



MENTAL HEALTH IN PRIMARY CARE: Update on Depression

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

A 52-year-old man, small business owner with a history of hypertension and AODM 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 but denies feeling sad. Physical examination is normal.



Depression in the U.S.

- ▶ In any 2-week period, 5.4% of Americans 12 years of age and older experienced depression.
- ▶ Only 29% of depressed persons report contacting a mental health professional in the past year
- ▶ 80% report some functional impairment, 27% report serious difficulties in work and home.

Absenteeism and “Presenteeism”

- ▶ Mental/behavioral disorders account for more incapacity benefit claims than musculoskeletal disorders
- ▶ “Presenteeism”: although present at work, performance may be substantially reduced



Schoenbaum M, et al. *JAMA*. 2001;286(11):1325-1330.
Rost K, et al. *Med Care*. 2004;42(12):1202-1210.

Disparities and Depression



- ▶ Depression is more common in women than in men.
- ▶ More than one out of seven poor Americans have depression.
- ▶ Non-Hispanic black persons have higher rates of depression than non-Hispanic white persons.

Data from NHANES, NCHS Brief No 7 Sept 2008

Relational Barriers to Care Seeking

- ▶ Focus group participants discussed problems of competence, openness and trust :

I don't think it's very good, to be honest with you, I really don't. People are not--well--that's not part of the scene or the plan when you have emotional or mental problems that you seek out help [from a doctor].

Kravitz et al 2010

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I feel that doctors are in the upper stratosphere of society, and you as the patient, you're in the lower stratosphere. And maybe you'll get a good doctor, maybe you won't. But either way, he's going to go home to his mansion and have a nice dinner.

Kravitz et al 2010

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

A 52-year-old man, small business owner . . . feels “frazzled” by his work and does not do anything for fun anymore . . .

You suspect depression and/or anxiety disorder. How would you screen him?

Should we screen for depression in adults?

- ▶ Prevalence 5% - 15% in primary care
- ▶ Systematic review of 9 trials concluded that routine screening not effective
- ▶ No evidence of harms from screening
- ▶ “The USPSTF recommends screening adults for depression *when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.*”

O'Connor *Annals* 2009

PHQ-9 (Patient Health Questionnaire)

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

Available at: <http://www.depression-primarycare.org>.

Kroenke K, et al. *J Gen Intern Med*. 2001;16(9):606-613.
Lowe B, et al. *Med Care*. 2004;42(12):1194-1201.

Diagnose depression and 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 diagnosis and monitoring in depression?

Mr. P. PHQ-9 Depression Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at All 0	Several Days 1	More Than Half the Days 2	Nearly Every Day 3
1. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself, or that you are a failure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Moving or speaking too slowly	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subtotals:		1	10	6
Total=17				

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
- ▶ Response = 50% ↓ or score < 10
- ▶ Remission = score < 5

Rule out Bipolar Disorder

- ▶ Screen for mania in all patients with depression
- ▶ Why? -- antidepressants may worsen the course of bipolar disorder
 - ▷ *Not effective in bipolar depression*
 - ▷ *May trigger mania/hypomania*
- ▶ MDQ - Self-administered, one-page questionnaire

<http://www.dbsalliance.org/pdfs/MDQ.pdf>

Sachs, GS et al. NEJM 2007; Hirschfeld RM et al. Am J Psychiatry 2003;

Suicide

- ▶ 1 million deaths/yr (10th leading cause worldwide)¹
- ▶ Primary care physicians assess for suicide in patients with depression in only about 1/3 of visits²
- ▶ Assess suicide risk
 - ▷ Ideation, intent, plan, availability, lethality
 - ▷ SAL (Specific, Available, Lethal)³
 - ▷ Consider "no suicide contract"

¹Hawton K. Suicide. *Lancet*. 2009

²Feldman MD. *Annals Fam Med*. 2007

³ · Cole et al in *Behavioral Medicine: A Guide for Clinical Practice*. 2008

Back to the case . . .

- ▶ 52-year-old small business owner with a history of HTN and AODM with anxiety and depression and 2-3 months of occasionally debilitating back pain
- ▶ He does not have mania
- ▶ PHQ-9 = 17
- ▶ How should he be treated?

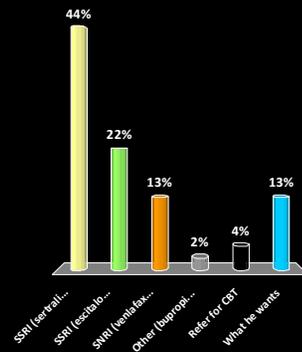
Depression Treatment Planning with PHQ-9

PHQ-9 Severity	Provisional Diagnosis	Treatment Recommendations
5 - 10	Mild/minimal depressive symptoms	Reassurance and/or supportive counseling
10 - 14	Moderate	<ul style="list-style-type: none"> ▶ 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.

What treatment would you suggest?

