Realities of Depression in Primary Care Setting

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Disclosure

I have no conflict of interest to disclose.

Mental Health Issues in Primary Care (PC)

- **10%** of patients **consume 63%** of the health care dollar – usually complex patients with comorbid chronical medical and mental illness (Hussain&Seitz 2014)
- More patients receive treatment for mental disorders in the primary care sector than in the mental health specialty setting (Kroenke 2017)
- 20-40% of PC patients have behavioral disorders
- Primary care patients with one chronic medical condition are twice as likely to have a psychiatric illness
- Primary care patients with 4 or more chronic medical conditions have 5x rates of psychiatric illness (Barnett et al. 2011)
  - Chronic pain 25-50%
  - Obesity 40-70%
  - Cancer 10-20%
  - Neurological disorders 10-20%
  - Heart disease 10-30%
  - Diabetes 10-30%

Depression in Primary Care

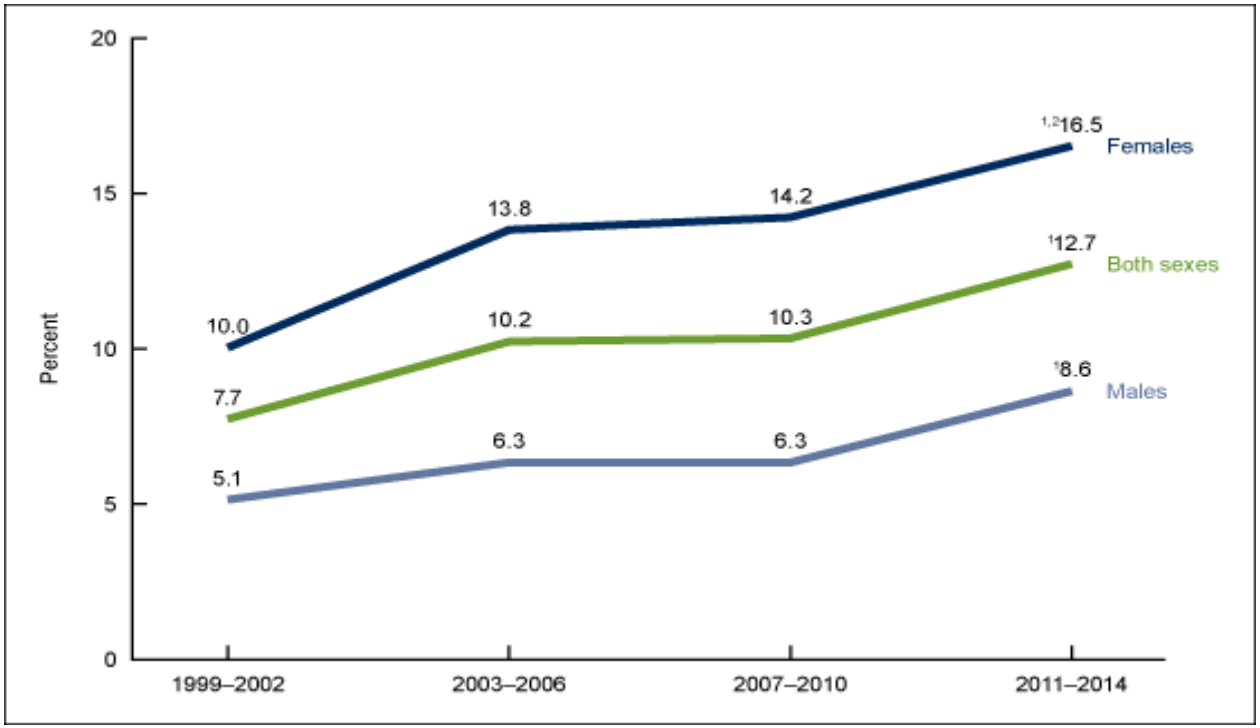
- Up to ¼ of adults will have a major depressive episode during their life-time
- Women > men (2:1)
- It is the leading of cause of disability and premature death in people aged 18-44
- Associated with worsened medical morbidity and mortality
- 10% of patients in primary care settings meet the criteria for MDD (major depressive disorder)
- 30-40% among patients with chronic medical illnesses (CAD, CVD, DM, obesity, HIV)

Depression in Primary Care, cont.

