THE BRIDGE STUDY

Patient-Centered Depression Care for African Americans

Funded by the Agency for Healthcare Research and Quality
and the National Institute of Mental Health

Cooper et al. Implement Sci. 2010 Feb 23;5:18.

Study Methods

- Approximately 5,000 patients are interviewed to identify panel of 250 patients with major depression to be followed for one year
- Outcomes
  - Patients' depressive symptoms and functional status
  - Patient adherence to antidepressant medication and/or psychotherapy visits
  - Patient-provider communication
  - Patient and provider satisfaction
  - Health service utilization

Provider Intervention Features

Intervention Features	Standard Intervention	Patient-Centered Intervention
2 detailing visits (CME)	X	X
Culture Specific Information		X
Communication Skills Interactive CD		X
Consultation Liaison Support	X	X

Patient Intervention Features

Intervention	Standard Intervention	Patient-Centered Intervention
Needs assessment by DCM	X	
Patient-centered needs assessment		X
Education and activation by DCM	X	X
Social support/informal counseling	X	X
Standard education materials	X	
Culturally targeted education materials		X
Black Mental Health Alliance List		X
Cultural information packet for mental health providers		X

Provider Goals

- What would you like to focus on within diagnosis and assessment of depression?
- How do you manage depression?
- Some Example of Provider Goals are:
  - Improve recognition of depression
  - Evaluate depressed patients more thoroughly (e.g., rule out substance abuse, anxiety)
  - Assess suicidal ideation
  - Elicit treatment preferences more often
  - Improve your pharmacologic management
  - Monitor symptoms more closely

Depression In Primary Care

Detailing Visit 1

Depression:Burden of Suffering

- Lifetime risk in population is 15-20%
- Functional impairment as great as most chronic diseases
- Direct treatment and indirect costs from lost productivity approximate 43 billion dollars per year
- Over half of depressed patients are seen only by primary care providers for their depression and other conditions
- Approximately 3-6% of all primary care patients meet full criteria for major depression

Depression and Medical Illness

Depression:

- is more common in women with the metabolic syndrome
  - High blood pressure
  - Elevated cholesterol
- increases the risk of Type 2 diabetes*
- is linked to cardiovascular disease**

* Golden SH, et al, Diabetes Care. 2004 Feb;27(2):429-35

** Wassertheil-Smoller S, et al, Arch Intern Med. 2004 Feb 9;164(3):289-98

Depression Under-Recognition and Under-treatment

- Recognition of depression in the primary care setting is a complex process;30%-70% of depression is missed
- Primary care patients are more likely than those treated in specialty settings to reject treatment*
- 50% of patients stop medication within the first three months
- Less than half of patients treated for depression achieve remission**

*Van Voorhees, et al, J Gen Intern Med. 2003 Dec;18(12):991-1000

** Jackson JL, Ann Intern Med. 2004 Jun 15;140(12):1054-6

Recognition & Diagnosis

- Clinician suspects that a patient may be depressed
- Some patients self-identify; many others present with somatic complaints
- Most clinicians rely on their general impressions
- Some clinicians use screening tools
- Formal assessment follows to confirm diagnosis

* MacArthur Initiative on Depression and Primary Care, Depression Management Tool Kit. V 1.3

Diagnostic Criteria for Major Depressive Disorder

At least 5 of the following 9 symptoms most of the day, nearly every day for at least 2 weeks:

- Depressed mood
- Diminished interest or pleasure in almost all activities
- Insomnia or hypersomnia
- Significant weight loss or gain
- Feelings of guilt or worthlessness
- Fatigue (loss of energy)
- Impaired concentration
- Psychomotor retardation or agitation
- Recurrent thoughts of death or suicide

DSM-IV Diagnostic Criteria for Major Depression

- Depressed mood or anhedonia
- A total of 5 out of 9 symptoms*
- Symptoms that persist most of the day, nearly every day, for 2 weeks

*See Clinician Resources Appendix I

Use of the PHQ

- Assess high-risk, 'red flag' patients
- Chronic illness
- Unexplained physical complaints
- Patients who appear sad or stressed
- Patients who have lost interest or pleasure in their lives
- Assess severity of depression

Scoring the PHQ: Severity

Count numerical values of symptoms

0-4	not clinically depressed
5-9	mild depression
10-14	moderate depression
>14	severe depression

See sample PHQ-9 in clinician tools

Assessing Severity of Depression

- How long is the current episode of major depression?
- Were there prior episodes?
- What degree of interepisode recovery has taken place?
- How severe are the current symptoms?
  - suicidal thinking
  - marked neurovegetative symptoms
- Is the patient functionally impaired?

