The second article in this two-part series focuses on supporting patients with depression

Mental health and long-term conditions 2: managing depression

In this article...
- Prevalence of depression in people with long-term conditions
- The role of nurses in recognising depression
- How to support clients with long-term conditions and depression

Author Mike Nash is lecturer in psychiatric nursing, Trinity College, Dublin; Justin McDermott is lecturer in mental health, Middlesex University.


This second article in a two-part series on mental health and long-term conditions discusses the complex area of comorbid physical health and mental health problems. It focuses on depression – one of the most common mental illnesses – examining its prevalence and symptoms in people with long-term conditions, and how it can affect the ability to self-manage them. It also examines how nurses can support clients who experience depression as part of their long-term condition.

In England, an estimated 15.4 million people have a long-term condition (Department of Health, 2008a). Conditions such as cardiovascular disease, diabetes and cancer are associated with mental illness; the more serious the condition, the higher the risk (Sederer et al, 2006). Long-term conditions can be complex and many people present with multiple conditions such as diabetes, obesity and hypertension. These conditions can impact on mental health, making clients more susceptible to anxiety or depression; comorbid mental ill health can present a risk to the successful management of long-term conditions.

5 key points
1. It is estimated that 15.4 million people in England have a long-term condition
2. Depression is two to three times more common in people with a chronic physical health problem
3. Pain and fear of the future are reasons why people with long-term conditions are at increased risk of depression
4. Depression can go unnoticed because patients may not mention symptoms for fear of being labelled “mentally ill”
5. Working in partnership is fundamental in managing comorbid physical and mental illness

Government policy is committed to reducing the number of people with physical ill health and long-term conditions who develop mental health problems (DH, 2011). This presents a significant challenge to nurses who have little or no training in mental health care.

Prevalence of depression in long-term conditions
Research has suggested a high prevalence of comorbid depression in a range of physical illnesses – for example, prevalence is 33% in people with cancer and 44% in those with HIV/AIDS (World Health Organization, 2003). The National Institute for Health and Clinical Excellence (2009a) stated depression is approximately two to three times more common in patients with a chronic physical health problem.

Respiratory disorders
Yohannes (2005) suggested depression affects as many as 40% of patients with chronic obstructive pulmonary disease and that this might be untreated.

Diabetes
Katon (2008) found depression frequently occurred comorbidly with diabetes, suggesting up to 80% of patients with diabetes and depression will experience a relapse of depressive symptoms over a five-year period. Depression was also found to be associated with non-adherence to diabetes self-care.

Cardiac conditions
Depression is a common problem in patients with acute and continuing cardiac conditions. In 2008, the British Heart Foundation found as many as three in every 10 people reported feeling anxious or depressed after a heart attack.

Why people with long-term conditions get depressed
There are several reasons why people with long-term conditions are at increased risk of depression. Pain is an obvious issue – in a systematic review Dickens et al (2002) found depression to be more common in patients with rheumatoid arthritis than in healthy individuals, partly because of the pain they experienced. Fear of the future is also a factor in degenerative conditions, for example people with multiple sclerosis are almost three times more likely to suffer from major depression than the general population (Reeves, 2003). Another reason people become depressed is the nature of the interventions for their physical condition. For example,
Invasive daily treatments like insulin injections or having to modify lifestyle are constant reminders of illness. This can be disempowering for individuals, who can then feel their life is no longer their own.

**Why depression might be missed**

Depression can go unnoticed in patients with long-term conditions. Often individuals do not disclose their symptoms for fear of being labelled “mentally ill”; to compound this, nurses may not feel confident asking patients about depression because they lack the knowledge and skills to recognise symptoms.

Nurses may also overempathise with patients; for example, in thinking: “If I had to inject insulin three times a day, I’d be depressed too,” they may actually be re-labelling legitimate symptoms of depression as natural responses to ill health. This response can delay diagnosis and treatment.

**Effects of depression on ability to self-care**

Depression can impair people’s abilities to self-care and affect their ability to eat, drink or sleep. Poor diet and irregular sleep patterns can also magnify existing physical symptoms such as fatigue.

