



Decreasing Disparities in the Treatment of Depression: Best Practices

Content based in part on a satellite symposium presented Wednesday, August 9, 2006 at the National Medical Association 2006, Annual Convention and Scientific Assembly.



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Statement of Need/ Program Overview

Depressive disorders such as major depressive disorder, dysthymia, and bipolar disorder are leading causes of disability in the United States. Compounding the traditional challenges of effective treatment for these disorders is a gap between the quality of health care provided to the majority of the population and to minority groups.

Variations in treatment approaches and adherence to practice guidelines for depression suggest a need to examine 1) diagnostic criteria, 2) consistency of treatment across depression types, 3) barriers to guideline adherence, and 4) physician education and impact on practice patterns.

Target Audience

This activity has been designed to meet the educational needs of primary care physicians who treat adults with depression.

Estimated Time to Completion

This activity should take approximately one-half hour to complete.

Educational Objective

Upon completion of this activity, participants should be better able to describe and apply best practices in diagnosis and treatment of depression.

Accreditation Statement

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the co-sponsorship of Vanderbilt University School of Medicine and the University of Alabama School of Medicine and the joint sponsorship of Vanderbilt School of Medicine and Indicia Medical Education, LLC. Vanderbilt University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

Decreasing Disparities in the Treatment of Depression is a series of 3 newsletters, based on a symposium at the National Medical Association 2006 Annual Convention and Scientific Assembly, that seeks to educate physicians about disparities in the diagnosis and treatment of depression in ethnic and minority populations. Major depression is prominent in racial and ethnic minorities and is frequently misdiagnosed or untreated in these populations. Moreover, the significant morbidity and mortality associated with depression exacerbate comorbid illnesses that commonly occur in minority patients. Compounding this issue are the multiple factors experienced by racial and ethnic minorities—socioeconomic factors, cultural issues, poor access to care, and biases among patients and health care providers—that contribute to disparities in care for these patients. The primary care setting is often the initial point of contact for many patients who suffer from depression. Primary care physicians thus require an awareness of screening tools as reliable markers for detecting depression, an understanding of the emerging and accepted best practice standards for treating depression, and the acumen for cultural competence and how depression may manifest within a specific racial or cultural context.

Each of the 3 newsletters contains a short learning module followed by a post-test. The first issue in this series discusses best practices in diagnosing and treating depression. Issue 2 will focus on enhancing cultural competence skills, and Issue 3 will discuss closing the gaps in the diagnosis and treatment of depression in minorities.

Introduction

Depression is one of the most common chronic illnesses seen in the primary care setting and ranks second only to hypertension as the most common chronic condition encountered in general medical practice.¹ Racial and ethnic minorities are at increased risk of suffering from major depression, which is far more likely to go unrecognized and untreated in these populations. The increased morbidity and mortality associated with major depression significantly slows or limits recovery from numerous medical conditions that are often highly prevalent in minority populations (eg, cardiovascular disease, diabetes).² A number of disparities exist that affect the mental health care of minorities, including access to and availability of treatment, fragmentation of services, cost, and the cultural stigma of mental illness. Decreasing these disparities and improving patient outcomes will require clinicians to be informed about cultural differences that affect mental illness to use the best available evidence to diagnose and treat depression.

Epidemiologic surveys have demonstrated that more than half of those who suffer from mental disorders and seek health care are treated in the primary care sector.³ Because primary care physicians (PCPs) are most likely to be the initial health care contact for many patients with depression, they are uniquely positioned to recognize and treat depression in their patient population. Although study estimates report a 10% prevalence of depression in primary care patients, the rate of recognition of depression by PCPs is reported to be only 29–35%.⁴

Obstacles to Recognition and Treatment of Depression in Primary Care Settings

Certain beliefs and perceptions that are held by both patients and physicians may be obstacles to the recognition and treatment of depression in primary care settings. Patients may perceive that depression is “normal” after certain life events and may ignore the need to seek

Method of Participation

This is a CME Enduring Material. It consists of a newsletter and a CME quiz. There are no fees for participating and receiving credit for this activity. To receive your CME credit in the period from November 2006 through November 6, 2007, you must 1) read the newsletter, including the learning objectives and disclosure information, 2) go to https://www.cme.vanderbilt.edu/online/onlinquiz/user/user_exam_view.php?COURSE_EX=PS2006P3501, 3) follow the instructions to log in, and 4) complete the CME quiz. If you answer 80 percent of the questions correctly, you will be prompted to print your certificate.

