



An Integrated Approach to Treating Depression in the Adult Primary Care Setting

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Disclosure

- The individuals involved in this presentation have no actual or potential conflict of interest in relation to this presentation

Disclosure (cont.)

- During this presentation we will discuss “off-label” uses of the following medications:
 - SSRIs
 - SNRIs
 - Bupropion
 - Mirtazapine
 - Sertraline
 - Escitalopram
 - Tricyclics
 - MAO Inhibitor

Learning Goals

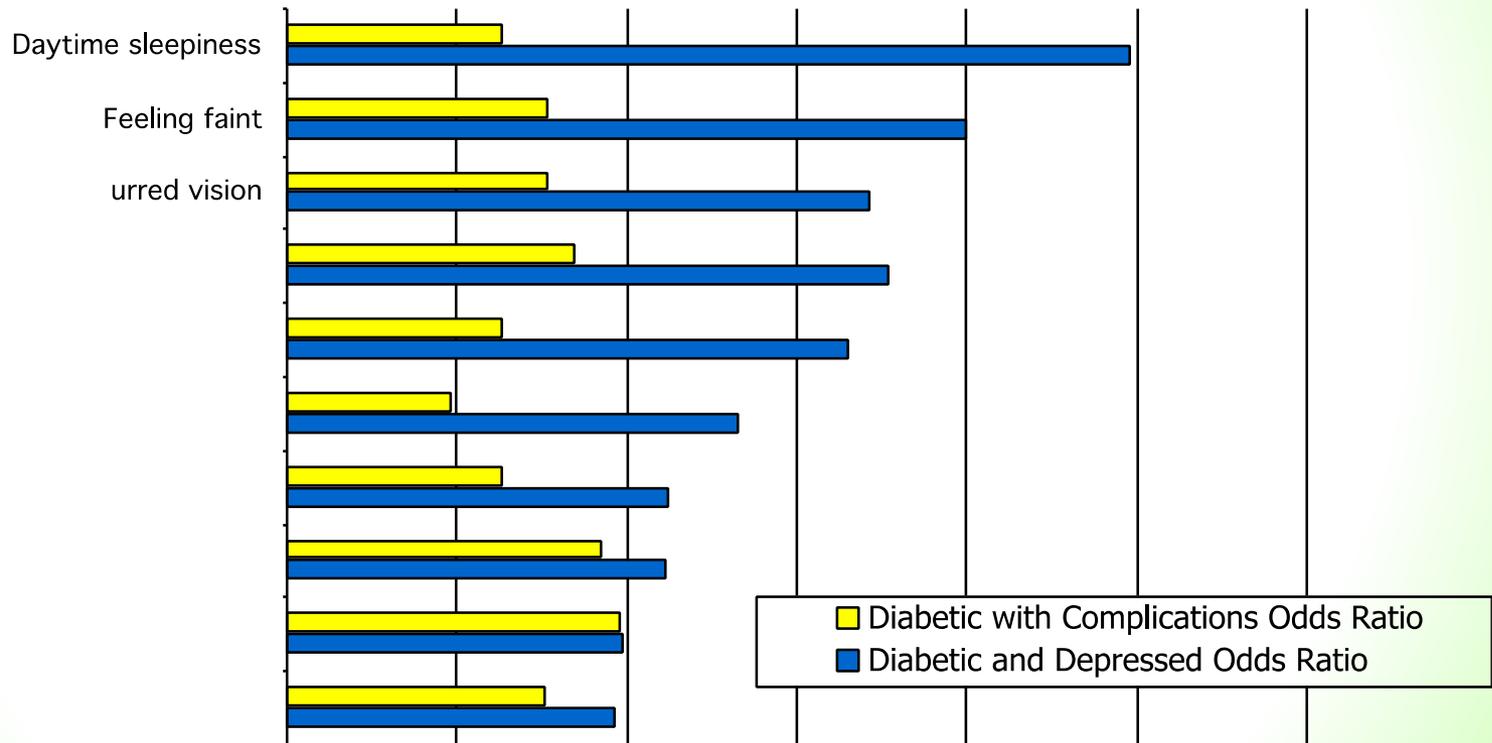
Participants will be able to:

- Describe the elements of an evidence-based program for treating depression in primary care.
- List the differences between an IMPACT model and a Behavioral Health Consultant model for integration.
- Describe the clinical routines between the physician and behavioral health clinician that foster successful engagement of patients in primary care behavioral health services.

Primary Care Behavioral Health Needs Assessment

	PHQ-3000	Merillac 500
• Major Depression	= 10%	24%
• Panic Disorder	= 6%	16%
• Other Anxiety Disorders	= 7%	21%
• Alcohol Abuse	= 7%	17%
• Any Mental Health Dx	= 28%	52%

Relationship of Depression to Diabetic Symptoms



Ludman et al, Gen Hosp Psychiat 26:430-436, 2004.