Depression can also negatively impact on mood, thinking, memory and concentration. This can impair the ability to “think straight” and may contribute to poor self-management of long-term conditions through unintentional non-concordance if a person’s ability to follow or understand complex treatment regimens may be compromised. Nurses should be mindful that variable treatment responses to established interventions could indicate depression in those clients who are vulnerable.

**The role of nurses in recognising depression**

Nurses need to recognise signs and symptoms of depression to intervene effectively. They also need to differentiate between depressive and physical symptoms as, at times, they can be similar. For example, poor memory and agitation may be mistaken for symptoms of dementia in older clients, rather than depression. Nurses need to be aware that having a long-term condition can increase the risk of experiencing a depressive episode.

Practitioners should note the various symptoms of depression; these are outlined in Table 1, which should be used as a general guide. If they have concerns about a patient, health professionals should contact the local mental health service.

<table>
<thead>
<tr>
<th>ICD 10 DIAGNOSTIC CRITERIA FOR DEPRESSION</th>
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<tr>
<td><strong>Key symptoms</strong></td>
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<td><strong>Other common symptoms</strong></td>
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<tr>
<th>Minor depressive episode</th>
<th>Moderate depressive episode</th>
<th>Major depressive episode</th>
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<tr>
<td>At least one symptom from: (a), (b) and (c) plus:</td>
<td>At least two from (a), (b) and (c) plus:</td>
<td>All three of: (a), (b) and (c) plus:</td>
</tr>
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<td>At least two common symptoms from: (d), (e), (f), (g), (h), (i) and (j) for a minimum of two weeks</td>
<td>At least three, or preferably four, common symptoms from: (d), (e), (f), (g), (h), (i) and (j) for a minimum of two weeks</td>
<td>At least four common symptoms from: (d), (e), (f), (g), (h), (i) and (j), some of which should be of severe intensity</td>
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<tr>
<td>Symptoms may not be present to an intense degree</td>
<td>Some symptoms may be present to an intense degree</td>
<td>Minimum duration of two weeks, but may also have a rapid onset</td>
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Once depressive symptoms have been recognised, they can be assessed using validated tools such as the Hospital Anxiety and Depression Scale or the Beck Depression Inventory for Primary Care (Beck et al., 1997; Zigmond and Snaith, 1983). These tools help nurses to screen clients and identify those who may need more specialised mental health care (Box 1). However, nurses should know how to interpret such tools – for example, depression has some physical signs and symptoms which, if similar to symptoms of the physical illness, may increase the depression score.

Initially nurses will need training and support in using these tools, but will develop confidence and competence naturally with practice. Support and supervision from mental health colleagues can also be helpful. The focus should be to enable general nurses to recognise signs and symptoms of depression and communicate these effectively; the intention is not to turn general nurses into “mini mental health nurses” but to safely extend practice in order to offer holistic, high-quality care to clients.

**Supporting clients with a long-term condition and depression**

NICE (2008b) suggested health professionals manage depression depending on: the number, duration and severity of the presenting symptoms; past family history; and availability of social support. Making care for people with comorbid physical and mental health problems seamless is an important goal requiring a coherent policy response. The Darzi report (DH, 2008b) suggested working in partnership is vital for high-quality health services and in managing comorbid physical and mental illness.

The role of the general nurse in managing a comorbid mental health problem is to provide safe and competent care for both conditions. At a basic level this will not be too problematic but management can become more complex if a client develops a major depressive illness.

General nurses can provide holistic care to clients, even though they may not have specialist skills. If clients appear “out of sorts” this should prompt nurses to ask about depression. This is important as they may have an existing depression that has not yet been diagnosed.

**Managing comorbidity interprofessionally**

Most general health services, such as primary care centres, A&E departments and hospitals will have access to specialist mental health practitioners who can supervise and educate colleagues on issues such as depression. Avenues for sharing care, such as having temporary mental health input into long-term conditions, would enhance the philosophy of inter-professional working.