- PCP prescribe 80% of all antidepressant medication in the US
- Only about 20-40% of patients with depression improve substantially in PC settings over a six-month period (Schulberg 1996)
- Only about half of patients referred to specialty mental health actually follow through with making an appointment (Grembowski 2002)
- > 2/3 of PCPs have difficulty finding mental health referrals or advice for their patients (Cunningham, 2009)

Antidepressant Use Among Persons Aged 12 and Over: United States, 2011–2014; cont.

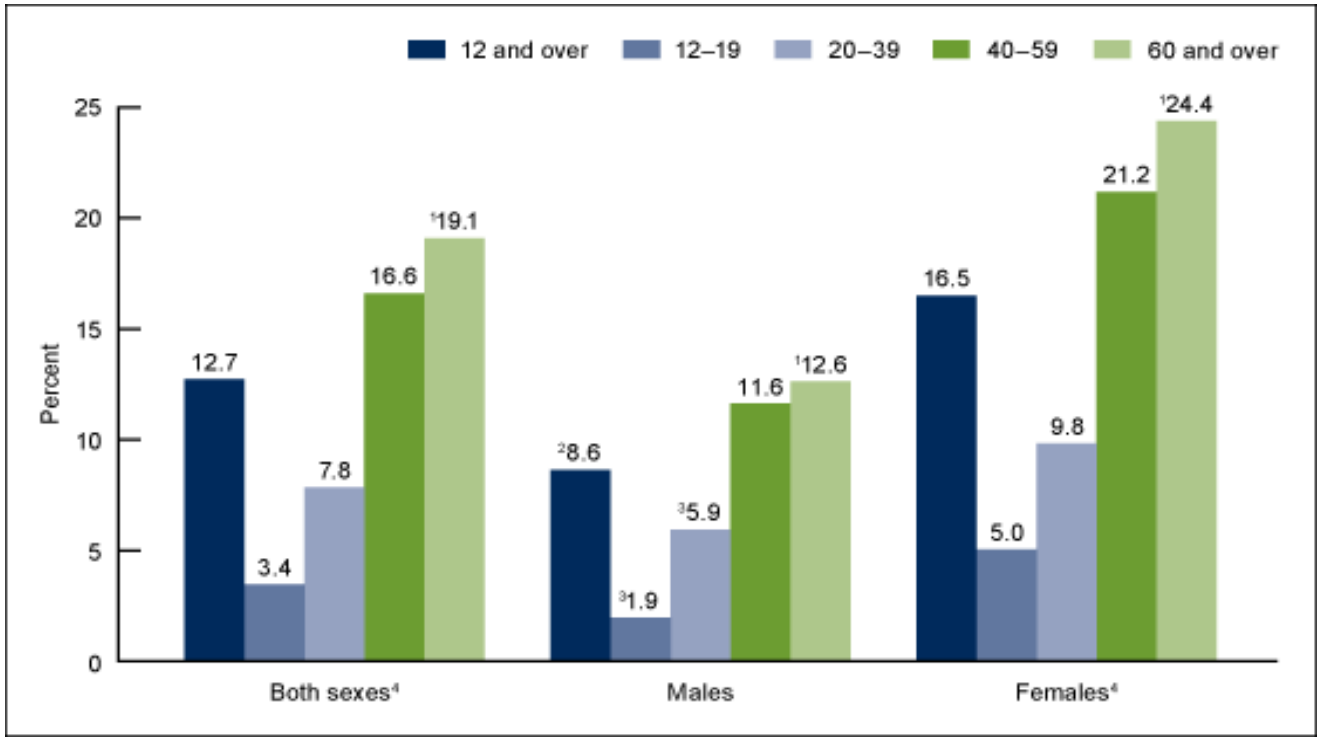
Trends in antidepressant use among persons aged 12 and over, by sex: United States, 1999–2014