Disclosures

Commercial Support

Vanderbilt University School of Medicine, the University of Alabama School of Medicine, and Indicia Medical Education, LLC, express appreciation to Wyeth Pharmaceuticals for generous support of this activity through an unrestricted educational grant.

Conflicts of Interest

As an accredited provider of CME, Vanderbilt University School of Medicine follows ACCME requirements regarding industry support of continuing medical education and provides the following information:

Altha Stewart, MD disclosed that she has no financial relationships related to the content of her presentation to disclose.

Planning Committee

Donald E. Moore, Jr., PhD, Vanderbilt University, disclosed that he has received a grant from Wyeth Pharmaceuticals. Vanderbilt CME has determined that there are no conflicts of interest between this financial relationship and the content of this symposium.

Robert E. Kristofco, MSW, University of Alabama School of Medicine, disclosed that he has no financial relationships to disclose related to the content of this symposium.

Karen M. Overstreet, EdD, RPh, FACME, Indicia Medical Education, LLC, disclosed that she has no financial relationships to disclose related to the content of this symposium.

Disclosure of Unlabeled Use

Dr. Stewart does not reference an unapproved, unlabeled, or investigational use of a therapeutic agent or biomedical device in this presentation.

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Credit Designation

Vanderbilt School of Medicine designates this educational activity for a maximum of 0.5 *AMA PRA Category 1 Credit*[™]. Physicians should only claim credit commensurate with the extent of their participation in the activity.

treatment. Moreover, the cultural stigma of having a mental illness is an overriding factor that prevents many patients from seeking medical help for depression. From the clinician perspective, physicians may assume that treating the medical problem will take care of the depression.

Understanding the Relevance of Culture in Assessing Mental Health

Providing culturally competent care is fundamental to treating depression in minority patients. Whereas “culture” refers to the attributes of a shared group, defined by a set of beliefs, norms, values, and perceptions, “cultural competence” implies having the skills and capacity to work effectively with culturally diverse clients.⁵ In addition to having the appropriate knowledge and tools to diagnose and treat depression, PCPs must also be aware of cultural influences that impact how this illness may manifest within specific racial or cultural contexts. Frames of reference in certain cultures regarding depression include beliefs that “this does not happen to us” and that depression is synonymous with being weak or “crazy.” Additionally, in certain cultures, strongly held spiritual beliefs that depression represents demonic possession or lack of faith are significant obstacles to treatment.

The Relationship Between Somatic Symptoms and Depression

Patients with depression often express their psychiatric symptoms in the form of somatic, or physical, complaints. In fact, study data have shown that primary care patients with depression report only physical symptoms in up to 69% of cases.⁶ Some patients are far more likely to present to their PCP with complaints of cardiovascular symptoms or irritable bowel symptoms, for example, than with complaints of sadness and anhedonia. Somatic symptoms have been reported to be

more common among African Americans (15%) than among white Americans (9%),⁷ and patients in non-Western cultures report somatic symptoms more frequently than those in Western or developed countries.⁶ Patients with depression have a 4-fold greater risk than non-depressed patients for having a chronic, painful physical condition.

In-office Assessment of Patients for Depression

Routine screening for depression in primary care is now recommended as “locally accepted best practice” in many areas. Office-based screening for depression provides a comprehensive assessment of patient need, improves overall treatment outcomes, and decreases morbidity and mortality related to comorbid disorders.

Tips for office-based screening of depression are shown in **Table 1**.

Screening becomes especially important when working with minority patients, in whom depression is often undetected or undertreated. Any appropriate assessment of depression risk must include recognition of symptoms as well as whether a patient’s functioning is impaired. To avoid missing a psychiatric diagnosis, PCPs should use a systematic approach when assessing a patient for depression, much like the approach used in the medical review of symptoms. The following screening tools are recommended:

- **Psychiatric review of symptoms (PROS)**—A series of questions designed to rapidly screen for the major psychiatric disorders, using the mnemonic “**d**epressed patients **s**eem **a**nxious, **s**o **c**laim **p**sychiatrists,” which represents the major psychiatric disorders (Depression, Personality disorders, Substance abuse disorders, Anxiety disorders, Somatization disorders, Cognitive disorders, Psychotic disorders).

