Mountain Plains (HHS Region 8)

MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Screening for, and Diagnosis of Depression in Primary Care

Presented by:
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SAMHSA
Substance Abuse and Mental Health Services Administration

Disclaimer and Funding Statement

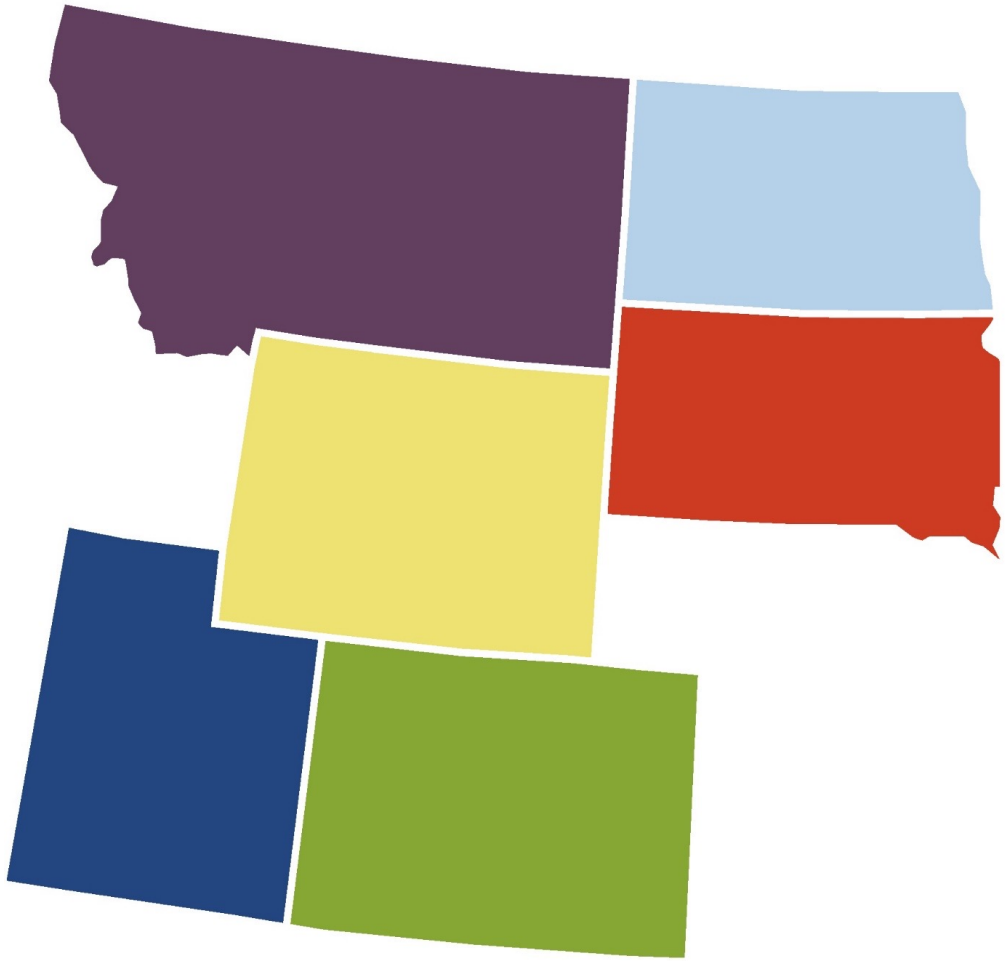
At the time of this presentation, Tom Coderre served as acting SAMHSA Assistant Secretary. The opinions expressed herein are the views of Andrew McLean & Robin Landwehr and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

The work of the Mountain Plains MHTTC is supported by grant H79SM081792 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



Land Acknowledgement Statement

Today, the University of North Dakota rests on the ancestral lands of the Pembina and Red Lake Bands of Ojibwe and the Dakota Oyate - presently existing as composite parts of the Red Lake, Turtle Mountain, White Earth Bands, and the Dakota Tribes of Minnesota and North Dakota. We acknowledge the people who resided here for generations and recognize that the spirit of the Ojibwe and Oyate people permeates this land. As a university community, we will continue to build upon our relations with the First Nations of the State of North Dakota - the Mandan, Hidatsa, and Arikara Nation, Sisseton-Wahpeton Oyate Nation, Spirit Lake Nation, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians.

