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Depression in adults with a chronic physical health problem: Treatment and management

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The NHS National Institute for Health and Clinical Excellence (NICE, 2009) publication – *Depression in adults with a chronic physical health problem: treatment and management* – is a clinical practice guideline for the UK which partially updates and extends the earlier depression management in primary and secondary care guideline (NICE, 2004). Like other clinical guidelines, it has been systematically developed from the best available research evidence to assist clinicians and patients, and service commissioners and providers in making decisions about the most appropriate treatment and service organisation for this important area of health care need. The National Collaborating Centre for Mental Health (one of a number of centres established by NICE for the purpose of clinical guideline development) together with a guideline development group, comprising health and social care professionals, lay and patient representatives, and technical experts, worked on the guidance. The process from initial scope preparation to the production of the final guideline took over two years. As with other NICE recommendations, the development of this guidance has involved extensive stakeholder consultations at the initial scoping phase that defined the aspects of care covered and to whom it would apply, and later when the draft guideline was prepared. The aim of this editorial is to bring this important document to the attention of nurses and midwives worldwide who work with depression sufferers.

1: CONTEXT

Guidelines for the management of depression have been developed by expert groups in many nations: a recent review identified 56 national guidelines addressing depression in primary care (Hegarty et al, 2009). However, existing depression guidelines are derived from an evidence base that relates poorly to people with depression and physical comorbidity, and hence they provide limited recommendations for the assessment and care of such patients. Depression frequently occurs in combination with physical illnesses, and this combination presents important challenges for health care activity (Komorovsky et al, 2008). Nurses working in primary and community care and in a range of in-patient settings are particularly likely to be playing a key role in managing patients who present with these combined conditions (Bai et al, 2008), or whose medical illness heightens their risk for depression (Welstand et al, 2009; Lee et al, 2008). Guidelines for medical conditions typically provide brief depression management recommendations as part of their overall guidance, and specific guidelines have been developed focussing on depression within particular disease groups such as cancer and stroke. However, there are important shared problems and approaches to assessment and clinical activity that merit depression guidance developed for the substantial group of people who experience chronic physical illnesses.

2. BACKGROUND

Depression is one of the leading causes of global disability on account of its prevalence and impact. Studies in the UK, Europe and the United States indicate point and 12-month prevalence rates of between 3% and 10% (Kessler et al, 2003; Ayuso-Mateos et al, 2001), whilst an estimated lifetime prevalence of 17% has been derived from large-scale representative surveys in the United States (Kessler et al, 2005). Depression is associated with substantial personal suffering, raised mortality and reduced quality of life and functioning (Eaton et al, 2008). It is currently the third leading cause of disease burden (measured by the disability-adjusted life-year) in the world, and the leading cause in middle and high income countries; and it is projected by 2030 to make the second largest contribution to the burden of disease globally (World Health Organisation, 2008).

Studies have consistently identified that depression is commonly unrecognised, misdiagnosed, or inadequately managed. This problem does not appear restricted by national boundaries, with investigators in many countries (Cepoiu et al, 2008) finding misdiagnosis rates for depression in

primary care in the order of 30–50%. The focus of most studies of depression recognition has been in relation to the practice General Practitioners (GPs) and the primary care centre setting; but depression detection problems are also evident in nursing homes and general hospital settings, and involving nurses (Plummer et al, 2000) and care workers (Eisses et al, 2005).

Depression is frequently present in conjunction with physical illness, with cross-sectional studies showing depression rates among a wide range of medically ill populations are two- to three-fold higher than among comparable groups of people not such illnesses (Egede, 2007). This association is particularly pronounced for people with chronic conditions. Heart disease, stroke, diabetes mellitus, respiratory disorders such as asthma and chronic obstructive pulmonary disease (COPD), cancer, and musculoskeletal and neurological disorders are the main groups of illnesses identified by research in this area.

This comorbidity is important, as it adversely affects the course and outcome of both disorders. Mortality is elevated for a number of medical conditions when associated with depressed mood (Cole, 2007), and the course of depression is worsened when there is accompanying physical illness (Koike et al, 2002). The combination of depression and medical illness is associated with increased disability (Lenze et al, 2001), and the extent of lost productivity, health care use and associated costs is markedly increased when these conditions co-exist (Chisholm et al, 2003).

