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SPECIAL REPORT

Tackling depression in patients with chronic conditions

How should patients be identified?

How should depression be classified?

What are the management options?



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FIGURE 1
Rheumatoid arthritis: comorbid depression is associated with increased pain, greater functional impairment, and reduced quality of life

COMPARED WITH THE GENERAL POPULATION, PATIENTS WITH A CHRONIC PHYSICAL health problem are two to three times more likely to be depressed.[1]

Moreover, for those with depression the prognosis is thought to be substantially worse: their depression is less likely to be recognised, they are less likely to accept and tolerate antidepressant treatment, and the impact of their physical illness is enduring.

Comorbid depression is associated with increased pain, greater functional impairment and reduced quality of life. Depressed patients may lack the confidence to self-manage their condition, increasing the risk of long-term complications.[2] Most studies report an association between depression and all-cause mortality, and there is an even stronger link with cardiac mortality.[3]

In October 2009, NICE issued separate guidance for depressed adults with a chronic physical health problem for the first time.[1] This should not be taken to imply that depression in these patients constitutes a distinct clinical entity, but is rather a recognition that we should consider their depression within the context of their chronic illness and disability. The main conditions covered by the guidance are listed in box 1, below.

Box 1

Chronic conditions covered by the NICE guidance

Cancer
Heart disease
Musculoskeletal disorders
Respiratory disorders
Neurological disorders
Diabetes

IDENTIFICATION

GPs are much less likely to recognise depression when patients have a chronic condition: in one study the detection rate was only 23% compared with 94% for those with depression alone.[4] This may be due to patients presenting indirectly with a worsening of their physical illness, misattribution of somatic symptoms to that condition, or time pressures within the consultation.[5] In an attempt to improve the recognition of depression, previous NICE guidance

had recommended the use of screening questions in high-risk groups, including patients with significant physical illnesses causing disability.

NICE acknowledges, however, that there are a number of arguments against routine screening:

- The positive predictive value for the Whooley two question screen (see box 2, below) is low (0.11 in diabetes patients)
- The number needed to screen is high (46 in a recent study of high-risk patients[6])
- Patients identified by screening are often reluctant to accept treatment
- Screening only improves outcomes when linked to care management programmes[7]

The new guidance therefore recommends a shift of emphasis from screening to identification. We should be alert to the possibility of depression in high-risk patients and consider using the two question screen. When used in this way, its main value is in ruling out depression: the negative predictive value is very high.

NICE recommends that we should consider asking the Whooley questions when patients with a chronic condition have associated functional impairment or a past history of depression. I would also suggest their use where there is evidence that patients are struggling to adjust to their illness. The following features are all predictors of maladjustment,[2] which is likely to be associated with depression:

- physical inactivity
- emotional repression
- poor self-management
- a focus on negative, rather then positive, outcomes of the illness

CLASSIFYING DEPRESSION

In a change from its previous guidelines, NICE has decided to use DSM-IV (see table 1, below), rather than ICD-10, diagnostic criteria. The advantages are:

- Most trials of treatments for depression use DSM-IV
- DSM-IV sets a higher threshold for diagnosis, which roughly corresponds to the point above which antidepressants become more effective than placebo.

The redefined severity ranges are:

- Subthreshold symptoms (2-4 symptoms of depression; function maintained)
- Mild depression (few, if any symptoms in excess of the five required to make the diagnosis; mild functional impairment)
- Moderate depression (symptoms or functional impairment between mild and severe)
- Severe depression (most symptoms + marked functional impairment)

The original category of mild depression is now subsumed within the category of subthreshold symptoms, and many of those previously categorised as moderate will now be considered to have mild depression.

Even so, the current DSM-IV definition of depression can lead to overdiagnosis in patients with a chronic condition, if somatic symptoms are caused by the physical illness itself, rather than depression.