Table 1. Tips for Office-Based Depression Screening

- Query patients who are high risk for depression about related symptoms and consider comorbid conditions (eg, history of substance abuse, grief, work/job loss, breakups, school, childcare responsibility, aging parents, etc)
- Suspect depression in patients with changed prognosis, realization of chronic/severe pain
- Review history and physical to rule out possible physical etiology for symptoms (medical condition, medication side effect, etc)
- Use normalizing language with open-ended questions that are non-threatening and non-stigmatizing

- Clinical interview to assess for symptoms of major depression and dysthymia, using the mnemonic SIGECAPS (Sleep disturbance, Interest loss, Guilt, Energy deficit, Concentration deficit, Appetite disturbance, Psychomotor retardation or agitation, Suicidality)
- Patient Health Questionnaire 9 (PHQ-9) — A 9-item, self-administered depression screening and diagnostic tool increasingly used in primary care and other medical populations.⁴

Diagnosing Major Depression

Although a full discussion of diagnosis of depressive disorders is beyond the scope of this newsletter, it is important for the PCP to be familiar with the diagnostic criteria for major depressive disorder. Each mood disorder is characterized by a unique set of symptoms, which are outlined in the *Diagnostic and Statistical Manual of Mental Disorders — Fourth Edition — Text Revised*.⁸ Major depression is a disorder of mood involving disturbances in emotional, cognitive, behavioral, and somatic regulation. The diagnosis of major depression requires at least

5 of the 9 symptoms listed in **Table 2**, including depressed mood or anhedonia during the same 2-week period, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Treatment of Major Depression

Clinical decision making for and management of patients with major depression by PCPs depends on recognition of this illness. In addition to the PCP prescribing the appropriate medication, it is critical to inquire about the patient’s social history, especially available support systems, as well as involve the patient and his/her support system in treatment-planning decisions. Because ethnic and minority patients often have strong church/faith relationships, it is important to ask whether the patient seeks assistance through this medium. **Table 3** shows general principles of psychiatric management that should be adhered to throughout the formulation of a treatment plan and all subsequent phases of treatment.⁹

Antidepressant medication (**Table 1**) and structured psychotherapy (ie, cognitive-behavioral therapy, problem-solving therapy, interpersonal psychotherapy) are effective treatments for major depression, and 50–60% of patients with depression in

Table 3. Principles of Psychiatric Management

- Perform a diagnostic evaluation
- Evaluate whether the patient is a danger to himself or others
- Evaluate and address functional impairments
- Determine the treatment setting
- Establish and maintain a therapeutic alliance
- Monitor psychiatric status and safety

Adapted from APA Practice Guidelines.⁹

primary care settings respond to initial therapy with these treatment modalities.¹ Many patients benefit from a combination of psychotherapy and pharmacotherapy: medication to gain relatively quick symptom relief and psychotherapy to gain insight into effective ways of coping with life’s problems. Electroconvulsive therapy (ECT) is utilized only in patients whose depression is severe and life-threatening, and/or in those who are refractory to the effects of antidepressant therapy.

In the acute phase of treatment, factors suggesting that an antidepressant may be preferred include:

Table 2. Diagnostic Criteria for Major Depressive Disorder (Single Episode)

- Depressed mood most of the day, nearly every day
- Markedly diminished interest or pleasure in almost all activities
- Substantial, unintentional weight loss or gain (may also be a decrease or increase in appetite)
- Insomnia or hypersomnia, nearly every day
- Fatigue or loss of energy, nearly every day
- Psychomotor agitation or retardation, nearly every day
- Feelings of worthlessness or excessive guilt, nearly every day
- Diminished ability to think or concentrate, nearly every day
- Recurrent thoughts of death or suicide (with or without a specific plan), or attempt of suicide

