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)


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


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

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

## Patient Health Questionnaire (PHQ-9)

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Item Description</th>
<th>Score Options</th>
<th>Score Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1. Little interest or pleasure in doing things</td>
<td>0, 1, 2, 3</td>
<td>Several days</td>
</tr>
<tr>
<td>2</td>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0, 1, 2, 3</td>
<td>Several days</td>
</tr>
<tr>
<td>3</td>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0, 1, 2, 3</td>
<td>Several days</td>
</tr>
<tr>
<td>4</td>
<td>4. Feeling tired or having little energy</td>
<td>0, 1, 2, 3</td>
<td>Several days</td>
</tr>
<tr>
<td>5</td>
<td>5. Poor appetite or overeating</td>
<td>0, 1, 2, 3</td>
<td>Several days</td>
</tr>
<tr>
<td>6</td>
<td>6. Feeling bad about yourself—then you are a failure or have let yourself or your family down</td>
<td>0, 1, 2, 3</td>
<td>Several days</td>
</tr>
<tr>
<td>7</td>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0, 1, 2, 3</td>
<td>Several days</td>
</tr>
<tr>
<td>8</td>
<td>8. Moving or speaking so slowly that other people could have noticed, or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0, 1, 2, 3</td>
<td>Several days</td>
</tr>
<tr>
<td>9</td>
<td>9. The thoughts that you would be better off alive, or of hurting yourself</td>
<td>0, 1, 2, 3</td>
<td>Several days</td>
</tr>
</tbody>
</table>

**Add column totals:**

- Total

**Note:** For interpretation of TOTAL, please refer to accompanying symptom chart.

### Additional Items:

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

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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.

• Screen for current or past hypomanic/manic episode:
  • 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?

• Be vigilant to the risk of suicide
  • 40% of adults and 50-70% of older adults visited their primary care provider 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

<table>
<thead>
<tr>
<th></th>
<th>SSRIs</th>
<th>SNRIs</th>
<th>NDRIs</th>
<th>Tetracyclics</th>
<th>Serotonin Modulators</th>
</tr>
</thead>
<tbody>
<tr>
<td>citalopram</td>
<td>desvenlafaxine</td>
<td>bupropion</td>
<td>mirtazapine</td>
<td>nefazodone</td>
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<tr>
<td>escitalopram</td>
<td>duloxetine</td>
<td></td>
<td></td>
<td></td>
<td>trazodone</td>
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<tr>
<td>fluoxetine</td>
<td>milnacipran</td>
<td></td>
<td></td>
<td></td>
<td>vilazodone</td>
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<tr>
<td>fluvoxamine</td>
<td>venlafaxine</td>
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<td></td>
<td>vortioxetine</td>
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<tr>
<td>paroxetine</td>
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<tr>
<td>sertraline</td>
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</tbody>
</table>
## Antidepressant Side-effects

<table>
<thead>
<tr>
<th>Class</th>
<th>Side-effects</th>
</tr>
</thead>
</table>
| 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 |
Identifying a patient in need of treatment for depression

PCP prescribes and antidepressant

Co-located psychiatrist in PC clinic

Refer to a psychiatrist outside of PC clinic

Collaborative Care model/Telemedicine

Inadequate response — refer to a psychiatrist and/or therapist(?)
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
Five Principles of Effective Integrated Health Care

1. Patient-Centered Team Care / Collaborative Care
   Primary care and behavioral health providers collaborate effectively using shared care plans. *Co-location does NOT mean collaboration, although it can.*

2. Measurement-Based Treatment to Target
   Each patient’s treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved.

3. Accountable Care
   Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

4. Evidence-Based Care
   Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.

5. Population-Based Care
   Care team shares a defined group of patients tracked in a registry to ensure no one “falls through the cracks.” Practices track and reach out to patients who are not improving and psychiatrist provides caseload-focused consultation, not just ad-hoc advice.
References

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• Kroenke K. Et al.: Closing the False Divide: Sustainable Approaches to Integrating Mental Health Services into Primary Care, J Gen Intern Med 32(4):404–10


