PEARLS FOR PRIMARY CARE- CLIENTS WITH CHRONIC OR RECURRENT MENTAL HEALTH DISORDERS

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OBJECTIVES

1. Examine the epidemiology and pathophysiology of chronic depression and anxiety.
2. Differentiate episodic, recurrent and chronic depressive or anxiety disorders.
3. Develop skills to accurately assess and identify depression and anxiety that requires a chronic care approach.
4. Evaluate current evidence based multi-modal treatment strategies for treating to remission and achieving optimal functional levels.

PREVALENCE

- Depression occurs in app. 8-10% of adults at this time, with more than half experiencing symptoms for >12 months.
- Anxiety 18% of adults experience an anxiety disorder as adult with 1/4 classified as severe.

WHY TREAT IN PRIMARY CARE?

- Nationally there is a shortage of psychiatrists. Current estimates suggest that it would require at least 3,000 additional to minimally address the shortage.

- FNPs, ANPs will see and treat many of those with depressive and anxiety disorders

MAJOR DEPRESSIVE DISORDER

- 1st episode
- Recurrent
- Chronic
- Severe with Psychosis

CHRONIC MDD IN PRIMARY CARE

- One or more major depressive episodes
- Absence of any history of manic, mixed, or hypomanic episodes
- Relapsing and remitting

SCREENING TOOLS

- PHQ-9
- Beck's Depression Inventory
- Good Resource- http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression

PHQ-9

Patient Health Questionnaire (PHQ-9)

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

Little interest or pleasure in doing things?

Feeling down, depressed, or hopeless?

Trouble falling or staying asleep, or sleeping too much?

Feeling tired or having little energy?

Poor appetite or overeating?

Feeling bad about yourself - or that you are a failure or have let yourself or your family down?

Trouble concentrating on things, such as reading the newspaper or watching television?

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?

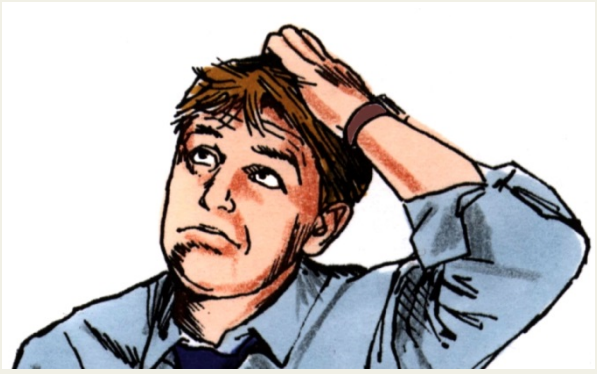
Thoughts that you would be better off dead, or of hurting yourself in some way?

Total = /27

Depression Severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe

SUICIDALITY

- People often feel uncomfortable talking about death. However, asking the adult, child, or adolescent whether he or she is depressed or thinking about suicide can be helpful.
- Rather than putting thoughts in the person's head, such a question will provide assurance that somebody cares and will give the person the chance to talk about problems
- Risk Management



COMORBIDITY AND DEPRESSION

- Screen patients with any chronic health condition for depression, especially patients with diabetes, cardiovascular disease, or chronic pain.
- CVD-Patients with cardiovascular disease (CVD) more likely to experience depression
- Obesity BMI ≥30 in women associated with nearly 50% increase in lifetime prevalence of depressive disorders
- Diabetes-Depression twice as prevalent in those with diabetes

ANXIETY DISORDERS

- Generalized Anxiety Disorder
- Panic Disorder
- OCD and PTSD no longer classified as Anxiety

GAD SYMPTOMS

- Excessive anxiety and worry that is difficult to control
- And at least 3 of 6 symptoms
  - Restlessness
  - Irritability
  - Difficulty concentrating
  - Muscle tension
  - Sleep disturbance
  - Being easily fatigued

Duration of the disorder for at least 6 months.