- A. SSRI (sertraline)
- B. SSRI (escitalopram)
- C. SNRI (venlafaxine or duloxetine)
- D. Other (bupropion or mirtazapine)
- E. Refer for CBT
- F. What he wants



Comparative efficacy and acceptability of 12 new-generation antidepressants*

- ▶ Meta-analysis of 117 RCTs
- ▶ Main outcomes: proportion of pts who responded to or dropped out of treatment.
- ▶ Mirtazapine, escitalopram, venlafaxine and sertraline had superior efficacy--
- ▶ Overall - sertraline most favorable balance of benefits, acceptability and cost.

*Cipriani 2009 *Lancet* and *Cochrane* 2010

Relative activation vs. sedation modern antidepressants

Activating	psychostimulants Bupropion Fluoxetine, Sertraline
Neutral or mixed	Venlafaxine, Escitalopram Citalopram
Mildly to Moderately Sedating	Paroxetine, Fluvoxamine Nefazodone Tricyclics
Strongly sedating	Trazadone Mirtazapine**

**higher dosage may be less sedating

Potential Adverse Effects of SSRIs

- ▶ **Suicide** -- Systematic review¹ and FDA re-analysis of clinical trial data² found:
 - ▷ SSRIs increased risk of attempted/completed suicide in adolescents
 - ▷ Reduced risk or no change in ages 25-64 and over 64
- ▶ **Sexual Dysfunction**
 - ▷ Common (4% - 80%)³
 - ▷ citalopram, paroxetine, fluoxetine, sertraline, and venlafaxine have highest rates (71% - 80%)
 - ▷ mirtazapine (24%) and escitalopram (37%) lower

¹Barbui 2009 ²Stone 2009 ³Serreti and Chiesa 2009

Potential Adverse Effects of SSRIs

- ▶ Increased risk of fractures¹
- ▶ GI bleeding²
- ▶ Hyponatremia -- particularly in older adults
- ▶ AODM (?)³
- ▶ Increased mortality from breast CA (paroxetine)⁴

¹Richards (2007) *Arch Int Med*

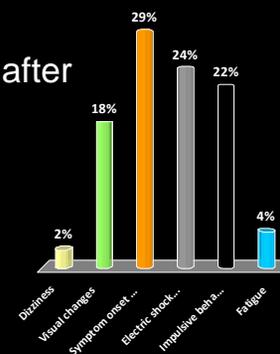
²Dalton (2003) *Arch Int Med*

³Lin (2009) *AFM*

⁴Kelly (2010) *BMJ*

Which of the following is not true of SSRI Discontinuation Effects

- A. Dizziness
- B. Visual changes
- C. Symptom onset 1-3 days after interruption of medication
- D. Electric shock sensations
- E. Impulsive behavior
- F. Fatigue



Discontinuation Syndrome

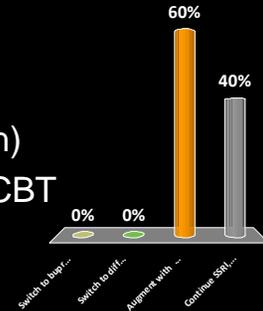


- ▶ Missed doses are common
- ▶ Other common symptoms include headache, irritability, insomnia, anxiety, fatigue
- ▶ Generally short-lived
- ▶ Taper dose over 4 weeks

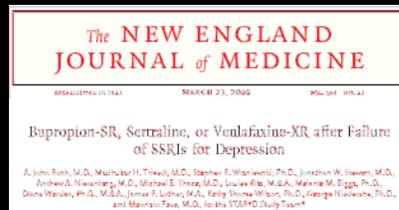
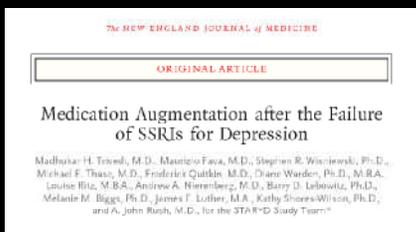
Our pt was started on sertraline 50 mg and is now taking 150 mg/day. He returns 3 months later and is somewhat better but not in remission (PHQ-9 = 11).

What should you do now?

- A. Switch to bupropion
- B. Switch to different SSRI
- C. Augment with another medication (eg bupropion)
- D. Continue SSRI, refer for CBT



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



STAR-D* Treatment Levels

- ▶ **Level 1:** Only 30% achieved remission on citalopram (40 mg/day)
- ▶ **Level 2 Switch or Augmentation:** 25% - 30% add'l remission:
 - ▷ **Switch to:** bupropion SR; sertraline or venlafaxine-XR
 - ▷ **Add:** bupropion SR (267 mg/day) or bupropion (40 mg/day)
- ▶ Switching or augmenting with **cognitive therapy** was equally effective

