# DEPRESSION, ANXIETY *and* CYSTIC FIBROSIS

GUIDE FOR CF CLINICIANS

## INTERNATIONAL GUIDELINES ON DEPRESSION AND ANXIETY IN CYSTIC FIBROSIS:

The Cystic Fibrosis Foundation, in collaboration with the European Cystic Fibrosis Society, developed guidelines for screening and treating depression and anxiety.[1] These guidelines provide recommendations for prevention: screening and initial clinical assessment, referral, and psychological and/or pharmacological interventions (Figure 1).

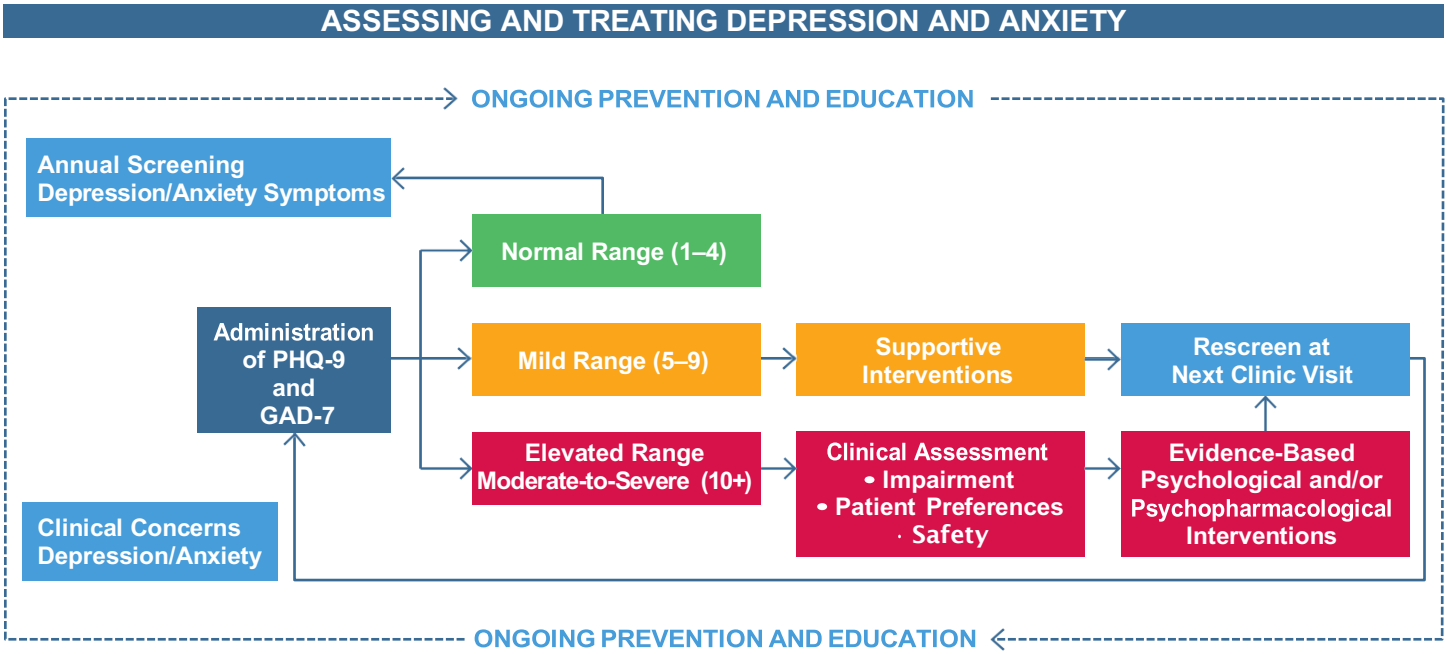


**FIGURE 1.** Strategy for Screening and Treating Depression and Anxiety

## WHY IS SCREENING AND TREATING DEPRESSION AND ANXIETY IN CF IMPORTANT?

A study in nine countries (the TIDES study) screened over 6,000 patients with CF, ages 12 years through adulthood, and over 4,000 parents.[2] The results showed that depression and anxiety were elevated in patients with CF and in parents of children with CF (Figures 2 and 3). **Elevations were two to three times those reported in community samples.**