Adapted from DSM-IV-TR.⁸

Table 4. Dose Ranges for Antidepressant Medications

Drug Class	Generic Name	Starting Dose (mg)	Usual Dosage (mg/day)
TCAs	Amitriptyline	25–50	100–300
	Imipramine	25–50	100–300
	Desipramine	25–50	100–300
SSRIs	Citalopram	20	20–60
	Escitalopram	10	10–20
	Fluoxetine	20	20–60
	Paroxetine	20	20–50
	Sertraline	50	50–200
SNRIs	Duloxetine	40	40–60
	Venlafaxine	37.5	75–375
	Venlafaxine ER	37.5	75–225
DNRI	Bupropion	150	150–300
Serotonin Modulators	Nefazodone	50	150–600
	Trazodone	50	75–400
Norepinephrine/Serotonin Modulator	Mirtazapine	15	15–45

DNRI=dopamine and norepinephrine reuptake inhibitors; ER=extended release; SNRIs=serotonin norepinephrine reuptake inhibitors; SSRIs=selective serotonin reuptake inhibitors; TCAs=tricyclic antidepressants.

Adapted from APA Practice Guidelines.⁹

- A history of prior positive response
- More severe symptoms
- Significant sleep or appetite disturbances or agitation
- Patient preference
- Lack of available alternative treatment modalities or reliable support system

Research has demonstrated that even when the diagnosis of depression is made, the dosing and duration of antidepressant therapy prescribed by PCPs is inadequate.³

Choosing an Antidepressant

Because there is comparable efficacy between and within classes of antidepressant medications, the initial selection of an agent is based largely on the following considerations:⁹

- Anticipated side effects
- Safety or tolerability of side effects for individual patients
- Patient preference
- Quantity and quality of clinical trial data
- Cost

Ethnopsychopharmacology

Numerous factors affect the way an individual will respond to medication, including genetic, physiologic, environmental, and cultural factors, as well as those related to the medication itself (Figure 1).¹³ Racial and

ethnic differences in drug response may result in pharmacokinetic and pharmacodynamic differences that have important clinical relevance. Psychotropic drugs, which include antidepressants, are known to have pharmacogenetic implications in minority populations, and thus require careful consideration in terms of dosing and the potential for drug-drug interactions. There is evidence that black patients require lower doses of both TCAs and SSRIs than white patients.¹⁰ The majority of the newer antidepressants are associated with a risk for clinically significant drug interactions, primarily related to the cytochrome P450 (CYP450) enzyme system, a major drug-metabolizing system whose activity may be considerably influenced by race. The CYP2D6 isoenzyme—one of the most important polymorphic genes involved in the metabolism of antidepressants and the most extensively studied P450 isoenzyme in psychiatry—has been shown to predict TCA and SSRI plasma concentrations.¹¹ The CYP3A isoenzyme metabolizes about 50% of all psychotropic drugs.¹² An overview of the major CYPs and their antidepressant substrates is shown in Table 5.¹³

Management of Medication Side Effects

Like all medications, antidepressants may produce unwanted side effects. Although various agents have different side effect profiles, most individuals experience fewer side effects with the newer classes of antidepressants, such as the SSRIs and SNRIs. Because medication adherence is critical to a successful treatment outcome, it is vital for physicians to discuss potential side effects with their patients when prescribing an antidepressant and to explain that certain side effects will dissipate as the body adjusts to the medication. Failure to discuss possible side effects with a patient may cause the individual to abruptly discontinue the antidepressant at the first occurrence of a side effect, and treatment will

Table 5. Major Cytochrome P450 Enzymes and Antidepressant Substrates

CYP450 Enzyme	Substrate
CYP2D6	Amitriptyline
	Desipramine
	Imipramine
	Trazodone
	Nortriptyline
	Duloxetine
	Fluoxetine
	Paroxetine
CYP3A4	Mirtazapine
	Nefazodone
	Sertraline
	Trazodone
	Venlafaxine
CYP2C19	Citalopram
	Escitalopram
	Sertraline
CYP1A2	Amitriptyline
	Imipramine
	Fluvoxamine

Adapted from Smith MW. *Clin Manual Cult Psychiatry*. 2006.¹³

not be successful. Suggested steps for the management of antidepressant side effects are illustrated in Figure 2.⁹

