Elsewhere in *JAMA Network Open*, Lapa and colleagues have provided an interesting report of the largest study of which I am aware that assesses adherence to cardiac medication regimens in patients with depression and coronary heart disease (CHD). The retrospective study included 124,443 patients who were followed for a year after receiving percutaneous coronary intervention (PCI). Nearly 17% of these patients had a documented diagnosis of a depressive disorder. The authors chose to evaluate adherence to 4 guideline-directed medical therapies for these patients: antiplatelet agents, β-blockers, statins, and renin-angiotensin-aldosterone system inhibitors. As a result of the large sample size and the availability of medical records with relevant information, the authors were able to compare rates of adherence between patients with and without depression in multivariable-adjusted regression models that included many of the major potential confounders. Adherence to all the medications except for renin-angiotensin-aldosterone system inhibitors was significantly lower in the group with depression than in the group without. The limitations of the study are acknowledged and discussed by the authors. Despite these limitations, the study offers strong support for routine screening and assessment of depression in patients with CHD to identify those who are likely not to fully adhere to the medical regimen.

Based on the evidence that depression is associated with a 2-fold increased risk for medical morbidity and mortality in patients with CHD, in 2008 the American Heart Association issued a scientific advisory recommending that routine depression screening be performed in patients following an acute coronary syndrome. Despite the consensus that depression carries a high risk for cardiac events, some prominent cardiologists and researchers in the field objected to this recommendation. Most of the objections focused on the lack of strong evidence that treating depression would improve event-free survival in these patients. The difference in depression outcomes between active and placebo groups or active and other comparison groups in clinical trials is generally small. Thus, to detect an effect for treatment on cardiac outcomes, a large sample size is needed, and a follow-up period of several years may be required to identify enough cardiac events to establish that treating depression is associated with better medical outcomes. Compared with most clinical trials in cardiology, the sample sizes in trials of depression in patients with CHD generally have been relatively small and had shorter follow-up.

The study by Lapa et al as well as smaller studies documenting poor adherence to cardiac treatment regimens in patients with depression suggest that better medical outcomes in patients with depression could be achieved by improving adherence to guideline-directed treatments that are known to result in longer event-free survival. While it is not clear whether it is possible to improve adherence to medical regimens without first treating depression, we have preliminary evidence that an individually tailored self-care intervention in patients with depression and heart failure can improve self-care regardless of whether the patient is currently receiving cognitive behavioral therapy treatment for depression.

For those who require more definitive evidence that screening for depression followed by a systematic intervention to improve adherence to treatment regimens in these patients will result in improved outcome, a clinical trial will be needed. In the meantime, if a patient is known to have depression, the prescribing physician can attempt to simplify the regimen, perhaps by trying a so-called polypill or medications that can be prescribed once rather than twice a day. The patient’s
physician or nurse may also ask for assistance from family members or recommend the use of pill reminder dispensers or other well-tested interventions for improving medication taking. Even motivational interviewing for both the patient and family that is designed to point out the benefits of patient adherence may be useful. Continued research is needed to identify additional methods to improve medical adherence in patients with depression as well as to determine whether improving medical adherence can reduce the excess medical morbidity and mortality associated with depression in these patients. However, there are well-tested interventions for improving adherence that can be administered while we await a more definitive clinical trial.

ARTICLE INFORMATION
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