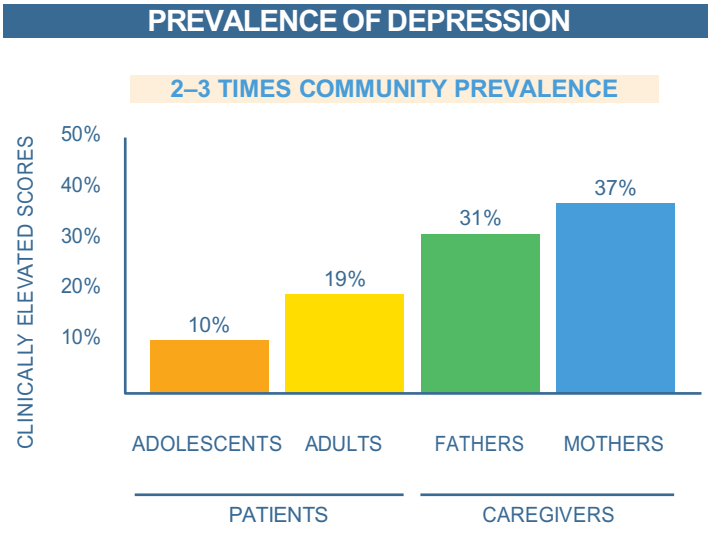


**FIGURE 2.** Prevalence of Depression among Individuals with CF and Parent Caregivers. **SOURCE:** Quittner et al. Thorax. 2014;69(12):1090–7

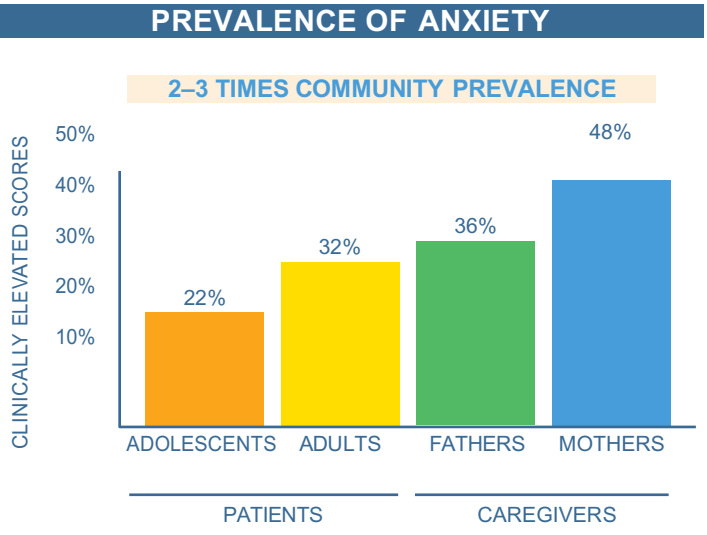


**FIGURE 3.** Prevalence of Anxiety among Individuals with CF and Parent Caregivers. **SOURCE:** Quittner et al. Thorax. 2014;69(12):1090–7

## ESTABLISH A CARE PATHWAY:

Care and referral pathways should be established *prior* to the initiation of screening. The pathways should address each of the following items:

1. Identify the clinician(s) on the team with mental health experience.
2. Develop or use recommended educational materials that can be found at cysticfibrosis.org.au/mhr
3. Develop and maintain a list of referral sources within the hospital and community.
4. Develop a plan to address high risk individuals, including those at risk for suicide or self-harm. Those who screen positive for suicide risk (question 9 on the PHQ-9) should complete a clinical interview with the designated mental health expert on the CF team and be assessed as soon as possible for risk of suicide or self-harm.
   - The Columbia Suicide Severity Rating Scale (C-SSRS) can be used to evaluate this risk. A brief training in the C-SSRS, including a version of the screener and recommended triage points, can be downloaded at cysticfibrosis.org.au/mhr

## KEY SCREENING RECOMMENDATIONS:

- CF teams must identify who will be responsible to initiate screening, coordinate care and monitor treatment effects.
- All individuals with CF ages 12 years and older should be screened annually for depression and anxiety with the Patient Health Questionnaire PHQ-9 and Generalised Anxiety Disorder GAD-7.
- At least one primary caregiver of a child with CF (ages 0–17) should be offered annual screening using the PHQ-9 and GAD-7. Depending on resource availability, the PHQ-8, PHQ-2, and/or GAD-2 may be offered as alternatives.