**Liaison psychiatry**

The Royal College of Psychiatrists (2010) suggested a quarter of all patients in general hospitals have mental health problems. Liaison psychiatry is the specialty that assesses and manages mental illness in patients with medical conditions. Harrison and Hart (2006) stated that it could be particularly beneficial in...
interventions and cognitive behavioural practitioners help jointly to manage com-
provide increased capacity in the primary care. Nurses and health visitors can benefit from
In the community, district and practice settings such as A&E, cardiology, cancer and perinatal units.
Liaison psychiatry can benefit general nurses through support, supervision and joint working, and their clients through holistic and specialised assessment and joint management. Waghorn (2010) found that liaison psychiatry based in emergency departments strengthened staff relationships, and had the potential to reduce unnecessary admission, increase interpro-
essional working and provide more responsive services.

Primary care graduate mental health workers
In the community, district and practice nurses and health visitors can benefit from support from primary care graduate mental health workers, whose role is to provide increased capacity in the primary care setting to improve the management of common mental health problems. These practitioners help jointly to manage complex referrals. They can use brief therapy interventions and cognitive behavioural therapy techniques with clients and pro-

settings such as A&E, cardiology, cancer and perinatal units.

Promoting independence, to give them back the sense of control they may feel has been taken away. However, this should be done cautiously and services should always be available to deal with any crises that occur with long-term conditions. Nurses also need to have the confidence to enable clients to make positive choices; this will come from education and training. They should also engage in reflect-


tive practice and clinical supervision to identify their learning and skills needs. **NT**

**BOX 1. POTENTIAL OUTCOMES OF SCREENING USING A STANDARDISED DEPRESSION ASSESSMENT**

- Nurse manages depression within existing care plan by offering support and advice on local peer support groups
- Routine referral to GP for further assessment
- Routine referral to liaison mental health team or primary mental health care worker
- Urgent referral to community mental health team/crisis team
- Urgent referral for admission to hospital

**TABLE 2: DEPRESSION INTEGRATED CARE PATHWAY**

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<th>Depression Care Standard</th>
<th>Integrated care pathways</th>
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<td>33 A validated measure of depression is used at initial assessment and repeated at regular intervals to monitor progress and outcome</td>
<td>NHS Quality Improvement Scotland has developed integrated care pathways (ICPs) for several mental health problems, including depression. It defines these ICPs as a system of care that encompasses how it is organised, coordinated and governed (NHSQIS, 2008). Although not specifically for comorbid presentations, the ICP for depression can be used as a guide to managing depression care. Split into non-complex and complex needs, it is divided into five standards. (Table 2). Complexity in ICPs can be defined by severity of depressive symptoms, with non-complex cases being managed without specialist mental health input. Complex cases – for example clients with suicidal ideas – would need specialist mental health intervention.</td>
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<td>34 There is a record of the offer and uptake of assessment of need, leading to appropriate self-help and signposting within four weeks of initial presentation</td>
<td>Nurses considering developing ICPs for clients should do so in an interprofessional way, involving mental health services so specialist advice and input is given at the planning stage. Client and carer views should also be sought as they can offer a unique insight into the reality of service provision, which at times fails to live up to the rhetoric.</td>
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</table>
| 35 There is a record of the offer and uptake of depression-focused brief psychological therapies within six weeks | **Conclusion** Depressive episodes can be, and are, effect-

ively managed by general nurses. Offering support, listening to clients and allowing them to express their feelings will reassure them. Nurses should encourage clients to join self-help or support groups, which can also provide peer support. Depression in physical illness is a modi-

ifiable risk factor – it can be changed. This will have implications for practice such as: providing individualised client care using evidenced-based guidelines and ICPs; edu-

cating clients about conditions and treatments so they can develop self-manage-

ment strategies; and, ultimately, promoting independence, to give them back the sense of control they may feel has been taken away. However, this should be done cautiously and services should always be available to deal with any crises that occur with long-term conditions. Nurses also need to have the confidence to enable clients to make positive choices; this will come from education and training. They should also engage in reflect-

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