



MANAGING DEPRESSION AS A TEAM EFFORT

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Objectives

- Understand the importance of having a team approach to Major Depressive Disorder (MDD)
- Learn how to administer the PHQ-9 checklist
- Review research on collaborative care for MDD
- Address challenges in clinical practice when treating MDD.
- Learn how to implement a collaborative care approach
- Know what factors would warrant patient referral to specialist care in MDD

Various Names Used to Describe Collaborative Care Team

- Collaborative Care Team/ Approach
- Collaborative Care Management
- Collaborative Care or CC
- Team Effort / Team Approach (in this PPT)

What is Major Depressive Disorder?

- 296.xx (F32.x and F33.x) – DSM-V
- **Five (or more)** of the following symptoms have been present during the **same 2-week** period and represent a change from previous functioning; at least one of the symptoms is either **(1) depressed mood** or **(2) loss of interest or pleasure**.
 1. **Depressed mood** (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (*Note: In children and adolescents, can be irritable mood.*)
 2. **Markedly diminished interest or pleasure** in all, or almost all, activities most of the day, nearly every day
 3. Significant weight loss when not dieting or weight gain
 4. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

Major Depressive Disorder (cont.)

5. Fatigue or loss of energy nearly every day
 6. Feelings of worthlessness or excessive or inappropriate guilt
 7. Diminished ability to think or concentrate, or indecisiveness, nearly every day
 8. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 - The episode is not attributable to the physiological effects of a substance or to another medical condition.
 - Note- exclude symptoms that are clearly attributable to another medical condition.

Prevalence of MDD

According to the 2016 National Survey on Drug Use and Health
Ages 18 and Older in the United States

- An estimated 16.2 million adults in the United States had at least one **major depressive** episode.
 - *6.7% of all U.S. adults.*
 - *The **prevalence of major depressive** episode was higher among adult females (8.5%) compared to males (4.8%).*
 - Major Depressive Episode is highest among individuals aged 18-25 (10.9%).

Prevalence of MDD

Adolescents

- An estimated 3.1 million adolescents aged 12 to 17 in the United States had at least one major depressive episode.
 - *12.8% of the U.S. population aged 12 to 17.*
- The prevalence of major depressive episode was higher among adolescent females (19.4%) compared to males (6.4%).

A Team Approach to MDD

- “Major depressive disorder (MDD) is frequently unrecognized and underdiagnosed by clinicians and thus remains untreated or inappropriately treated in routine clinical practice.” - Sato
- Though symptoms of MDD are recognized by clinicians, this disorder is more prevalent than had previously been thought.
 - *It is challenging to diagnose and treat because of comorbid conditions and somatic symptoms*

A Team Approach to MDD (cont.)

- MDD is associated with **increased morbidity and mortality** as well as with higher healthcare costs and more severe functional impairment.
- Optimal treatment for MDD should include:
 - *collaboration focused on comorbid physical diseases*
 - *rehabilitation aimed at restoring social functioning; and,*
 - *pharmacotherapy designed to ensure complete remission including psychological and physical symptoms, as well as functional recovery.”*

What is Collaborative Care?

- ‘Collaborative care’ is an innovative way of treating depression and anxiety.
- It involves several health professionals working with a patient to help them improve.
- The Collaborative care team consists of a medical doctor, a case manager trained in depression, and a mental health specialist (psychiatrist and/or therapist).

Why is it Important to Implement Collaborative Care?

- 75% of suicide victims visited their primary care versus 33% of suicide victims had contact with mental health services within a year of their suicide.
- 20% had contact with their mental health professional **within a month** before their suicide versus 45% had contact with their primary care.
- Studies have found that **75% of older adults** who completed suicide had visited their primary care physician within one month prior to their death.
- 1 in 10 suicides are by people seen in an ED within 2 months of dying.

Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am J Psychiatry*. 2002;159:909-916

Raue, P.J., Ghesquiere, A.R., Bruce, M. L.. Suicide Risk in Primary Care: Identification and Management in Older Adults. *Curr Psychiatry Rep*. 2014 Sep; 16(9): 466.