## WHY THE PHQ AND GAD?

- The PHQ-9 for depression screening and GAD-7 for anxiety screening are free, brief, reliable and valid.
- They contain optimal cut-off scores for detecting psychological symptoms.
- They are available in all major languages.

**Download manuals and screeners from cysticfibrosis.org.au/mhr**

## KEY TREATMENT RECOMMENDATIONS:

- CF teams must identify who will be responsible to initiate and coordinate care and monitor treatment effects. Treatment should be based on the clinical diagnosis made by appropriately trained and licensed health care providers.
  - A stepped care model of clinical interventions (Figure 4) should be developed and implemented in close collaboration with patients, caregivers, the multidisciplinary team and other mental health care providers.
  - Screening can be carried out by any member of the CF team, with an appropriate background such as a social worker, psychologist, psychiatrist, nurse practitioner or physician with additional mental health training.

    **Of note:** An individual with a positive screen requires further clinical assessment prior to the initiation of or referral for treatment.
  - A positive assessment includes: identification, presence, duration, and severity of symptoms, prior history, and risk factors for depression and/or anxiety.
  - Identification of a significant mental health disorder or those identified as at-risk for suicide or self-harm, must be referred to an appropriate mental health specialist within or identified by the CF Centre.

## STEPPED CARE MODEL FOR DEPRESSION AND ANXIETY INTERVENTIONS FOR PEOPLE WITH CF:

The PHQ and GAD will identify the presence and severity of depression and anxiety. Recommended interventions are based on the severity of symptoms (Figure 4). Interventions should be collaboratively developed and tailored to account for individual patient/caregiver preferences, medical status, psychiatric comorbidities, treatment history, and resource availability.

- Mild Depression and/or Anxiety (5–9)
  - Brief check-in
  - Education about depression and/or anxiety, preventative or supportive interventions, initiated and carried out by the CF team member with mental health experience.
  - Rescreening at the next visit.
- Moderate Depression and/or Anxiety (10–14)
  - Offer or provide a referral for psychological interventions, including cognitive behavioral therapy (CBT) and interpersonal therapy (IPT).
  - If psychological interventions are not available, declined or not fully effective, antidepressant treatment should be considered.
  - Combined psychological interventions and antidepressant pharmacotherapy
- Severe Anxiety (GAD-7: 15+)
  - Exposure-based CBT
  - If exposure-based CBT is unavailable, declined or not fully effective, antidepressant medications can be considered.

## PHARMACOTHERAPY:

- The selective serotonin reuptake inhibitors (SSRIs) are appropriate first-line medications for most individuals with CF requiring pharmacotherapy for depression or anxiety.
- In selecting an antidepressant and adjusting its dosage, close monitoring of therapeutic effects, adverse effects, drug–drug interactions and medical comorbidities is recommended.