The Full Cost of Poor Employee Health

Medical &
Pharmacy Costs
\$3,376 PEPY

25%

Personal Health Costs
Medical Care
Pharmacy

Health-Related
Productivity Costs
\$10,128 PEPY

75%

Productivity Costs

Absenteeism

Short-term Disability
Long-term Disability

Presenteeism

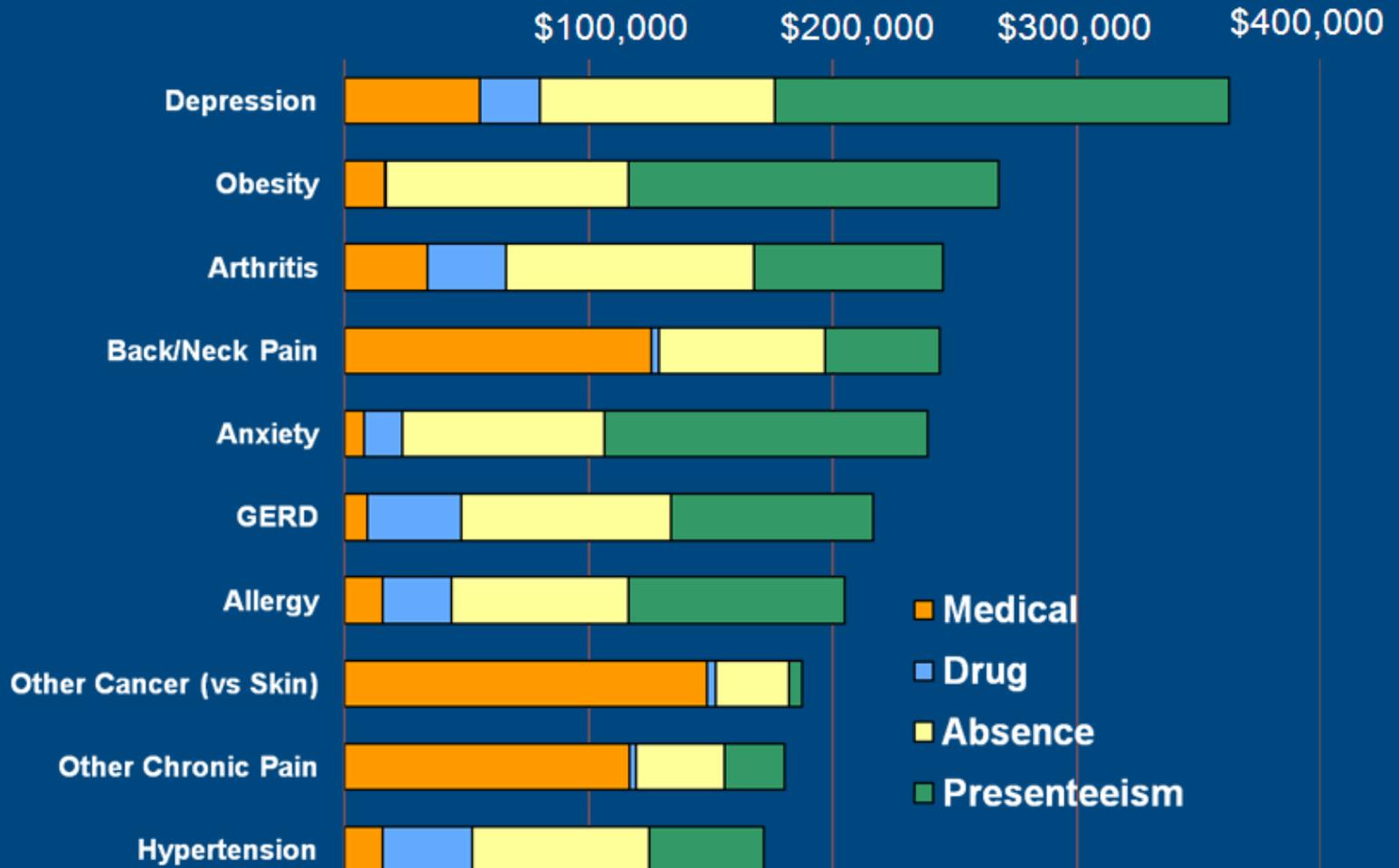
Overtime
Turnover
Temporary Staffing
Administrative Costs
Replacement Training
Off-Site Travel for Care
Customer Dissatisfaction
Variable Product Quality

Total Costs =
\$13,504 PEPY



Total Medical, Pharma&Productivity Costs -- per 1000/FTEs --

(HPBS – Phase 2 Employers)



Source: "Health and Productivity as a Business Strategy," *JOEM*. Vol. 51, No. 4, April 2009

Primary Care is the only setting for a population approach to behavioral health

- The vast majority of people will not accept a referral to specialty MH offered by a PCP. It is care in primary care or none.

[Regier DA](#), [Narrow WE](#), [Rae DS](#), [Manderscheid RW](#), [Locke BZ](#), [Goodwin FK](#). The de facto US mental and addictive disorders service system, [Arch Gen Psychiatry](#). 1993 Feb;50(2):85-94.

- Even if all of the difficulties with referral are addressed (arrangements, reminders, transportation), at least 50% better access to MH care if offered in primary care.

(Bartels, Coakley, Zubritsky, et al. Am J Psych, 2004)

Screening for Depression

- **Adults**

- 2002 - U.S. Preventive Services Task Force (USPSTF) recommends screening adults for **depression** to improve **detection & patient outcomes**, provided that **effective systems** are in place to ensure accurate diagnosis, effective treatment, & appropriate follow-up (Grade B)

- Few suggestions offered for selecting screening instruments

Sharp. L.K. & Lipsky, M.S. (2002). Screening for depression across the lifespan: a review of measures for use in primary care settings. *American Family Physician*, 66 (6), 1001-1008.

