Depression in Primary Care

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Epidemiology of Depression in Primary Care

- Prevalence of 10~15%
- 1 of 5 most common conditions in primary care
- Nearly 10% of all primary care office visits are depression related
- PCPs provide about 50% of the outpatient care for depressed pts (the “hidden mental health system”)

Functional Impairment in Depression and Other Chronic Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Physical Functioning Score</th>
<th>p-Value vs Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>75</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Hypertension</td>
<td>80</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Diabetes</td>
<td>85</td>
<td>&lt;0.005</td>
</tr>
<tr>
<td>Arthritis</td>
<td>90</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>No Chronic Condition</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Higher prevalence in patients with co-morbidities
- Pain syndromes, diabetes mellitus (DM), heart disease, neurological disorders, HIV

Prior depression appears to be a risk factor for development of CAD and diabetes mellitus

Patients with co-morbid chronic illness and depression have:
- More symptoms
- Worse function
- Impaired self care and adherence
- Higher costs

Depression and CHD

- Depression is a risk factor for development of CHD.
- Depression present in 30%-40% of pts with CHF and in 50% s/p CABG and ACS.
- SADHART RCT: trend towards decreased mortality in depressed pts s/p MI treated with SSRIs.

Whooley MA. JAMA. 2006.

Case Vignette
“My Back Hurts...and I Feel Frazzled”

- Mr. P is a 52-year-old small business owner with a history of hypertension and AODM.
- He reports 2-3 months of fatigue and chronic, occasionally debilitating back pain treated with OTC analgesics.
- He feels “frazzled” by his work and does not do anything for fun anymore.
- He denies feeling sad.
- The remainder of the history is unremarkable.
- On physical examination, he has no spinal tenderness and neurological exam is normal.

Primary Care Patients With Depression Usually Present With Physical Symptoms

69% presented only with physical symptoms.

N=1146 patients with major depression.


Diagnosis of Depression Often Missed When the Presentation Is Physical

Types of Clinical Presentation

- 77% of Physician Recognition and Diagnosis of MDD/Anxiety Disorder
- 22% of Psychosocial Complaints

N=685

Depression and Pain

Multicausality Model

Concurrent Depression and Pain

Case Vignette

“Mr. P is a 52-year-old small business owner with a history of hypertension and AODM.

He reports 2-3 months of fatigue and chronic, occasionally debilitating back pain treated with OTC analgesics.

He feels “frazzled” by his work and does not do anything for fun anymore.

He denies feeling sad.

The remainder of the history is unremarkable.

On physical examination, he has no spinal tenderness and neurological exam is normal.”
**Screening and Diagnosis**

- How would you screen this patient for depression?

**Rating Scales**

- “SIGECAPS”
- HAM-D
- CES-D
- Zung Self-Rated Depression Scale
- Beck Depression Inventory
- **PHQ-9**

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**Initial Screen: The PHQ-2**

- During the past 2 weeks, have you had any of the following:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>Little interest in doing things?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Felt down, depressed, or hopeless?</td>
<td>☐</td>
<td>☐</td>
</tr>
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</table>

**Mr. P. Initial Screen: The PHQ-2**

- During the past 2 weeks, have you had any of the following:

<table>
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<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>
Mr. P. PHQ-9 Depression Scale

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>Not at All</th>
<th>Several Days</th>
<th>More Than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>6. Feeling bad about yourself, or that you are a failure</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>8. Moving or speaking too slowly</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Subtotals: 1 10 6

Total=17

PHQ-9

- Patient self-administered
- Validated in Spanish and Chinese
- Association between increasing PHQ-9 scores and likelihood of MD
- Useful for monitoring change over time

PHQ-9 Score

(HgbA1C for Depression)

- Remember 5, 10, 15, 20
- Cut points for depression severity
  - ≥5 mild
  - ≥10 moderate
  - ≥15 moderately severe
  - ≥20 severe
- Significant improvement = 5 point ↓
- Response = 50% ↓ or score < 10
- Remission = score < 5

Available at: [http://www.depression-primarycare.org](http://www.depression-primarycare.org)

Depression Screening in the UCSF GMP

Depression Treatment Planning Guidelines

<table>
<thead>
<tr>
<th>PHQ-9 Severity</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10</td>
<td>Mild/minimal depressive symptoms</td>
<td>Reassurance and/or supportive counseling</td>
</tr>
</tbody>
</table>
| 10-14          | Moderate              | Watchful waiting  
|                |                       | Supportive counseling  
|                |                       | If no improvement after ≥1 month, consider antidepressant |
| 15-19          | Moderately severe      | Patient preference for antidepressant and/or counseling |
| ≥20            | Severe major depression | Antidepressants alone or in combination with counseling |

Adapted from MacArthur Foundation Depression in Primary Care Initiative.

Monitor progress using the PHQ-9

- Wouldn’t treat blood pressure without measuring it at every visit
- Wouldn’t prescribe hypoglycemic agents without following the HgbA1c
- Why accept casual, imprecise monitoring in depression?

