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Screening, assessment and treatment for depression in patients with chronic heart failure

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Chronic heart failure (CHF) is increasing internationally with over 1 million new diagnoses per year worldwide (Jeon et al, 2010). In Europe, over 15 million people have heart failure; while in Australia, it is estimated to affect around 300 000 people with 30 000 new cases diagnosed each year (Dickstein et al, 2008; National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand, 2011). Conrad et al (2018) have, however, recently questioned the accuracy of heart failure incidence studies, and therefore our ability to accurately assess the true health burden of heart failure. Based on population-level rather than cohort data, they found that in the UK, from 2002 to 2014, heart failure incidence (standardised by age and sex) decreased, similarly for men and women, by 7%. However, the estimated absolute number of individuals with newly diagnosed heart failure in the UK increased by 12% (from 170 727 in 2002 to 190 798 in 2014), largely owing to an increase in population size and age. The absolute number of people living with heart failure in the UK increased by 23%, from 750 127 in 2002 (1.3% of the total population) to 920 616 in 2014 (1.4% of the total population). Of concern is their finding that socioeconomically deprived individuals were more likely to develop heart failure than were affluent individuals (incidence rate ratio 1.61, 95% CI 1·58–1.64), and did so earlier in life than those from the most affluent group (adjusted difference -3.51 years, 95% CI -3.77 to -3.25) and that socioeconomically deprived individuals also had more comorbidities, despite their younger age. The implication of this analysis is that the burden of heart failure in the UK is increasing.

ABSTRACT

Patients with chronic heart failure (CHF) have clinically significant depression at a rate two to three times higher than the general population. Depression is associated with poorer survival, limitations in daily functioning, and more frequent adverse cardiac outcomes. Guidelines on the management of CHF have highlighted a need for screening and assessment of depression in patients with CHF using validated instruments such as the Beck Depression Inventory and the Patient Health Questionnaire, which should be administered routinely post-hospitalisation, while recognising that not all symptoms are related to CHF alone. Following referral to a mental health specialist, collaborative care, cognitive behavioural therapy, and positive psychology interventions are most likely to deliver benefits for depression in people with CHF. They may also benefit from assistance with any limitations in terms of physical activity and fatigue, health behaviours, social isolation, and adherence to their medical treatment.

KEY WORDS

◆ Chronic heart failure ◆ Depression ◆ Screening ◆ Mental health ◆ Psychology

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CHF is a complex clinical syndrome characterised by underlying structural abnormality or dysfunction to the action of the heart (measured by ejection fraction). Most people who develop heart failure have (or had) another heart condition first. The most common conditions that can lead to heart failure are ischaemic heart disease, hypertension, valvular heart disease, cardiomyopathies, and congenital heart disease, with heart failure often coexisting with diabetes and kidney-related disease (Australian Institute of Health and Welfare, 2007; Jeon et al, 2010) as well as anaemia and sleep-disordered breathing (Yancy et al, 2017). In the 5 years after myocardial infarction, up to 31% of patients

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will experience heart failure (Velagaleti et al, 2008). The New York Heart Association (NYHA) classification has traditionally been used to classify severity of heart failure from essentially asymptomatic well-treated patients in whom symptoms have been relieved (NYHA I), to mild (NYHA II, slight limitation in physical activity), to moderate (NYHA III, symptoms while walking on the flat), to severe heart failure (NYHA IV, breathless at rest and essentially housebound). The chronic and relapsing course of this condition typically results in periods of recurrent hospitalisations, associated with substantial costs for both patients and the healthcare system.