Screening for Depression

• Teens

- 2009 - USPSTF recommends screening adolescents aged 12–18 years for major depressive disorder in primary care, provided that systems are in place to ensure further evaluation, psychotherapy, and follow-up (Grade B)

<http://www.teenscreen.org/home>

- PHQ-A (Modified PHQ-9 for Adolescents)
- *Screening for Major Depressive Disorder in Children and Adolescents*, March 2009. U.S. Preventive Services Task Force.

<http://www.uspreventiveservicestaskforce.org/uspstf/uspschdepr.htm>

- Original Article by Williams et al. *Pediatrics*, 2009 716-735

PHQ-9: Use and Context

- 9-item depression scale of the Patient Health Questionnaire based on DSM criteria for MDD
- PHQ-2 correlates highly
- Components:
 - Assess symptoms and functional impairment to make a tentative depression diagnosis
 - Severity score to select & monitor symptoms & treatment
- Tool can be scored by PCP or office staff
- Available in many languages

PHQ-9: Benefits

- Short (3 min to complete)
- First 2 questions correlate well with whole instrument
- 6-9th grade reading level
- Can be administered in person, by telephone, or self (over time to assess change)
- Provides assessment of symptom severity
- Proven effective with geriatrics, post-natal
- Well validated in a variety of populations, many languages
- Free download:

<http://www.phqscreeners.com/overview.aspx>

PHQ-9: Limitations

- When used alone, focuses conversation on one MH problem when depression may be a part of a larger picture.
 - (In PC we commonly find people with trauma histories who show very high anxiety scores but moderate depression scores.)
- Some symptoms may be related to physical disorders

Introducing Screening to Adults

- **General**

- “We routinely give this screening to our patients as a quick way to better understand some of the difficulties people may have in addition to those we have time to discuss in our visit.”

- **Specific**

- “I am concerned about how much stress you’ve been describing in your life and would like to see if you would take this short screening questionnaire. It would help me better understand your situation.”

Communicating Screening Results

- Briefly explain purpose of the screener
 - “The PHQ-9 is a screening tool that helps us identify how much depression is an aspect of your life.”
- Briefly explain general scoring
 - “The PHQ-9 helps identify most people who are either experiencing mild, moderate or severe depression.”

Communicating Screening Results

- Explain patient's results
 - “Based on your own report, it appears that you are reporting a moderate amount of depression in the past 2 weeks. Would you say this is accurate?”
- Discuss recommendations
 - “There are many options we have from here. We can help you focus on reducing some of your most frequent symptoms and their severity through a combination of behavioral and medication-related strategies.”

Goals of Meeting After a Positive Screen

- Engage the patient in a relationship for care.
 - Caring attitude, orient patient to team
- Look for some exception, strength or different point of view that fosters a little hope.
- Orient patient to possible next steps (meds?, talk?, watchful waiting?) and possible team roles (PCP w. BH consultation, BH w. PCP consultation, PCP w. care management).
- Start treatment plan, if possible.

PHQ-9: Scoring Rubric

Adopted from: Kroenke K, Spitzer RL, Psychiatric Annals 2002;32:509-521

PHQ-9 Symptoms & Impairment	PHQ-9 Severity	Provisional Diagnosis*	Treatment Recommendations**
1 to 4 symptoms, functional impairment	5-9	Mild or Minimal Depressive Symptoms	<ul style="list-style-type: none"> -Education to call if deteriorates -Physical activity -Behavioral activation -If no improvement after one or more months, consider referral to Behavioral Health for evaluation
2 to 4 symptoms, question 1 or 2 positive, functional impairment	10-14	Mild Major Depression	<ul style="list-style-type: none"> -Pharmacotherapy or psychotherapy -Education -Physical activity -Behavioral activation -Initially weekly contacts to ensure adequate engagement, then monthly
≥ 5 symptoms, question 1 or 2 positive, functional impairment	15-19	Moderate Major Depression	<ul style="list-style-type: none"> -Pharmacotherapy and/or psychotherapy -Education -Physical activity -Behavioral activation -Initially weekly contacts to ensure adequate engagement, then every 2-4 weeks
≥ 5 symptoms, question 1 or 2 positive, functional impairment	≥ 20	Severe Major Depression	<ul style="list-style-type: none"> -Pharmacotherapy necessary & psychotherapy when pt able to participate -Education -Physical activity -Behavioral activation -Weekly contacts until less severe

PHQ-9 to Evaluate Suicidal Ideation

- **Item 9:**

“In the last two weeks, how often have you had thoughts you would be better off dead or of hurting yourself in some way?”

- **Any response other than “not at all” requires further assessment.**

- **Take action according to risk level**

Risk Assessment

Lily Awad, MD

Screening for Suicide Risk

- Over the past month, have you had any thoughts of suicide or self harm?
- Over the past month have you tried to harm yourself in any way?
- Have you ever tried to harm yourself or had serious thoughts of suicide in the past?

Screening for Homicide Risk

- In the past month, have you had any thoughts of causing serious harm to others?
- Over the past month, have you tried to harm anyone?
- Have you ever tried to cause serious harm to others or had serious thoughts of doing so?