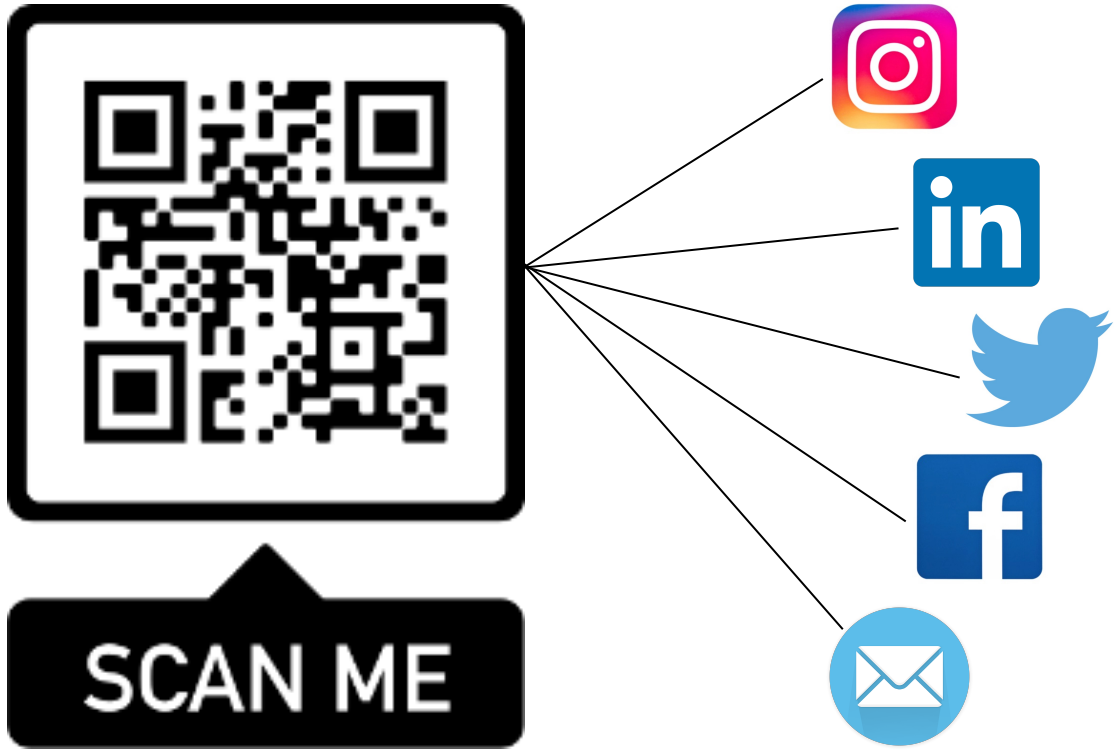
The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered and trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Stay Connected

Scan this QR code to follow us on Instagram, LinkedIn, Twitter, and Facebook. You can also join our e-mail newsletter!



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Series

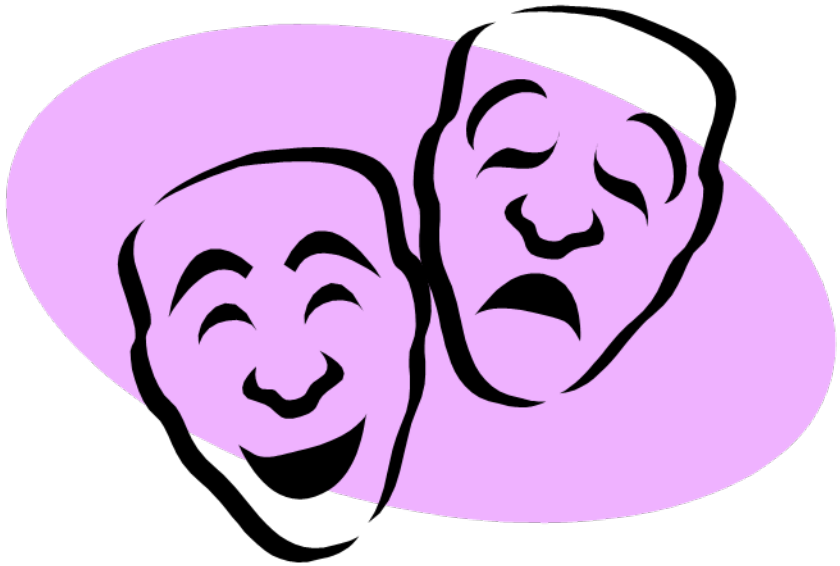
- Feb. 15; Screening For and Diagnosis of Depression/Suicide Risk in Primary Care.
- March 1; Evidence-Based Treatment of Depression
- March 15; Pathways to Care: Building a Depression Follow-up Program

