse presentations underscore the need for nuanced assessment and tailored pathways to intervention. Contemporary conceptualisations position depression as a systemic condition that invokes complex neurobiological, cognitive, and social mechanisms; this provides additional support for the categorization of depression as a long-term condition rather than an isolated acute illness (Malhi & Mann, 2018).

Prevalence and Global Burden

Depression is among the most frequent conditions in mental health, affecting an estimated 280 million people of all ages worldwide. It is the leading cause of disability, contributing more to YLDs than any other condition.

In the UK, prevalence rates have increased steadily in the last decade. The Office for National Statistics report that, in 2023, roughly:

- 16% of adults report moderate-to-severe depressive symptoms
- 26% of young adults aged 16–29 meet diagnostic criteria
- Women are twice as likely to report depressive symptoms as men.
- People with LTCs are 2–3 times more likely to develop depression.

The COVID-19 pandemic produced long-lasting changes in population mental health. Studies by Pierce et al. (2021) report that the rates of depression remain higher years after its outbreak, influenced by socio-economic stressors (bereavement, chronic illness), induced by long-term uncertainty.

According to NHS Digital (2022), this has implications for service demand:

- Mental health referrals reached a record high in 2022
- The waiting lists for psychological therapies increased considerably.
- Young people's referrals to mental health services doubled in the last decade

These figures show the rising importance of depression in setting priorities for public health in the UK.

GLOBAL: https://www.who.int/health-topics/depression#tab=tab_2
UK: <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions>

Economic Burden

Depression is considered one of the most economically burdensome health conditions in the UK. According to the Centre for Mental Health (2021), mental ill-health costs the UK approximately £117.9 billion a year. Depression contributes substantially through:

Direct costs:

- GP appointments
- Antidepressant prescriptions
- Psychological therapy
- Inpatient psychiatric care
- Emergency care utilisation

Indirect costs:

- Lost productivity because of absenteeism
- Reduced work performance or presenteeism
- Long-term unemployment
- Disability claims
- Informal care by families

The OECD (2021) reports that workers with depression are far more likely to withdraw early from the labour market and struggle to return to work. Untreated depression worsens physical conditions, resulting in greater hospitalisations and pressure on the NHS.

https://www.centreformentalhealth.org.uk/wp-content/uploads/2024/03/CentreforMH_TheEconomicSocialCostsofMentalIllHealth.pdf



Risk Factor / Aetiology

Depression is a result of the interplay between biological, psychological, and social determinants. A person-centred approach to assessment and targeted intervention requires an understanding of this multifactorial aetiology.

Biological Factors

Genetic contribution:

Family studies put the estimates of heritability at 30–40% (Sullivan et al., 2020). Some gene polymorphisms, such as 5-HTTLPR, may confer susceptibility to depression.

Neurochemical dysregulation:

Imbalance of serotonin, dopamine, and noradrenaline affects mood, cognition, and motivation.

Neuroinflammation:

Depression has been linked with high levels of inflammatory cytokines including IL-6 and CRP, showing overlapping pathophysiology with autoimmune and metabolic disorders.

Comorbid physical LTCs:

Depression is twice as common in people with:

- Diabetes
- Cardiovascular disease
- Cancer, COPD
- Chronic pain

Poor management of physical LTCs increases the risk of depression and vice versa.

Psychological Factors

- Cognitive distortions, such as negative automatic thoughts and self-blaming.
- Maladaptive coping mechanisms
- Trauma, abuse and neglect
- Low resilience and emotion regulation difficulties
- Poor self-esteem and hopelessness

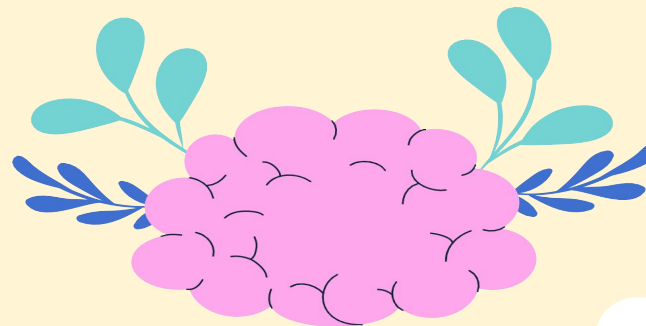
ACEs increase the lifetime risk of depression by as much as threefold.