Suicide and Homicide Risk Factors

- Prior history of attempts
- History of violence
- Substance abuse
- Depression
- Hopelessness
- Paucity of social supports
- Access to firearms

Suicide Risk Factors (continued)

- Chronic pain
- Recent diagnosis of a serious medical illness
- Worsening of a serious medical illness
- Recent loss of job or financial support
- Recent loss of a significant relationship or social support

Past Attempts

- Risk v. rescue potential
- Precipitants and circumstances
- How did patient feel upon having survived the attempt?
- Patient's perception of lethality of attempt
- Parallels to patient's current day situation?

Protective Factors

- Strong social supports
- Spiritual or religious prohibitions against self harm
- Being the primary caretaker for children
- Inquire about pets
- Having a strong alliance with a mental health professional
- Ability to engage in meaningful safety planning

Safety Planning

- What are your warning signs that you may become unsafe or that you are at risk for harming yourself?
- What are 3 safe coping strategies you can use?
- Who can you call for support (try to get 3 names and phone numbers)?
- How would you access help if it's an emergency?
- Keep a copy of the safety plan and print one for the patient.
- Your safety plan template might include SAMHSA's National Crisis Hotline 1-800-273-TALK(8255) and website: www.suicidepreventionlifeline.org. The website provides live chat as well as other resources.

Screening for Mania

- Screen before starting an antidepressant to avoid precipitating mania
- Ask about a week or more of the following symptoms:
 - Elevated, expansive or irritable mood
 - Grandiosity or inflated self-esteem
 - Decreased *need* for sleep
 - Flight of ideas, feeling that thoughts are racing
 - Distractability
 - Increase in goal-directed activities
 - Spending sprees, sexual indiscretions, ill-advised investments

Is Depression Primary or Secondary?

- Depression and anxiety secondary to alcohol abuse will usually resolve within a month of sobriety - ask about drug and alcohol use in detail
- Ask about mood during extended substance-free times
- Ask about family history of depression
- Try to determine which disorder came first – may use a life event timeline strategy

Treating Mild/Moderate Unipolar Major Depression

Ron Adler, MD

Initial Approach to Treatment -1

- Successful treatment requires that patients accept the Dx
- Patient education is critical and should include the facts that depression is:
 - A common condition
 - Treatable
 - Associated with both emotional and physical Sx
 - The PHQ-9 itself can facilitate communicating this as a concrete illustration

Initial Approach to Treatment -2

- Pharmacotherapy \approx Psychotherapy
- Pharmacotherapy + Psychotherapy is superior to either alone
- Pharmacotherapy is generally more acceptable to patients.
- Psychotherapy often yields benefits that last longer.
- When choosing, consider:
 - Prior Tx history
 - Patient preferences
 - Comorbidities
 - Cost/Availability

Initial Approach to Treatment: Choosing a Drug - 1

- SSRIs are an excellent first choice
- Reasonable alternatives include:
 - SNRIs
 - Bupropion
 - Mirtazapine
- Efficacy is similar within and across classes
- Some evidence suggests sertraline and escitalopram provide the best combination of efficacy and tolerability*

*Cipriani A, Furukawa TA, Salanti G, et al. Lancet 2009; 373:746

Initial Approach to Treatment: Choosing a Drug - 2

Because no agent or class is clearly superior, consider the following:

- Patient's prior experience with antidepressant meds
- Safety/side effect profile
- Target symptoms
- Co-morbidities
- Other meds and potential interactions
- Cost/formulary coverage
- Patient preferences
- Dosing frequency
- Family history of response to meds