Detection of Suicidal Ideation

- 9th question of PHQ is a suicide screening question
- If NOT using PHQ start by asking patients about sleep disturbance, mood disturbance, guilt or worthlessness, and hopelessness*
  - A positive answer to each question receives one point (scores range from 0-4)
  - Those with higher scores are more likely to have suicidal ideation

*Cooper-Patrick et al, JAMA 1994; 272:1757-1762

Suicide Screening Questions

- When a diagnosis of Depression is made, suicide risk requires assessment. For all depressed patients the following question may be asked:
  - Have you thought a lot about death -- your own, someone else's, or death in general?
  - Have you had any thought that life is not worth living or that you would be better off if you were dead?
  - What about thoughts of hurting or even killing yourself?
  - If YES, what have you thought about? Have you actually done anything to hurt yourself?

Assessment of Suicide Risk

Risk	Description	Action
□Low Risk	No current thoughts, no major risk factors*	Continue follow-up visits and monitoring
□Intermediate Risk	Current thoughts, but no plans, with or without risk factors	Assess suicide risk carefully at each visit and contract with patient to call you if suicide thoughts become more prominent; consult with an expert as needed
□ High Risk	Current thoughts with plans	Emergency management by qualified expert.

* See Clinician Resources Appendix I

Comorbidity in Depression is Common

- Alcohol/substance abuse
- Concurrent medication
- General medical disorder
- Other current psychiatric condition
- Grief reaction

Identifying Substance Abuse

- CAGE questionnaire

  1. Have you ever tried to **cut down** on your drinking or drug use?

  2. Have your family members or friends made you **annoyed** by asking you about your drinking or drug use?

  3. Do you ever feel **guilty** about your drinking or drug use?

  4. Have you ever had a drink or used drugs as an **eye-opener**, to get you going in the morning or to prevent a hangover?

- Health consequences
- Social consequences
- Emotional or psychological consequences

Concurrent Medications

Depressive-like symptoms may be an idiosyncratic effect of some medications. The drugs listed below have been implicated in the development of depression

Anti-hypertensive medications and other cardiovascular drugs	Methyldopa, reserpine, clonidine, beta-blockers, digoxin, diuretics (hypokalemia or hyponatremia).
Sedative-hypnotic agents	Alcohol, benzodiazepines, barbiturates, chloral hydrate, meprobamate
Anti-inflammatory agents and analgesics	Opioid (narcotic) analgesics
Hormones	Corticosteroids, oral contraceptives, estrogen withdrawal. Anabolic steroids

General Medical Disorder

- The presence of a depressive syndrome should not be explained away by the existence of a concurrent medical condition
- Medical conditions commonly associated with depression
  - stroke
  - dementia
  - diabetes
  - coronary artery disease
  - cancer
  - chronic fatigue syndrome
  - fibromyalgia

Medical Work-up of Depressed Patients

There is no empirical evidence that a physical exam, maneuver, or lab test can improve the diagnosis or outcome of depression. However, one *may consider* the following medical work-up:

- Medical History
- Physical Exam
- Labs: CBC, CMP*, TFT's
- Tests: EKG, MRI (for persons over 65 with first episode of depression)
- For patients with unusual features suggesting a secondary diagnosis (e.g. atypical course of illness, cognitive symptoms of dementia), do additional work-up as indicated

*Comprehensive Metabolic Profile

Adapted from AHRQ Guidelines

Other Current Psychiatric Conditions

- Primary mood disorders
  - Mania
  - Dysthymia
- Generalized anxiety
- Panic disorder
- Obsessive-compulsive disorder
- Post-traumatic stress disorder
- Phobic Disorders

Differential Diagnosis of Primary Mood Disorders

- Major Depressive Disorder
- Dysthymic Disorder
- Bipolar Disorder
- Major depressive disorder in partial remission
- Depression, not otherwise specified

Dysthymic Disorder

- Depressed mood for most of the day, for more days than not, for at least 2 years
- Two or more of the following:
  - Poor appetite or overeating
  - Insomnia or hypersomnia
  - Low energy or fatigue
  - Low self-esteem
  - Poor concentration or difficulty with decisions
  - Feelings of hopelessness
- Symptoms intermittent, but relief no longer than 2 months
- Symptoms cause significant distress/functional impairment
- 10% of people with dysthymia also have major depression

Bipolar Disorder

- Has there ever been a period of at least four days when you were so happy or excited that you got into trouble or your family or friends worried about it, or a clinician said you were manic?
- IF YES, assess further for mania:
  - A distinct period of abnormal, persistently elevated/expansive/irritable mood
  - Less need for sleep
  - Inflated self-esteem/grandiosity
  - More talkative than usual (pressured speech)
  - Distractibility
  - Increased goal-directed activity or psychomotor agitation
- Excessive involvement in pleasurable activities without regard for negative consequences (buying sprees, sexual indiscretions, foolish ventures, etc.)

