



Best Practice in Depression: Decreasing Disparities and Improving Outcomes

Altha J. Stewart, MD

President

American Psychiatric Foundation

Overview

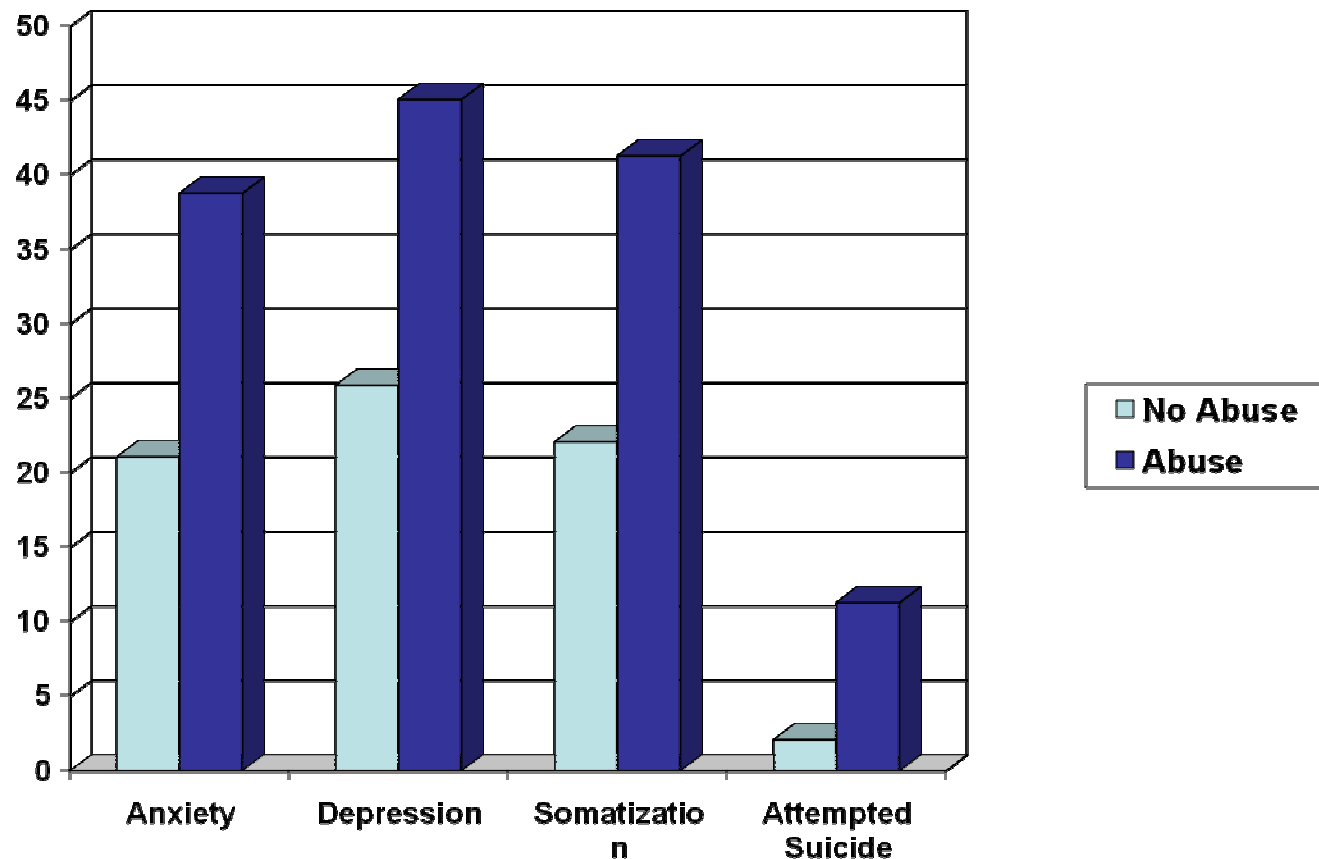
- Prevalence in primary care setting
 - Reported 10% prevalence of depression in primary care patients
 - Rate of recognition only 29–35%
- Racial/ethnic minorities at increased risk
 - More likely unrecognized/undertreated
- Increased risk of morbidity and mortality
 - Primary and secondary factors
 - Significant factor in slowing or limiting recovery from a variety of serious medical conditions, including hypertension and stroke

Complications in Routine Primary Care Practice

Patients with depression:

- Often present with somatic as well as psychological symptoms
 - Studies concluded that primary care patients with depression report only physical symptoms in up to 69% of cases
- 4 times greater risk than non-depressed patients for having a chronic painful physical condition
- More likely than non-depressed patients to have chronic medical conditions

Association Between Childhood Sexual and/or Physical Abuse and Adult Mental Health Symptoms in Primary Care



Obstacles to Recognition and Treatment of Depression in Primary Care Settings

- Patient
 - “Depression is normal after....”
 - Viewed as weak, “crazy”
- Physician
 - Treating the medical problem will take care of the depression
 - Can’t treat depression because of medical problem



Understanding Relevance of Culture in Assessing Mental Health

- Values and behavioral styles—stigma, weakness, “snap out of it”
- Nonverbal communication—body language suggests hopelessness, helplessness, unworthiness, guilt, shame
- Cognitiveness—attention span, focus, concentration, work performance
- Cultural frames of reference—doesn't happen to us, myth of strong black woman—“do what you gotta do,” demonic possession due to lack of faith or demonstration of faith





Decreasing disparities in depression and improving patient outcomes will require knowledge and use of available best practices.