NCHS, National Health and Nutrition Examination Survey, 1999–2014

Antidepressant Use Among Persons Aged 12 and Over: United States, 2011–2014

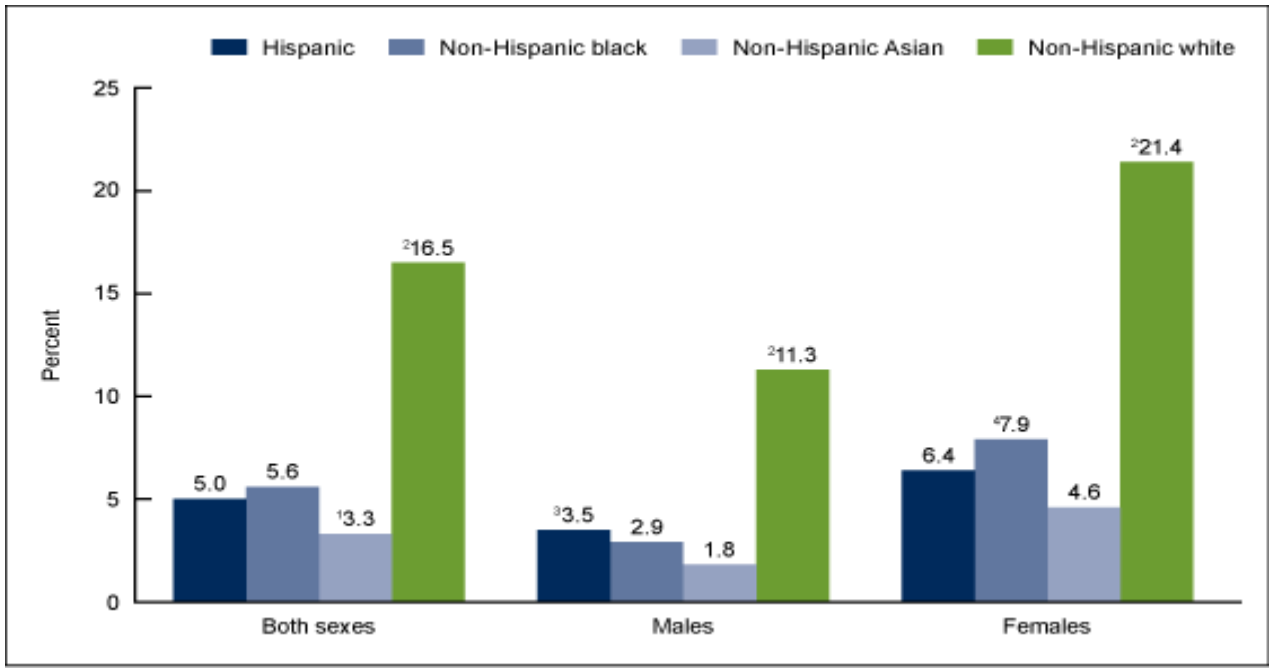
Percentage of persons aged 12 and over who took antidepressant medication in the past month, by age and sex: United States, 2011–2014



NCHS, National Health and Nutrition Examination Survey, 2011–2014.

Antidepressant Use Among Persons Aged 12 and Over: United States, 2011–2014; cont.

Percentage of persons aged 12 and over who took antidepressant medication in the past month, by sex and race and Hispanic origin: United States, 2011–2014



NCHS, National Health and Nutrition Examination Survey, 2011–2014.

Depression in Primary Care - Challenges

- Physicians can overestimate or underestimate levels of distress in patients
- Not all depressed individuals spontaneously express emotional symptoms
- Depressed patients often present with physical symptoms (geriatric)
- Not all depressive symptoms imply a diagnosable disorder
- Complexity of fitting the continuous variation in depression severity into a categorical diagnosis
- 75% of patients with depression see primary care providers BUT:
  - PCP can accurately identify about half of true cases (more severe cases diagnosed more reliably than less-severe forms)
- About 80% of non-depressed patients are correctly reassured
- Short appointments can compromise diagnosis in difficult cases