Several different pathways appear to link depression and physical illnesses: prospective studies have identified an elevated risk of depression among people who have been diagnosed with asthma, COPD, cancer, diabetes, arthritis, and heart disease (Prince et al, 2007). This increased risk appears to relate in part to the disabling effects of these diseases particularly those involving functional limitations, although a range of factors are likely to be involved, with persistent pain found to be an especially important predictor (Bair et al, 2003). For some neurological and endocrine conditions, it appears that specific pathophysiological processes may operate to elevate depression risk, for example Parkinson's disease, stroke, and hypothyroidism. Conversely, a history of depression appears to increase the likelihood of developing certain medical conditions, with strongest evidence of such prospective associations for cardiovascular disease and diabetes, and weaker evidence linking depression to the incidence of diseases including cancer, back pain and hypertension.

3. THE NEED FOR EXPERT GUIDANCE

3.1. CASE RECOGNITION

The detection of depression in people with physical illnesses presents particular challenges for the health professional. Studies in the UK, Europe and the USA have indicated that the recognition of depression is more problematic when people are presenting with physical problems. This is because the somatic features of depression – appetite disturbance, weight loss, sleep disturbance, lack of energy, and psychomotor retardation – may all be related to the medical condition or its treatment. The presence of concurrent physical illness is likely to affect patient attributions of depression symptoms, and act as an obstacle to the clinician's evaluation of the entire symptom picture.

3.2. DEPRESSION TREATMENTS

The clinician's uncertainties about the acceptability and efficacy of standard depression treatments for individuals with comorbid conditions are likely to influence treatment decisions. For antidepressant treatment, there will be concerns about the additional risks of side effects and drug interactions, whilst for psychological treatments in this client group the available evidence has not been accessibly reviewed.

3.3. ORGANISATIONAL APPROACHES

Research conducted primarily in the USA, but also in several European countries has highlighted the importance of coordinated approaches to depression management, characterised as system level changes or service reorganisations and typically involving a combination of structured follow-up with multidisciplinary care protocol based care, and case management. These approaches are linked to the chronic disease management model, and there is good reason to expect that they are an appropriate way of organising services for people with depression and physical health problems. However, much of this development has been based on and evaluated in relation to depression in general, and there is uncertainty concerning the effectiveness for this population, as well as questions concerning the relative value of differing combinations of interventions.

4. NICE GUIDANCE

4.1. DEPRESSION CASE IDENTIFICATION

The use of structured assessment tools for depression case finding in primary care has received considerable attention in the UK and other countries; and following earlier NICE (2004) guidance on depression an approach based on validated scales has been adopted and incentivised within UK primary care through the Quality and Outcomes Framework (QOF). QOF promotes the use of an assessment tool for new cases of depression at the outset of treatment and 5–12 weeks later, and – of particular relevance here – the use of specific case identifying methods at the annual health checks for all primary care patients with coronary heart disease and diabetes. The instrument identified for the latter purpose within NHS primary care is a two-question screen based on the presence of the core features of depression (closely linked to the nine-item Patient Health Questionnaire – PHQ-9) (Whooley et al, 1997). The PHQ-9 is the instrument most widely used in NHS primary care (of three recommended) for assessing and follow-up of depression cases, irrespective of the presence of physical illness.

Limitations in the existing literature and uncertainty concerning the most valid case identifying instruments for depression in people with chronic physical health problems, prompted the guideline team to undertake a systematic review and meta-analysis studies of instruments most appropriate for use in UK primary care.

The findings (based on a total of 129 studies, 52 of which were on people with chronic physical health problems) provide support for current practice, within community, primary care and general medical settings. Differences were found between the most commonly used measures, but these were modest, with these scales all performing adequately. The two-question screen requesting a Yes or No response that is presently used in UK primary care –

1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?
2. During the past month, have you often been bothered by little interest or pleasure in doing things?