Prevalence of depression in CHF

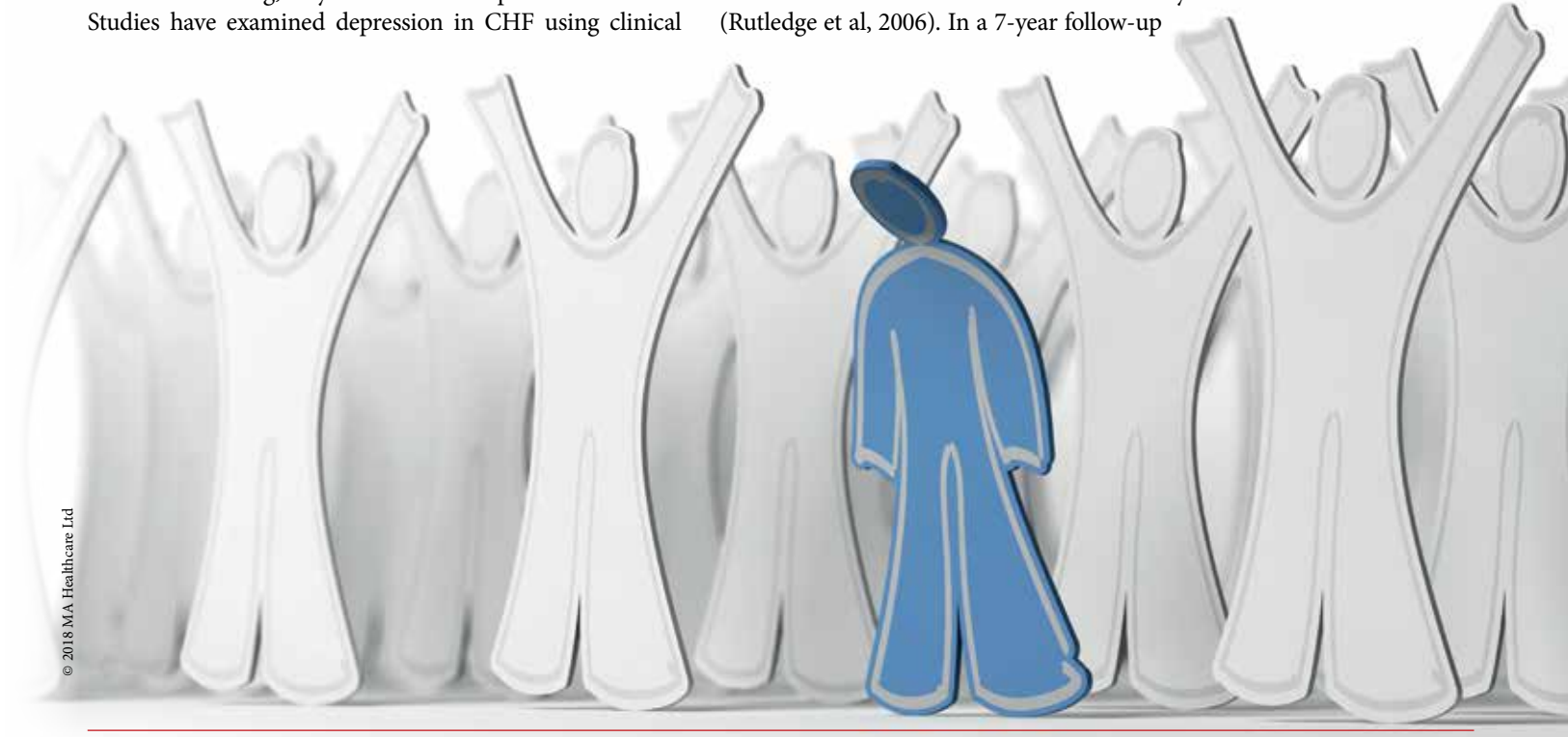
Not surprisingly, depression frequently accompanies CHF. Although much attention has been paid to the relationship between depression and cardiac events, with about one in five patients experiencing severe depression in the year after their acute event (Blumenthal et al, 2003; Thombs et al, 2006; Murphy et al, 2016), less attention has been paid to the relationship between heart failure and depression. It is well known that depressive symptoms frequently accompany physical illness, but the association between the two is complex (Olver and Hopwood, 2012).

