Addressing Depression in Primary Care

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The Problem

- Providers are often so busy handling just the clinical demands of modern medicine that we almost **dread identifying a depressed patient**.
- **Oh no! Now what do I do**, and where will I find the time to do it?

Who is the one that's depressed now?

Session Description

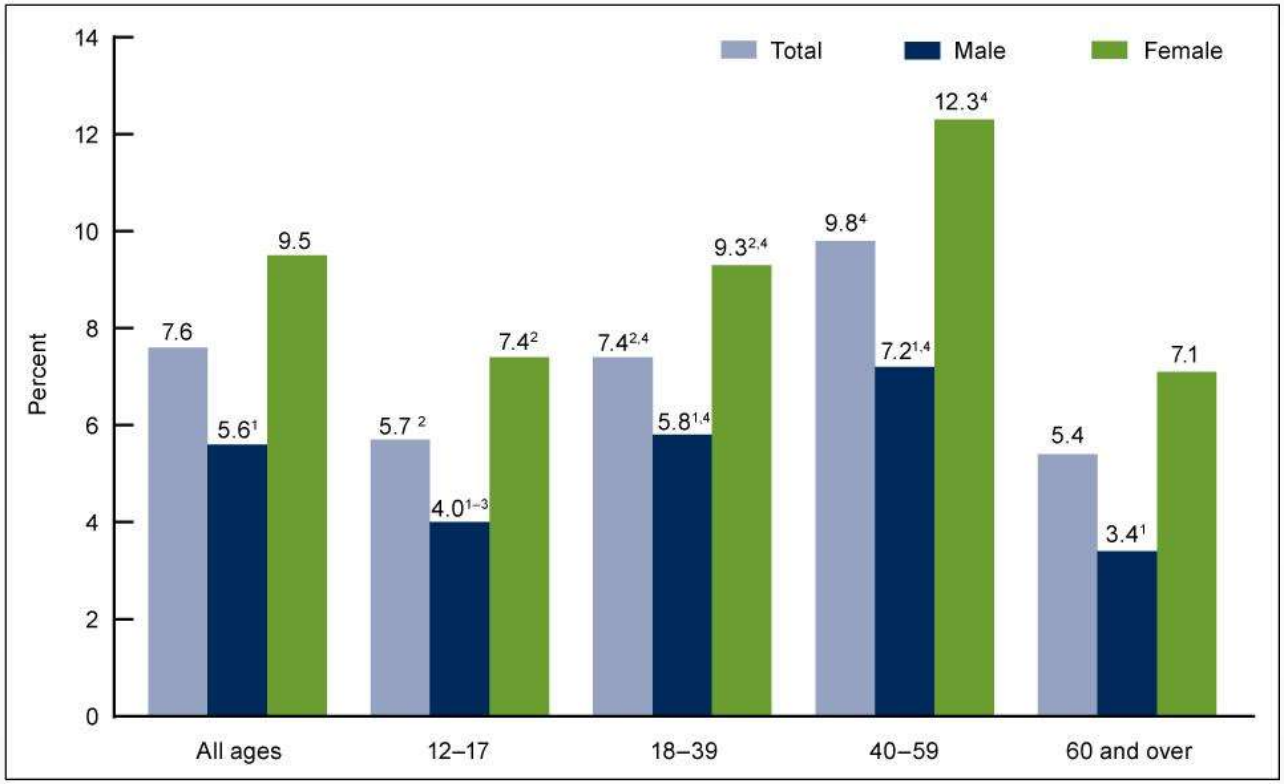
- **Depression is a pervasive problem** in our society that has been identified as a leading cause of disability worldwide. Recent studies indicate that about 8% of those over age 12 [*double in poor*] have experienced depression at least once during the previous year.
- **We're beginning to screen** with instruments like the PHQ-2 and PHQ-9, but what do we do then in primary care, especially in faith-based primary care?
- This workshop will present for interactive discussion **a dynamic and faithful way to understand, evaluate, communicate about, and treat depression** in the office setting.

Objectives

1. **Recognize the problem** that primary care providers have in finding time or energy to identify and treat depressed patients in busy office settings.
2. **Present a way of understanding depression** that makes identification and treatment straightforward, efficient, faithful, and mutually enjoyable to both provider and patient.
3. **Outline opportunities for action and growth** in identifying and assisting depressed patients in the primary care setting.