Prognosis: Mild to Moderate Unipolar Major Depression

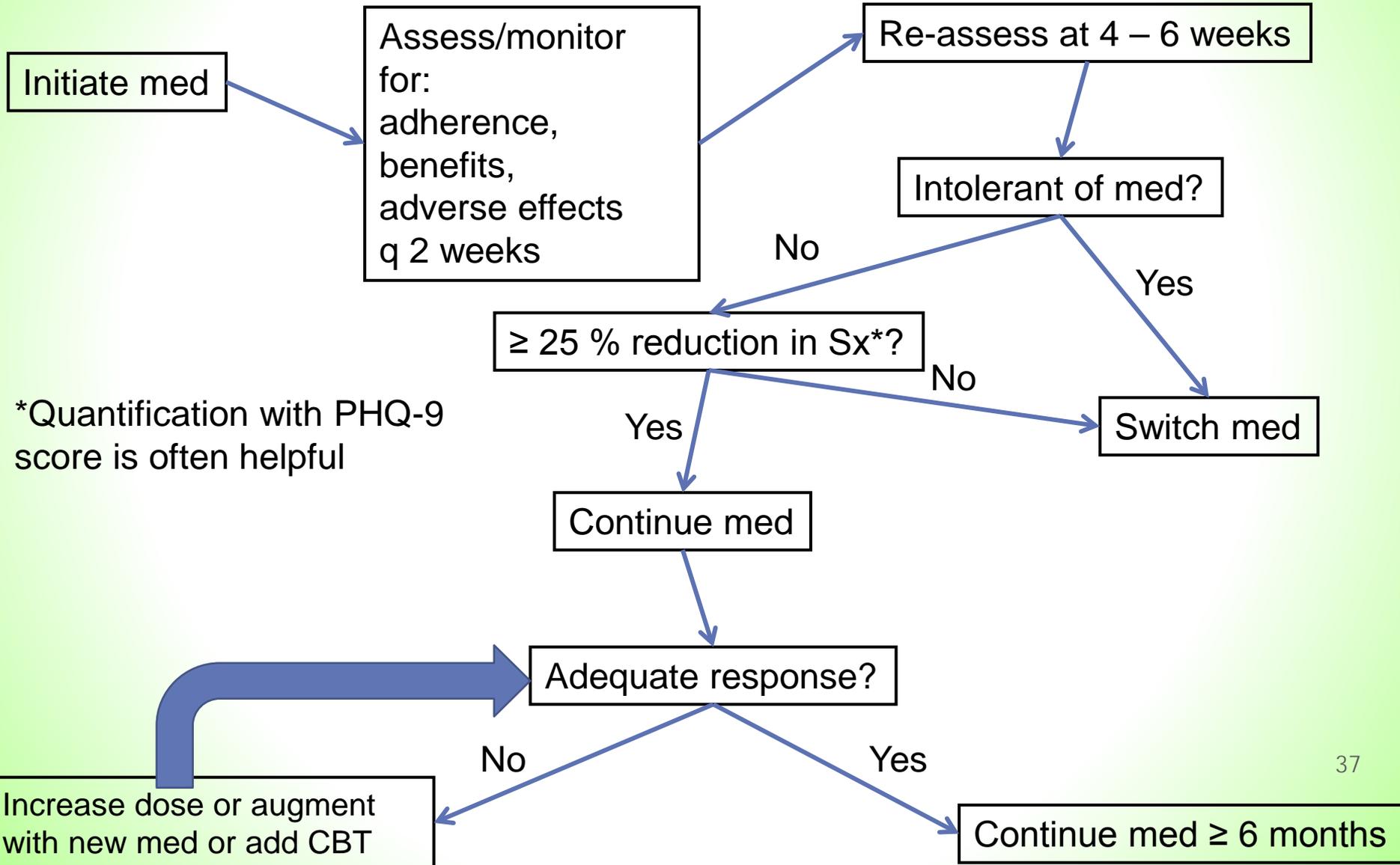
- Response: 48 – 63 %
- Remission: 33 – 47 %

Mean time to

- Improvement ($\geq 20\%$ reduction in Sx): 13 days*
- Remission: 7 weeks

*Early improvement predicts eventual remission (87 – 100%)
J Clin Psychiatry 2009; 70:344

Anti-Depressant Medication Protocol



*Quantification with PHQ-9 score is often helpful

Medication Choices/Sequence

- 1st Line: SSRI
- 2nd Line:
 - Alternative SSRI
 - SNRI
 - Bupropion
 - Mirtazapine
- 3rd Line: Tricyclics
- 4th Line: MAO Inhibitor

Assess Adherence to Treatment Plan

- Gain understanding of initial treatment plan from referring provider.
 - Meds/counseling/self management goals
- Initial adherence assessment (usually 1 week post referral)
 - Determine success in initiating plan
 - Identify barriers and problem solve
 - Provide reinforcement and encouragement
 - Monitor progress with PRN calls based on pt. need and preference

PHQ-9 to Assess Treatment Response

- **Depression treatment proceeds through phases related to clinical state of patient**
 - **Acute phase** (usually 6 to 12 weeks)
 - Goal = symptom “remission” (PHQ-9 score < 5)
 - PHQ-9 should be administered at initial office visit, and again at 4 week intervals during “acute phase”
 - **Continuation phase** (4 to 9 mo. after reaching remission)
 - Goal is to keep patient in remission
 - **Maintenance phase** (1 year or longer after continuation)
 - Long term maintenance reduces recurrence in pts with recurrent depressive episodes

PHQ-9 to Assess Treatment Response

Initial response to antidepressant – Can be measured by change in PHQ-9 after 4 weeks of adequate dose.

Initial response to counseling – Can be measured by change in PHQ-9 after Six weeks.

PHQ-9 to Assess Treatment Response

- 5 point drop = *adequate initial response* - no treatment change
- 2-4 point drop = Consult with psychotherapist. Probably no treatment change needed.
- 1 point drop/no change = *sub-optimal response* - consider adding antidepressant or offering pt the option to change to a different therapist (if available)

Medication Non-Adherence

- Common¹:
 - 42% discontinue by 1 month
 - 72% discontinue by 3 months
- Factors associated with non-adherence²:
 - Reluctance to start meds
 - Experienced adverse effects
 - Stopped med because they felt better
 - Less educated

1. Am J Psychiatry 2006; 163:101

2. Lancet 2006; 367:2041

Eliciting Non-Adherence

- Typically not readily-disclosed by patients
- Anticipate/expect it and inquire about it in non-judgmental, open ways:

“A lot of my patients tell me that they miss some of their doses. In a typical month, how many times do you take (or miss) your medication?”