Depressive symptoms can be clustered into somatic, psychological and social symptoms. The somatic symptoms associated with depression are frequently also present in CHF, causing uncertainty about their attribution to either depression or the physical illness. Physical illness is inevitably associated with losses, and depressive symptoms such as sadness, worry and irritability may be judged by clinicians, patients and primary carers as an 'understandable' reaction to these losses, and subsequently minimised in importance (Olver and Hopwood, 2012). In a similar way, social symptoms of depression, including withdrawal and impairments in role functioning, may occur in both depression and CHF. Studies have examined depression in CHF using clinical interviews, review of patient's medical records and depression symptom inventories.

A meta-analysis found that patients with CHF have clinically significant depression at a prevalence rate that is two to three times higher than those of the general population, at 21.6% (Rutledge et al, 2006). The prevalence of minor depression (e.g. depressive symptoms) as measured by self-report questionnaires has been reported as ranging up to 60%, but with a high degree of heterogeneity in study measures, cut-off scores and cohort studies (Rutledge et al, 2006). Whether the quality or severity of depressive symptoms varies among subclasses of CHF remains to be determined.

Despite compelling evidence of the interrelation between depression and CHF, depression is under-recognised and undertreated in these patients (Cully et al, 2009). In a prospective study of 158 patients with heart failure, Cully et al (2009) found depression to be highly prevalent at 41.8% of the sample. Despite this, it was only recognised in 57.5% of the patients with depression. Of those patients whose depression was recognised, only 60.3% had received some form of mental health treatment during the 18-month follow-up period. Another study found that 70% of a sample (n=702) with suspected major depression had not been diagnosed before (Angermann et al, 2011). An Australian study showed that 53.4% of patients with CHF who met Structured Clinical Interview (SCID) criteria for depression did not have depression listed in their medical records in the preceding 6-month period (Tully et al, 2014).

The presence of both major and minor depression is an independent predictor of adverse cardiac morbidity events in patients with CHF independent of disease severity, making it imperative to consider among other cardiac risk factors such as previous myocardial infarction, diabetes and smoking (Jiang et al, 2001). Depression in patients with heart failure is associated with more frequent adverse clinical events and twice the risk of mortality (Rutledge et al, 2006). In a 7-year follow-up



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of patients with CHF, the mortality risk increased by level of depressive symptoms: mild (21% mortality); moderate (53%); and severe depressive symptoms (83%) (Jiang et al, 2007). Another study found that each one point increase in depressive symptom scores, indicating higher levels of depressive symptoms, is associated with a 7.5% increase in risk of a cardiac event (HR 1.075; 95 % CI 1.025–1.127) (Lee et al, 2014). Furthermore, the presence of depressive symptoms, even in the absence of a confirmed diagnosis of major depression, is associated with an increased risk of non-adherence to CHF self-care behaviours (van der Wal et al, 2006), delays in seeking hospital care (Johansson et al, 2011) and increased healthcare use (Johansson et al, 2007). Even minimal depressive symptoms appear to increase the risk for adverse outcome in CHF populations (Piepenburg et al, 2015; Deveney et al, 2016).

The relatively high prevalence and deleterious impact of depression upon many aspects of CHF care, underscores the need to accurately identify depression symptoms with the option to facilitate early management and intervention. To illustrate, there are indications that disease management programmes (DMPs) may not be as effective in patients with comorbid depression (Jaarsma et al, 2010). An evaluation of chronic disease self-management (CDSM) programmes found a differential response: only patients with CHF without depression showed improvements in reduced mortality and hospitalisation admissions (Jaarsma et al, 2010). This effect was not found for patients with depression, who were in fact more likely to present to hospital post intervention.