Symptoms must be distressing or impairing and not adequately explained by another related disorder

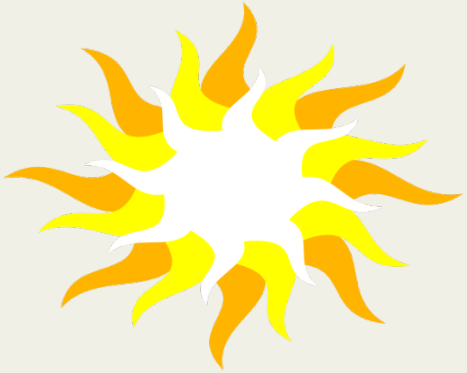
ANXIETY AND CHRONICITY

- Studies demonstrate that less than ½ of patients with GAD recover fully within 2 years. 1/3 will achieve only partial remission and a full ¼ no recovery.

- Anxiety disorders are strongly correlated with impairments in social and occupational function, reported lower quality of life and increased disability.

TREATMENT GOALS

- Remission
- Resumption
- Renew
- Recover
- Release

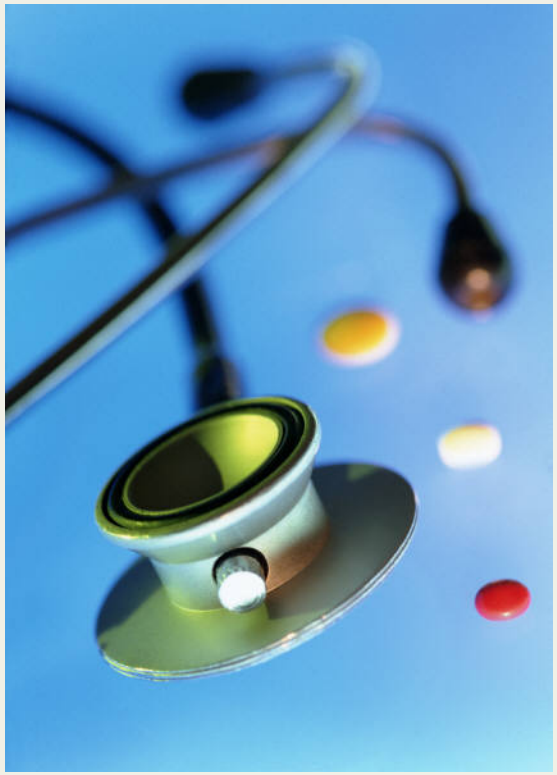


MDD TREATMENT

- Select an agent – SSRI, unless patient history indicates previous problems or ineffective.
- Pearl: Be familiar with one or two agents from the classes and use these.
- Step issues-generic first, many times 2-3 failures required prior to approval of newer agents.
- Recurrent- Review previous treatment and use as initial treatment.

CHRONIC MDD

- May need to use more than one agent
  - SSRI and Buproprion, SSRI and Mirtazapine
- May need to evaluate for addition of
  - Lithium or other mood stabilizer
  - Thyroid replacement hormone
  - Atypical agent (use caution) **



CASE STUDY

- Discussion

FOLLOW UP

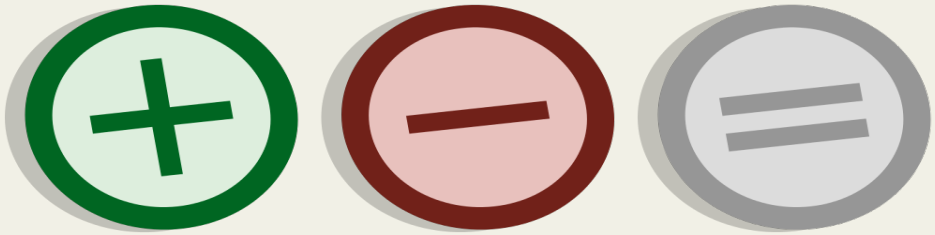
- Ensure that the treatment has been administered for a sufficient duration and at a sufficient frequency or dose.
- Generally, 4–8 weeks are needed before it can be concluded that patient is partially responsive or unresponsive to a specfic intervention.
- No treatment should continue unmodified if there has been no symptomatic improvement after 1 month.