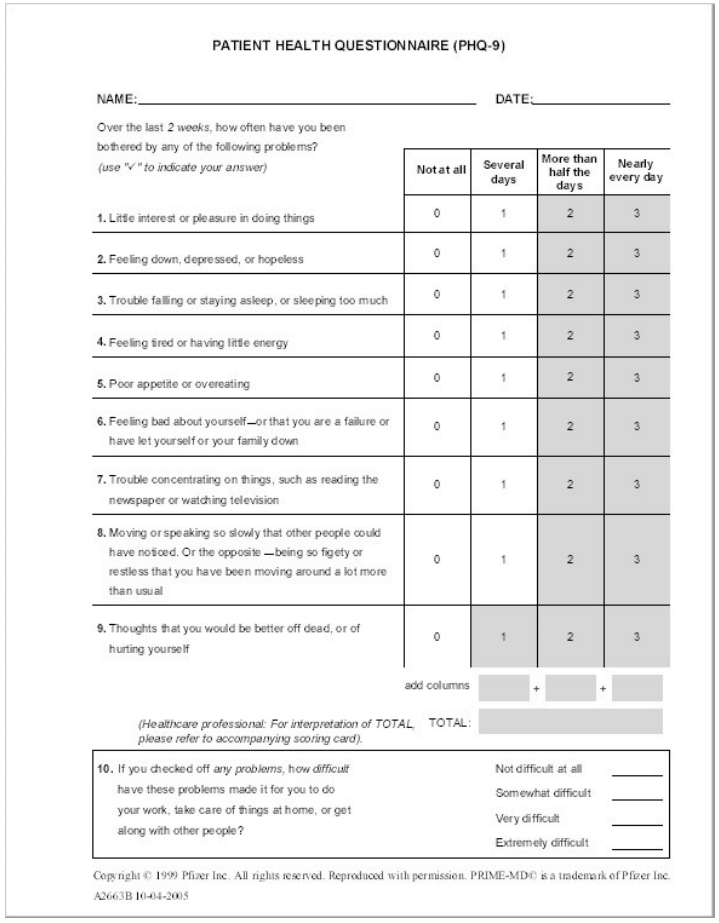
Mitchell et al., 2009

U.S. Preventive Services Taskforce Recommendation

- Screening improves the accurate identification of adult patients with depression in primary care settings, including pregnant and postpartum women.
- At least moderate certainty that there is a moderate net benefit to **screening** for depression in adults, including older adults, who receive care **in clinical practices that have adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up after screening.**
- **Screen at initial primary care visit and every 1-2 years thereafter**
- Higher risk of depression in:
  - Women
  - Young and middle aged adults
  - Lower education
  - Unemployed
  - Chronic illness
  - Other mental health disorders
  - Family history of psychiatric disorders

A. Siu et al.: **Screening for Depression in Adults** US Preventive Services Task Force Recommendation Statement**,** *JAMA* on January 26, 2016 (*JAMA*. 2016;315(4):380-7)

Patient Health Questionnaire (PHQ-9)



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite —being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Diagnosis of Depression

- 1st step in diagnosis:

  Ask about depressed mood or anhedonia over the past 2 or more wks

- Patient Health Questionnaire (PHQ-2):

  1. Over the past 2 weeks have you felt down, depressed, or hopeless?

  2. Over the past 2 weeks have you felt little interest or pleasure in doing things?

- A positive response to either warrants a thorough review of DSM-5 criteria for major depression

DSM-5 Major Depressive Episode

AT LEAST 5/9 Sx MOST OF THE DAY, EVERY DAY FOR **AT LEAST 2 WEEKS** INCLUDING 1 OR 2

① Depressed Mood OR

② Anhedonia (Lack of interest/ability to enjoy pleasure)

- ↑ or ↓ Sleep
- ↑ or ↓ Appetite/Weight
- ↑ or ↓ Activity
- ↓ Concentration
- Fatigue/Loss of Energy
- Worthlessness/ Guilt
- Suicidal Ideation

Diagnosis of Depression, cont.