Common Anxiety Disorders

- Panic disorder
  - Have you ever had a spell or attack when all of a sudden you felt frightened, anxious, or very uneasy in situations when most people would not be afraid?
- Generalized anxiety disorder
  - Have you ever had a period of a month or more when most of the time you felt worried and anxious?
- Obsessive-compulsive disorder
  - Have you ever been bothered by having certain unpleasant thoughts all the time?
  - Have you ever felt you had to do something over and over again even though you know it is really foolish?

Common Anxiety Disorders cont…

- Post-traumatic stress disorder
  - Symptoms must last at least one month for a diagnosis of PTSD
  - In your life have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month you…
    - Had nightmares,
    - tried hard not to think about it or went out of your way to avoid situations,
    - were constantly on guard,
    - felt numb or detached from others

Ouimette, PA, et al, Primary Care Psychiatry 2003; 9: 9-14

- Phobic disorders
  - Do you have any persistent, irrational fears or avoidances of specific things such as animals, heights, closed spaces, social situations, or using public transportation?

Grief Reaction

1. Did your most recent period of feeling depressed or sad begin just after someone close to you died?

2. IF YES TO QUESTION 1, ASK: Did the death occur more than two months ago?

If 'NO' to first question, or if 'Yes' to both questions, treat the patient for depression. Be sure to obtain a history of prior depression

- Normal grief reaction persists 2-6 months
- Improves steadily without treatment
- Rarely causes significant and prolonged impairment in work or other functions
- If the major depressive episode persists for more than 2 months after the loss, the depression should be diagnosed and treated

Assessing Functional Status

- Occupational: Have you been able to get to work/school most days in the past week?
- Family: How do your family members think you are doing? How are you handling your household chores/child care responsibilities?
- Social: Are you going out and spending time with people as much as you usually do?

Summary of Recognition and Diagnosis

Step A	Through interview and examination, the clinician may suspect depression
Step B	Diagnostic criteria are explored and (if appropriate) a depression diagnosis is confirmed
Step C	Rule out other causes of depressive symptoms

Appendix I: Recognition and Diagnostic Information

- Clinician Memory Aids
- Assessment Fact Sheet
- PHQ-9 Patient Health Questionnaire

Approach to Patient Education

- If the diagnosis is confirmed, the clinician and staff educate the patient about
  - depression
  - the care process
- Incorporate patient's view of the illness
- Determine patient preferences for treatment
- Provide educational materials and support in terms the patient can understand

Appendix II: Patient Education Materials

(Additional Resources Available at http://www.depression-primarycare.org/clinicians/toolkits/materials/patient_edu/)

Topic of Handouts	Title	Description
Understanding Depression	What is Depression	Concise, easy to understand information about depression and its treatment
Managing Depression	Understanding the Process for Managing Depression	List of steps involved in the treatment process
Antidepressant Therapies	Persons Considering Medication Treatment	Explanations about how antidepressants work and steps the patient should take
	Frequently Asked Questions About Antidepressants	Common questions and answers about antidepressant medications
Psychological Counseling	Persons Considering Psychological Counseling Treatment	Explanations of types of mental health specialists and what to expect from psychological counseling
Website Materials	Patient Education Materials	Links with national organizations for patient education materials

Depression In Primary Care

Treatment & Referral

Detailing Visit 2

Depression Care Process*

Treatment	The clinician and patient select a management approach for treating depression: □ Watchful waiting, with supportive counseling □ Antidepressant medication □ Mental health referral for psychological counseling □ Combination of antidepressants and psychological counseling
Monitoring	The clinician and support staff monitor compliance with the plan and improvement in symptoms/ function and modify treatment as appropriate

* MacArthur Initiative on Depression and Primary Care, Depression Management Tool Kit. V 1.3

Treatment Information

Overview of the Treatment Process

Step A Clinician selects treatment approach with the patient, then works with patient to set goals for treatment outcomes and discusses phases of treatment (acute, continuous, and maintenance)