Prevalence

Figure 1. Percentage of persons aged 12 and over with depression, by age and sex: United States, 2009–2012



[1]Males have significantly lower rates than females overall and in every age group.
[2]Significantly different from 40–59. [3]Significantly different from 18–39. [4]Significantly different from 60 and over.
NOTES: Depression is defined as having moderate to severe depressive symptoms. Access data table for Figure 1 at: http://www.cdc.gov/nchs/data/databriefs/db172_table.pdf#1.
SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey, 2009–2012.

Recognizing Depression

It's Obvious

- Visible symptoms
- Identified by patient as presenting problem
- Becomes clear as patient describes their condition

~~It's hidden~~

- Not immediately visible
- Screen positive but not identified by patient
- Masquerades as pain or other physical symptoms

Screening Tools

Validated tools that can be incorporated in EMR

Developed and tested extensively

- PHQ-2 consists of the first 2 questions in the PHQ-9 and can be administered easily as a screening tool by a nurse or medical assistant along with Vital Signs as patient is being roomed.
- PHQ-9 is the full questionnaire, administered if PHQ-2 is positive or as a follow up tool for monitoring course of depression and response to treatment.
- We use both instruments in our clinics.

❖ Consider ACE Score questionnaire if PHQ-9 is positive.

PHQ-9 Questions

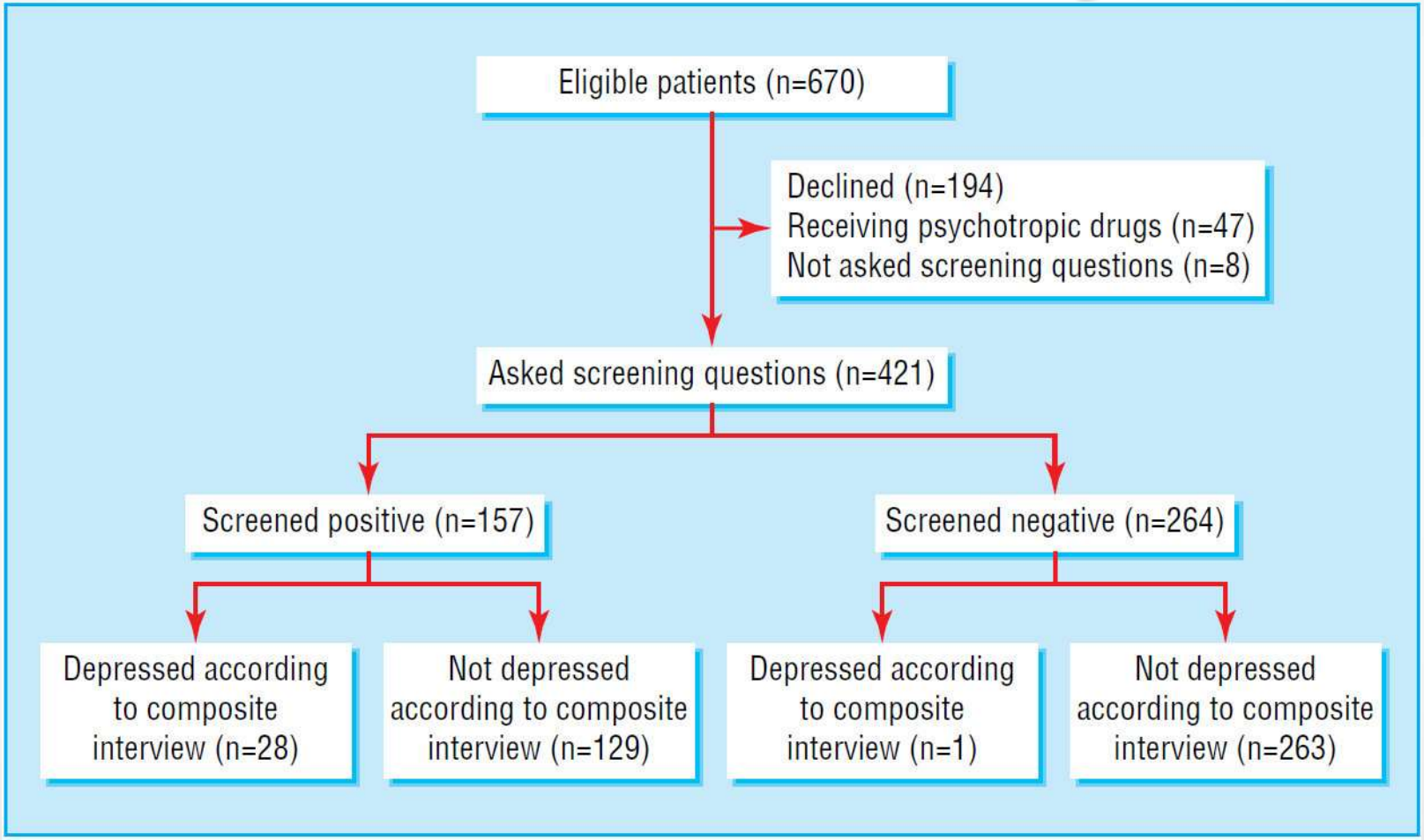
Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless

