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COMMENTARY

Commentary on Haws J, Ramjeet J & Gray R (2011) A national survey of GP and nurse attitudes and beliefs towards depression after myocardial infarction. *Journal of Clinical Nursing* 20, 3215–3223

Author: Mark Haddad

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The recent article by Haws *et al.* (2011) seeks to extend understanding of clinicians' views and knowledge about the association between depression and coronary heart disease (CHD). The authors draw attention to the raised prevalence of depression among people following myocardial infarction (MI) and the negative effects of this comorbidity on health outcomes – a topic of clear clinical and public health significance.

The association between medical conditions and common mental disorders is not restricted to CHD and depression: evidence from large-scale community studies indicates that the prevalence of mood, anxiety and substance use disorders is consistently elevated in people experiencing a wide range of medical conditions (Wells *et al.* 1989, Moussavi *et al.* 2007). Most research has examined comorbid depression, and typically, its prevalence is two- to three -fold increased among people with common long-term conditions such as asthma, diabetes, hypertension or stroke, resulting in increased disability and higher health care usage.

Haws *et al.* (2011) rightly note that cardiac mortality rates are increased in patients who have developed depression following MI; systematic review evidence indicates a 2.5-fold increase. These negative consequences, together with the likelihood that comorbidities of this sort will become increasingly common with population ageing and improved healthcare, provide a powerful imperative for better condition recognition and treatment (Haddad 2009). New studies are extending evidence for treating mental health problems like depression in combination with medical conditions, and guidelines have been developed to assist clinical decision-making and service management.

Psychological treatments (delivered not only face-to-face, but via the internet, telephone and text messaging) and antidepressants have been found effective, as have service delivery approaches typically combining a case identification with stepped care arrangements, structured follow-up and case management (usually involving primary care-based nurses). However, and contrary to the claim made in the article's discussion section, the use of screening tools is associated with only modest improvements in depression recognition and with a lack of clinical benefits unless additional organisational changes are in place to enable delivery of appropriate therapeutic responses.

Haws *et al.* (2011) conducted an internet survey, aimed to ascertain the knowledge, attitudes and related clinical practice of nurses and GPs in this area. These aims may help determine need for training, or other resources to support practice changes, but importantly, the value of findings is dependent upon the adequacy of the methods used. Unfortunately, the design and reporting of this study appear flawed. The sample selection and response rate (of around 9%) are discussed by the authors, but there remain important questions about this sample's representativeness of the population of interest: the means of contacting staff together with the response rate raise the possibility of selection bias.

Most importantly, the authors may misrepresent the state of clinicians' knowledge concerning depression among people following MI. They repeatedly provide a rate of 45% for post-MI depression prevalence, stating this one-year prevalence to be based on epidemiological research. A key part of their article involves comparing this prevalence with participants' responses to the question: 'Can you estimate the percentage of patients you see post-MI who are depressed?', and they report as a central finding that GPs' estimates were around 24%, whilst for nurses, this was just less than 18%. The authors discuss and summarise this finding as a most striking observation involving a dramatic underestimation or failure to recognise how commonly depression occurs in post-MI patients.

The validity of this conclusion is obviously dependent upon the accuracy of the post-MI depression rate that the study authors have used. And problematically, this rate of 45% differs markedly from that noted in the literature, which comprised of a sizeable number of independent studies and systematic reviews, together with most recent American Heart Association guidelines, indicates a prevalence of post-MI depression of around half this size.

A well-conducted systematic review (Thombs *et al.* 2006) identified a post-MI depression prevalence of 19.8% (95% CI 19.1–20.6%), using standardised clinical interviews ($n = 10,785$; 8 studies). If the findings of this review are accurate, it would appear that the survey respondents in this study, rather than underestimating the prevalence of post-MI depression, may be well informed about this aspect of comorbidity.

Conflicts of interest

Mark Haddad is currently part of the UPBEAT-UK research team (Tylee *et al.* 2011) that is investigating the association between depression and coronary heart disease and evaluating approaches to improved treatments.

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