Objectives

Following the presentation, the participant should:

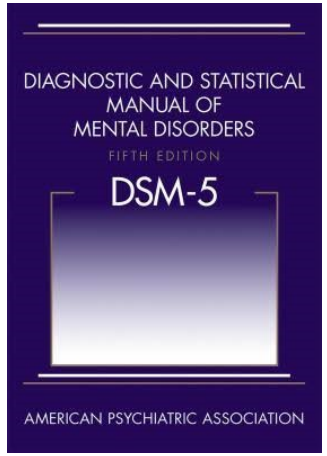
- Have an understanding of the use of common screening tools for depression/suicide risk in primary care.
- Be able to identify common differentials/co-morbidities of depression
- Be able to utilize (or refer for) standard treatments of depression.

Mood Disorders



Depressive Disorders (not all)

- Major Depressive Disorder (Single/Recurrent episodes)
- Persistent Depressive Disorder (Dysthymia)
- Premenstrual Dysphoric Disorder
- Disruptive Mood Dysregulation Disorder
- Other (including medical conditions, bipolar depression…)



Differential Diagnosis (What else could this be?)

- Medical conditions
(thyroid disease, anemia, sleep disorders, infections, etc…)
- Other psychiatric disorders
- Medication side effects
- Bereavement
- Psychosocial stressors / adjustment
- Substance use
- Other

COMORBIDITY IS THE RULE!

Adult Depression in Primary Care Seventeenth Edition/March 2016

Common presentations for patients not complaining of major depression or anhedonia include:

- Multiple (more than five per year) medical visits
- Multiple unexplained symptoms
- Work or relationship dysfunction
- Dampened affect
- Changes in interpersonal relationships
- Poor behavioral follow-through with activities of daily living or prior treatment recommendations
- Weight gain or loss
- Sleep disturbance
- Fatigue
- Memory/other cognitive complaints such as difficulty concentrating or making decisions
- Irritable bowel syndrome
- Volunteered complaints of stress or mood disturbance

Major Depressive Disorder—Diagnostic Criteria

Five or more of the following symptoms are present most of the day, nearly every day, during a period of at least 2 consecutive weeks:

At least 1 of these 2 symptoms

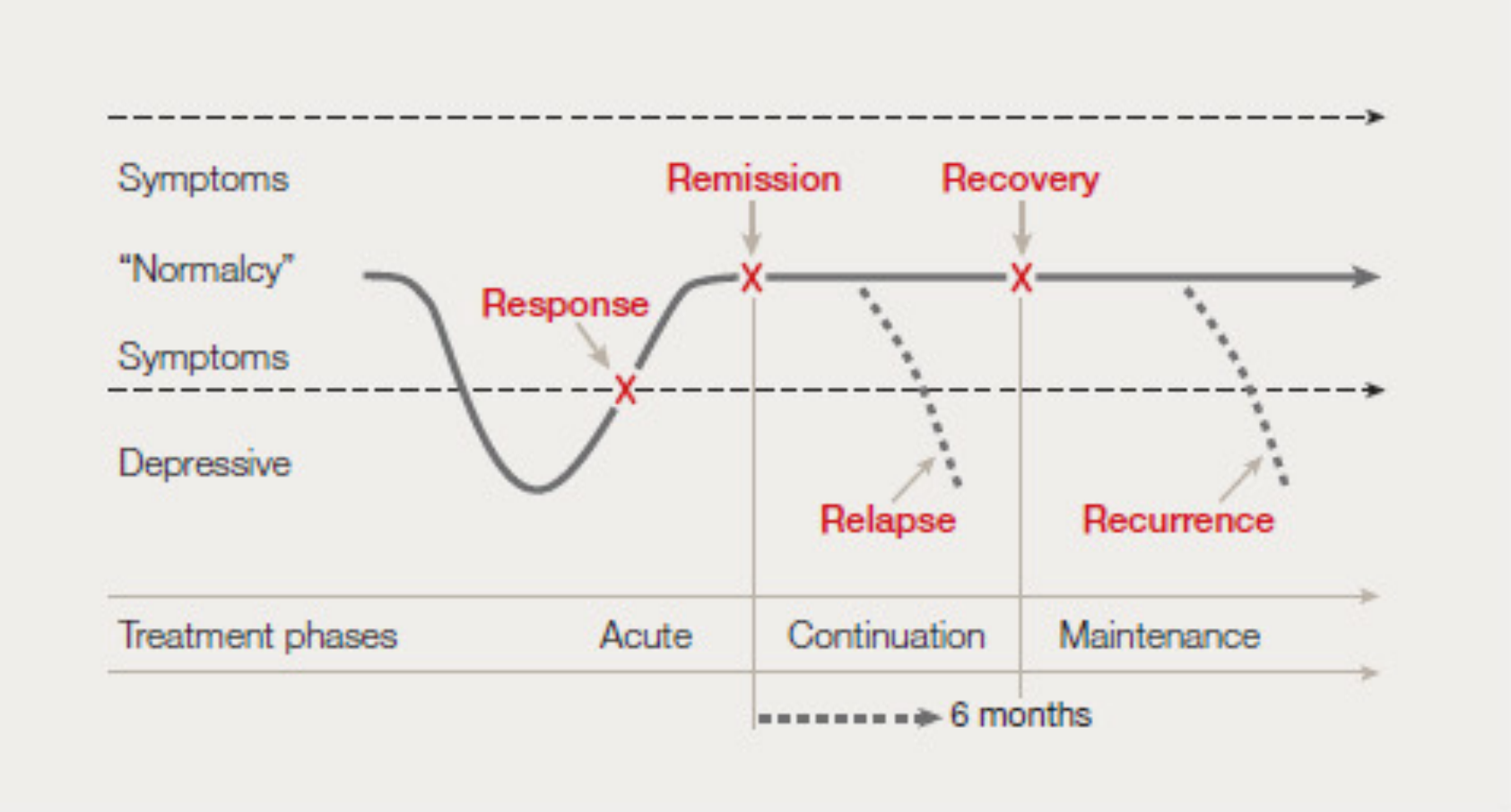
1. Depressed mood
2. Loss of interest or pleasure in all, or almost all, usual activities