One proposed solution is to simplify the diagnostic criteria by restricting these to the five psychological symptoms (depressed mood, lack of interest, worthlessness, poor concentration and thoughts of death). Three symptoms would then be needed for a diagnosis.[8] NICE recommends that we should focus on the psychological symptoms when arriving at a diagnosis of depression in patients with a chronic condition. Cognitive changes, duration and illness trajectory should also be taken into account.

NICE acknowledges the complexity of diagnosing depression and the impossibility of setting precise boundaries. It cautions against thinking that we can categorise patients with certainty and concluding that a particular severity rating should automatically imply a specific treatment. Severity rating scores such as the PHQ-9 can be particularly misleading in patients with a chronic condition, as they do not discriminate between somatic symptoms caused by the illness and those caused by depression.

MANAGEMENT

For patients with persistent subthreshold symptoms, mild to moderate depression or subthreshold symptoms that complicate management of the chronic condition, NICE recommends offering one of the following options:

- structured group physical activity programme »

Box 2

The Whooley two question screen

1 During the past month have you often been bothered by feeling down/depressed or hopeless? (Yes/No)

2 During the past month have you often been bothered by having little interest or pleasure in doing things? (Yes/No)

Table 1

Abridged DSM-IV-TR criteria for major depressive episode*

A. Over the past 2 weeks, five of the following symptoms (which must include 1 or 2) should be present. Symptoms 1-8 should be present on nearly every day:

1 Depressed mood most of the day
2 Loss of interest or pleasure in almost all activities most of the day
3 An increase or decrease in appetite or significant weight loss or gain (more than 5% change in 1 month)
4 Insomnia or hypersomnia
5 Psychomotor agitation or retardation (observable by others)
6 Fatigue or loss of energy
7 Feelings of worthlessness or excessive or inappropriate guilt (not merely self-reproach about being sick)
8 Diminished ability to think or concentrate, or indecisiveness (either by subjective account or observation by others)
9 Recurrent thoughts of death (not just fear of dying), or suicidal ideation, or a suicide attempt or a specific plan for committing suicide.

B. Symptoms cause clinically significant distress or impairment in functioning.

C. Symptoms are not due to substance abuse, medication or physical illness. Symptoms are not better explained by bereavement (although this can be complicated by major depression). Episodes are classified as mild (symptoms barely meet minimal criteria, mild functional impairment), moderate (more than minimum symptoms and functional impairment between mild and severe), severe (most symptoms present, marked or greater functional impairment).

*Adapted from American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (4th edn). Text Revision (DSM-IV-TR). 2000 American Psychiatric Association, Arlington, VA, USA

Table 2

Evidence for low-intensity psychosocial interventions in patients with a chronic condition[1]

Intervention	Number of participants (studies)	Quality of evidence	SMD (effect estimate)*	Statistical significance
Exercise	361 (3)	Low	-0.58 (moderate)	× (marginal)
Peer support	191 (3)	Moderate	-0.32 (small)	✓
Guided self-help	103 (3)	Moderate	-0.40 (moderate)	× (marginal)
CCBT	-	-		-

Table 3

Evidence for high-intensity psychosocial interventions in patients with a chronic condition[1]

Intervention	Number of participants (studies)	Quality of evidence	SMD (effect estimate)*	Statistical significance
Group CBT	580 (9)	Moderate	-0.54 (moderate)	✓
Individual CBT	338 (4)	Moderate	-0.55 (moderate)	✓
Behavioural couples therapy	-	-	-	-

*For depression at end of treatment. Comparison with standard care rather than active comparison group, hence part of the effect likely to be a nonspecific effect of the increased attention given to the treatment group

Table 4

Simplified treatment recommendations for depression

Severity	NICE (patients with chronic conditions)	British Association for Psychopharmacology[12]
Persistent subthreshold symptoms (>2-3 months)	Low-intensity psychosocial intervention*	Consider antidepressants †
Mild	Low-intensity psychosocial intervention*	Antidepressants are an option + should be considered if persistent (>2-3 months) or previous moderate to severe depression ‡
Moderate	High-intensity psychological treatment, preferably group CBT	Antidepressants are first-line treatment. ‡ Psychological treatments (CBT, interpersonal psychotherapy) are an alternative in mild to moderate major depression
Severe	Antidepressants + individual CBT	Antidepressants + CBT

*Consider antidepressants if previous moderate to severe depression, mild + complicates management of chronic conditions , or dysthymia.