Why is it Important to Implement Collaborative Care? (cont.)

- Primary care is an ideal setting to initiate mental health care.
 - *It's ideal to identify suicide risk.*
- According to Vlasveld, et al., though there are evidence-based treatments available for MDD, they show disappointing results.
- Both a primary care treatment model along with collaborative care efforts were developed to improve depression outcomes in the U.S.

Key Elements of Collaborative Care Include:

1. collaboration between healthcare professionals (primary physician, nurses, social workers, therapists, etc.);
2. access to a consultant psychiatrist;
3. access to a care manager, who coordinates care, assists in the management of MDD and monitors treatment progress; and,
4. The continuous monitoring of symptoms
 - e.g. utilizing assessment tools such as the PHQ-9 in order to prevent relapse and manage progress.

Kaiser Permanente Los Angeles is Currently
Working Towards Collaborative Care
- Dr. Jack Der Sarkissian

LAMC Depression Care

< PHQ9 Questionnaire Score >

1 to 9

Educational Resources
&
Lifestyle Changes

10 to 19

Population Care
Brief depression treatment
& medication management

20+

Psychiatry
Traditional Behavioral
Health Interventions

If PHQ9 1–9:

- Provide Krames booklet, "A Guide to Managing Stress"
- Promote exercise, healthy eating, and healthy living

If PHQ9 10–19:

- Place referral to Population Care for further assessment and brief treatment (HC Referral: Population Care)

If Medication prescribed:

- Prescribe 100 day supply
- Book f/u TAV within 4 weeks of visit
- Promote 6 month adherence to medication regimen for optimal results

If PHQ9 20+:

- Place Routine referral to Psychiatry
- (HC Referral: Psychiatry)
- Promote keeping psychiatry appointments

KP National- Clinical Practice Guidelines for Adult Depression

- Depression screening (PHQ-9 and PHQ-2)
- First-Line Treatment (can include antidepressant medication or psychotherapy)
 - *Behavioral activation for patients with mild to moderate depression (weak recommendation)*
 - *Monitoring patients who are prescribed antidepressants for signs of new or worsening suicidal ideation is recommended (strong rec.)*

KP National- Clinical Practice Guidelines for Adult Depression (cont.)

- Consultation or collaboration with a psychiatrist before prescribing TCAs or venlafaxine for patients with suicidal ideation or who have made previous suicide attempts is an option. (Weak recommendation)
- Consultation with specialty behavioral health for patients with MDD who are expressing suicidal intent or plan is an option. (Strong recommendation)
- Atypical antipsychotics are not recommended as first-line treatment for (non-psychotic) MDD. (Strong recommendation)

PHQ-9- The Nine Symptom Checklist

You have handouts in your folders. Please take them out, and be prepared to answer the questions yourself. You won't need to share your responses with anyone.

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

a. Little interest or pleasure in doing things.

Not at all / Several days/ More than half the days/ Nearly every day

b. Feeling down, depressed, or hopeless

Not at all / Several days/ More than half the days/ Nearly every day

c. Trouble falling asleep, staying asleep, or sleeping too much

Not at all / Several days/ More than half the days/ Nearly every day

d. Feeling tired or having little energy

Not at all / Several days/ More than half the days/ Nearly every day

PHQ-9- The Nine Symptom Checklist (cont.)

e. Poor appetite or overeating.

Not at all / Several days/ More than half the days/ Nearly every day

f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down.

Not at all / Several days/ More than half the days/ Nearly every day

g. Trouble concentrating on things such as reading the newspaper or watching television.

Not at all / Several days/ More than half the days/ Nearly every day

h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual.

Not at all / Several days/ More than half the days/ Nearly every day

i. Thinking that you would be better off dead or that you want to hurt yourself in some way.

Not at all / Several days/ More than half the days/ Nearly every day

PHQ-9- The Nine Symptom Checklist (cont.)

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all / somewhat difficult / very difficult / extremely difficult

PHQ-9- The Nine Symptom Checklist (cont.)