3. Significant weight loss when not dieting, or weight gain
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive or inappropriate guilt
8. Diminished ability to think or concentrate or indecisiveness
9. Recurrent thoughts of death or suicide

Symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and are not attributable to another substance or medical condition

DSM-5.

Major Depressive Disorder

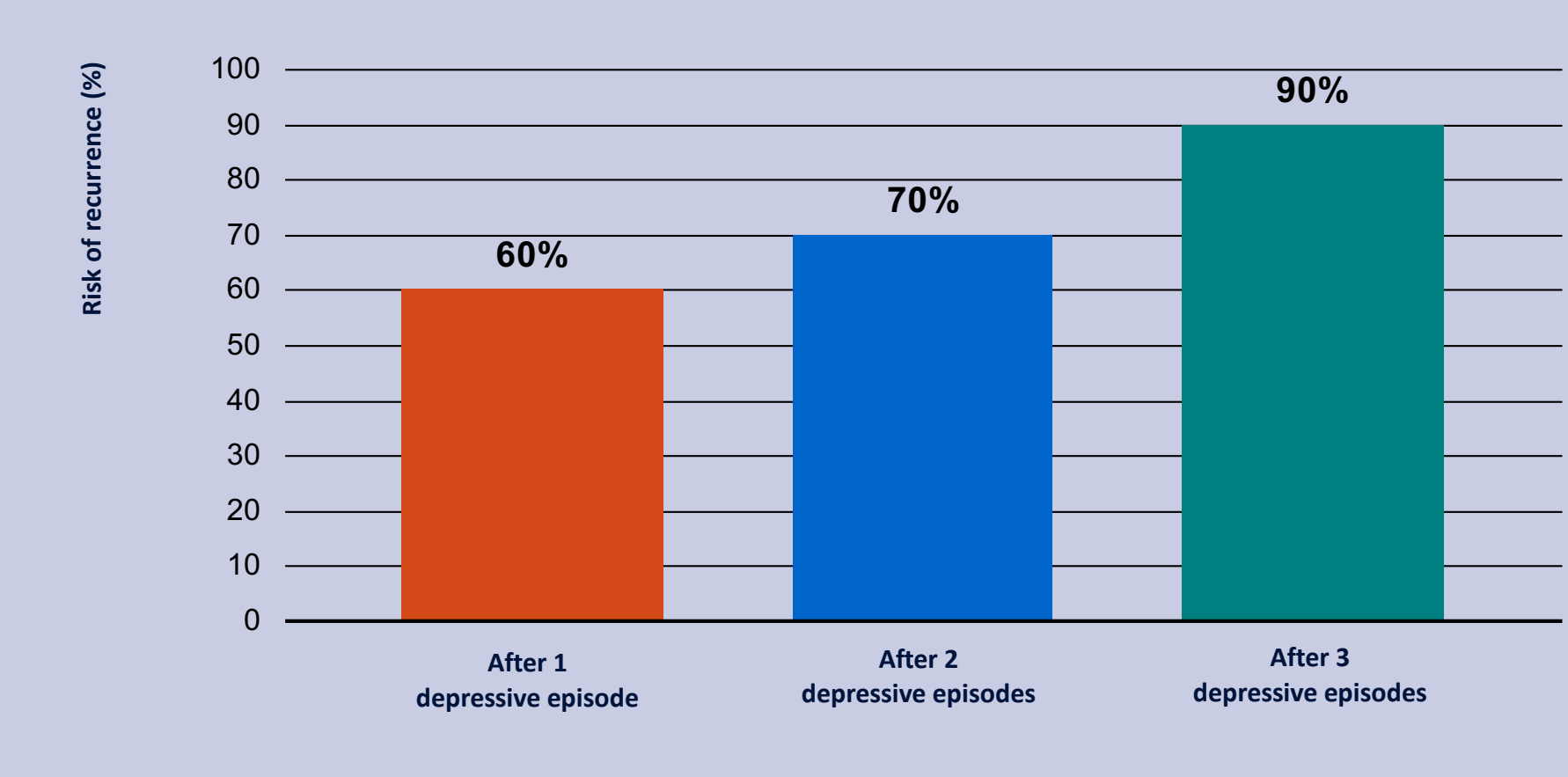


Remission: symptom free
Recovery: > 4 months post remission

Severity and Course Specifiers

SEVERITY	COURSE
Mild	Single episode
Moderate	Recurrent episode
Severe	
With psychotic features	
In partial remission	
In full remission	

Depression-a highly recurrent disorder



Screening Tools

Find one you are comfortable with, such as:

- PHQ-2/PHQ-9 Symptom Checklist
- BDI (Beck Depression Inventory)

Many others…

- Consider using Mood Disorder Questionnaire to assist in ruling out/in Bipolar Affective Disorder

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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
☐	☐	☐	☐

Interpretation/PHQ-9 scoring

- Use clinical judgment, treat the patient, not the score….

Total Score	Depression Severity
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately Severe
20-27	Severe

C-SSRS

	Past 1 Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, answer questions 3, 4, 5 and 6 If **NO** to 2, go directly to question 6		