Treating Major Depression

- APA's Practice Guideline for the treatment of patients with major depressive disorder
 - Psychiatric management
 - Diagnostic evaluation and initial treatment recommendations
 - Patient's/others' safety
 - Functional impairment
 - Treatment setting
 - Patient education

Acute Phase

Medication may be required if:

- History of prior positive response
- More severe symptoms
- Significant sleep/appetite disturbances
- Patient preference
- Lack of other treatment alternative or reliable support system



Antidepressant Medications

Drug Class	Specific Agents	Starting Dose (mg)	Therapeutic Range (mg)
1. TCAs	Amitriptyline Imipramine Desipramine	25–50 25–50 25–50	100–300 100–300 100–300
2. SSRIs	Citalopram Escitalopram Fluoxetine	20 10 20	20–60 10–20 20–60
3. SNRIs	Duloxetine Venlafaxine	40 37.5	40–60 75–375
4. DNRI	Bupropion	150	150–300

DNRI=dopamine and norepinephrine reuptake inhibitors; TCAs=tricyclic antidepressants; SNRI=serotonin-norepinephrine reuptake inhibitors; SSRI=selective serotonin reuptake inhibitors

Management of Medication Side Effects

- Inform patient of potential side effects
- Monitor for appearance of side effects
- If problem side effects appear
 - Watch and wait (if no immediate medical risk)
 - Alter dose, frequency, or time of administration
 - Change to different medication
 - Treat specific side effects
- Continue monitoring side effects, especially related to treatment adherence, medical risk, or patient satisfaction



Failure to Respond

- If no improvement (4–8 weeks after initiating treatment and additional 4–8 weeks after reassessment) consider:
 - Possible comorbid medical or psychiatric conditions (eg, substance abuse)
 - Undisclosed psychosocial problems
 - Psychiatric consultation
 - Other



Discontinuation of Treatment

- Consider probability of recurrence and frequency/severity of any past episodes
- Discontinue medication by tapering dose over several weeks
- Have a plan to restart treatment in case of relapse
- Follow-up visits—monitor for reappearance of depressive symptoms, potential comorbid conditions, functional impairments, suicidality, loss of social supports, etc



Ethnopsychopharmacology

Consider drug metabolism/target organ receptor effects and known racial/ethnic differences

- Select appropriate drug
- Dose to therapeutic dosing effect
- Educate the patient
- Monitor the patient at each follow-up visit



In-office Assessment

- Ask high-risk patients
- Review H&P to rule out possible physical etiology (medical condition, medication side effect, etc)
 - Elicit beliefs, past medical/family history, use of alternative/complementary treatments
- Psychiatric review of systems (“P-R-O-S”)
- Appropriate choice of medication
 - Past medical/family history, concurrent medications (including diet, food supplements, and herbs)
- Involve patient and support system in treatment-planning decisions



Assessment Tools

- Psychiatric review of symptoms– “*depressed patients seem anxious, so claim psychiatrists*”
(depression, personality disorders, substance abuse disorders, anxiety disorders, somatization disorders, cognitive disorders, psychotic disorders)
- Clinical interview–check for symptoms of major depression and dysthymia – **SIG+E+CAPS**
(Sleep disturbance, interest loss, guilt + energy deficit + concentration deficit, appetite disturbance, psychomotor retardation or agitation, suicidality)
- PHQ-9



Tips for Office-based Depression Screening

- Think comorbid (especially if history of substance abuse, grief, work/job loss, breakups, school, childcare responsibility, aging parents, etc)
- Use normalizing language—open-ended questions, non-threatening, non-stigmatizing
- Have a high level of suspicion in patients with changed prognosis, realization of chronicity/severity pain, etc
- **“P-R-O-S”** if any of above
- Ask about social history, especially available support system—ask, don’t assume!
- Train staff to recognize changed behaviors, known stressors, etc
- If person has strong church/faith relationship, inquire if assistance sought there



Office-based Depression Screening Makes Good Sense

- Provides comprehensive assessment of patient needs
- Improves overall treatment outcomes
- Decreases morbidity and mortality related to comorbid disorders
- Impacts entire office
- It's good medicine!