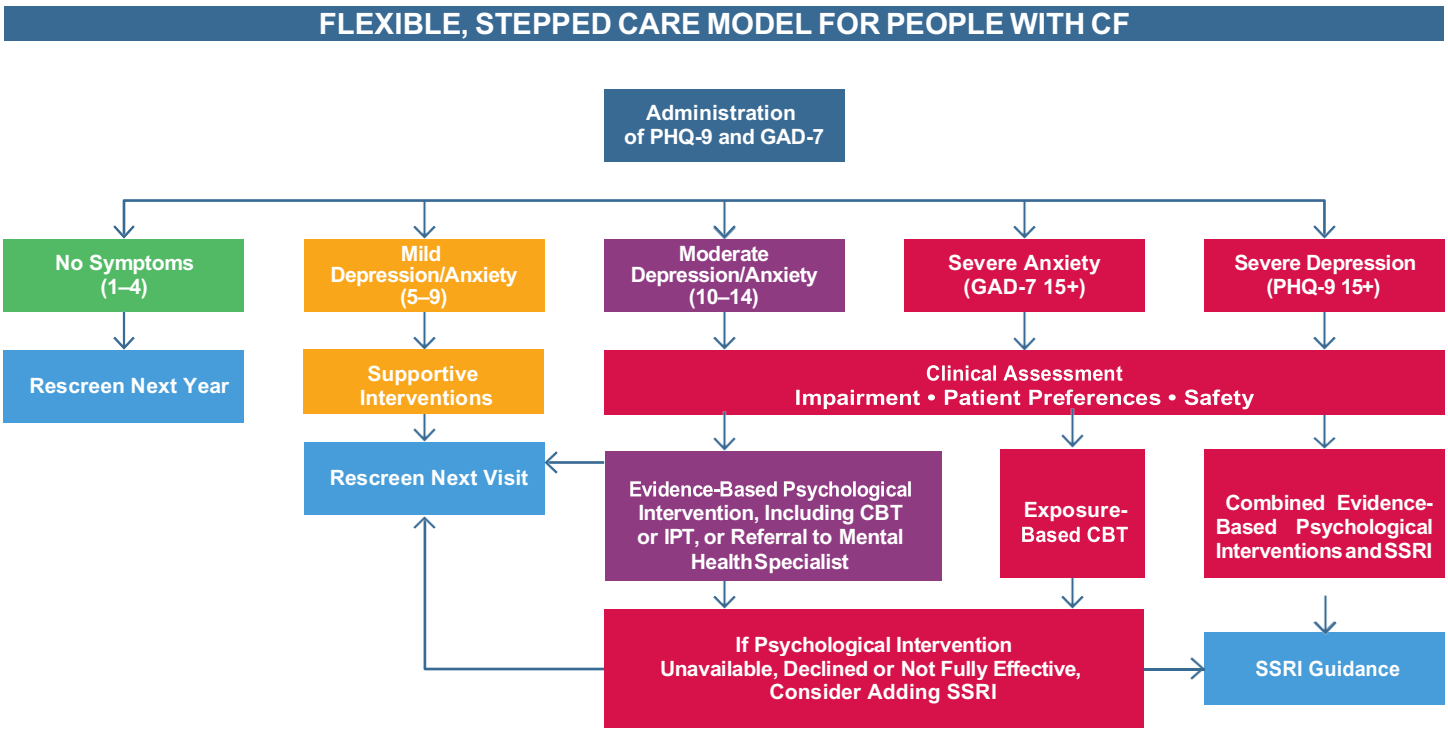


**FIGURE 4.** Flexible Stepped Care Model for Screening and Interventions for Individuals with CF

## STEPPED CARE MODEL FOR DEPRESSION AND ANXIETY INTERVENTIONS FOR FAMILY CAREGIVERS:

- Recommended interventions for family caregivers are also based on the severity of symptoms (Figure 5).
- For *family caregivers only*, centres that do not have the resources to assess suicidality may choose to omit question 9 on the PHQ-9 that assesses self-harm.

## IS MENTAL HEALTH CARE COVERED BY MEDICARE?

Yes. A GP can work with patients to develop a Mental Health Treatment Plan (MHTP) and referral to a mental health specialist (e.g. psychologist, social worker, psychiatrist). Medicare will subsidise some of the cost of the first six sessions in the MHTP. Medicare subsidises up to ten sessions per calendar year.

In addition, prescription medications such as antidepressants or anti-anxiety medications will generally be subsidised through the Pharmaceutical Benefits Scheme (PBS).

Some private health insurance policies may also reimburse some of the cost of seeing a mental health specialist.