Major Depressive Syndrome is suggested if:

- Of the 9 items, 5 or more are circled at least “More than half the days”
- Either item 1a or 1b is positive, that is, at least “More than half the days”

Minor Depressive Syndrome is suggested if:

- Of the 9 items, b, c, or d are circled as at least "More than half the days"
- Either item 1a or 1b is positive, that is, at least "More than half the days"

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

Guide for Interpreting PHQ-9 Scores -

- 0-4 Suggests the patient may not need depression treatment
- 5-14 Mild major depressive disorder. Provider uses clinical judgement about treatment based on patient's duration of symptoms and functional impairment.
- 15-19 Moderate-major depressive disorder. Warrants treatment for depression using antidepressant, psychotherapy, or a combination of treatment.
- 20+ Severe major depressive disorders. Warrants treatment with antidepressant or a combination of antidepressants and psychotherapy.

Research on Collaborative Care

Improving Mood- Promoting Access to Collaborative Treatment (IMPACT PROGRAM)

- An evidence-based practice in the treatment of MDD is the IMPACT .
- Largest treatment trial for depression to date
 - *Dr. Jürgen Unützer and his team of researchers followed 1,801 depressed, **older adults** from 18 clinics across the U.S. for two years.*
- Collaborative Care more than doubled the effectiveness of depression treatment.
 - *At 12 months, 45% of the patients receiving Collaborative Care reported at least a **50 percent or greater reduction in depressive symptoms from baseline**, compared with only **19 percent** of those in usual care.*

IMPACT Intervention

- Intervention participants received:
 - *20-minute educational videotape*
 - *Booklet about late-life depression*
- Intervention participants were encouraged to have an initial visit with a depression care manager at the primary care clinic.
- Care managers were composed of nurses or psychologists who were specifically trained as a depression clinical specialist (DCS).

An Overview of Impact





Evidence-based 'team care' for depression

TWO PROCESSES	TWO NEW 'TEAM MEMBERS' Supporting the Primary Care Provider (PCP)	
	Care Manager	Consulting Psychiatrist
<p>1. Systematic diagnosis and outcomes tracking</p> <p>e.g., PHQ-9 to facilitate diagnosis and track depression outcomes</p>	<ul style="list-style-type: none"> - Patient education / self management support - Close follow-up to make sure pts don't 'fall through the cracks' 	<ul style="list-style-type: none"> - Caseload consultation for care manager and PCP (population-based) - Diagnostic consultation on difficult cases
<p>2. Stepped Care</p> <p>a) Change treatment according to evidence-based algorithm if patient is not improving</p> <p>b) Relapse prevention once patient is improved</p>	<ul style="list-style-type: none"> - Support anti-depressant Rx by PCP - Brief counseling (behavioral activation, PST-PC, CBT, IPT) - Facilitate treatment change / referral to mental health - Relapse prevention 	<ul style="list-style-type: none"> - Consultation focused on patients not improving as expected - Recommendations for additional treatment / referral according to evidence-based guidelines

The Benefits of Collaborative Care by Dr. Jurgen Unutzer

- 36,000 older patients commit suicide per year in the U.S. particularly in older men.
- Most older adults go to their primary care and not to a psychiatrist and/or therapist
 - <https://www.youtube.com/watch?v=jVxgGGbjpL8>

M.C. Vlasveld's Study (2012)

- Based on Dutch occupational healthcare setting
 - *Dutch workers with MDD are absent 8-9 times more than their colleagues without MDD*
- Subjects included 126 employees on sick leave with MDD
- 61 were under usual care versus 65 were in collaborative care
- A significant difference was found between collaborative care and usual care in achieving a response:
 - *with 50% response in the collaborative care group and 28% response in the usual care group.*
 - *More individuals in the collaborative care group had at least a 50% reduction in symptoms.*

Collaborate Care Intervention

In Vlasveld's study, the collaborative care intervention consisted of:

- 6-12 sessions of problem-solving treatment;
- Manual-guided self-help;
- Workplace intervention; and,
- Anti-depressant medication

Treatment was monitored using the PHQ-9

Angstman et al Study (2012)- Self-Assessment Factors Predictive of PDS 6 Months After Enrollment in CCM