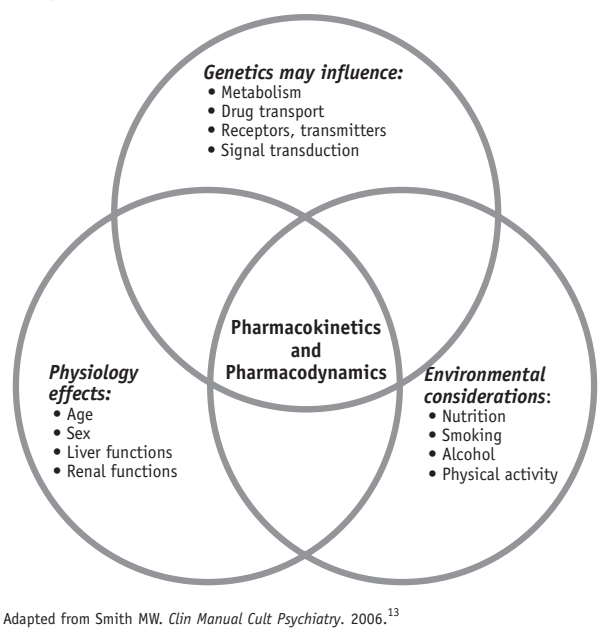
Failure to Respond

If a patient is not at least moderately improved after 4 to 8 weeks of antidepressant therapy, a reappraisal of the treatment regimen is recommended, including investigation of the patient’s adherence to treatment, possible pharmacokinetic/ pharmacodynamic factors that may be affecting treatment, and consideration for switching to another antidepressant. If a patient does not show at least moderate improvement after an additional 4 to 8 weeks, the physician should consider the presence of other factors that might interfere with improvement, such as comorbid medical or psychiatric conditions (eg, substance abuse) and undisclosed psychosocial problems, and consider a psychiatric consultation.

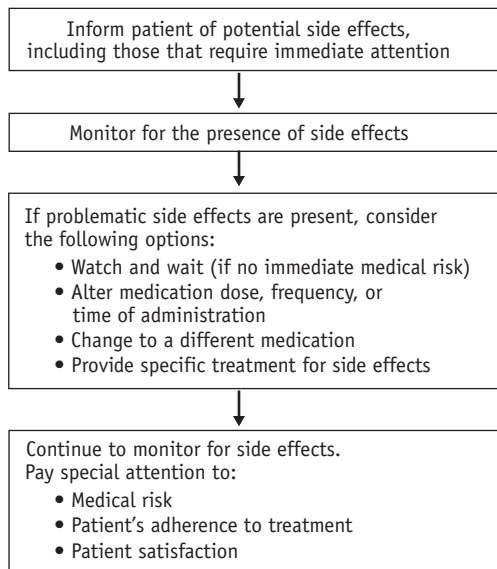
Discontinuation of Treatment

Consideration of whether to discontinue antidepressant therapy should be based on the same factors considered in the decision to

Figure 1. Multiple Factors in Therapeutic Response and Adverse Effects



Adapted from Smith MW. *Clin Manual Cult Psychiatry*. 2006.¹³

Figure 2. Steps in Managing Antidepressant Side EffectsAdapted from APA Practice Guidelines, 2000.⁹

initiate maintenance treatment. For example, consider the probability of recurrence and the frequency/severity of past episodes. To discontinue an antidepressant properly, the dose should be tapered over at least several weeks. This facilitates a more rapid return to a full dose if symptoms occur and minimizes the risk of antidepressant discontinuation syndromes that are more likely with antidepressants with a shorter half-life. It is also important to establish a plan to restart treatment in the event of a relapse. During follow-up visits, the patient should be monitored for signs that depression may be recurring, such as the reappearance of depressive symptoms, potential comorbid conditions, functional impairments, suicidality, and loss of social supports.

Conclusions

The prevalence of major depression in the primary care setting is extremely high, whereas the rate of recognition of this illness by PCPs is reportedly very low. Ethnic and racial minorities are far less likely than whites to be screened, diagnosed, and treated for depression. Moreover, numerous disparities affect the physical and mental health care of minority populations. Thus, it is incumbent on the PCP—the health care provider likely to have first contact with minority patients—to be aware of and help decrease these disparities in care. An important component of managing depression in minority patients is cultural competence—the ability to serve and work with culturally diverse patients with a background different from one's own. Diagnosing and treating depression has a number of implications specific to ethnic and minority patients, including the effect of depression on medical conditions that are prevalent in minorities, the relationship between somatic symptoms and depression, and ethnopsychopharmacology. Giving consideration to these issues and incorporating best practices of diagnosing and treating depression will contribute to improved treatment outcomes.

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