} PHQ-2

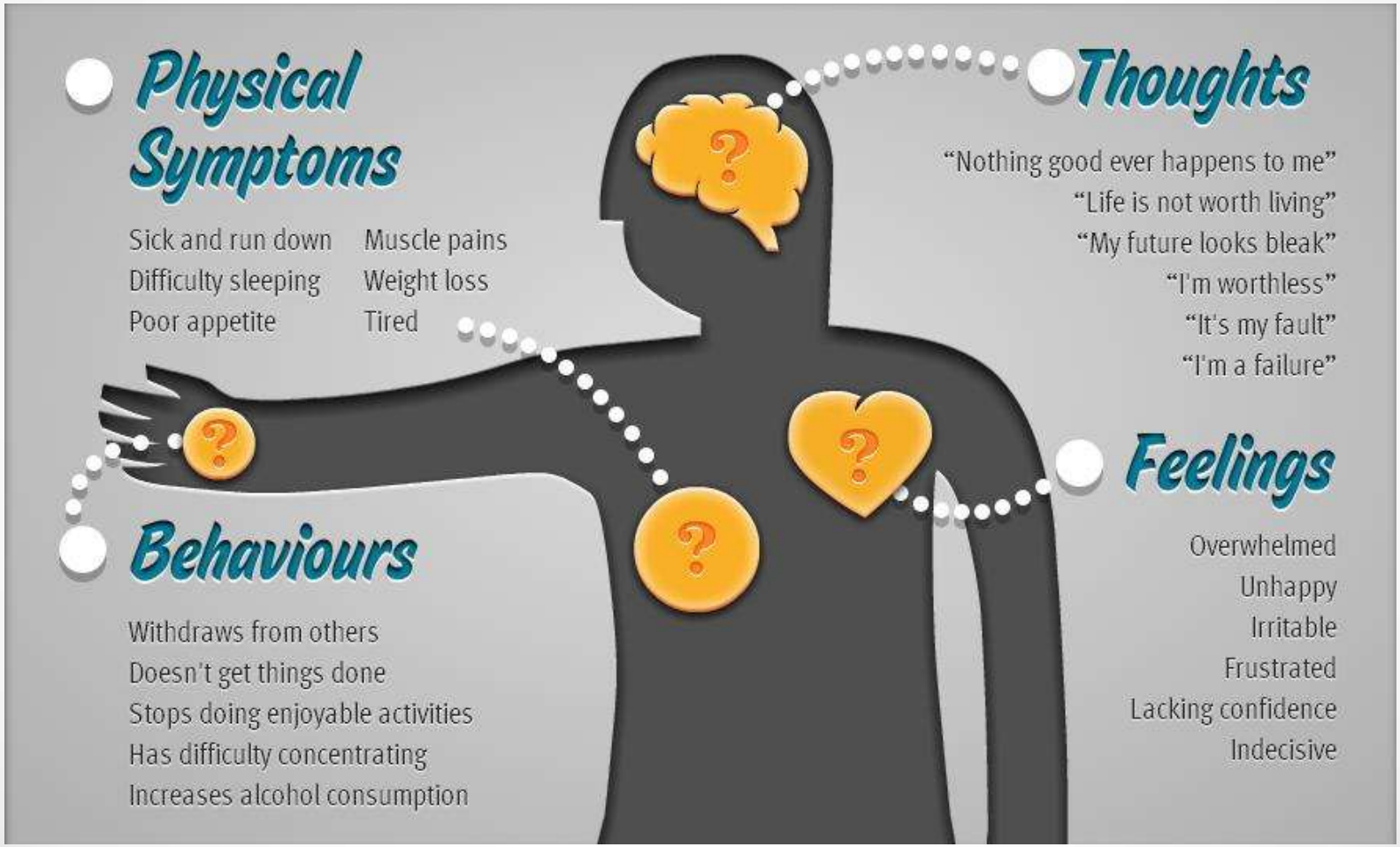
3. Trouble falling/staying asleep, sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television.
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.
9. Thoughts that you would be better off dead or of hurting yourself in some way.