- has excellent sensitivity and is recommended as the instrument to be used in assessments of people with chronic physical health problems. A positive score response to either (or both) questions merits more detailed assessment, which may involve a longer validated tool. Assessment requires more than a simplistic symptom count, with attention directed to past history (of depression and treatment response) and current impairment associated with depression and social supports and stressors.

4.2. PHARMACOLOGICAL AND PSYCHOSOCIAL TREATMENTS

For around half of those people who experience a depressive episode this disorder is of relapsing and remitting or chronic form. The presence of chronic physical health problems exerts a negative influence on depression course. The guideline acknowledges that even with evidence based treatment a substantial minority of patients fail to respond or respond only partially to treatments, or relapse later. However, therapeutic optimism is justified: the two broad conventional treatment approaches, antidepressants and psychotherapy, both appear to have clear, but moderate effects, in comparison with standard care.

The guideline review of psychosocial treatments was based on 42 trials that evaluated depression outcomes among this client group. In line with the findings for depression in the absence of physical illness, lower intensity intervention such as guided self-help, exercise, and peer support groups were found effective – with the pattern of evidence indicating most support for their use in milder forms of depression. Higher intensity treatments, notably individual and group cognitive and behavioural therapy, were judged the preferred option in moderate depression.

The review team examined the efficacy of antidepressants for the treatment of depression in people with chronic physical health problems; evidence was based on 61 trials. Much of the research in this area concerned the use of SSRIs (selective serotonin re-uptake inhibitors); for these and other classes of antidepressant there was clear evidence of small-to-medium benefit compared to placebo. As with the general evidence base, SSRIs are better tolerated than older antidepressants. A systematic review of adverse effects of antidepressants among the target population was conducted for the guideline, and summary details of drug interactions adverse effects and recommendations are

likely to be of particular usefulness both to prescribers and health professionals monitoring and assisting treatment adherence. As in previous guidance, SSRIs are recommended as first line treatment, with sertraline and citalopram noted as probable drugs of first choice on the basis of lower interaction potential and safety in respect of cardiac events. The patient's physical condition and its treatment, their views concerning treatment options, antidepressant response history, and potential drug interactions will be key considerations in treatment decisions.

4.3. SERVICE-LEVEL INTERVENTIONS

A number of approaches to service delivery are considered and reviewed by the guideline team. The approaches include stepped care, case management and collaborative care. There appears considerable overlap between these types of care delivery, and alongside attempting to clarify the active ingredients of these service level interventions, their inter-relationship is acknowledged by the use of the over-arching term 'enhanced care' within the guideline.

Most consistent evidence was found for collaborative care: 17 eligible trials were reviewed, but conclusions to other settings such as the UK are limited because most of the evidence is derived from US studies, and these involve a variable range of components. Key elements that appear associated with benefit are: the involvement of a case manager (frequently a nurse, but also GP, psychologist, social worker); interventions are based on a stepped care model, usually a choice of either antidepressant medication or a psychological intervention (most frequently problem solving therapy) is first-line treatment, and commonly patient and physician education, monitoring of progress, supervision of staff by a psychiatrist, and a focus on medication adherence.

5. IMPLICATIONS FOR NURSES

Nurses play a key role in the detection and the management of depression. Practice and district nurses, and nurses working in general hospital and intermediate care settings are particularly likely to be caring for people who are experiencing chronic physical health problems (Coster & Norman, 2009). As described in the background literature, these individuals have increased vulnerability to depression, and the combination of mental and physical problems has clear and marked effects on quality of life, functional disability, and disease course. For nurses - who play a central role in all aspects of the care of these patients - there is a crucial opportunity to identify and assist in the management of depression. This work requires knowledge of the presentation and evidence-based management of depression, and skills in assessment and interventions that will promote appropriate adaptive responses and concordance with treatment plans. Working with people with chronic physical illness, and their families and carers necessitates a central focus on patient and carer education and the promotion of self-management approaches; and where depression is a part of the clinical picture this guiding principal of care remains of key importance and will require additional knowledge and skill on the part of health professionals. Practice innovations in a number of countries have highlighted the role of nurses in primary care within a collaborative system of care, and this new NICE guidance gives added impetus and direction to these developments based on rigorous evidence review.

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