Social Determinants

- Poverty and debt
- Unemployment and precarious employment
- Poor housing and overcrowding
- Social Isolation and Loneliness
- Discrimination and structural racism
- Poor healthcare access

According to the Marmot Review (2020), deprivation and inequality are strongly linked to the increase in the prevalence of depression.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC8699555/>



Impact of Depression on Individuals & Families



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Physical Impact

Depression is primarily classified as a disorder affecting mental health; however, it has significant physical dimensions. People quite regularly complain of somatic symptoms: fatigue, headache, gastrointestinal upsets, muscle ache, and sleep disturbance (NICE 2022). These can be misattributed and/or minimized as purely medical conditions themselves, thus delaying recognition and intervention.

Sleep Disturbance and Fatigue

One of the most common physical symptoms of depression is sleep disturbance—insomnia, hypersomnia, or fragmented sleep. Chronic sleep disruption leads to impaired immune function, vulnerability to illness, and reduced daytime functioning (Felger, 2018). Fatigue further leads to reduced motivation and impaired engagement in activities of daily living.

Cardiovascular and Metabolic Effects

Depression has been clearly associated with increased risk of CVD. Meta-analyses indicate that individuals with depression are 30–50% more likely to have heart disease and have poorer cardiac outcomes (Naylor et al., 2016). Chronic stress and hypothalamic-pituitary-adrenal axis dysregulation contribute to hypertension, insulin resistance, and obesity.

Interaction with Physical Long-Term Conditions

Depression worsens prognosis and treatment adherence for physical long-term conditions such as diabetes, COPD, chronic kidney disease and chronic pain conditions. People with comorbid depression and diabetes, for instance, show poorer glycaemic control and more complications, resulting in increased hospitalisations and healthcare costs (Naylor et al., 2016). This bidirectional relationship reinforces the need for integrated mental and physical healthcare models.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC4818200/>

<https://pmc.ncbi.nlm.nih.gov/articles/PMC6659182/>

Psychological and Cognitive Impact

Depression has profound effects on psychological well-being. Central symptoms include persistent sadness, emptiness, feelings of guilt, hopelessness, and a loss of interest, often accompanied by fear, irritability, or emotional numbness. These emotions undermine quality of life, self-worth, and interpersonal functioning.

Cognitive Impairments

Cognitive symptoms are under-recognized yet significantly impair functioning. They include:

- Reduced attention and concentration
- Impaired short-term memory
- Information processing difficulties
- Slowed thinking (psychomotor retardation)

According to the research of Rock et al. (2014), even when mood symptoms improve, cognitive deficits can persist, leading to functional impairment in employment, academic settings, and social relationships.

Suicidality and Safeguarding

The most critical psychological consequences include suicidal ideation or behavior. Depression is considered one of the major risk factors in suicides, hence the need for stringent measures in safeguarding. According to the World Health Organization (2023), suicide claims more than 700,000 lives in a year globally, and most of them are linked to depression. It is paramount that there is great care in the evaluation of risk and timely intervention by health professionals when people experience severe hopelessness, psychosis, or substance abuse.

Social Impact

Depression can dismantle the foundations of social wellbeing. Individuals often withdraw from social interaction due to low energy, lack of interest or fear of stigma. Over time, social networks shrink, resulting in isolation, loneliness, and reduced access to support.

Employment and Education

Depression is a leading cause of reduced productivity and work-related disability. According to the Mental Health Foundation, 2022, people experiencing depression are more likely to take sick leave, work below capacity, or leave employment permanently. In students, it diminishes academic attainment and raises dropout risk.

Stigma and Discrimination

Despite growing awareness of the problem, stigma is still a major barrier to help-seeking. According to Thornicroft et al. (2016), stigma leads to social rejection, discrimination in the workplace, and reluctance to disclose symptoms. Internalized stigma can also worsen self-esteem and increase symptom severity.

Economic Hardship

Depression reduces work participation, and this carries the implication of financial strain. Such economic difficulty tends to amplify depressive symptoms, initiating an unbreakable vicious cycle between poverty and poor mental health.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC11403199/>

Impact on Families and Carers

Families are very important in providing support to patients with depression, but this can place considerable emotional, physical, and financial burdens.

Emotional Impact

Carers often feel stress, anxiety, guilt, and helplessness when they see the suffering of their loved one. Parents with depressed children feel frightened and unsure of how to cope, while spouses may deal with disruptions in emotional intimacy and relationship dynamics.

Role Strain and Burnout

Carers often take on extra responsibilities, such as managing appointments, providing emotional support, or assisting with daily functioning. This can sometimes result in burnout, particularly among those who do not have support networks themselves.