- Kurt Angstman, et al, looked at Persistent Depressive Symptoms (PDS) 6 months after enrollment in Collaborate Care Management.
- A subset of patients will continue to have symptoms after 6 month.
- 1110 adult primary care patients with MDD
 - *Evaluated those with PDS (PHQ-9 score of 10 or greater) 6 months after enrollment*

Angstman, K. B., Shippee, N. D., MacLaughlin, K. L., Rasmussen, N. H., Wilkinson, J. M., Williams, M. D., & Katzelnick, D. J. (2013). Patient self-assessment factors predictive of persistent depressive symptoms 6 months after enrollment in collaborative care management. *Depression And Anxiety*, 30(2), 143-148.

Results from Angstman et al Study

- The following at baseline were independent predictors of Persistent Depressive Symptoms:
 - *an increased depression severity;*
 - *worsening symptoms of generalized anxiety;*
 - *an abnormal screening on the Mood Disorder Questionnaire (MDQ); and,*
 - *the diagnosis of recurrent episode of depression*
- If the patient had severe, **recurrent depression**, an **abnormal MDQ screen**, and **severe anxiety** at baseline, then the probability of PDS at 6 months was at **42.1%**
- A patient with a moderate, **first episode of depression**, **normal MDQ screen**, and **no anxiety** had a low probability of **6.6% of PDS**.

Such predictions should alert the team to monitor select patients more closely.

Results from Angstman et al Study (cont.)

Four key clinical predictors were identified:

1. Initial PHQ-9 score of 15 or higher
2. Initial GAD-7 score of 5 or higher
3. Baseline diagnosis of recurrent depression
4. Abnormal MDQ screen

If the patient has one or more of the above when enrolling into CCM, the clinician should be alerted to the **difficulty under CCM**.

- It's recommended for CCM strategies to have:
 - *more frequent monitoring*
 - *anxiety treatment (therapy or medication)*
 - *management of depression with medication or therapy.*

Some studies show evidence that clients can significantly improve their symptoms within 6 months of treatment, while others need treatment for up to 1 year.

Length of treatment is also easier to determine when providers work together.

Anxiety and Depression

- In a small pilot study by Angstman published in 2011
 - *Used a depression registry*
 - *Suggested that a higher screening score for Generalized Anxiety Disorder Questionnaire (GAD-7) correlated with an increased risk of depression reoccurring after 4 months of graduation from CCM.*

Collaborative Care for People with Depression and Anxiety

- Archer et al - found 79 randomized controlled trials (RCTs) comparing routine care or alternative treatments to collaborative care.
- Most studies focused on depression
 - *CC is better than routine care in MDD for up to 2 years*
- Some studies focused on anxiety
 - *CC is better than usual care for up to 2 years*
- Overall, CC helps with the increase of medication compliance, and can improve ones quality of life in relation to mental health.

Additional Research

Findings that Collaborative Care Management is an Effective and Proven Treatment Model for Depression

- Ell K, Aranda MP, Xie B, et al. Collaborative depression treatment in older and younger adults with physical illness: pooled comparative analysis of three randomized clinical trials. *Am J Geriatric Psychiatry* 2010;18:520-530
- Gilbody S, Bower P, Fletcher J, et al. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. *Arch Intern Med* 2006;166:2314-2321.
- Katon W, Unutzer J, Wells K, Jones L. Collaborative depression care: history, evolution and ways to enhance dissemination and sustainability. *Gen Hosp Psychiatry* 2010;32:456-464.
- Unutzer J, Katon W, Callahan CM, et al. Collaborative Care management of late-life depression in the primary care setting: a randomized controlled trial. *J Am Med Assoc* 2002;288:2836-2845.

Address Challenges in Clinical Practice When Treating MDD

- According to Nakao (2001), the majority of patients with MDD complain about their physical symptoms, including fatigue (86%), insomnia (79%) and nausea (51%).
- Physical symptoms and MDD have a high correlation, irrespective of underlying medical diseases.
 - *Patients consult primary physicians rather than psychiatrists for help.*
- 30% of those with MDD experience physical symptoms for almost 5 years prior to getting properly diagnosed.

Challenges (cont.)