STAR-D* Take Home Points

- ▶ Measurement based care is essential
- ▶ Inadequate response in 4-6 weeks and side effects tolerable, **increase the dose**
- ▶ No remission by 8-12 weeks: 1) **augment** with bupropion or 2) **switch** to another agent
- ▶ Overall, 67% of patients achieve remission, but likelihood of further improvement after 2 medication trials is low
- ▶ Remission associated with better long-term prognosis

Treatment Resistant Depression (TRD)



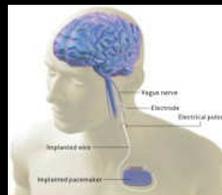
- ▶ 1/3 or more of pts with major depression will not respond to 2 **adequate*** trials of antidepressants (TRD)
- ▶ Rule out:
 - ✓ Non-adherence
 - ✓ Substance use (alcohol)
 - ✓ Psychiatric co-morbidity
 - ✓ Medical co-morbidity

Little A. *AFP*. 2009.
Regier D. *Arch Gen Psych*. 1993.

*Adequate = dose, duration and compliance

Treatment Options for TRD

- ▶ Maximize standard treatment
- ▶ Adjunctive pharmacotherapy
 - ▷ Atypical antipsychotics, Li, T3
- ▶ Electroconvulsive therapy
- ▶ Vagal Nerve Stimulation (VNS)
- ▶ Mindfulness Based Cognitive Therapy
- ▶ Repetitive transcranial magnetic stimulation (rTMS)
- ▶ Deep Brain Stimulation



NeuroStar TMS Therapy System

- ▶ FDA approval in 2008 (510k)
- ▶ Focused, pulsed magnetic fields administered in high or low frequency. Higher frequency activates stimulated brain regions while low frequency has an inhibitory effect.
- ▶ 40-minute outpatient procedure, no anesthesia or sedation
- ▶ Treatment administered daily for four to six weeks (20-30 treatments).



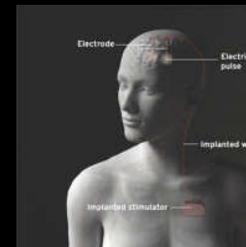
rTMS: Summary of Evidence

- ▶ rTMS has some real effect in decreasing symptoms of major depression during the active treatment phase.
- ▶ However, the evidence is still evolving:
 - ✓ Lack of consensus on how to perform rTMS
 - ✓ Lack of evidence supporting continued efficacy after cessation of therapy
 - ✓ Many ongoing clinical trials
- ▶ Bottom line--not ready for prime time



Deep Brain Stimulation

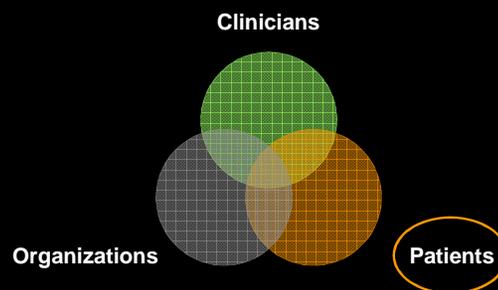
Broadman Area 25 in the subcallosal cingulate gyrus (SCG) - target for deep brain stimulation in treatment resistant depression.



Decreased activity seen with antidepressants and ECT

Depression now viewed as a systems-level disorder affecting integrated *pathways* linking select cortical, subcortical, and limbic brain regions with their related neurotransmitter systems.

Patient Activation and Depression Care



Patients as Agents for Quality: Rationale

- ▶ Patients are motivated to improve their own outcomes
- ▶ Patients have substantial influence on physician practice
- ▶ Patients are at the “sharp end” of clinical care
 - ▷ there are few if any intervening steps between the decision and the enactment

Direct to Consumer Advertising of Antidepressants

Understanding Depression



Influence of Patients' Requests for Direct-to-Consumer Advertised Antidepressants

- ▶ What are the effects of patient's DTC-related requests on physician's initial treatment decisions in patients with depressive symptoms?

Patient Requests Improve Quality of Depression Care

- ▶ Standardized patients' requests increased:
 - ✓ Appropriate antidepressant prescribing¹
 - ✓ More complete depression history taking²
 - ✓ More guideline based care¹
 - ✓ Improved recognition of depression²
 - ✓ Increased screening for suicide³

¹Kravitz RL, Epstein R, Feldman MD. *JAMA* 2005

²Feldman MD et al. *Medical Care*. 2006

³Feldman MD et al. *Annals Fam Med*. 2007

Give patients the treatment they want?

- ▶ RCT found significant interaction between treatment preference and outcomes¹
 - ▷ Pts had higher remission rates when given their preferred treatment
- ▶ Most pts preferred combo tx
- ▶ Primary care pts (UCSF) prefer psychotherapy²

¹Kocsis JH. *Jnl Clin Psych* 2009

²Mohr DC. *Ann Beh Med* 2007

Provider 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



Values and Choices

“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 MD and Christensen J.
Behavioral Medicine: A Guide for Clinical Practice.
McGraw-Hill, 2008.

Thank You!

“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