- <u>Screen for current or past hypomanic/manic episode:</u>
  - Have you ever experienced your mood being abnormally elevated, where friends and family were worried because you were excessively active and happy?
  - AND
  - During that time, did you have a high level of energy to the point that you didn't have to sleep for at least a few nights in a row without getting tired?

- <u>Be vigilant to the risk of suicide</u>
  - 40% of adults and 50-70% of older adults visited their primary care provide within a month of suicide[1].
  - 90% of suicidal youth saw their primary care provider within the previous 12 months.[2]
  - < 40% of Family Physicians asked pts presenting with depression or requesting antidepressants about suicide.

Luoma 2002

“All that is depressive may not be depression”

Not to be missed:

- Suicidal thoughts
- Homicidal thoughts
- Opportunities to reduce access to firearms and medications that can be harmful if taken in large quantities
- Psychotic symptoms
- Illicit drug or alcohol abuse
- Systemic medical causes of depression (e.g. hypothyroidism, B12 deficiency)
- Bipolar disorder with depressed and mixed episode

Depression secondary to medical causes

- CNS: Trauma, Tumor, Stroke, Infection, Degenerative (Movement d/os), Demyelinating, etc.
- SYSTEMIC: Endocrine, Metabolic, Infectious, Hypoxic/ischemic, Toxic
- SUBSTANCE INDUCED (e.g. alcohol)
- MEDICATION INDUCED (e.g. corticosteroids)

When to Treat

- SEVERE: All or almost all MDD Sx persistently present
- Functional impairment from the depression
- Suicide Risk
- Prior Hx severe episode with recovery
- (+) FH
- Pt. preference
- Availability of support, psychotherapy
- Co-morbid Medical Illness

Treatment

- Mild to moderate depression: antidepressant medication *or* psychotherapy
- Severe depression: combined antidepressant and psychotherapy
- Choice of an antidepressant:
  - Side effect profile (can be beneficial, e.g. sedating effects of mirtazapine)
  - SSRI or SNRI
  - Drug-drug interactions (e.g. fluoxetine or paroxetine 2D6 inhibitory)
  - Cost (generic vs brand)