3) Have you thought about how you might do this?		
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?	High Risk	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		High Risk

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Any YES indicates that someone should seek behavioral healthcare.
However, if the answer to 4, 5 or 6 is YES, seek immediate help: go to the emergency room, call 1-800-273-8255, text 741741 or call 911. STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

Columbia-Suicide Severity Rating Scale

Treatment of Major Depressive Disorder (expanded upon- 3/1/2022 presentation)

- **Psychotherapy** {Cognitive Behavioral Therapy (CBT). Other therapies such as Interpersonal Psychotherapy, Problem Solving Therapy, etc… can be helpful. Usually provided for a number of weeks to months.}
- **Lifestyle** (Social Rhythms, etc…)
- **Medications** (for moderate to severe depression). Primarily antidepressant medications. Usually provided for a number of months (at least 6, depending on how many episodes) If Bipolar Depression, other medications
- **Procedural** For severe, unresponsive major depressive episode, Electroconvulsive Therapy (ECT/ "shock treatment") is sometimes necessary. Vagal Nerve Stimulation (VNS) is FDA approved, as is repetitive Transcranial Magnetic Stimulation (rTMS). Esketamine nasal spray was recently approved.
- **Phototherapy** 10,000 lux for a brief period after awakening.
- **Other/alternatives:** Supplements?