Step B Clinician or support staff reassess patient symptoms and function after therapy has begun. Continues with therapies that reduce depressive symptoms or achieves remission. Adjust therapies with partial or no response

Step C Follows Continuation/ Maintenance guidelines to prevent relapse or recurrence

Three Phases of Treatment

Acute phase- Aims at minimizing depressive symptoms and achieving remission

- Usually last 3 months, aimed at remission of symptoms;
- monitor every 1-2 weeks

Continuation phase- Tries to prevent return of symptoms during current episode

- The 4-9 months of treatment when symptoms have improved;
- monitor every 4-6 weeks

Maintenance phase- Focus is to prevent lifetime return of new episodes

- 1 or more years of treatment to prevent recurrence;
- monitor every 2-3 months for at least 6 months, after that, quarterly for 2 years and every 6 months thereafter

Acute Phase of Treatment

- Key issues include using sufficient dosages, monitoring the patient closely, changing to new medication if response inadequate

- Careful assessment-watch for:
  - Mania
  - Substance abuse
  - Suicide risk

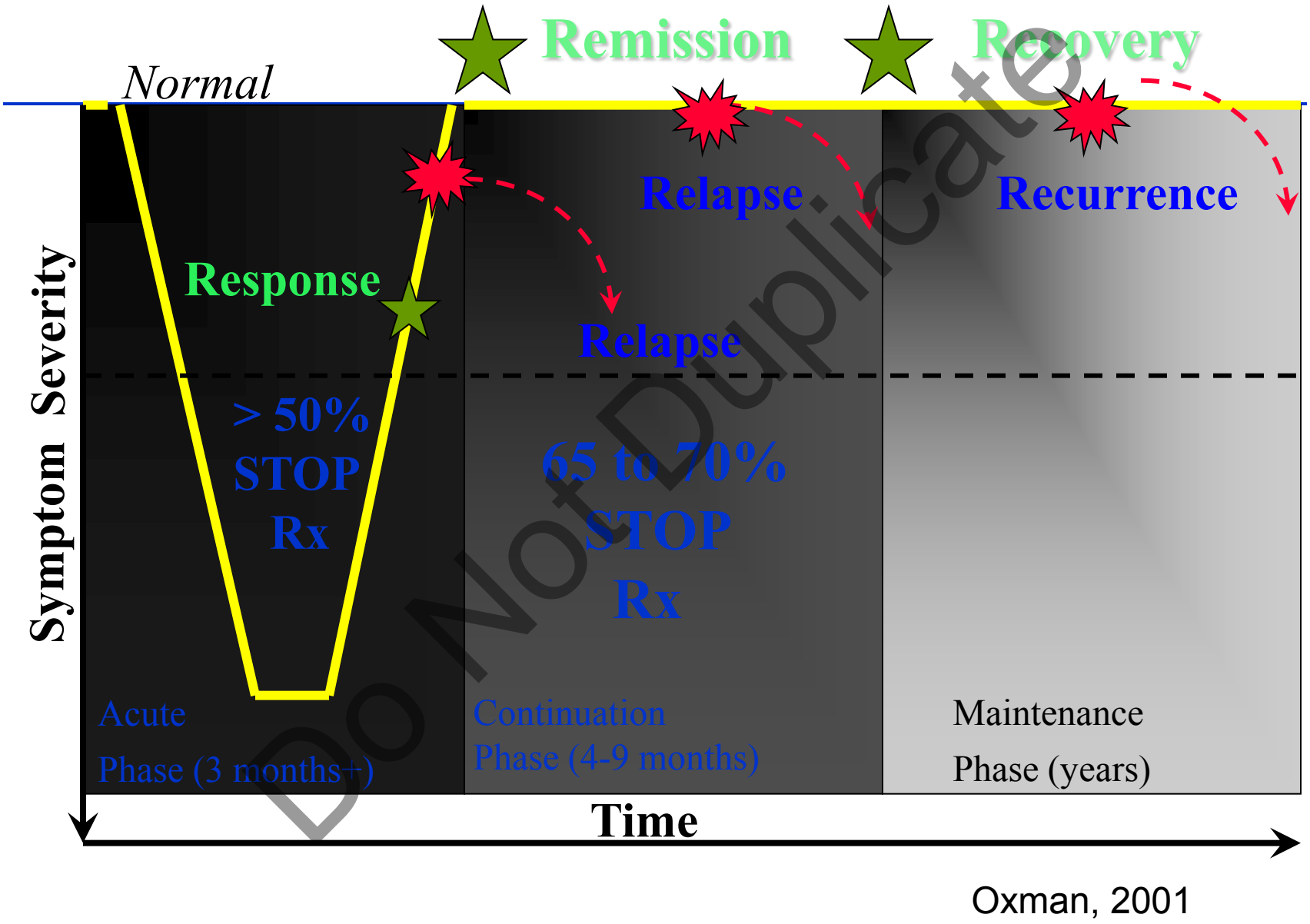
Continuation Phase

- 40-60% risk of relapse if medication is stopped in the first few months of treatment
- Continued treatment reduces risk to 5-10%
- Tricyclics and SSRI's studied for continuation therapy; work equally well

Maintenance Phase

- First depressive episode: not recommended
- One prior episode: recommended
- Two or more episodes: strongly recommended
- Risk factors for recurrence: number of prior episode, dysthymia preceding episode, poor interepisode recovery, current episode> 2 year's duration, age of onset before age 20 or after age 50, family history, psychosis or suicidality

Three Phases of Treatment



Oxman, 2001

Definitions of the "Five R's"

1. Response: significant reduction of symptoms
2. Remission: a reduction of symptoms to the point of "wellness"→ PHQ <5
3. Recovery: sustained remission

   Sustained: 3 months of symptom reduction with at least one PHQ < 5
4. Relapse: exacerbation of symptoms after a response or remission but before recovery
5. Recurrence: a new episode after recovery

TREATMENT SELECTION: FOUR OPTIONS

Watchful waiting

Psychotherapy

Pharmacotherapy

Combination therapies

Watchful Waiting (WW)

- Many depressions remit spontaneously
- WW is an acceptable "treatment plan"
- Initial treatment of choice for minor depression
- Use this "waiting" time to negotiate specific degrees of improvement or worsening conditions. You should agree on a time when 'enough is enough,' and the possibility of starting treatment

  - Intensity of WW
    - Low: repeat PHQ only (mild depression)