Depression risk factors in CHF

Few studies have examined the influence of selected patient characteristics such as gender and ethnicity on the prevalence of depression in patients with CHF. In one study, which had a substantial proportion of participants with CHF and an ejection fraction of <40%, nearly half scored as depressed; of those patients, more than half were women (Gottlieb et al, 2009). Lossnitzer et al (2009) identified five independent predictors of minor and major depression: previous depressive episode (Odds Ratio (OR): 4.04); history of previous resuscitation (OR 2.44); current smoking (OR 2.06); frequent visits (>4 per year) to general practitioner >4 (OR 1.67); and NYHA functional class (OR 1.54). Others have found increased risk for those with comorbid conditions such as chronic obstructive pulmonary disease (COPD) (Angermann et al, 2011) and those living alone (Jiang et al, 2007).



Depression trajectories in CHF

It is unclear how depressive symptoms in patients with CHF develop over time and how this trajectory is associated with hospital admission and prognosis (Johansson et al, 2013). Nonetheless, there is emerging evidence that can guide our clinical practice. Johansson et al (2013) examined the trajectory of depressive symptoms in 611 patients with CHF at discharge and 18 months follow-up. At discharge, 61% had depressive symptoms as measured by the Centre for Epidemiological Studies Depression Scale. At 18-month follow-up, 61% of these had recovered, and 39% had ongoing depression. Of those who had no depression at discharge, 18% had developed depression at follow-up. Similarly, another study found that 50% of patients experienced improvements in depressive symptoms within 3–6 months (Dekker et al, 2011).

Much of the research on depression trajectories is conducted in hospital. Hospital admissions, however, are only a small part of the CHF journey, as most care of patients with CHF is as outpatients. It is important to note that in-hospital depressive symptoms considered in isolation are unreliable, just as they are for patients with ACS (Murphy et al, 2013). For example, Dekker et al (2011) found that patients with CHF screened to have depressive symptoms during a period of hospitalisation are more likely to experience remission from depressive symptoms 3–6 months later compared with cases of depression identified in outpatients (Dekker et al, 2011). This is similar to the 'cardiac blues'—a generally transient bereavement response to a cardiac event that usually resolves, whereas symptoms of depression observed in an outpatient setting are likely to be significant (Murphy et al, 2016). For example, studies have found that outpatients with CHF who report ongoing or worsening depressive symptoms are at higher risk for decline in health-related quality of life (Dekker et al, 2011), physical functioning (Shen et al, 2011), cardiovascular hospitalisations or death (Sherwood et al, 2011). Similarly, Johansson et al (2013) found that patients who developed depression or remained depressed at 36 months follow-up post discharge had a worse prognosis and more hospital admissions.

Suicide risk and CHF

There has been little investigation of suicide in CHF. A study of coroner reports of 1354 elderly people found that patients with CHF may be at increased risk of completed suicide with an odds ratio (OR) of 1.73 (Juurlink et al, 2004). Of concern is that almost half of the elderly, chronically ill patients in this study visited a physician 1 week before taking their own life. Suicidal ideation is the contemplation of ending one's own life and can vary from fleeting thoughts to preoccupation and even detailed planning. A cross-sectional study of 294 patients with CHF found that 17.1% of the sample reported experiencing suicidal ideation and/or ideas of self-harm as measured by the Patient Health Questionnaire (PHQ9). The OR for suicidal ideation was 10.8 for those with lifetime depression and 3.9 in first-episode patients (Lossnitzer et al, 2009). In patients with CHF presenting for clinical assessment after a positive depression screen, it has been shown that 11.0% were at a current suicide risk (score of PHQ suicidality item ≥2, verified at structured interview), and 17.8% disclosed a previous suicide attempt during their lifetime (Tully et al, 2014). After initial screening, patients with significant depression should be assessed for suicide risk. Indications for immediate referral to psychiatry include recent self-harm or thoughts of suicide, expressed intent and/or plan for suicide and psychotic symptoms (Rustad et al, 2013; Newhouse and Jiang, 2014).