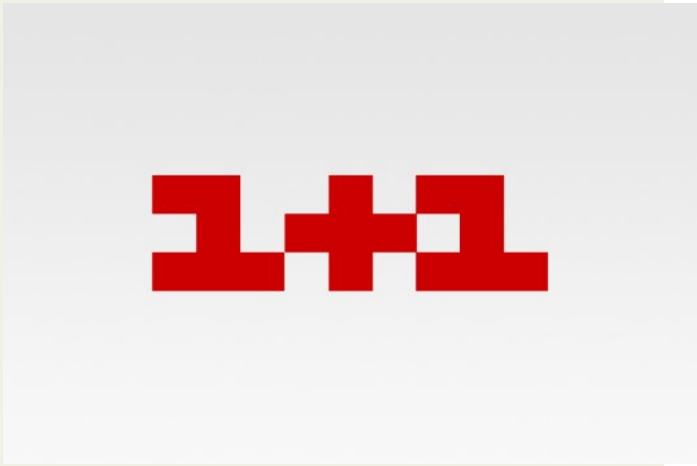
- Follow up with patients on antidepressants for MDD:
  - At least once within the first month
  - At least once more 4 to 8 weeks after the first contact

- Assess for adherence, side effects, suicidal ideation, and response.

ANXIETY DISORDER TREATMENT

- Generalized anxiety disorder is common and remains chronic if not treated.
- Effective treatments include serotonergic antidepressants, benzodiazepines, other drugs, and certain forms of psychotherapy.
- If monotherapy fails to bring about remission, other approaches can be tried, eg, augmentation with a drug from another class, switch to drug with a different mechanism, or addition of psychotherapy.





THERAPY AS A ADJUNCT

- Patients are often reluctant to engage in therapy.
- More than half of patients treated for depression in primary care practices stopped drug treatment within 3 weeks.

Why??

- Weren't told how long it would take to feel better
- Weren't warned about side effects
- Weren't told I needed to continue once I felt better[2]

REASSESSMENT

- A typical follow-up visit for depression includes reassessment of the diagnosis, identification of any risk for self-harm or harm to others, measuring changes in symptom severity based on PHQ scores, and making appropriate treatment changes if no improvement is noted

MANAGING PATIENTS

- Individualize visit frequency for each patient
- Patient's starting or switching to a new RX should be seen every two weeks until stable
- Patient's at increased risk for suicidality or self-injury seen more frequently
- Contact all patients in early phase of treatment to assess for suicidality or self-injury
- Assess response with validated tool

ADHERENCE

- To improve adherence:
  - Understand the patient's model of the illness
  - Identify social and financial barriers to adherence
  - Address patient concerns about the medication
  - Discuss patient understanding about treatment and ability to follow through (i.e. health literacy)

TREATMENT GOALS

- Patients with one lifetime episode of MDD who achieve remission on antidepressants should continue to take them for another 6 to 12 months.
- Patients with two or more episodes should be maintained an additional 15 months to 3 years.
- Patients with chronic MDD or MDD with concurrent dysthymia should be continued on antidepressants an additional 15 to 28 months after the acute phase treatment.

INITIAL TREATMENT, NOT FULLY EFFECTIVE

- Medication trial should last 8-12 weeks
- If no side effects or tolerability issues, increase dosage every 2-3 weeks until
  - Remission achieved
  - Max dose achieved
  - Side effects limit titration
- Combine antidepressants and psychotherapy
- Combine antidepressants or consider augmentation trial
- Considering tailoring your treatment for specific sub-populations (e.g., elderly, midlife women etc).

- American Psychiatric Association Clinical Practice Guidelines
- International Psychopharmacology Algorithm Project (IPAP)
- Canadian Clinical Practice Guidelines for the Management of Anxiety Disorders
- British Association for Psychopharmacology (BAP)
- International Consensus Group on Depression and Anxiety
- National Institute for Clinical Excellence (NICE) in the UK

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