Depression and Suicide

- Primary care physicians assess for suicide in patients with depression in only about 1/3 of visits
  - 50% of persons who commit suicide had sought professional help in prior month
- Assess suicide risk
  - Ideation, intent, plan, availability, lethality
  - Ask: “This past week, have you had any thoughts that life is not worth living or that you’d be better off dead?”
  - Consider “no suicide contract”

Treatment Options

- Watchful waiting and support
- Antidepressants
- Referral for counseling
- Combination of antidepressants and counseling

Watchful Waiting and Support

- Watchful waiting for mild episode
- Patient self management: UB-PAP (ultra-brief personal action planning)\(^1\)
  - Ask patient to set a specific goal or activity to help improve their depression
  - Ask patient to assign a level of confidence to the plan (1 - 10)
  - Arrange short term follow-up to assess level of attainment

Depression Stages of Treatment

PCPs Adherence to Practice Guidelines

- Most PCPs recognized depression and provided initial treatment
- Most did not screen for EtOH or suicide
- Only 46% of patients completed initial treatment


The STAR*D Trial
(Sequenced Treatment Alternatives to Relieve Depression)

- National consortium 23 psychiatric and 18 primary care clinics
- Four levels of treatment, each lasting 14 weeks
- Level 1 = Citalopram: if no remission by 14 weeks patients moved to next level to switch or augment the medication
- Patients and physicians had some choice in treatment

STAR-D* Treatment Levels

- **Level 1**: 30% achieved remission on citalopram (40 mg/day)
- **Level 2 Switch**: 1/4 achieved remission on bupropion SR (283 mg/day); sertraline (135 mg/day); or venlafaxine-XR (193 mg/day)
- **Level 2 Augmentation**: 30% achieved remission: bupropion SR 267 mg/day or buspirone 40 mg/day
- Switching or augmenting with cognitive therapy was equally effective to medication

STAR-D* Take Home Points

- Measurement based care is possible in primary care--use PHQ-9
- If inadequate response in 4-6 weeks and side effects tolerable, increase the dose
- If no remission in 8-12 weeks, 1) augment with bupropion or 2) switch to another agent
- Likelihood of improvement after 2 medication trials is low: 6% additional remission step 2-3
- Consider psychiatric consultation if can’t achieve remission, suspect bipolar disorder, function significantly impaired, or suicidal thoughts persist
- Remission is associated with better prognosis
Late-Life Depression

- 10% of adults > 65 in primary care settings have clinically significant depression
- More common in pts with persistent insomnia and after stressful life events
- Often undetected, especially in men and URM persons
- Older men have highest rates of completed suicide

Unutzer J. NEJM. 2007

Improving the Quality of Depression Treatment in Primary Care

- Clinicians
- Organizations
- Patients

Social Influences on Practice Study (SIP)

Design

- Randomized trial using *unannounced* Standardized Patients (SPs)
- 152 physicians from 4 physician collectives in 3 cities
  - Sacramento, CA
  - San Francisco, CA
  - Rochester, NY

Antidepressant Advertising
SP Roles

- “Louise Parker”
  - 48 yo divorced Caucasian woman
  - Depressed mood for a month,
  - Worse past 2 weeks
  - Low energy, early awakening, no suicidality
- “Susan Fairly”
  - 45 yo divorced Caucasian woman
  - Insomnia and low energy
  - No sleep/appetite disturbances and no significant interference with functioning

Distribution of SP Visits

<table>
<thead>
<tr>
<th></th>
<th>Major depression</th>
<th>Adjustment disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Request</td>
<td>n=51</td>
<td>n=48</td>
</tr>
<tr>
<td>General Request</td>
<td>n=50</td>
<td>n=49</td>
</tr>
</tbody>
</table>

Results: Impact on Prescribing

<table>
<thead>
<tr>
<th>Major depression</th>
<th>Brand specific request (n=51)</th>
<th>53%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General request (n=50)</td>
<td>76%</td>
</tr>
<tr>
<td></td>
<td>No request (n=48)</td>
<td>31%</td>
</tr>
</tbody>
</table>

Adjusted Results

<table>
<thead>
<tr>
<th>Disease Type</th>
<th>Major Depression</th>
<th>Adjustment Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request Type</td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
</tr>
<tr>
<td>Brand Specific</td>
<td>2.7 (1.1-6.8)</td>
<td>13.3 (4.2-42.1)</td>
</tr>
<tr>
<td>General</td>
<td>8.0 (3.0-21.6)</td>
<td>6.3 (2.0-20.1)</td>
</tr>
</tbody>
</table>

Kravitz RL, Epstein R, Feldman MD. JAMA 2005
Patient Requests Improve Quality of Depression Care

- Standardized patients’ requests increased:
  - Antidepressant prescribing,
  - Depression history taking,
  - Inquiries about suicide,
  - Guideline based care
  - Recognition of depression

- Patient requests a two-edged sword
  - Patient less likely to be under-treated if depressed
  - Patients more likely to be over-treated if not depressed

1Feldman MD et al. Medical Care. 2006
2Feldman MD et al. Annals Fam Med. 2007

Well-being

“The secret of the care of the patient is caring for the patient.”
Peabody 1927

“The secret of the care of the patient is caring for oneself while caring for the patient.”
Candib 1995

Value Determination

“Well-being arises in part from the personal values that we develop and cherish, as well as the choices we make in our attempts to honor those values.”
(Feldman and Christensen, 2001)

“Meaning is not something you stumble across, like the answer to a riddle or the prize in a treasure hunt. Meaning is something you build into your life. You build it out of your own past, out of your affections and loyalties . . . out of your own talent and understanding, out of the things you believe in, out of the things and people you love, out of the values for which you are willing to sacrifice something.”
John Gardner