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Comorbid anxiety disorders in CHF

Anxiety disorders in CHF appear to be equally as common as depression. However, there are few reports of how to treat anxiety disorders and treatment efficacy in CHF. Recently it was shown that patients with CHF and comorbid generalised anxiety disorder and major depression benefitted most from multidisciplinary interventions (Tully et al, 2014). Specifically, a structured exercise programme, cognitive behavioural therapy (CBT), anxiolytics and anti-depressants were found to have beneficial effects on depression and anxiety symptoms at follow-up. Tully (2015) has also shown that panic disorder developing simultaneously with CHF, especially when undetected, is associated with longer durations of hospital stay commonly ascribed to cardiac causes (Tully, 2015). Otherwise, there is very limited data on the methods to treat anxiety disorders in CHF, such as with interoceptive symptom induction and behaviour (Tully et al, 2017). This may constitute a limitation to applying traditional CBT techniques to this precarious population.

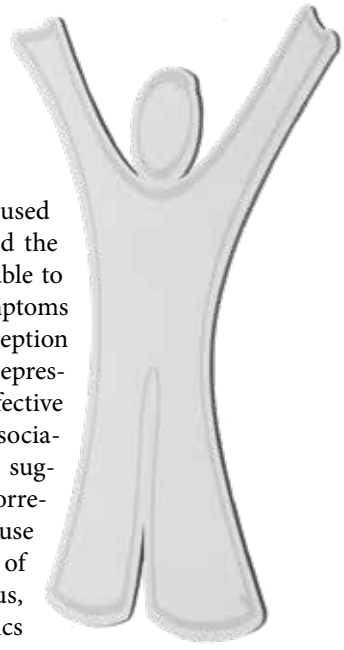
Cognitive impairment

Disturbances in concentration and memory are common in both CHF and depression. For some people, this may be indicative of cognitive impairment. Cognitive impairment is another important but poorly assessed complication of CHF (Cameron et al, 2011). Mild cognitive impairment may occur in as many as three of four patients with CHF, and is associated with poorer CHF self-care (Cameron et al, 2010). The Montreal Cognitive Assessment is a screening tool for mild cognitive impairment and, when used in clients with CHF, has identified subtle but clinically relevant cognitive dysfunction (Cameron et al, 2013). A small randomised controlled trial (RCT) integrating a memory-enhancing component into a CHF education-support intervention found an improvement in self-care and depression symptoms (Clark et al, 2015).

CHF guidelines on depression screening

International CHF guidelines affirm that there is strong and consistent evidence of an independent causal association between depression, social isolation and lack of quality social support and CHF (National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand, 2011; Ponikowski et al, 2016). Furthermore, the severity of depressed mood correlates with both impaired functional capacity and CHF symptoms.

Consequently, Australian guidelines, as an example, identify the presence of depression in CHF as a practical indicator of increased risk of premature morbidity and mortality, and of readmission to hospital. The National Heart Foundation of Australia (NHFA) Guidelines for Multidisciplinary Care state that routine consideration of patients' psychological health is best practice. The 2016 European Society of Cardiology (ESC) guidelines and the NHFA recommend routine screening of patients with CHF for depression using valid and reliable instruments such as the Patient Health Questionnaire (PHQ) and the Beck Depression Inventory-2, followed by referral of patients with depression or other mental illness for appropriate treatment.



Routine depression screening

Table 1 highlights some of the available tools used to detect depression in patients with CHF and the advantages/benefits of these. The PHQ2/9 is able to distinguish symptoms of depression from symptoms of heart failure, and may assist in patient perception of their disease. Multiple studies have divided depression symptoms measured by the PHQ9 into affective and somatic components, and examined the association with cardiovascular outcome. Evidence suggests that the affective depressive symptoms correlate with time to first cardiac event and all-cause mortality; whereas the physical symptoms of depression are independent of health status, clinical and sociodemographic characteristics (Schiffer et al, 2009; Lee et al, 2011). This suggests that the PHQ9 is an adequate measure of depressive symptoms in patients with CHF (Newhouse and Jiang, 2014).

