Depression Management
Presentation 1 of 3

- ✓ Documented diagnosis
- ✓ PHQ tool
- ✓ Depression care assessment

Diagnosis: DSM-V Criteria for Major Depressive Episode

- Must have a total of 5 symptoms for at least 2 weeks
- One of the symptoms must be depressed mood or loss of interest.
- Impaired functioning in home work social situation
- No other obvious explanation

DSM-V Criteria for Major Depressive Episode

1. Depressed mood most of the day, nearly every day
2. Markedly diminished interest or pleasure in all almost all activities
3. Significant (>5% body weight) weight loss or gain, or increase decrease in appetite
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feeling of worthlessness or inappropriate guilt
8. Diminished concentration or indecisiveness
9. Recurrent thoughts of death or suicide

Depression is Not Adequately Treated in Usual Primary Care

- Depression is under-diagnosed and under-treated
- 46-57% of 12 million cases reported in the US are receiving treatment
- Only 18-25% are adequately treated
- Over 60% of patients with depression see a primary care physician in usual care
- 50% of depressed patients go undetected in usual primary care
- Only 20-40% of patients improve substantially 12 months after diagnosis (Archives of General Psychiatry 2003 and Jama 2003)

Depression Management in Primary Care

- Over 16% of the population in the US will have an episode of major depressive disorder sometime in the lifetime
- Over 20% in women
- 10-20% of patients in primary care settings are depressed

To Screen or Not to Screen?

- The U.S. Preventive Services Task Force (USPSTF)
  - B recommendation- routine depression screening for all adults and adolescents (age 12-18) but
  - **only in clinical practices that have systems in place with care management, staff assistance or mental health specialist involvement to assure accurate diagnosis, effective treatment and follow-up**.
- American College of Preventive Medicine (ACPM) supports this recommendation and adds that all primary care practices should have such systems of care in place.

Patient Health Questionnaire (PHQ) – A Standardized Tool

- PHQ-2 (screening questions)
- PHQ-9 (confirming questions and used to monitor patient symptoms
- Rates symptom intensity and improvement
  - Assists in determining treatment modification
  - Provides a measurement response and remission rates

Two Question Screen (PHQ-2)

1. "Over the past two weeks have you felt down, depressed, or hopeless?" (mood)
2. "Over the past two weeks, have you felt little interest or pleasure in doing things?" (anhedonia)

- Helpful as case finding screen but needs to be followed up if positive
- Workflow issues
  - To screen or not to screen?

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

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Scoring – Add Up All Checked Boxes

For every check:
Not at all = 0
Several days = 1
More than half the days = 2
Nearly every day = 3

Total Score:	Depression Severity:
0-4	No depression
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

9-Item Patient Health Questionnaire (PHQ-9)

- Validated for measuring depression severity (Kroenke, 2001; Spitzer, 1999)
- Validated for telephone administration (Pinto-Meza, 2005)
- Validated in other languages including Spanish (Wulsin, 2002) and Chinese (Yeung, 2008)
- Available in many other languages (www.phqscreeners.com)
- Elderly with mild cognitive impairment can reliably complete (Lowe, 2004)
  - See PHQ-9 tool in resourceshttp://uwaims.org/files/videos/initialvisit.html

PHQ-9 = DSM criteria if confirmed clinically

- Specificity if score >9 (77-99%)*
  - That is a positive result rules in the diagnosis

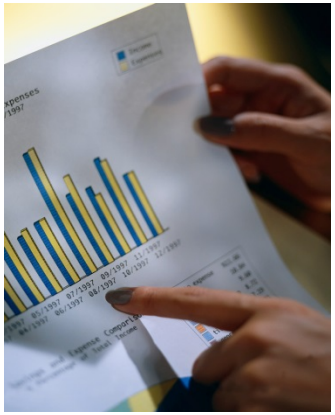
>>Gilbody metaanalysis IGIM 2007

No PHQ?

If you went to the doctor for hypertension treatment, how would you feel if they did not check your blood pressure?