PHQ-2 Efficacy

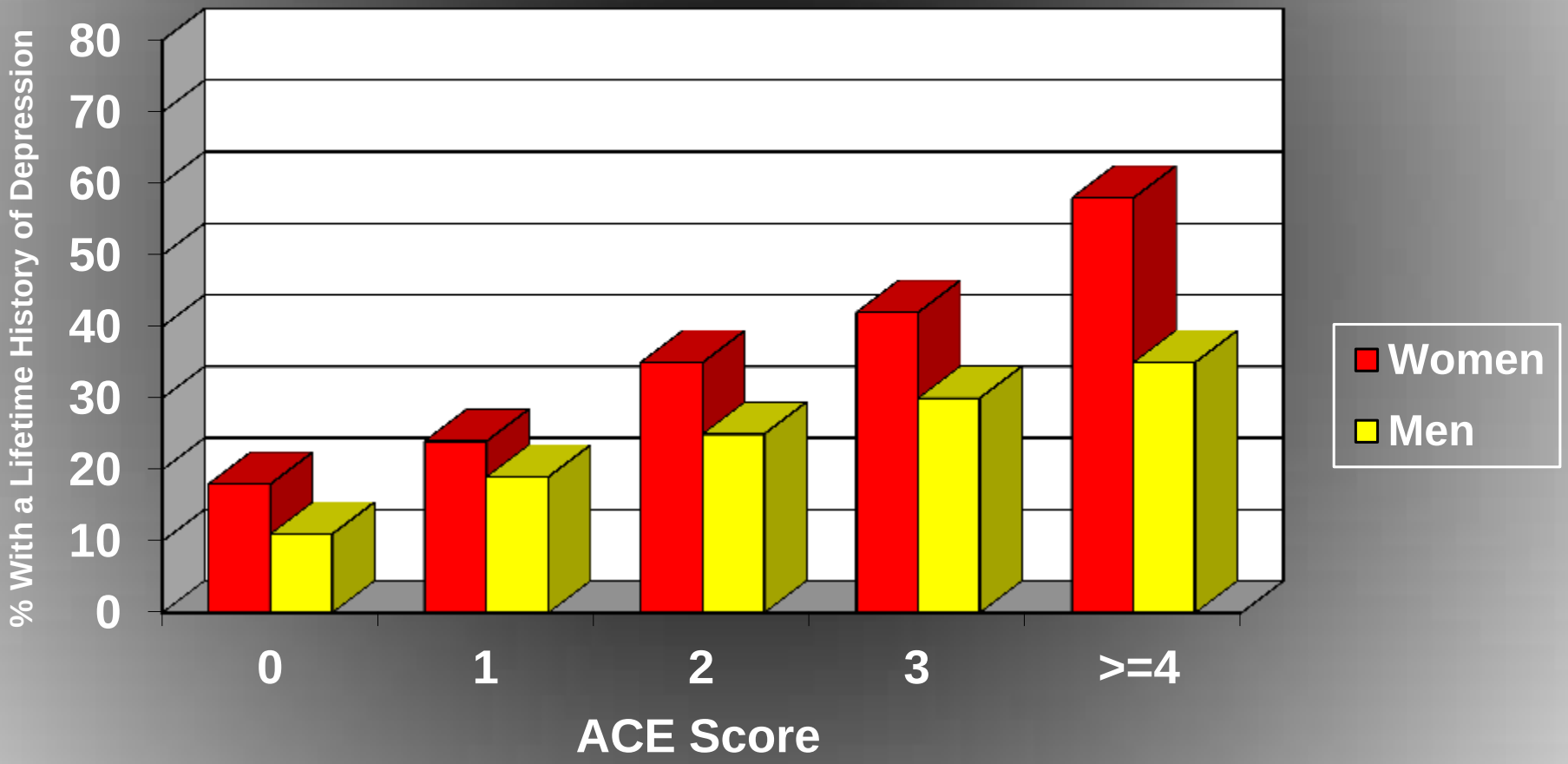


Arroll, et al – BMJ 2003;327:1144-6

Clinical Clues



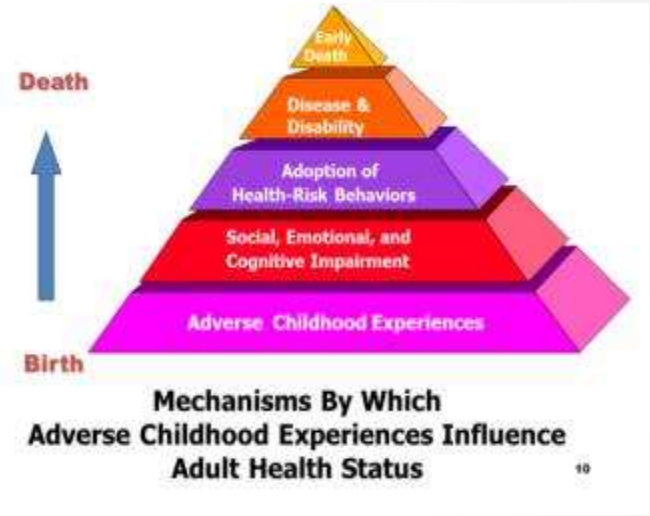
Childhood Experiences Underlie Chronic Depression



From Felitti and Anda – AJPM 1998;14:245-258

The Role of ACEs

- A large body of research documents that **ACEs**, including the presence of negatives (abuse) and absence of positives (neglect), are behind much of the chronic human dis-ease we see in the office.
- The more adverse the balance is, the worse well being gets.



- Damage and the resulting impairment of maturation flow into adulthood and continue their negative influence.
- The **Gospel** restores what was lost by calling people to be "born again" and start over as children who have been adopted and are being raised again by a divine Father within a redeemed family.

Why in Primary Care?

Primary care is ideal place to identify and treat depression

- **Doctor-patient relationship has continuity** and is broad-based with no psychiatric stigma
- **Condition can be understood and handled in context** of patient's family, life, and other conditions
- **If referral is needed,** primary care can tailor choice to patient and **then co-manage**
- **Often depression has an impact on other clinical problems** or members of the family and addressing it can build relationship, improve compliance, and help other areas

OK, how to identify?

- **Ask open-ended "fishers of men" questions** at onset of encounter with brief personal interaction
  - *"Hi, I'm Dr. X… how have you been?"*
  - *"How's life been treating you lately?"*
- **Institute and note results of PHQ-2 screen**
- **Pursue sensitively with more defining inquiries** while evaluating presenting complaint or issues (injury, illness, chronic condition follow up, etc.)
- **Return to positive depression results** by addressing issue directly (*"What happened to you?"*) and offering empathetic support and follow up

Categorizing findings

Major

- Significant impairment
- Often chronic or recurrent
- Influenced by events with underlying vulnerabilities (look for **ACEs**)
- "Endogenous"
- Distinguish bipolar or schizoaffective

Minor

- Troublesome
- Usually subacute and situational
- Some emotional roots but primarily learned ways of coping (look for **ACEs**)
- "Exogenous"
- Look for compounding factors

❖ Apply an accurate ICD-10 diagnosis code

Treatment options

Major

- Gain appreciation of duration and degree of impairment
- Investigate underlying issues, **ACEs**, and **faith dynamics**
- Under current care?
- What has worked well in the past?
- Medications helpful – SSRIs, TCAs, SNRIs, atypicals