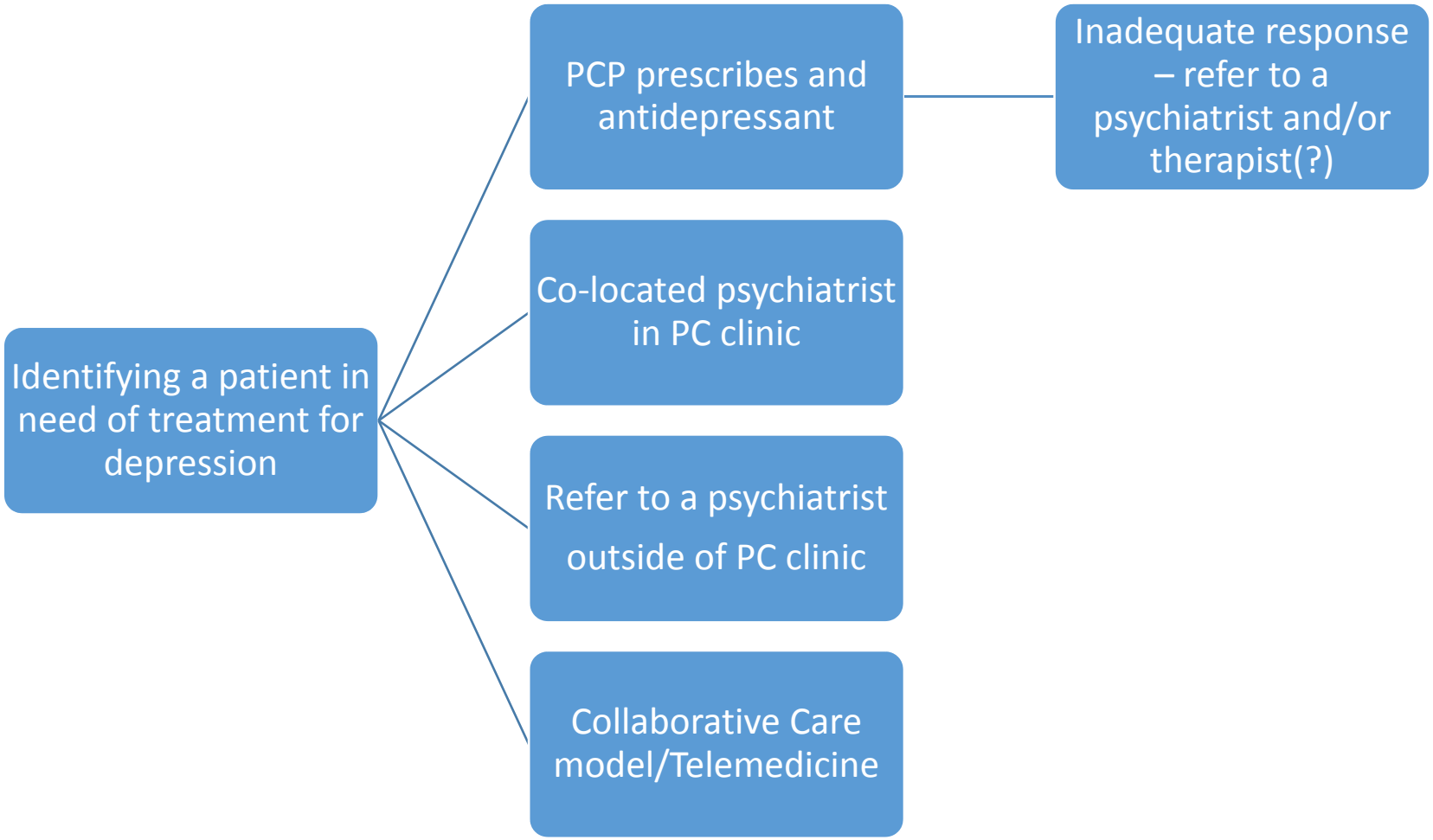
Antidepressants

Second Generation Antidepressants				
SSRIs	**SNRIs**	**NDRIs**	**Tetracyclics**	**Serotonin Modulators**
citalopram	desvenlafaxine	bupropion	mirtazapine	nefazodone
escitalopram	duloxetine			trazodone
fluoxetine	milnacipran			vilazodone
fluvoxamine	venlafaxine			vortioxetine
paroxetine				
sertraline				

Antidepressant Side-effects

SSRI (Prozac, Zoloft, Paxil, Luvox, Celexa, Lexapro)	**Sexual Dysfunction; Insomnia** **GI Upset/GI Bleed: ↑ with NSAIDS, Anticoagulants** **Dullness/Apathy** **Rare Movement d/o; CYP450 Interactions** **QTc Prolongation (CIT, ESCIT>SRT>Others)**
SNRI (Effexor, Cymbalta, Savella, Fetzima)	Sexual Dysfunction; Insomnia GI Upset; GI Bleed: ↑ with NSAIDS, Anticoagulants HTN/Tachy Sweating
BUPROPION (Wellbutrin, Zyban)	No sexual Dys; Rare Sz; Rare Psychosis, Mvmt
MIRTAZAPINE (Remeron)	No sexual Dys; Wt. Gain; Sedation
TCA (Elavil, Pamelor, Tofranil, Silenor)	Anticholinergic; QT Prolongation; Orthostatic Hypotension, sedation, wt. gain; DEATH IN OD
MAOI (Emsam)	NOT dietary BUT **Drug Interactions**; Insomnia;skin
VILAZODONE (Viibryd)	GI, Insomnia; headache
VORTIOXETINE (Brintellix)	GI (nausea, diarrhea), dizziness, headache