    - Moderate: w/active Self Management Support (SMS): daily activities that keep the illness under control. Pick at least one goal in which the patient can have a success rate $\geq$ 70%

Psychotherapy

Psychotherapy

- Effective
  - Mild to moderate major depression
  - Adjunct to antidepressants
  - Chronic depression
- Possibly effective
  - Minor depression
  - For patients in life transitions or with personal conflicts
  - See Treatment Tools Appendix III

Counseling in Primary Care

Communicating with depressed patients- "empathize, encourage, educate"

- Cognitive Therapy- "you feel what you think"
- Behavioral Therapy- "you feel what you do"
- Problem-Solving Therapy
- Interpersonal Therapy

See Appendix II for detailed guide

Adapted from AHRQ Treatment Guidelines

Antidepressants

Drug Type	Generic Name	Brand Name
Selective serotonin reuptake inhibitors (SSRIs)	Citalopram Escitalopram Fluoxetine Fluvoxamine Paroxetine Paroxetine, controlled released Sertraline	Celexa Lexapro Prozac Luvox Paxil Paxil CR Zoloft
Serotonin and norepinephrine reuptake inhibitors	Trazodone Venlafaxine Venlafaxine, extended released	Desyrel Effexor Effexor XR Cymbalta
Tricyclics (TCAs)	Amitriptyline Desipramine Doxepin Imipramine nortriptyline Protripyline trimipramine	Elavil Norpramin Sinequan Tofranil Aventyl Pamelor Vivactil Surmontil
Dopamine and norepinephrine reuptake inhibitors	Bupropion Bupropion, sustained-release Bupropion, extended-release	Wellbutrin Wellbutrin SR Wellbutrin XL
Tetracyclics	Maprotiline Mirtazapine	Ludiomil Remeron Remeron Sol Tab
Monoamine oxidase (MAO) inhibitors	phenelzine tranylcypromine	Nardil Parnate

Treatment Guidelines: Acute Phase

Treatment Guidelines

- Most people start with SSRI, TCAs or Dopamine reuptake inhibitor
- Increase every 2-4 weeks
- Treat to remission (PHQ<5)
- If no response, switch class
- If partial response at maximum dose, consider augmentation or consultation

Suggested Algorithm

- If patient elderly or has comorbid panic or anxiety start low, titrate slowly
- Assess every few weeks
- Titrate dose for total remission

Treatment Guidelines: Continuation Phase

- Continue for *at least* 4-9 months after full remission (PHQ≤5)

- Longer continuation decreases risk of relapse

At 6 weeks, assess symptomatic outcome:

- Partial response: presence of some clinical improvement but the patient still has significant symptoms at 6 weeks:
  - Continue with medication at therapeutic dose until weeks 8-12; consider switching medication class (can switch at 8 weeks if vegetative symptoms predominate)
  - Considering adding psychotherapy
  - Consider augmentation
  - Consider consultation
- Failure to respond: no or minimal response by 6 weeks (with adequate dose):
  - Consider switching medication class

Treatment Guidelines:
To Maintain Or Not To Maintain?