Minor

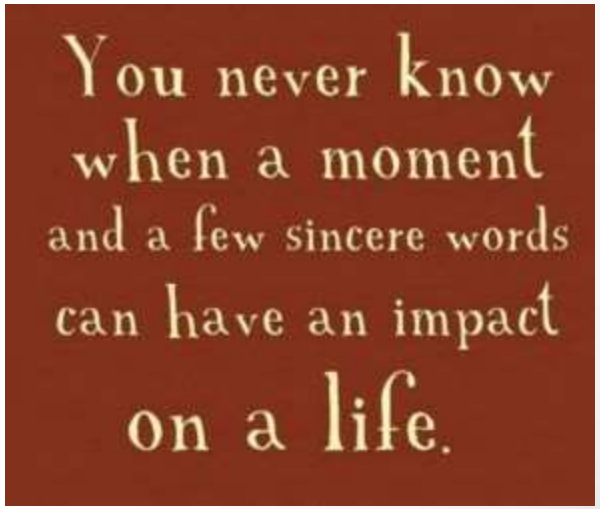
- Investigate situation and look for constructive approaches
- What is person's current support system like?
- Reframing, applying faith
- Empathetic listening and support
- Medications may be helpful, especially SSRIs

✕ Avoid benzodiazepines whenever possible

Treatment Analogy

Brief Counseling

- **Solution oriented approach** very effective in faith-based primary care context with good provider-patient relationship
- **Investigate** ways that patient/others may be contributing to their circumstances (sin) and identify approaches to change
- **Emphasize** that in Christ the issue is no longer blame (who should bear guilt and shame) but responsibility (who is able to respond with forgiveness and healing)
- **Develop** a mutual plan of action that includes provider interventions (support, testing, medication, referral) and things patient can do to help
- **Arrange** timely follow up
- **PRAY with patient**, including specifics



Depression - Antidote

Bad News

- Life is hard, especially if childhood was hard
- People develop sinful (dysfunctional) ways of coping, like addiction
- Only a progressive awareness of and open commitment to God can set people free (Steps 1-3…)
- Life can be lonely
- It's pretty dark out there

Good News

- God loves and forgives all the children He created
- Forgiveness can overcome dysfunctional patterns, addictions, pain/anger, etc.
- Being adopted and raised again by God as a healthy father is a wonderful and growing experience
- We can help
- Fields are ready for harvest