It can also be useful, with the patient's consent, to obtain collateral information from family when assessing for depression. In addition, depression scales should be used to monitor therapeutic efficacy (Rustad et al, 2013).

In a prospective study of 158 patients with CHF, use of the Geriatric Depression Scale (GDS) was related to subsequent mental health treatment. Patients who screened positive for depression during an 18-month medical record review period, as measured by the GDS, were more than three times as likely to receive either psychotropic medications or to use mental health services (Cully et al, 2009). Emerging evidence suggests, however, that implementing depression screening in CHF populations may be far from routine, with key barriers including staff unfamiliarity with screening tools and a lack of clarity around suitable follow-up procedures (Jackson et al, 2016). It is important to note that even with routine screening for depression in CHF, the severity and complexity of mental health needs of some patients with CHF may be underestimated. Tully et al (2014) have evaluated the psychosocial needs of patients with CHF in a CDSM programme that used routine depression screening. Using a stepped procedure, a structured clinical interview and psychologist appointment was offered to people scoring ≥10 on the PHQ. Patients with CHF and major depression were more likely to meet criteria for personality disorder (41.7% vs. 4.0%, $p<.001$) and an active alcohol or substance use disorder (25.0% vs. 4.0%, $p=0.03$) (Tully et al, 2014). These findings suggest that routine depression screening may underestimate the severity and extent of mental health needs in CHF, and underscore the importance of establishing appropriate referral and follow-up procedures.

Treating depression in CHF

Enhancing self-care

The successful treatment regimen for CHF is largely

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Table 1. Depression screening tools

Tool	Advantages	Potential issues
Beck Depression Inventory-2 (Beck et al, 1996) A comprehensive review found in general studies reported a sensitivity of ≥ 0.70 and specificity ≥0.73 (Wang and Gorenstein, 2013)	◆ Recommended in Guidelines e.g. National Heart Foundation of Australia (NHFA) ◆ It is shown to be valid in CHF patients against clinical based interview (Lahlou-Laforêt et al, 2015)	◆ Cost ◆ Does not closely match diagnostic criteria for depression
Cardiac Depression Scale (Hare and Davis, 1996). Found to have 97% sensitivity and 85% specificity for diagnosing major depression in cardiac patients (Shi et al, 2010).	◆ Recommended by NHFA ◆ Specifically designed based on statements made by cardiac patients to detect depression. ◆ Shown to be applicable to CHF patients (Ski et al, 2012)	◆ Limited data on sensitivity and specificity to detect depression ◆ Has not been validated against gold standard structured interview ◆ Unclear whether depression should be diagnosed differently in cardiac populations
Patient Health Questionnaire 9 (PHQ9) and Patient Health Questionnaire 2 (PHQ2) (Kroenke et al, 2003). PHQ 2 was found to have 90% sensitivity and 69% specificity for the diagnosis of major depressive disorders among patients with coronary heart disease (McManus et al, 2005)	◆ Recommended for CHF population in international literature (Lichtman et al, 2008) ◆ Brief/easy to administer ◆ Closely parallels DSM criteria for depression ◆ General stepped treatment recommendations exist based on severity and treatment response (Lichtman et al, 2008)	◆ PHQ2 has low specificity (Elderon et al, 2011) ◆ Evidence shows that PHQ2 positive screen followed by a PHQ9 screen is difficult to apply in routine practice with nurses and allied healthcare staff
Geriatric Depression Scale has a 84% sensitivity rate and a 95 % specificity rate (Yesavage et al, 1982)	◆ Widely used in elderly population ◆ Used in CHF population (Cully et al, 2010)	◆ Not applicable for younger patients with CHF

dependent on a patient's ability and willingness to carry out a series of complex and multifaceted self-care activities (Evangelista and Shinnick, 2008) such as:

- Monitor daily weights
- Exercise
- Follow sodium restrictions
- Follow fluid restrictions
- Take prescribed medications.