Impact on Children and Young Carers

Children of parents with depression are at an increased risk of behavioural problems, low educational attainment, and mental health problems. Young carers are also subject to disrupted schooling, social isolation, and emotional distress, and specifically require policy support.

Care Act 2014 Protections

The Care Act 2014 provides statutory rights for carers, including assessments, support plans, and respite options, in recognition of carers' essential contribution and vulnerabilities.

Evidence-Based Treatment & Management in the UK

NHS Stepped-Care Model

Step 1:

Recognition and Evaluation

GPs carry out an assessment, risk evaluation, and monitoring, supported by tools including PHQ-9 (NICE, 2022).

Step 2:

Low-intensity Interventions

- Guided self-help
- Psychoeducation
- Digital CBT programmes (NHS Talking Therapies)

Step 3:

High-intensity Psychological Therapies

Cognitive Behavioural Therapy (CBT)
Interpersonal Therapy (IPT)
Behavioural Activation

Step 4:

Specialist Interventions

- Psychiatric services
- Crisis teams
- Secondary mental health services

<https://www.nice.org.uk/guidance/ng222>

Pharmacological Treatment

Antidepressants are highly prescribed for moderate-to-severe depression. NICE 2022 recommends:

- SSRIs (e.g., sertraline, fluoxetine): first-line
- SNRIs (e.g., venlafaxine): for partial responders
- TCAs (e.g., amitriptyline): limited due to side effects
- MAOIs: reserved for specialist treatment
- Atypical antidepressants include mirtazapine and trazodone.

Effectiveness and Limitations

Cipriani et al. (2018) confirm that antidepressants outperform placebo in large meta-analyses. However:

- Up to 30% have a minimal response
- Possible side effects such as nausea, weight gain, sexual dysfunction may impact adherence
- Long-term treatment requires monitoring for relapse and withdrawal symptoms.

The combination of medication and therapy is usually most effective.

Psychological Therapies

Psychological therapies remain important components of the management of long-standing depressions.

Cognitive Behavioural Therapy (CBT)

CBT helps individuals to identify, challenge, and modify dysfunctional thoughts and behaviors; it has the strongest evidence base for depression.

Interpersonal Therapy (IPT)

IPT addresses interpersonal conflict, role transitions, grief, and communication patterns. It is suitable for the individual whose symptoms relate to relationship difficulties.

Mindfulness-Based Cognitive Therapy

MBCT incorporates CBT with mindfulness; hence, it decreases the risk of relapse in recurrent depression.

Behavioural Activation (BA)

BA focuses on increasing engagement in valued activities, counteracting avoidance patterns.

Counselling and Psychodynamic Therapy

Useful for patients with complicated trauma or psychosocial stressors.



Theoretical Models

Understanding depression as a long-term condition requires grounding practice in robust theoretical frameworks. These frameworks guide assessment, intervention, service design and policy development. This section critically analyses both UK-based and international models that underpin contemporary depression care.

UK Model: The Biopsychosocial Model & NICE Stepped Care

The Biopsychosocial Model, first put forth by Engel in 1977, represented a paradigm shift from biomedical to holistic care. It recognises that depression arises from dynamic interactions among:

Biological factors: genetics, neurochemistry, inflammation

Psychological factors: cognition, coping, trauma, behaviour

Social determinants include poverty, relationships, discrimination.

Strengths of BPS in Depression Care

Holistic Assessment

Encourages clinicians to consider social stressors, lifestyle factors, trauma history, and family dynamics-not just symptoms.

Supports Multi-Agency Collaboration

Aligns with NHS integrated care frameworks to enable joined-up working between health, social care, and voluntary sectors.

Encourages person-centered practice

Recognises each person's experience of depression as unique.

Limitations

But despite its worth, the model is criticized for being a conceptual catch-all and variably applied between service providers. Where resources are scarce, social and psychological needs take a backseat to biomedical treatments; Rose et al., 2018. Moreover, some social factors-poverty, housing, unemployment-outside of the intervention purview of the NHS.

NICE Stepped-Care Model (Expanded)

NICE provides the most influential operating framework for depression care in the UK. The model prioritises:Correct diagnosis and risk assessment

Evidence-based interventions matched to severity

Stepped escalation or de-escalation

Patient choice and shared decision-making

Strengths

Standardises care nationally

Evidence-based, yet cost-effective

Ensures access to psychological therapies

Supports early intervention

Limitations

Long waiting lists for talking therapies can reduce effectiveness

Stepped-care might oversimplify the complex cases with multiple comorbidities.

Inequality of provision persists at the regional level.

