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Poor uptake of depression care in cardiology

Depression is associated with poorer coronary heart disease (CHD) outcomes; however, routine screening for depression is controversial and difficult to implement in clinical practice, and randomised clinical trial (RCT) evidence is scarce.¹ The DEPSCREEN-INFO parallel group efficacy RCT reported by Löwe *et al*² randomised participants to written patient-targeted feedback versus no written patient feedback after depression screening. The sample comprised in-patients and out-patients with CHD, but also those with arterial hypertension. Löwe *et al* argued that the role of the patient within the depression screening process had not yet been studied. Previously, we reported two examples of depression screening involving patient, general practitioner and cardiologist feedback in heart failure³ and cardiac surgery populations.⁴ Our findings, and those of others,^{5,6} diverge from Löwe *et al*'s in terms of mental health service use.

Lowe *et al* showed that 13% of participants contacted a psychotherapist, which might reflect generous health insurance benefits in Germany, including up to 2 years of psychotherapy. By comparison, in England an RCT for depression and CHD or diabetes by Coventry *et al*⁵ revealed that 33% of individuals randomised to collaborative care did not attend any depression treatment session. Coventry *et al*⁵ used the Improving Access to Psychological Therapy (IAPT) services in the English National Health Service (NHS). Other depression screening studies in CHD indicate that uptake of mental health services is <2% in the USA⁶ and Australia,⁴ with the latter study providing a rebate for mental health services similar to IAPT. Mounting evidence indicates incongruity between international efforts to improve depression care and the uptake of mental health services by the CHD patients we are targeting with depression screening. Integration of mental health services within cardiology and primary care services may be warranted. Clearly, more concerted efforts are required internationally to improve existing mental health services by adopting innovative methods such as 'blended' collaborative care, computerised cognitive-behavioural therapy (CBT) and telehealth. It remains crucial to better align mental health services with CHD patient needs in order to better engage CHD patients.

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Authors' reply: We thank Dr Tully for his thoughtful comments on the DEPSCREEN-INFO randomised controlled trial.¹ We share his conclusion about the need to better align mental health services with cardiac patient needs,^{2–4} and we appreciate the studies he cited in his letter. However, these studies did not specifically investigate the efficacy of patient-targeted feedback after depression screening using a randomised controlled study design. In fact, the lack of studies specifically investigating the potential of providing feedback on depression screening results to the patients themselves was the initial point for the DEPSCREEN-INFO trial. Of note, DEPSCREEN-INFO is not a depression screening trial. The screening method was identical across the two conditions, whereas the active component of this trial was the patient-targeted feedback intervention that was applied after depression screening.

Results of the DEPSCREEN-INFO trial indicated that patient-targeted feedback in addition to physician feedback, compared with physician feedback alone, resulted in a small but significant improvement in depression severity 6 months after depression screening. Secondary study results revealed that the patient feedback group was more concerned and more active in their approach to depression than the control group, e.g. by seeking information regarding depression more actively. Although the DEPSCREEN-INFO trial did not investigate the modes of action in more detail, the patient group who received targeted patient feedback appeared to use the opportunity to mobilise coping responses. In response to Dr Tully's assumption that the German healthcare system might offer intensive mental healthcare, our results rather suggest that there is a gap between mental and physical healthcare in cardiology in Germany as well: of the 259 screen-positive patients in both study groups, only two patients (0.8%) were referred to a mental health professional, and in only five patients (2%) was suicidality addressed within the cardiac consultation. However, there were no significant differences between the study groups.¹

If cardiologists do not refer depressed patients to mental healthcare, then we need interventions that address patients as active partners. In fact, the DEPSCREEN-INFO study results highlight that patient-targeted feedback in addition to depression screening has the potential to engage the patient as an active information seeker and to improve depression severity. However, additional studies are needed to assess the generalisability of our study results to other settings, and to more directly investigate the underlying mechanisms of patient-targeted feedback. To boost the small but significant effect on depression severity, we need to know what single feedback mechanisms are essential to address patients' needs. As empirical data are scarce and feedback interventions are often designed atheoretically, studies are needed to understand the mode of action by which feedback triggers patients to seek help for depression. Recently, a study has shown that treatment for depression after an acute myocardial infarction may decrease the risk of dying 1 year after myocardial infarction.⁵

We believe that it is worthwhile to further investigate the potential of targeted patient-feedback after depression screening as an easily implementable complement to more intensive interventions in depressed cardiac patients.

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Communication skills training for psychiatrists

It is encouraging to see studies emerge regarding communication skills training for psychiatrists.¹ Although the authors claim that this is the first study to test an intervention for psychiatrists to enhance communication with patients with psychosis, we would like to draw readers' attention to other work that has been published in this area. In Australia, since 2013, an advanced communication skills training programme for postgraduate psychiatry trainees (ComPsych) has been part of psychiatry trainees' formal postgraduate education.² This focuses on improving doctor–patient communication about schizophrenia diagnosis, prognosis and treatment. Two pilot studies have been published about this programme: evaluating trainees' attitudes and self-efficacy regarding the programme and their confidence in their own communication skills;³ and an objective evaluation of their skills using standardised patient assessments.⁴ It is our hope to continue this important work, and we are encouraged to also see the work done by the authors of this paper.

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Authors' reply: The pilot study by Ditton-Phare *et al.*¹ which was not published at the time of writing our paper, is a most welcome addition to the field. Their focus on how to communicate about diagnosis and prognosis is particularly helpful, given that there can be a reluctance to disclose a diagnosis of psychosis for fear of causing harm.² As Ditton-Phare *et al.* describe, they evaluated trainees' skills '*in vitro*' using role plays with actors. While assessing trainees' skills interacting with actors (or simulated patients) is a useful tool in training, there are 'qualities of the psychiatrist–patient encounter that may be resistant to simulation'.³ Our study⁴ differed in testing an intervention in the natural clinic setting with patients. Hence, as far as we are aware, this is the first study to enhance communication with patients with psychosis.

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