Self-care is vital but many patients do not develop sufficient expertise to avoid repeated hospitalisation (Riegel et al, 2007). Indeed, an examination of 5964 patients across 15 countries found that self-care behaviours are sub-optimal in patients with heart failure and need to be improved worldwide (Jaarsma et al, 2013). Interventions designed to increase adherence to self-care behaviours include:

- Educational interventions targeted to improve understanding about CHF condition and treatment regimen
- Behavioural interventions targeted to motivate and empower patients to adhere to self-care regimens
- Psychosocial interventions targeted to promote positiv perceptions, beliefs, and attitudes toward the regimen.

A review of the CHF self-care literature found that effective interventions integrate strategies that motivate, empower, and encourage patients to make informed decisions and assume responsibility for self-care (Evangelista and Shinnick, 2008).

Antidepressants

Despite the adverse outcomes of depression in CHF, few clinical trials testing treatment efficacy have been published. Prior trials are predominantly focused on antidepressants, exercise and some CBT. For example, the SADHART-CHF study (n=469) examined treatment with antidepressants compared to placebo and found that such treatment did not significantly reduce clinical depressive symptoms, nor improve outcomes (mortality) (O'Connor et al, 2010). There was also no effect of treating depression on clinical outcomes of depression. A later meta-analysis of 13 RCTs (n=1718) showed that exercise training, as well as selective serotonin reuptake inhibitor (SSRI) antidepressants, are both effective in treating depression in CHF, and that there is no statistically significant difference between these two choices in terms of the size of their effect. A trend, however, was shown for the superiority of SSRIs, but this should be interpreted with caution, taking into account the beneficial effects of exercise training on other dimensions of the CHF syndrome. Interestingly, no evidence was found to support hospital-based over home-based exercise training rehabilitation for the improvement of depression (Samartzis et al, 2013).

Cognitive behavioural therapy

No large-scale studies have been carried out to evaluate the effects of psychotherapy in patients with heart failure

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(Newhouse and Jiang, 2014), although there are a number of small studies which are promising. One study compared the effectiveness of a combined 12-week home based exercise/CBT programme (n=18) with CBT alone (n=19), exercise alone (n=20) and usual care (n=17). Only those in the combined CBT/exercise condition had sustained lower depression scores and showed the greatest improvements in health-related quality of life (Gary et al, 2010). Another small RCT (n=41) found that a brief, nurse-delivered cognitive therapy intervention, delivered during hospital admission and followed by a 1-week booster phone call improved short-term, event-free survival at 3 months (Dekker et al, 2012). A later RCT (n=158) showed that a CBT intervention for depression and CHF self-care improved depression symptoms and depression remission rates, but did not lead to improvements in measures of CHF self-care maintenance and confidence (Freedland et al, 2015). A recent meta-analysis of six CBT trials (n=320) found greater improvement in depression scores immediately after CBT and at 3 months, compared with usual care, but there was no difference in hospital admissions and mortality (Jeyanantham et al, 2017).

Positive psychology

Positive psychology interventions are applicable to CHF as they can help focus patients on targeted activities (e.g. performing acts of kindness); gratitude (e.g. systematically recalling positive life events); optimism (e.g. imagining positive future outcomes); and using one's personal strengths in a deliberate manner (Huffman et al, 2011). An 8-week, phone-based positive psychology intervention found the intervention to be feasible. It also resulted in improved optimism and was judged by patients as being helpful overall. Participants showed greater improvements in depressive symptoms, anxiety, happiness and health-related quality of life relative to participants in relaxation response or active control (recollection response) (Huffman et al, 2011).

Collaborative care

Components of collaborative care include: a multidisciplinary approach to patient care; structured patient management plans; scheduled follow-up; and enhanced inter-professional communication (Gunn et al, 2006). When compared with usual care, collaborative care is associated with significant improvement in depression and anxiety outcomes over the short, medium, and long term (Archer et al, 2012). Collaborative care programmes featuring interventions that work to improve adherence to medical and psychiatric treatments improve both cardiovascular disease and depression outcomes (Rustad et al, 2013). Collaborative depression care may lead to reductions in adverse cardiac events in the short term, but these beneficial effects may not be sustained (Tully and Baumeister, 2015). Interventions that incorporate patient preferences for psychotherapy and/or antidepressants, by internet or face-to-face, have fared better in terms of depression response and short-term cardiovascular events (Davidson et al, 2010; 2013). However, little research has been performed in patients with CHF.