If no previous episode of major depression
- → 50% chance of recurrence if stop medication

If one previous episode of major depression
- → 75% chance of recurrence

If two previous episodes of major depression
- → 90% chance of recurrence

- Maintenance decision made in partnership with patient based on above information, patient preferences and severity of depressive episode(s)
- Maintenance dose is a FULL treatment dose

PHQ-9: Monthly **Follow-Up** Guide for Clinically Significant Depression

Adapted from Oxman, 2002

PHQ-9	*Treatment Response*	*Treatment Plan*
Drop of ≥ 5 points from baseline or PHQ < 5	**Adequate**	**No treatment change needed. Follow-up monthly until remission, then every 6 months.**
Drop of 2-4 points from baseline	**Possibly Inadequate**	**Consider change in plan: increase dose or change medication; increase intensity of SMS, psychotherapy**
Drop of 1 point, no change or increase	**Inadequate**	**Obligate change in plan (as above); consider specialist consultation, collaboration, referral**

Function of Antidepressant classes

Selective Serotonin Reuptake Inhibitors (SSRIs)

Work by slowing down reabsorption of the neurotransmitter serotonin in the gaps between the nerve cells

Dopamine Reuptake Inhibitor

Work blocking the reabsorption and inactivation of dopamine, which is both a neurotransmitter and a precursor of other neurotransmitters

Tricyclic

Work by slowing down reuptake of serotonin and noradrenaline but also have other effects on the nervous system

Managing Side Effects

- Side effects from antidepressants range from relatively minor, annoying, but fairly frequent, problems (e.g., dry mouth or constipation) to more significant, but less frequent, side effects (e.g., orthostatic hypotension) to substantial side effects (e.g., cardiovascular conduction abnormalities with classic tricyclic antidepressants [TCAs])

- Most side effects are dose-dependent, requiring dosage adjustments in many cases. For most patients, the benefits of treatment far outweigh the risks.

- See chart for managing antidepressant side effects in Appendix III page 36

FDA Public Health Advisory

- Points out the need to closely monitor patients receiving antidepressants for worsening and suicidality especially at beginning of treatment and with changes in dosage

- Also need to instruct patients and families to be alert for worsening or suicidal thoughts and to immediately report such symptoms

FDA Public Health Advisory, March 2004

Drug Interactions*

- Obtain medication history
- Be aware that all drugs can affect the action and serum, levels of others
- Monitor the clinical effects and serum levels of all medications
- Use electronic data base

*See Appendix III: Table 2: Selected Antidepressant Drug Interactions

Depression Co-Occurring with Other General Medical Disorders

- Many general medical conditions are risk factors for major depression*
- Major depressive disorder, when present, should be viewed as an independent condition and specifically treated
- Treatment may include:
  - optimizing the treatment of the general medical disorder and/or
  - providing specific treatment for the depression.

*See Appendix III: Somatic treatments of depression in patients with medical illness

Combination Therapies

Combination Therapy

Combined treatment with psychological counseling and antidepressants are recommended for:

- Patients who have partial response to either type of treatment alone
- Patients with personality disorders
- Patients with complex psychosocial problems
- Patients who prefer psychological counseling, but have severe depression
- Prior course of illness is chronic or characterized by poor inter-episode recovery

Specialist Decision Support

Consider three types of decision support:

- Consultation: One-time specialist evaluation
- Collaboration: (co-management) specialist provides decision support on regular or intermittent ongoing basis*
- Referral: Care provided by specialist**

*Appendix III: Supportive Counseling

**Appendix IV: Monitoring Tools

Consultation, Collaboration, or Referral

- Suicidality
- Psychosis
- Bipolarity
- Chemical dependency
- Personality disorder

Appendix III: Treatment Information

- Treatment Fact Sheets
- Drug Administration Information

Appendix IV: Monitoring and Follow-Up Information

- Depression Monitoring Tools
- Referral for Psychological Services Tools