Reducing Non-Adherence

- Provide anticipatory guidance
 - Daily (or BID), i.e., **not** prn
 - Though adverse effects may occur early, therapeutic response typically takes weeks
 - Once initiated, Tx should be continued \geq 6 months
- Provide support
 - Frequent contact, especially in first 2 months
 - Encourage patient to call for any questions, concerns, or issues re: possible side effects

Models of Integrated Behavioral Health

Alexander Blount, EdD

Models of Integrated Behavioral Health

- Expanded care management – IMPACT/Diamond
- Behavioral Health Consultant model

IMPACT:

Disease based
Research heritage
Patient outcome evidence
Care manager (SW or Psychologist)

BHC:

Program based
Clinical heritage
Cost and satisfaction evidence
Behavioral Health Consultant

Care Management came from chronic illness approach to depression

- Screening to see who is at risk for the illness
 - Who
 - When
 - What triggers?
- Assessment/diagnosis for positive screens
- Protocol
 - Types of care offered
 - Phone calls/visits to team members to support adherence
 - Visits for physician to monitor progress
 - Re-screening/outcome
- Patient Registries

Implementing a Program

- Authority of evidence
- Medical champion
- Better patient care trumps
- Involve all affected staff to the degree they are affected
- Train everyone before implementing
- Roll out date the people can see coming

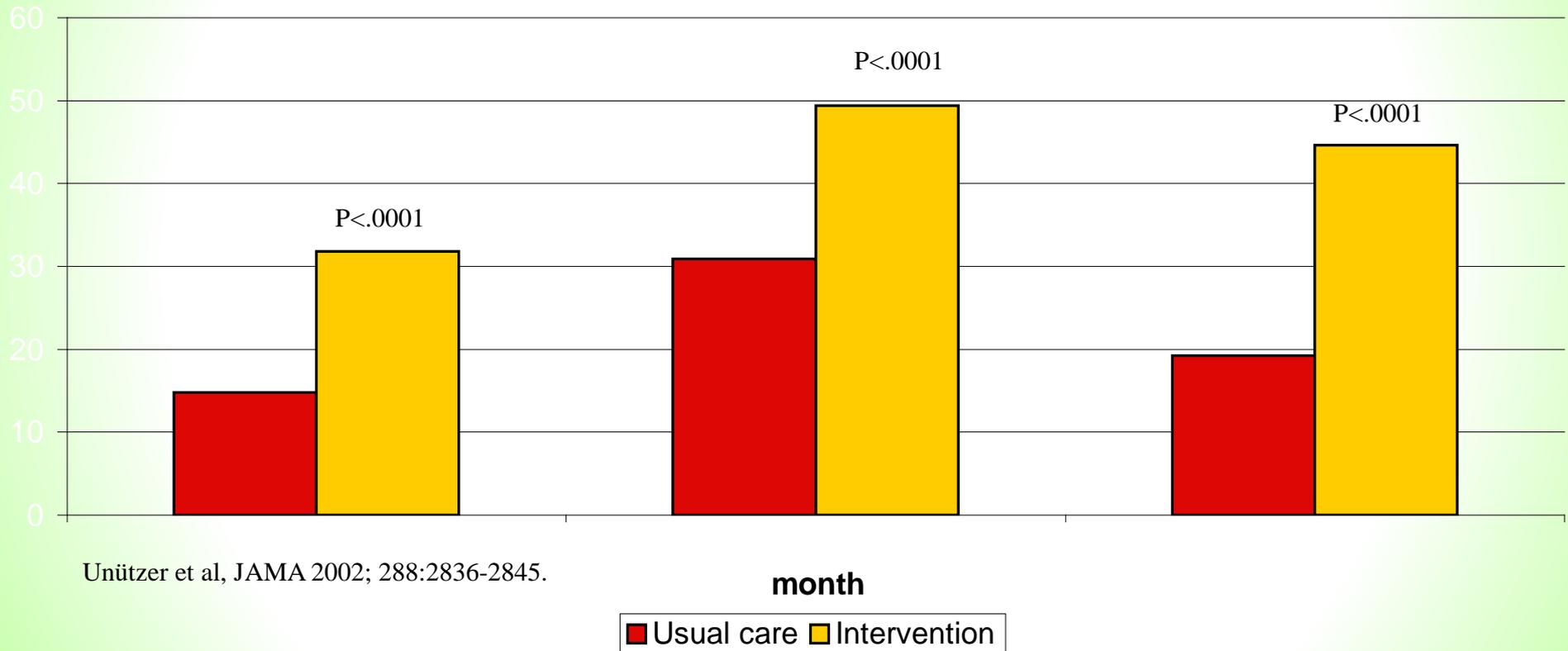
Integrated Primary Care: The IMPACT Treatment Model



<http://uwaims.org/about.html>

- **Collaborative care model includes:**
 - **Care manager: Depression Clinical Specialist**
 - Patient education
 - Symptom and side effect tracking
 - Brief, structured psychotherapy: PST-PC
 - **Consultation / weekly supervision meetings with**
 - Primary care physician
 - Team psychiatrist
- **Stepped protocol in primary care using antidepressant medications and/or 6 - 8 sessions of psychotherapy (PST-PC)**

Substantial Improvement in Depression ($\geq 50\%$ Drop on SCL-20 Depression Score from Baseline)