Primary Care & Psychiatry Relationship



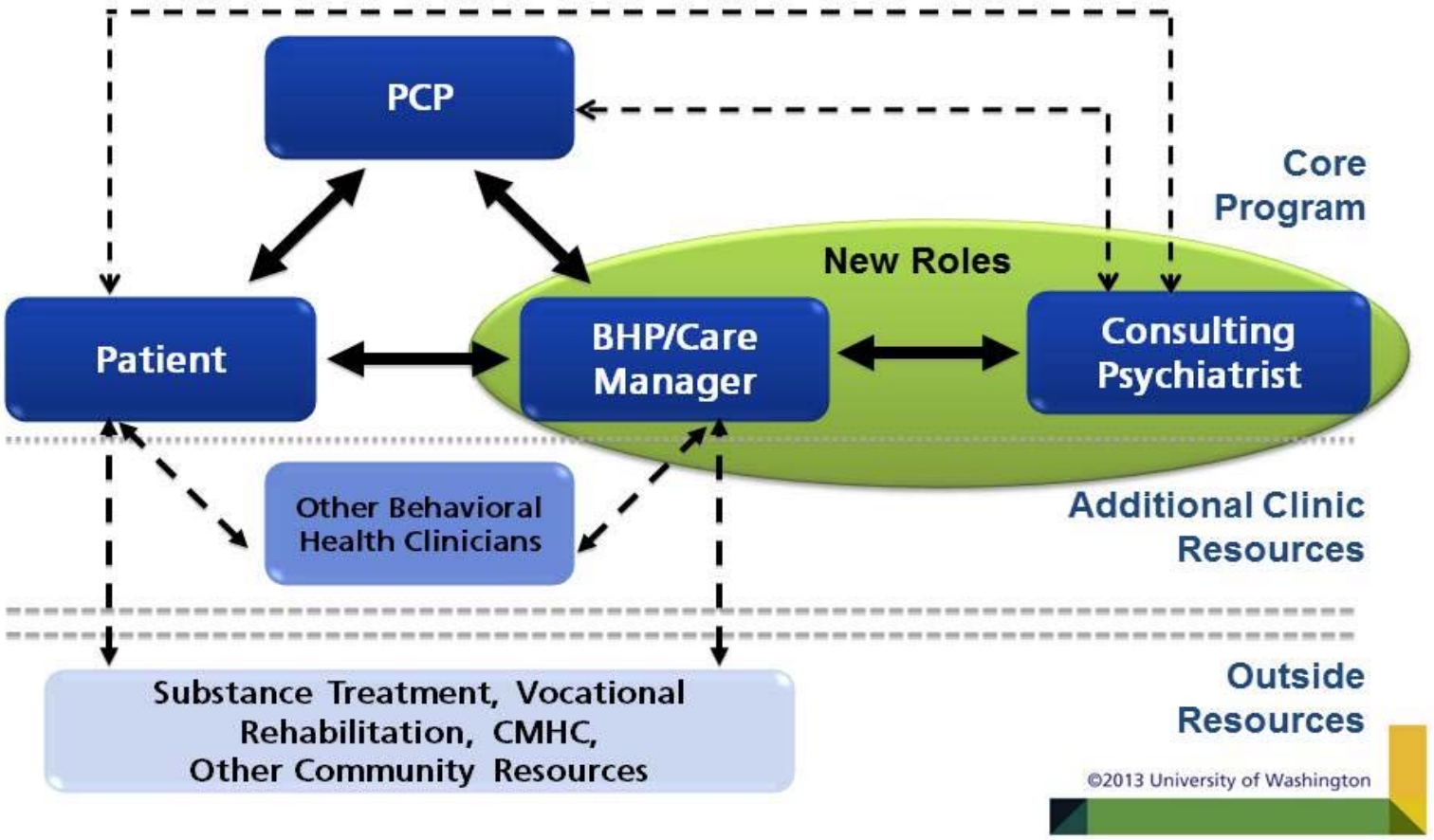
Collaborative Care

- Moving beyond a traditional consultative of co-location model of psychiatric services
- > 80 randomized controlled trials have shown Collaborative Care to be more effective than usual care further substantiated by several meta-analyses of the evidence, including a 2012 Cochrane Summary that reviewed 79 randomized controlled trials and 24,308 patients worldwide.