■ Comorbid Physical Diseases

- *According to the STAR*D study (1500 patients), physical diseases had 53% prevalence.*
- *Musculoskeletal diseases was found in 43% of patients with MDD*

■ Diabetes Mellitus

- *The risk of comorbid MDD in people with diabetes was two times more than people without diabetes. (Based on meta-analysis of 42 studies)*

■ Chronic Physical Diseases

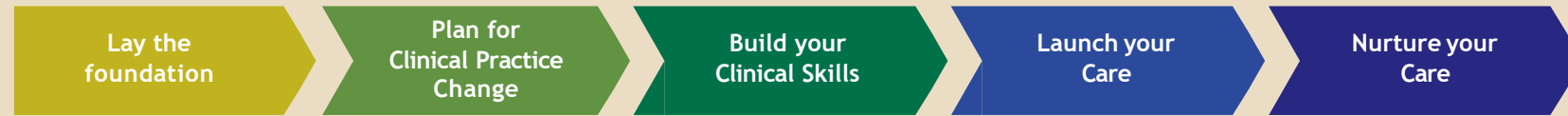
- *MDD is more prevalent in medically ill patients.*
- *Comorbid MDD*
 - *Exacerbates patients' physical symptoms*
 - *Decreases their pain threshold*
 - *Increases functional impairment*
 - *Consequently, treatment adherence is impacted*

How to Create A Collaborative Care Team

Impact Collaborative Care Implementation Guide

- Step-by-step guide: an overview of the major steps to successfully implement a Collaborative Care program.
- Steps were designed by the AIMS Center after working with over 1,000 organizations.
- <https://aims.uw.edu/sites/default/files/CollaborativeCareImplementationGuide.pdf>

COLLABORATIVE CARE: A step-by-step guide to implementing the core model



Collaborative Care is a new way of doing medicine and requires an openness to creating a new vision that everyone supports.

Time to clearly define care team roles, create a patient-centered workflow, and decide how to track patient treatment and outcomes

Effective Collaborative Care creates a team in which all of the providers work together using evidence-based treatments.

Is your team in place? Are they ready to use evidence-based interventions appropriate for primary care? Are all systems go? Time to launch!

Now is the time to see the results of your efforts as well as to think about ways to improve it.



Develop an understanding of the Collaborative Care approach, including its history and guiding principles.

- ✓ Develop strong advocacy for Collaborative Care within organizational leadership and among the clinical team.
- ✓ Create a unified vision for Collaborative Care for your organization with respect to your overall mission and quality improvement efforts.
- ✓ Assess the difference between your organization's current care model compared to a Collaborative Care model.

✓ Identify all Collaborative Care team members and organize them for training.

- ✓ Develop a clinical flowchart and detailed action plan for the care team.
- ✓ Identify a population-based tracking system for your organization.
- ✓ Plan for funding, space, human resource, and other administrative needs.
- ✓ Plan to merge Collaborative Care monitoring and reporting outcomes into an existing quality improvement plan.

✓ Describe Collaborative Care's key tasks, including patient engagement and identification, treatment initiation, outcome tracking, treatment adjustment and relapse prevention.

- ✓ Develop a qualified and prepared care team, equipped with the functional knowledge necessary for a successful Collaborative Care implementation.
- ✓ Develop skills in psychotherapy treatment that are evidence-based and appropriate for primary care (e.g. Problem Solving Treatment, Behavioral Activation, etc)

✓ Implement a patient engagement plan

- ✓ Manage the enrollment and tracking of patients in a registry
- ✓ Develop a care team monitoring plan to ensure effective collaborations
- ✓ Develop clinical skills to help patients from the beginning to the end of their treatment, including a relapse prevention plan

✓ Implement the care team monitoring plan to ensure effective team collaborations

- ✓ Update your program vision and workflow
- ✓ Implement advanced training and support where necessary



I. Lay the Foundation- Collaborative Care requires openness to a new vision

- Develop an understanding of the Collaborative Care approach
- Develop strong advocacy for Collaborative Care within organizational leadership and among the clinical team.
- Create a unified vision for Collaborative Care for your.
- Assess the difference between your organization's current care model compared to a Collaborative Care model.