Purpose of PHQ

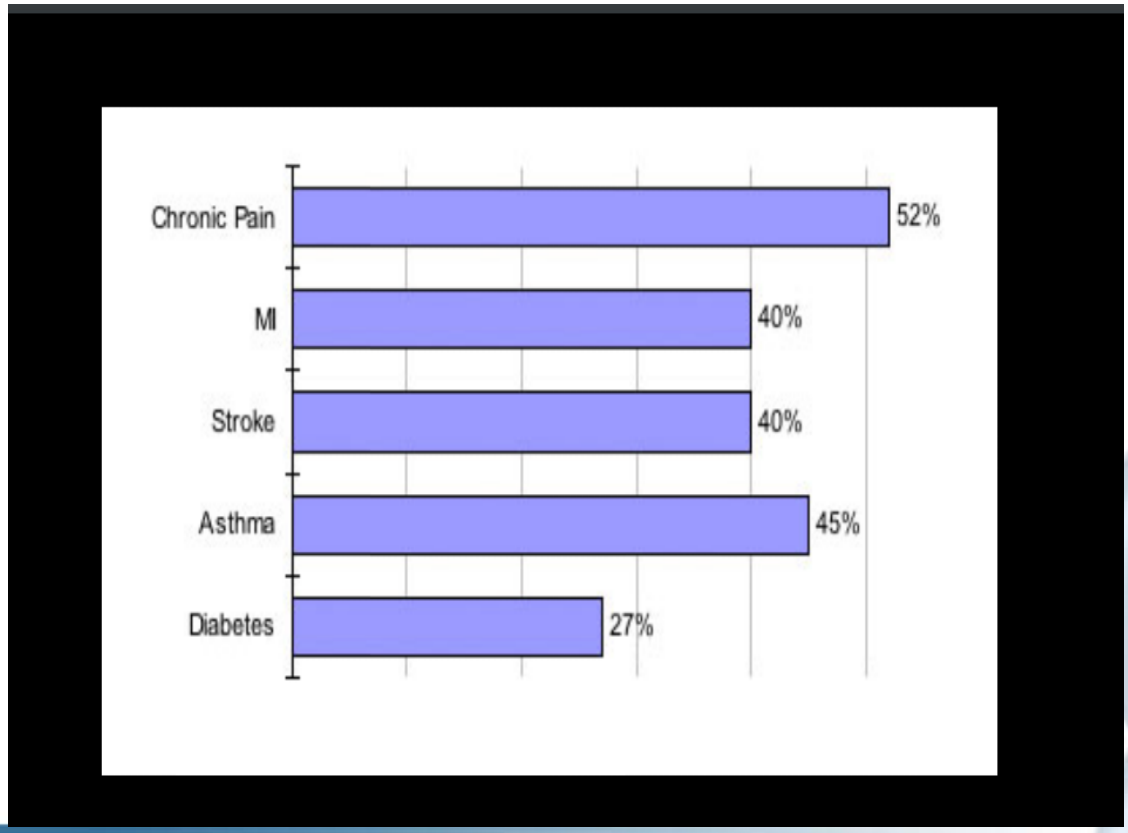
Like a blood pressure reading, the PHQ serves as a quantitative depression score. It allows the patient and provider to gauge improvement and drive treatment decisions for depression.



Who to Screen
Consider Co-morbid Conditions

- Suicide Risk Suspected/Reported
- Diabetes
- Chronic Pain
- Cardiovascular Disease

Depression and Co-Morbidity of Other Chronic Diseases



Consider Special Populations

- Older adults
- Perinatal women
- Cultural considerations

- PHQ-9 has been validated in these populations.
- Cultural issues in administering, evaluation, and scoring require local knowledge and clinician involvement.

Assessment for Depression

What to Include in the Comprehensive Assessment when the PHQ is positive

Substance Misuse or Psychiatric Comorbidity

- Review the medical history for substance misuse.
  - Value
    - Substance misuse can impact the effectiveness of treatment
    - Consider medication interactions
- Psychiatric Comorbidity
  - Value
    - Co-morbid psychiatric diagnosis can impact the medication treatment for depression
      - Bipolar, Schizophrenia

Supports

Psychosocial

- Living arrangements
- Education
- Employment
- Marriages
- Children

Suicide Risk Screening

- If suspected
  - Consider
    - Level of Risk
      - Current thoughts?
      - How Often
      - For how long?
      - Plan?
      - Intent?
      - Means? Preparation?
      - Previous attempts?
      - Family history of suicide?
      - Current use of alcohol or drugs?
      - Severe stressors?
      - Marked coping difficulties
      - High-risk factors (psychosis, agitation, history of aggressive or impulsive behavior, hopelessness, high anxiety, comorbid physical illness, high-risk demographics (male sex, advanced age, divorced or separated, Caucasian or Asian race)

- Resource: http://www.teamcarehealth.org/Portals/0/Documents/Suicide%20Protocol%202013-07-25%20(white).pdf

- **More specific detail will be covered in presentation 2 of the 3 part series on Depression Care

Mental Health History

- Past Psychotropic Medications
- Other mental health treatment and response
  - Inpatient hospitalization
  - ECT
  - Outpatient Mental Health Treatment/Psychotherapy
  - Substance Abuse Treatment
- Stressors, strengths and resources
- Health habits and activities
- Treatment barriers (logical, social, physical, psychological)
- Patient knowledge

Presentation 1 of 3

- Presentation 2:
  - Key components of the treatment plan, evidence based models,
  - Medications – common medications, side effects and interaction concerns
  - Key components to consider for suicide risk protocol
- Presentation 3:
  - Monitoring
  - Relapse prevention/self-management action plan for depression

Thank You

Open to Questions