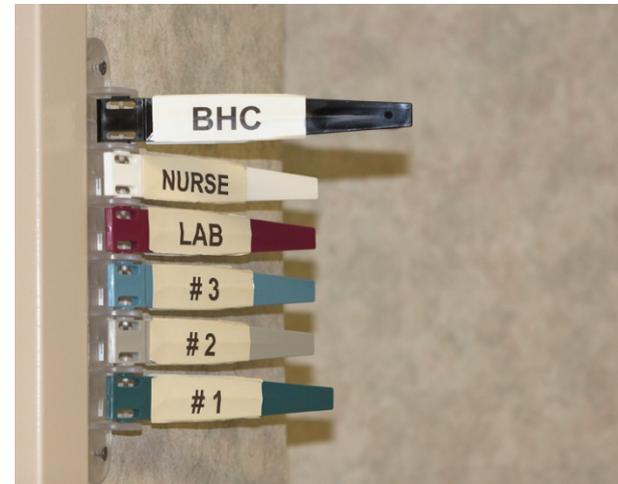
Unützer et al, JAMA 2002; 288:2836-2845.

The IMPACT can lead to broader integration

- Teaches BH by protocol
- Teaches PCPs to work with a team and to have conversations about behavioral issues
- Teaches BHC's to work quickly in a medical setting and to work with screening and outcome measures
- Developer of the model (Jurgen Unutzer, MD) now advocates addressing life crises, substance abuse, anxiety and health behavior in primary care