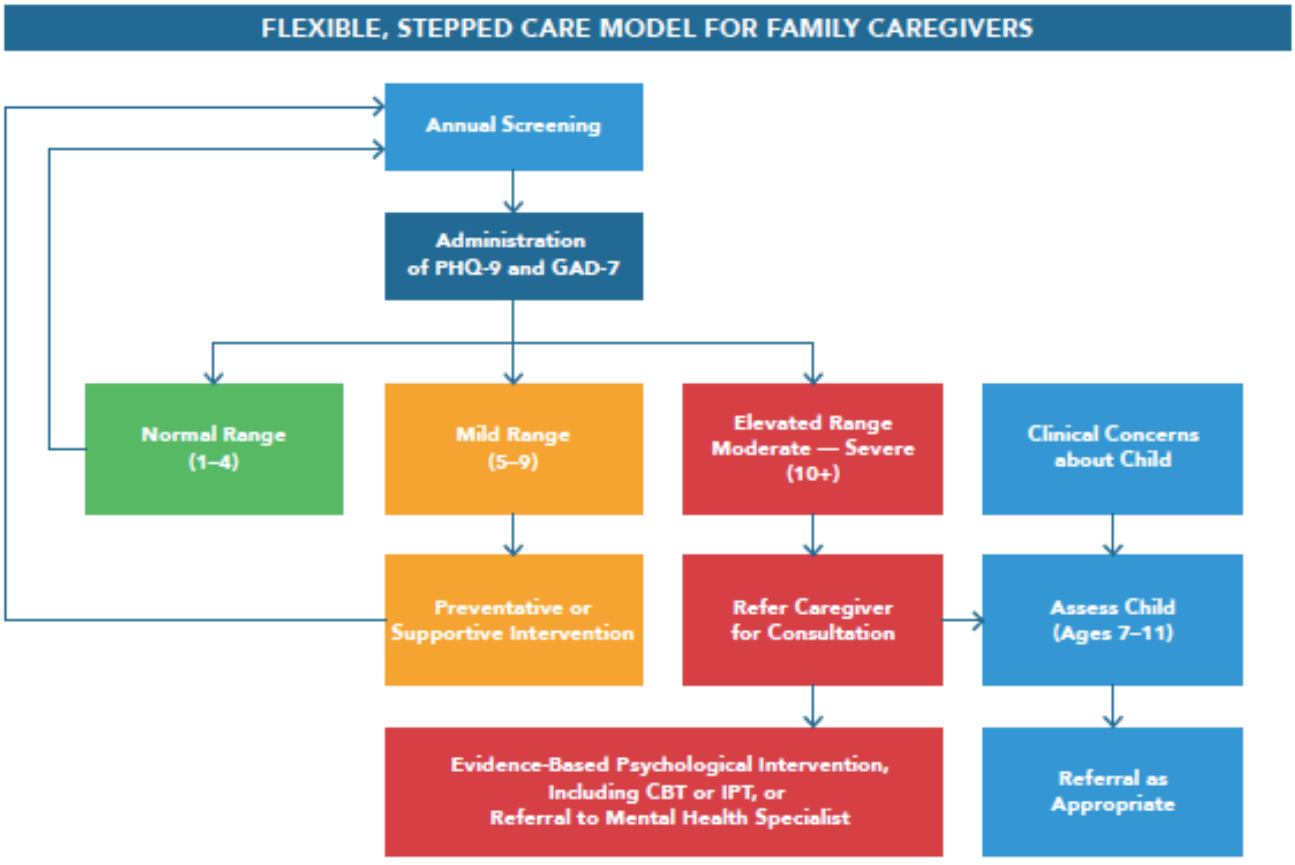


**FIGURE 5.** Stepped Care Flow for Family Caregivers of People with CF

For questions, call + 61 02 9889 5171
or email CFA1@cfa.org.au.

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**References: 1.** Quittner AL, Abbott J, Georgiopoulos AM, Goldbeck L, Smith B, Hempstead SE, Marshall BM, Sabadosa KA, Elborn S, and the International Committee on Mental Health. International Committee on Mental Health in Cystic Fibrosis: Cystic Fibrosis Foundation and European Cystic Fibrosis Society consensus statements for screening and treating depression and anxiety. Thorax thoraxjnl-2015-207488 Published Online First: 9 October 2015 doi:10.1136/thoraxjnl-2015-207488. **2.** Quittner AL, Goldbeck L, Abbott J, Duff A, Lambrecht P, Solé A, Tiboshc MM, Brucefors AB, Yüksel H, Catastini P, Blackwell L, Barker D. Prevalence of depression and anxiety in patients with cystic fibrosis and parent caregivers: results of The International Depression Epidemiological Study across nine countries. Thorax. 2014;69:1090-1097. doi:10.1136/thoraxjnl-2014-205983.