International Model: WHO Mental Health Gap Action Programme (mhGAP)

The WHO Mental Health Gap Action Programme (mhGAP) has the objective of scaling up mental health care globally, especially in low- and middle-income countries. WHO (2016)

Core Principles

- Integrating mental health into primary care
- Training non-specialist health workers
- Early intervention and community engagement
- Low-cost, scalable intervention

Strengths

- Reduces reliance on specialist psychiatric services
- High applicability in settings with limited resources
- Supports community-based approaches consistent with recovery models

Limitations

- Not tailored for high-income healthcare structures like the NHS.
- Requires strong governance and monitoring for effectiveness.
- Variability in adaptation across contexts



https://www.nice.org.uk/media/default/sharedlearning/251_243supportinginfo.pdf

<https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme>

Policy & Political Agendas

It is informed at a national level by priorities, political commitments, and public health challenges which evolve over time. The emphasis on depression reflects its prevalence and socioeconomic impact.

National Policies

NHS Long Term Plan 2019

This major strategic document outlines commitments to:

- Expand access to NHS Talking Therapies
- Improve crisis support within community settings
- Embed mental health services within primary care networks (PCNs).
- Address inequalities through tailored local responses
- Increase funding for mental health by £2.3bn per year by 2023/24

The plan frames depression as a priority LTC that, indeed, requires integrated and preventive approaches.

NICE Guidelines (CG90 and NG222)

NICE provides detailed, evidence-based clinical guidance on:

- Assessment
- Risk assessment
- Treatment (psychological, pharmacological)
- Relapse prevention
- Long-term management

NICE ensures consistency across NHS services and plays a central role in healthcare education and training.

Mental Health Act, 1983; amended 2007

This is the legislation controlling the detention and treatment of patients who present a risk either to themselves or others. Major depression with severe suicidal ideation or psychotic symptoms might lead to a detention under the Act. This ongoing review aims at strengthening patients' rights and reducing inequalities.

Care Act 2014

The Care Act requires:

- Support for carers
- Safeguarding responsibilities
- Person-centred assessments
- Promotion of well-being and prevention

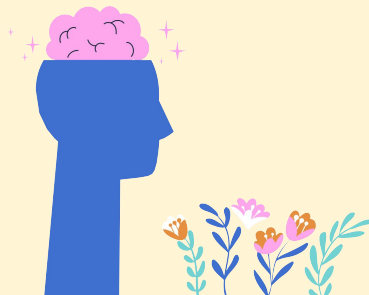
This bill is important, considering the burden that depression places on families.

Local Policies

Local Integrated Care Systems (ICSs)
implement national policy, focusing on:

- Reducing inequalities
- Improving access to psychological services
- Developing community-based support

Local authority public health teams also contribute to prevention through mental health promotion, anti-stigma initiatives, and community wellbeing programmes.



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Recommendations for Person-Centred Care & Self-Management

Strengthening Person-Centred Approaches

- Encourage shared decision-making and care planning from Coulter & Collins, 2011.
- Provide culturally competent and trauma-informed care.
- Recognize determinants of mental health (poverty, social-exclusion) within treatment planning.

Enhancing Self-Management

Evidence favors:

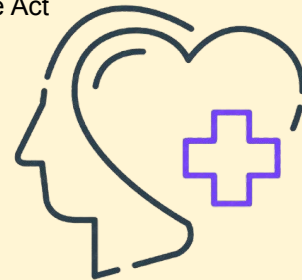
- Digital CBT apps (e.g., SilverCloud, Beating the Blues)
- Peer-support groups
- Wellness planning (WRAP)
- Lifestyle approaches: physical activity, sleep hygiene, healthy diet (NICE, 2022)

SilverCloud[®]
by Amwell[®]



Supporting Families & Carers

- Carer assessments under the Care Act
- Psychoeducation for families
- Respite services
- Carer peer networks



Mental Health

End-of-Life Considerations

In severe recurrent depression with co-existing chronic illness, professionals must consider:

- Advance care planning
- Palliative psychological support
- Holistic symptom management



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Conclusion

Depression is a complex, recurrent long-term condition that poses significant challenges for individuals, families, and health and social care systems. Its multifactorial aetiology demands integrated, holistic, and evidence-based practices. UK policy frameworks such as the NHS Long Term Plan and NICE Stepped Care provide robust guidance, while international models like WHO mhGAP offer broader strategies for improving access. Strengthening person-centred care, self-management, and cross-sector collaboration remains key to better outcomes and reduced inequalities. Health and social care professionals are crucial in ensuring that there is early intervention, continuity of care, and compassionate support for people who live with depression.



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