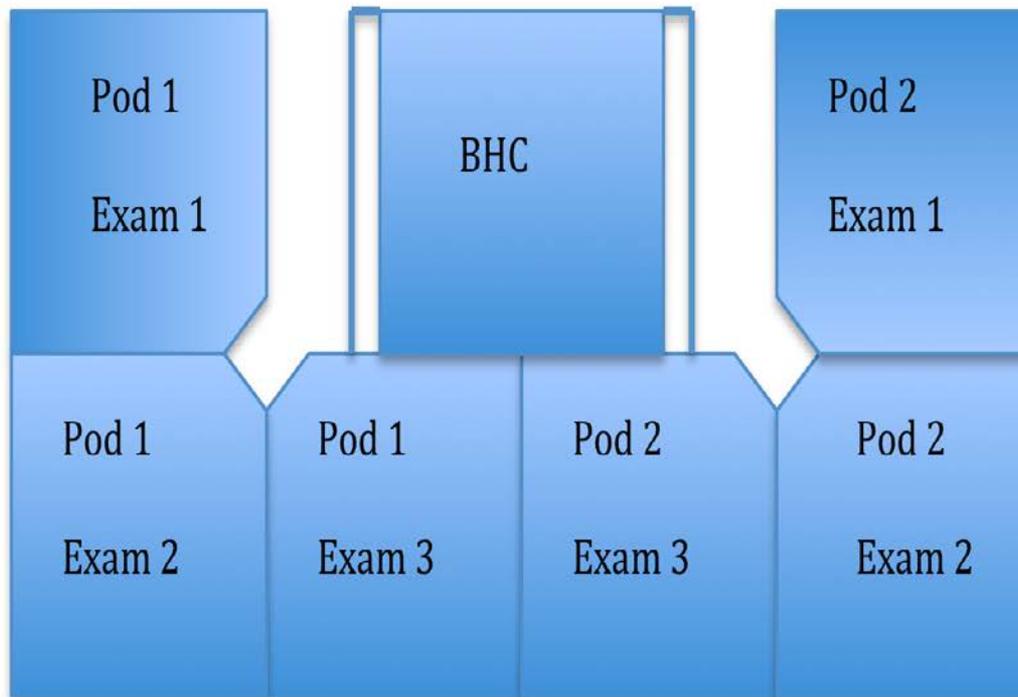
Behavioral Health Consultant

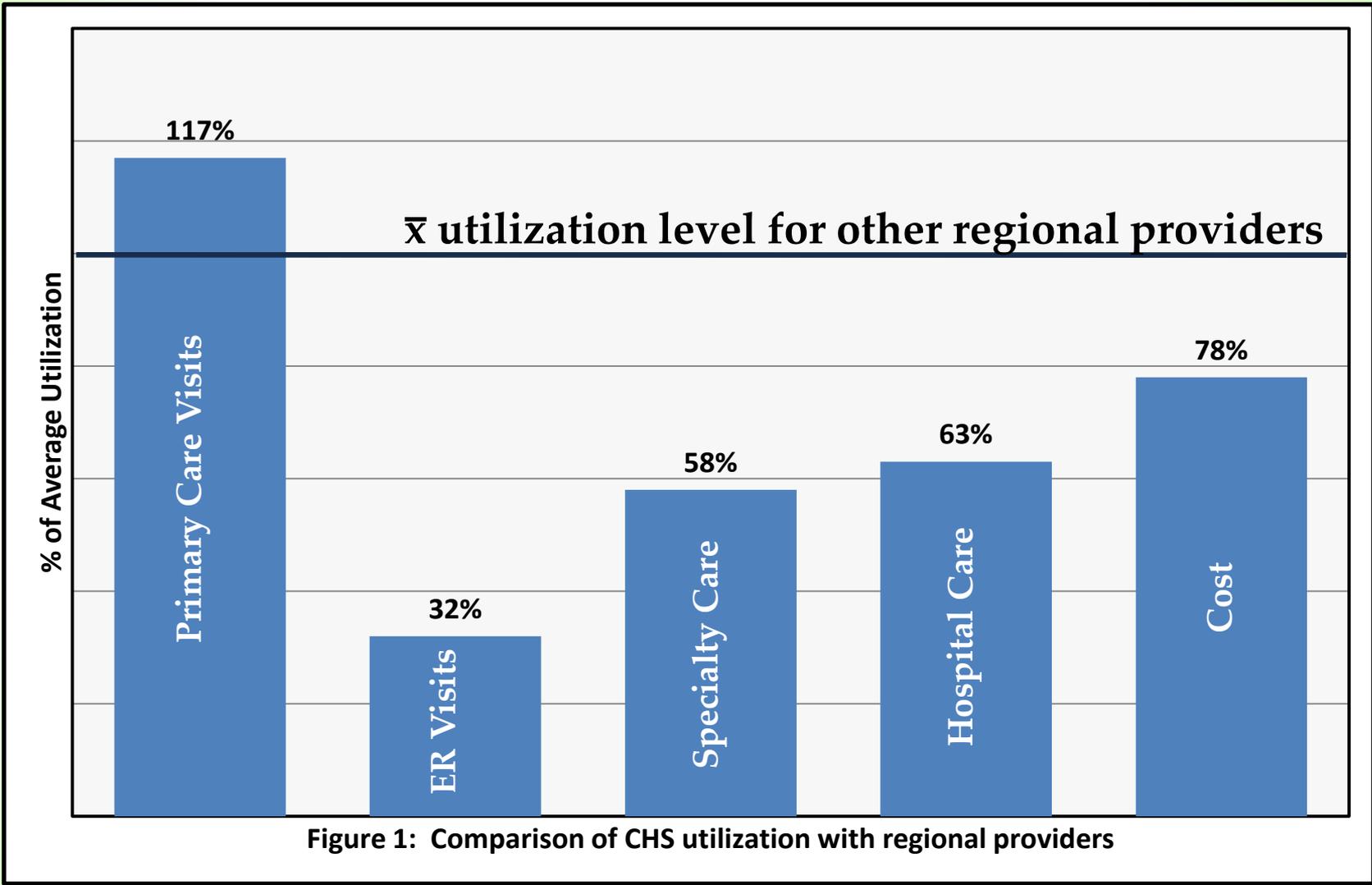
- Management of psychosocial aspects of chronic and acute diseases
- Application of behavioral principles to address lifestyle and health risk issues
- Consultation and co-management in the treatment of mental disorders and psychosocial issues



Model developed by Kirk Strosahl, PhD

The architecture says it all,
and makes it work.





Relationship with “Specialty Mental Health”

- Still important for longer term care
- Makes referrals to SMH more likely to be successful
- Specialty MH able to better target high need populations
- Consultation backup to PCP
- In some systems SMH has developed specialized teams to support generalist PCBH clinician

Primary Care Behavioral Health Team

- **Primary Care Provider (MD, DO, NP, PA)**
 - Patient's primary connection to the practice
 - Leader of the team for the patient
- **Care Manager (MSW, PhD, RN)**
 - Necessary role but not always a job slot (sometimes done by nurse or BHC)
 - Assess and support adherence to treatment plan (including medical aspects)
 - Offer brief activating interventions
 - Assess treatment response
 - Communicate information to providers
- **Behavioral Health Clinician (PhD, MSW, MFT, LMHC)**
 - May also play Care Manager role
 - Offers CBT, PST or BA
 - Consults to PCP and CM, may supervise CM
- **Consulting Psychiatrist (MD, NP)**
 - Consults to PCP and other team members around medication, diagnosis and treatment planning
 - May see some patients for diagnosis as part of consultation

Every member has to learn new approaches

- **Primary Care Provider (MD, DO, NP, PA)**
 - Take the lead in involving other team members
 - Discuss BH issues as part of regular care
- **Care Manager (MSW, PhD, RN)**
 - Address both behavioral health and chronic illness
 - Offer MI, goal setting and Behavioral Activation
- **Behavioral Health Clinician (PhD, MSW, MFT, LMHC)**
 - Learn to work in brief contacts as a BH generalist
 - Be comfortable communicating with the team
 - Offer behavioral health treatment for chronic illness
- **Consulting Psychiatrist (MD, NP)**
 - Be comfortable as a consultant rather than as treating professional
 - Train PCPs to expand areas of comfort with medications so stable patients on complex regimens can be managed in PC

BHC and CM Skill Set and Fit (Discipline is not a good guide to fit)

- It takes training, or experienced support to get the orientation necessary to learn on the job.
- Good at making relationships with all of the roles in primary care. (New roles in primary care are inconvenient to everyone.)
- They must do well in ambiguous situations, dive in rather than wait for an invitation.
- Because the jobs integrate the separated worlds the disciplines train people for, ideas about what discipline is needed are often wrong.

Depression Care Resources

- Depression in primary care, RWJ and MacArthur programs.

<http://www.depression-primarycare.org/>

- Training for BHCs

<http://umassmed.edu/cipc/pcbhoverview.aspx>

- Training for Care Managers

<http://umassmed.edu/cipc/ICMoverview.aspx>

Questions or Comments?

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