

# Stepped Care for Affective Disorders and Musculoskeletal Pain (SCAMP) study Design and practical implications of an intervention for comorbid pain and depression

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## Abstract

**Objective:** Depression and pain are common comorbid conditions that have reciprocal adverse effects on disability and treatment outcomes. The objective of this article is to describe a study that tests the effectiveness of a stepped-care approach using a combined medication–behavioral intervention.

**Method:** Stepped Care for Affective Disorders and Musculoskeletal Pain (SCAMP) is an NIMH-sponsored randomized clinical trial nested within a prospective cohort study. A total of 250 patients with clinically significant depression (PHQ-9 scores  $\geq 10$ ) and musculoskeletal pain of the lower back or legs (hip or knee) and 250 nondepressed patients with similar pain are enrolled, with baseline and serial follow-up assessments to be conducted over 12 months. The depressed patients are randomized to either a stepped-care intervention group or a usual-care control group. Stepped-care patients receive 12 weeks of optimized antidepressant management (Step 1) followed by six sessions of a pain self-management (PSM) program over the next 12 weeks (Step 2), all delivered by a nurse care manager who is supervised by a physician specialist. Approximately two thirds of the care manager contacts are by telephone.

**Results:** The target sample of 500 subjects has been successfully enrolled, and randomization of the depressed patients has resulted in balanced groups of patients with moderately severe pain and depression. Mean SCL-20 depression severity in the clinical trial group is 1.9, with most meeting *DSM-IV* criteria for major depression (76.3%) and the rest having dysthymia only (18.4%) or minor depression (5.3%). Pain is about equally distributed between lower back (53%) and hip or knee (47%). A rational algorithmic approach to antidepressant selection and dosing, as well as an overview of the PSM program, is provided.

**Conclusions:** When completed, SCAMP will test whether optimized antidepressant management improves outcomes in patients with comorbid depression and pain and whether PSM produces additional benefits. The findings will be important for both primary care and mental health clinicians confronted by the prevalent depression–pain dyad.

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## 1. Introduction

### 1.1. Pain and depression dyad

Pain is the most common presenting somatic symptom in medical outpatients [1–3], and depression is the most

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common mental disorder [4,5]. Pain complaints account for more than 40% of all symptom-related outpatient visits or more than 100 million ambulatory encounters in the United States alone each year [6], and depression is present in 10–15% of all patients attending primary care. Both conditions are often inadequately treated and result in substantial disability, reduced health-related quality of life and increased health care costs and utilization [5,7–9]. Moreover, pain and depression frequently coexist (30–50% co-occurrence) and have an additive effect on adverse health outcomes [10–12]. Pain negatively affects the response of depression to treatment, and depression has a similar effect on the therapeutic responsiveness of pain [13,14].

Musculoskeletal conditions account for half to two thirds of all pain disorders presenting in primary care [6,15]. The lower back and lower extremities (particularly hip and knee) are especially common sites of persistent musculoskeletal pain. Simple analgesics by themselves are insufficient for many of these patients [16]. Opioid analgesics are not uncommonly a “treatment of last resort” in patients with chronic musculoskeletal pain, but their usage is accompanied by concerns about habituation as well as state and federal regulatory oversight. The importance of persistent pain is highlighted by data regarding its burden as a clinical problem in primary care as well as the requirement by certain accrediting bodies for routine assessment of pain as a “fifth vital sign” [17].

### 1.2. Antidepressant and pain self-management treatment

Two types of treatment — one pharmacological and the other nonpharmacological — could prove synergistic in the treatment of comorbid musculoskeletal pain and depression. Antidepressants are a well-established therapy for depression, and several meta-analyses have confirmed their efficacy for musculoskeletal pain disorders in particular [18] as well as for chronic pain in general [19,20]. Pain self-management (PSM) programs, in turn, have proven efficacious in numerous trials for both lower back pain and osteoarthritis (most commonly located in the hip and/or the

knee) [21–23], with possible secondary benefits in reducing psychological distress [24–26]. While literature syntheses have suggested that self-management programs may have a smaller effect on outcomes in musculoskeletal conditions than in other diseases such as diabetes, hypertension and asthma [27,28], others argue that outcomes such as pain and function are more complex as are the components of PSM [29,30]. Thus, depression and musculoskeletal pain are an ideal dyad for studying mental and physical comorbidity, and antidepressants and PSM represent prototypical treatments with the potential of mitigating both the physical and psychological suffering associated with persistent pain.

Despite evidence regarding the efficacy of antidepressants and PSM for musculoskeletal pain, there are several barriers to the dissemination of these treatments to current practice. First, most of the clinical trials in pain have used the older tricyclic antidepressants (TCAs), which, for tolerability and safety concerns, have largely been replaced in practice by newer antidepressant agents. Among the latter, SSRI antidepressants are by far the most commonly prescribed for depression, yet their efficacy for pain is less clear [31]. Second, while self-management programs have proven efficacy for musculoskeletal pain alone, they are not yet widely available in many settings. Third, the benefit of PSM in patients with pain and comorbid depression (in ameliorating both pain and depressive symptoms) is less certain. Fourth, while evidence exists for the efficacy of both antidepressants and PSM as individual treatments for pain, their additive value in patients with an inadequate response to monotherapy has not been established.

### 1.3. Conceptual model for the SCAMP trial

Fig. 1 illustrates the conceptual model underlying the Stepped Care for Affective Disorders and Musculoskeletal Pain (SCAMP) intervention. Antidepressants and self-management programs have proven therapeutic efficacy in reducing depression and pain severity, respectively, represented by the thick arrows and the caption *improves*. There is also evidence that antidepressants reduce pain severity,

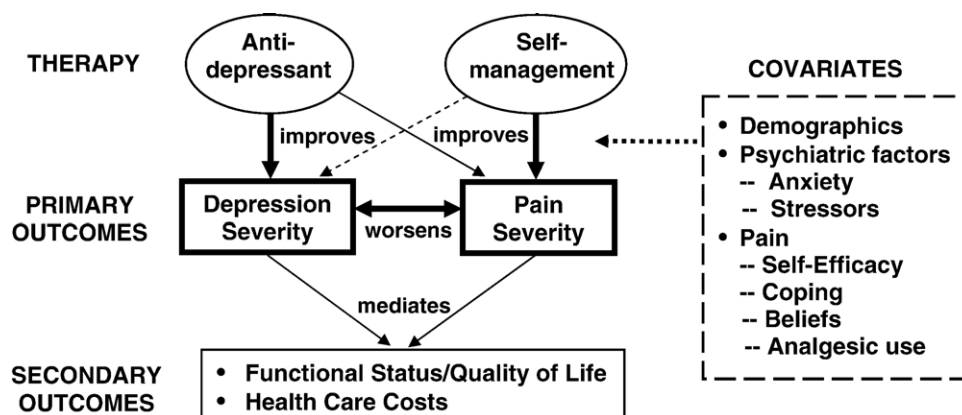


Fig. 1. Conceptual model underlying the SCAMP trial. The thickness of each arrow indicates the postulated strength of effect.

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