II. Plan for Clinical Practice Change

Define care team roles, and decide a tracking system for patient treatment and outcomes

- Identify all Collaborative Care team members.
- Develop a clinical.
- Identify a population-based tracking system for your organization.
- Plan for funding and administrative needs including HR.
- Create a quality improvement plan by merging CC monitoring and reporting outcomes.

III. Build Your Clinical Skills: Providers to use Evidence-Based Treatments

- Provide main tasks for the team
 - *patient engagement, treatment initiation, outcome tracking, treatment adjustment when necessary, and relapse prevention.*
- Develop a qualified and prepared care team
- Develop skills in mental health treatment that are evidence-based and appropriate for primary care (e.g. Problem Solving Treatment, Behavioral Activation, etc.)

IV. Launch Your Care: Is Everything in Place?

- Implement a patient engagement plan
- Manage the enrollment and tracking of patients in a registry
- Develop a care team monitoring plan
- Develop clinical skills to help patients from the beginning to the end of their treatment
 - *This includes a relapse prevention plan*

V. Nurture Your Care: Assess the Results and Consider Ways to Improve Your Methods

- Implement the care team monitoring plan
- Update your program vision
- Update your program workflow
- Implement advanced training and support

Are You a Physician/Dentist in Private Practice?

Recommendations to implement a Collaborative Care Team:

- Have one or two of your nurses get trained with becoming a Depression specialist
- A care manager who will oversee this process and ensure follow through in the upcoming year
- Work with several psychiatrists and therapists to create a team in various locations you serve
 - *Use the PHQ-9 (anyone can use PHQ-9)*
 - *Question #9 to trigger to ask specific follow up questions*
- Have collaborative team meetings to review ways to improve

Facts on Suicide

According to the Centers for Disease Control and Prevention (CDC) in 2016, the leading causes of death reports:

- 10th leading cause of death for all ages in the US (45,000 people)
 - 2nd leading cause of death for ages 10-34 in the US
 - 4th leading cause of death for ages 35-54.
-
- There were more than twice as many suicides (44,965) in the US as homicides (19,362).

RECOGNIZE the Warning Signs of Suicide

Warning signs which necessitate taking Immediate Action

- Threatening or talking of wanting to hurt or kill self
- Planning for ways to kill self by seeking access to firearms, available pills, rope, or other means
- Talking or writing about death, dying or suicide, especially when these actions are out of the ordinary for the person

Additional warning signs

Acting more anxious and agitated than usual	Increased substance use
Sleep disturbance including insomnia	Acting recklessly / more risky behaviors
Hopelessness	Withdrawing from friends and family
Drastic mood swings	Saying bye to friends and family, and perhaps preparing their will
Feeling trapped / no solutions	Talking about the extreme guilt they feel, and about being a burden on others
Giving important belongings away	Not having a purpose
Helplessness	Not having a reason to live

ASSESSMENTS

- Use screenings for depression and risk for suicide - PHQ-9
- MDQ- The Mood Disorder Questionnaire- screening for Bipolar Disorder
- Use screenings for anxiety – GAD-7

Referring the Patient to Collaborative Care

- *Symptoms and risk factors for making an MDD diagnosis for MDD and referring the patient to collaborative care.*
- *Patients will exhibit a combination of psychological symptoms and physical symptoms.*
- **Treat Or Refer Patients With Ideation Of Suicide or Depression**

Resources:

- Los Angeles Police Department System-wide Mental Assessment Response Team (SMART).
- 800 854-7771 (PET) Psychiatric Emergency Team
- National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or contact the Crisis Text Line by texting TALK to 741-741.
- L.A. Suicide Prevention Center -Didi Hirsch Suicide Prevention Center at 877-727-4747

Conclusions

- Patients with MDD will present with both psychological and physical symptoms
- Collaborative care achieves better outcomes for patients with depression
 - Happier patients
 - Physically better functioning patients
- It involves health care professionals working collaboratively to help the patient improve.
- It is a more cost effective way of treating patients and saves agencies money.

Contact

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