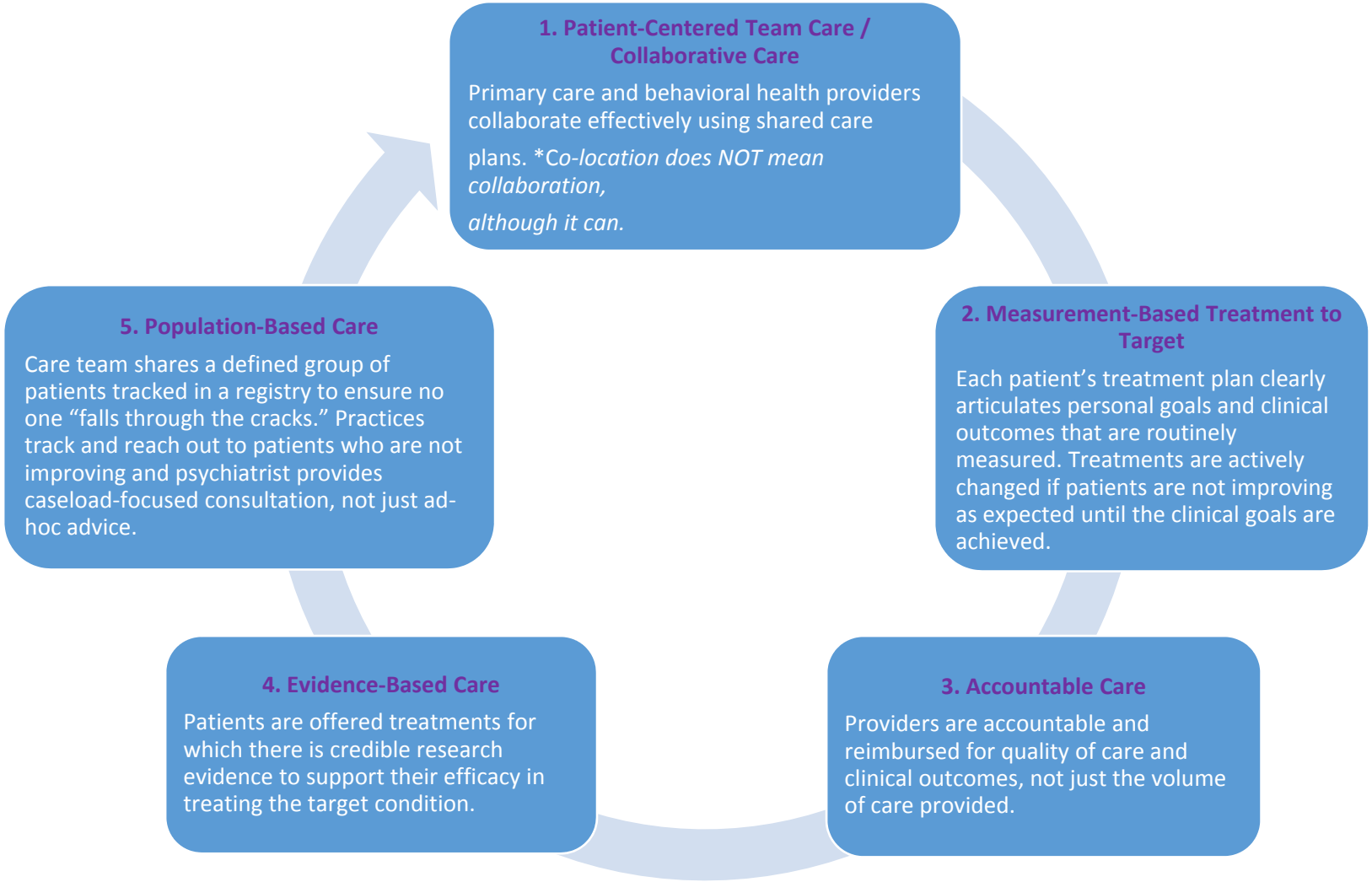
- Outcomes remained improved for as long as 2-5 years (Gilbody 2006, Verughese 2012)

- www.aims.uw.edu

Collaborative Care Team Structure



Five Principles of Effective Integrated Health Care



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