† First line if ≥2 years (dysthymia)

‡ CCBT and guided self help not routinely recommended but could be considered for self-motivated individuals. Supervised exercise could be considered but only as an adjunct to other treatments

- group-based peer support (self-help) programme
- individual guided self-help based on the principles of CBT (bibliotherapy)
- computerised CBT (CCBT)

Antidepressants should only be considered if these prove ineffective, or for those with:

- a previous history of moderate or severe depression
- mild depression complicating the care of the chronic condition
- subthreshold symptoms which have been present for at least two years (dysthymia)

For those patients who do not respond to a low-intensity psychosocial intervention, a high-intensity psychological intervention should be considered as an alternative to antidepressant treatment.

Exercise therapy will also improve functional ability and facilitate adjustment. It is a particularly attractive option in depressed CHD patients where inactivity is the principal mediator of the increased cardiovascular risk,[9] and where neither antidepressants nor CBT have been shown to reduce the event rate.[10]

Peer support groups encourage ventilation of feelings and sharing of experiences,[11] which is an important component of psychological adjustment to chronic disease.[2] However, for all of the low-intensity psychological therapies, the evidence of efficacy in patients with a chronic condition is very limited (see table 2, above).

Moderate depression

NICE recommends one of the following high-intensity psychological interventions for patients with moderate depression (see table 3, above):

- group-based CBT
- individual CBT (if group-based CBT is declined, not appropriate or unavailable)
- behavioural couples therapy (where the relationship may contribute to the development or maintenance of depression)

Group-based CBT is preferred on cost grounds. Combination therapy with antidepressants is not recommended as patients with a chronic condition may be reluctant to take further drugs for depression, and may be more vulnerable to side effects and drug interactions.

Severe depression

Combination treatment with individual CBT and an antidepressant (SSRI) is recommended for those patients with severe depression.

Table 4 (above) compares the NICE treatment recommendations with those from the British Association for Psychopharmacology.

THE QOF INDICATORS

Indicator 1

The main difficulty with indicator 1 (see table 5, opposite) is filtering out the large number of false positives. NICE recommends that, when patients have answered 'yes' to either of the Whooley questions, the accuracy of the initial mental health assessment can be improved by asking:

key points

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Compared with the general population, patients with a chronic physical health problem are two to three times more likely to be depressed. Their depression is less likely to be recognised and they are less likely to accept and tolerate antidepressant treatment. Comorbid depression is associated with increased pain, greater functional impairment and reduced quality of life. Depressed patients may lack confidence to self-manage their condition, increasing the risk of long-term complications.

The new NICE guidance on depression in adults with a chronic physical health problem recommends a shift of emphasis from screening to identification. We should be alert to the possibility of depression in high-risk patients and consider using the two question screen. When used in this way, its main value is in ruling out depression: the negative predictive value is very high.

The current DSM-IV definition of depression can lead to overdiagnosis in patients with a chronic condition, if somatic symptoms are caused by the physical illness itself, rather than depression. One proposed solution is to simplify the diagnostic criteria by restricting these to the five psychological symptoms. Three symptoms would then be needed for a diagnosis.

NICE recommends that patients with persistent subthreshold symptoms, mild to moderate depression or subthreshold symptoms that complicate management of the chronic condition should be offered one of the following: structured group physical activity programme; group-based peer support (self-help) programme; individual guided self-help based on the principles of CBT (bibliotherapy) or CCBT. Antidepressants should only be considered if these prove ineffective, or for those with: a previous history of moderate or severe depression, mild depression complicating the care of the physical health problem or subthreshold symptoms which have been present for at least two years.