Table 2. Depression care algorithm for CHF

1. Screen all patients
a. Start with PHQ2 and follow-up with PHQ9 or formal diagnostic interview
2. Psychoeducation
a. Prevalence, importance of mental health and heart health
3. Offer treatment
a. Structured exercise—e.g. CHF Rehabilitation programmes
b. Chronic disease self-management support
c. Psychosocial supportive intervention
d. Enlist social support. When people are depressed, they are likely to withdraw from friends and family. It is important that with the client's permission, family/friends are encouraged to provide extra instrumental or emotional support as required. This is particularly important if the client has memory problems or cognitive deficits.
e. Refer to general practitioner or community-based physician to develop a mental healthcare plan, which may include antidepressant medications
4. When to refer to specialist mental health
a. Depression not improving
b. Suicidal ideation
c. Refer to psychiatrist if: has had trial of two antidepressants and/or development of psychotic and/or manic symptoms
5. Regular review
a. Check in with your patient's mental health and progress
b. If you work with patients over the long term (e.g. 6–12 months) re-screen for depressive symptoms. Aim to use the PHQ2/9 at 6-monthly intervals and prior to discharge.

Conclusion

Comorbid depression is common in patients with CHF. Depression increases the mortality and morbidity risk of patients with CHF. Guidelines for the management of CHF recommend routine depression screening of all people with CHF. The authors have suggested that screening after hospitalisation is more useful as a morbidity and mortality predictor than in-hospital screening. For those CHF patients who participate in CHF rehabilitation programmes, programme entry is an ideal time for depression screening and referral if warranted. For other patients with CHF, assessment at outpatient visits or general practitioner visits at around 2 months post hospitalisation would be useful. From their review of the literature on depression and heart failure, Newhouse and Jiang (2014) developed a depression care algorithm for patients with CHF. *Table 2* presents an adaptation of the algorithm.

Hopefully, patients with comorbid depression and CHF will be increasingly referred for assessment and treatment by clinical or health psychologists, whose specialised role in this process primarily includes clinical assessment, formulation of treatment recommendations and provision of depression-

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Key Points

- Patients with chronic heart failure (CHF) have elevated rates of depression, negatively affecting quality of life, morbidity and mortality
- It is often difficult to distinguish between the somatic effects of depression, such as fatigue, and the effects of CHF; depression often goes unrecognised in this population without routine screening
- The Patient Health Questionnaire 2 and 9 and the Beck Depression Scale 2 are recommended in various national CHF management guidelines for routine screening of depression in CHF
- Multidisciplinary collaborative care including clinical and health psychologists has been shown to be effective in reduction of depression in patients with CHF, leading to better self-management

focused psychotherapies. The intervention studies reviewed in this paper suggest that this specialised treatment is best undertaken within a model of multidisciplinary collaborative care. This is not to underestimate, however, the challenges faced at a systemic level to develop sustainable person-centred care in heart failure management which includes multidisciplinary care planning (Kell et al, 2015). The authors agree with the Australian Medical Association's view that there is a serious and continuing problem in the inability to link and integrate the mental health care provided to patients in primary care with the crisis or acute care they receive as hospital inpatients, and that the mental health component of health budgets generally does not reflect the proportion of total burden of disease that they contribute (Australian Medical Association, 2018). BJCN

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CPD Reflection Questions

- Why does depression often go unrecognised and untreated in patients with heart failure?
- What is the limitation of in-hospital assessments of depression in patients with CHF?
- What are the recommended treatments for depression in patients with CHF?

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