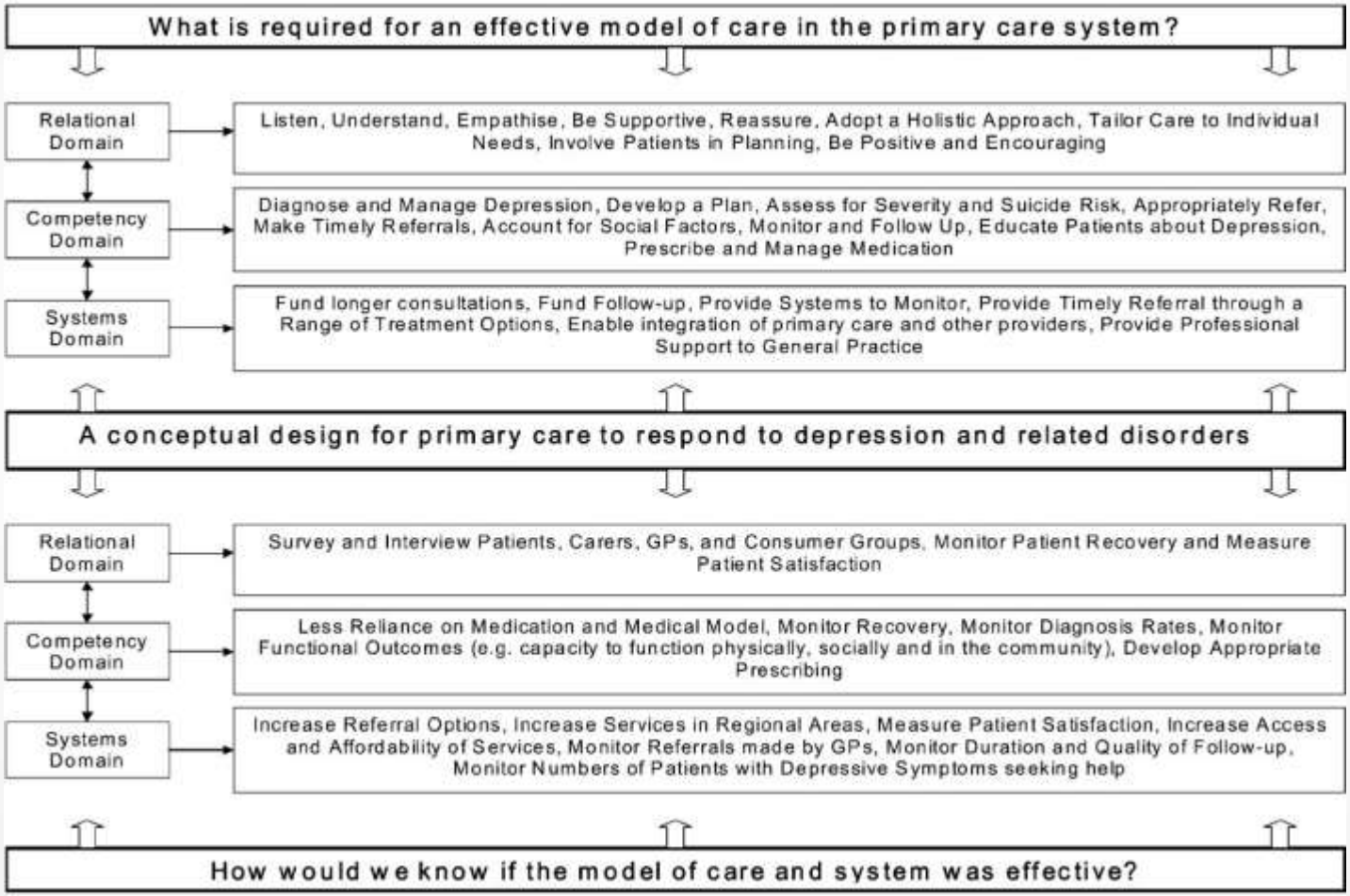
4-Rs of Treatment

Memnonic	Meaning
Remission	All symptoms have cleared
Recovery	Apparently returned to and staying normal
Restoration	Underlying vulnerable areas reconciled
Relapse	Symptoms return under renewed stress

Follow up

- **Take sensitive interval history**, investigating development of circumstances, relationships, issues
- **Evaluate degree of progress** toward "normalcy"
  - *"How are you doing and how far have you come?"*
  - *"On a scale of 0-100%, where were you and where are you now?"*
- **Define and discuss the 4-Rs** of depression and identify together how patient is improving
- **Adjust medication** as indicated
- **Begin to marshal resources** to help during recovery and restoration phases
- **Emphasize need to continue medication**

Manage and Evaluate



Palmer, et al – Family Practice 2010; 27:447-458

Now What?

Purpose to make some changes like these when you get back to your practice:

- **Incorporate** PHQ-2/PHQ-9 screening into your rooming routine and EMR
- **Sensitize your group** to depression and ACEs by doing a study together
- **Start looking** more proactively for signs and symptoms
- **Strengthen** your referral and support network
- **Find practical ways** to share the Gospel
- **Don't forget** to incorporate the Word and prayer regularly in your encounters

Selected References

- *Depression in the U.S. Household Population, 2009–2012* – Pratt and Brody – NCHS Data Brief No. 172 – 12/14
- *Screening for depression in primary care with two verbally asked questions: cross sectional study* – Bruce Arroll, Natalie Khin, Ngaire Kerse – BMJ 2003;327:1144-6 – 11/15/03
- *Statistical Question – Evaluating the performance of a screening test for depression in primary care* – BMJ 2015;350:h1801 – 4/9/15
- *Diverse voices, simple desires: a conceptual design for primary care to respond to depression and related disorders* – Victoria Palmer, et al – Family Practice 2010; 27:447-458 – 4/8/10
- *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults - The Adverse Childhood Experiences (ACE) Study* – Felitti and Anda – AJPM 1998;14:245-258 (see further https://acestoohigh.com)

Handouts

- PHQ-9 (includes PHQ-2) Questions
- ACE Study Questionnaire
- Some Sobering Statistics (with references)
- Energy Balance and Resistance in Whole Person Care
- Depression, Gospel, and the 4 Rs

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Questions?