In moderate depression NICE recommends one of the following: high-intensity psychological interventions; group-based CBT; individual CBT; behavioural couples therapy. In severe depression, combination treatment with individual CBT and an SSRI is recommended.

When patients have answered 'yes' to either of the Whooley questions, the accuracy of the initial mental health assessment can be improved by asking - during the past month, have you often been bothered by: feelings of worthlessness; poor concentration or thoughts of death?

Patients should be referred to psychiatric services if: there is a high suicide risk; they are psychotic or have bipolar affective disorder. Referral for collaborative care is indicated if patients have moderate to severe depression which has not responded to initial psychological interventions, pharmacological treatment, or a combination of both.

Table 5

Quality and Outcomes Framework: Depression indicators

Records

DEP 1 The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions. **8 points**

DEP 2 In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care. **25 points**

DEP 3 In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 5-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care. **20 points**

During the past month, have you often been bothered by:
- feelings of worthlessness?
- poor concentration?
- thoughts of death?

The assessor should also consider the psychosocial impact of (and adjustment to) the chronic condition, depressogenic effects of medication and whether treatment of the physical condition is optimal.

Indicator 2

NICE endorses the use of a validated severity measure to inform and evaluate treatment. Of the two most commonly used measures, the PHQ-9 now maps directly onto NICE guidance and incorporates a measure of functional impairment; the HADS omits somatic symptoms and is thus less likely to overdiagnose depression. If using the PHQ-9, I suggest that the important boundary between mild and moderate should be set at 14/15 to reduce overdiagnosis and bring the severity ratings in line with the HADS.[13] Where there is doubt regarding the origin of somatic symptoms, there would be some logic in using a PHQ-5.

Indicator 3

The rationale behind this indicator is to improve adherence to antidepressant treatment or, where medication is not prescribed, to encourage watchful waiting. Case management (see box 3, right) may help us to achieve this target and is advocated by the British Association for Psychopharmacology guidelines.[12] However, NICE does not recommend the use of antidepressants as first-line treatment for the majority of depressed patients with a chronic condition, and it concludes that the evidence for case management in this context is sparse.

NICE recognises that collaborative care (see box 3, below) is a cost-effective intervention,[16] but restricts this to patients with moderate to severe depression who have not responded to first-line treatment.

REFERRAL

If these guidelines are followed, the expectation would be that most depressed patients with a chronic condition will be offered referral to the

Box 3

Case management and collaborative care

Case management[14]
- active follow-up*
- encouragement of patients to adhere to treatment and monitoring of depression symptoms
- adjustment of treatment plans when patients do not improve

*e.g. by healthcare assistants

Collaborative care[15]

Case management plus:
- involvement of at least one other professional (nurse †, psychologist, psychiatrist or pharmacist) in patient care
- use of an evidence-based protocol
- enhanced liaison between primary and secondary care

† e.g. specialised depression nurses trained to provide problem-solving treatment[16]

Improving Access to Psychotherapies (IAPT) programme. An IAPT service should comprise a team of therapists (40 for an average population of 250,000) employed by a PCT in order to deliver both low- and high-intensity psychological treatments in accordance with NICE guidance. Most patients will be referred into the service from primary care, but they will also be allowed to self-refer. Most therapy should be delivered close to home e.g. in GP surgeries.[17] The IAPT website lists those PCTs which currently provide a service (www.iapt.nhs.uk/).

Patients should be referred to psychiatric services:

- if there is a high suicide risk
- if they are psychotic or have bipolar affective disorder
- for collaborative care if they have moderate to severe depression which has not responded to initial psychological interventions, pharmacological treatment, or a combination of both

CONCLUSION

This guidance should help to reduce overdiagnosis and inappropriate prescribing of antidepressants and increase acceptance of treatment by depressed patients with a chronic condition. However, the evidence base for the proposed low-intensity psychological treatments is weak and it can be argued that it may have been better to concentrate limited resources on providing more effective care for patients with moderate to severe depression.

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