Summary of DSM-5 Classification of Bipolar Disorders

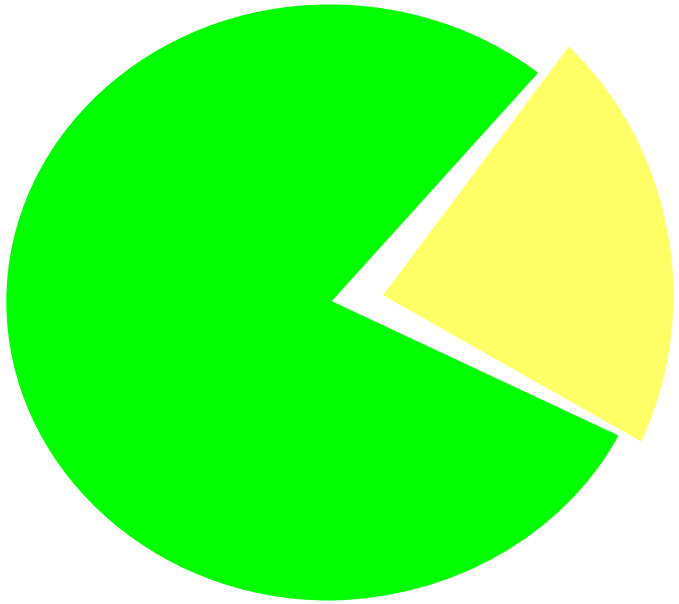
Bipolar I	Bipolar II	Cyclothymic	Bipolar Disorder Other
One or more manic or mixed episodes, usually accompanied by major depressive episodes	One or more major depressive episodes accompanied by at least one hypomanic episode	At least 2 years of numerous periods of hypomanic and depressive symptoms*	Substance induced, medical, unspecified, other specified…

* Symptoms do not meet criteria for manic and depressive episodes.

Under-recognition of Bipolar Disorder
Patients Treated for Depression in a Family Medicine Clinic

649 outpatients receiving treatment for depression

Estimated bipolar prevalence among 649 depressed patients ~ 28%



Screened positive* for BD – 21%

MDQ sensitivity = 58%;
MDQ specificity = 93%;
based on Structured Clinical Interview for *DSM-IV* (SCID)

*Using the Mood Disorder Questionnaire (MDQ)
BD = bipolar disorder

Hirschfeld RM, et al. *J Am Board Fam Pract*. 2005;18:233-239.

Bipolar Depression *

- **Clues:**

Might*:

- be more "atypical" (think hibernation)
- have Hx of early, often abrupt onset/psychosis
- be associated with other cyclical problems (seasonal…)
- be associated with post-partum
- have family history
- have history of "overstimulation" with antidepressants.
- Migraines?

Mixed Episode-DSM-5

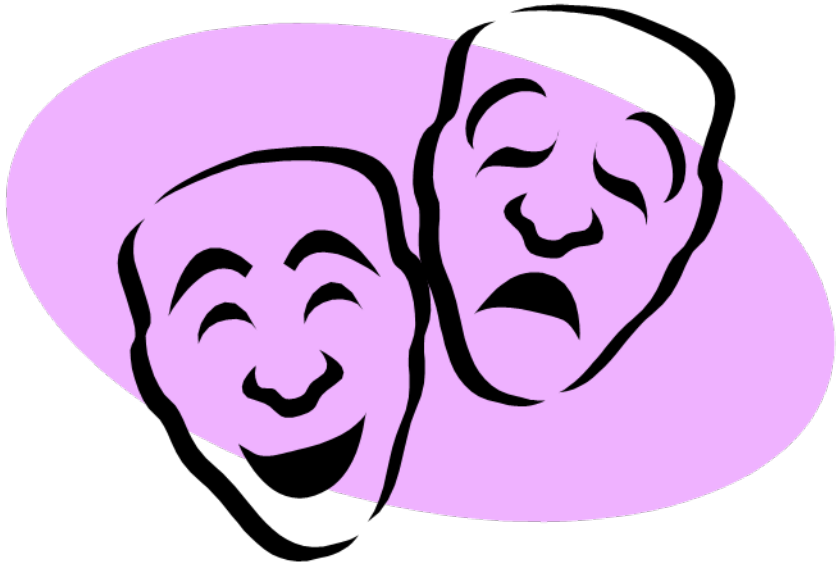
- Interestingly, DSM-5 indicates can have:

-Manic/hypomanic episodes with mixed features and/or

-Depressive episodes with mixed features (more common in Bipolar II)

Common Bipolar Mixed State

- "Dysphoric Hypomania"
- Often misdiagnosed as agitated depression, anxiety, histrionic personality
- Insomnia
- Suicidality
- Impulsivity



Different from "Rapid Cycling"
which is actually 4 or more episodes per year

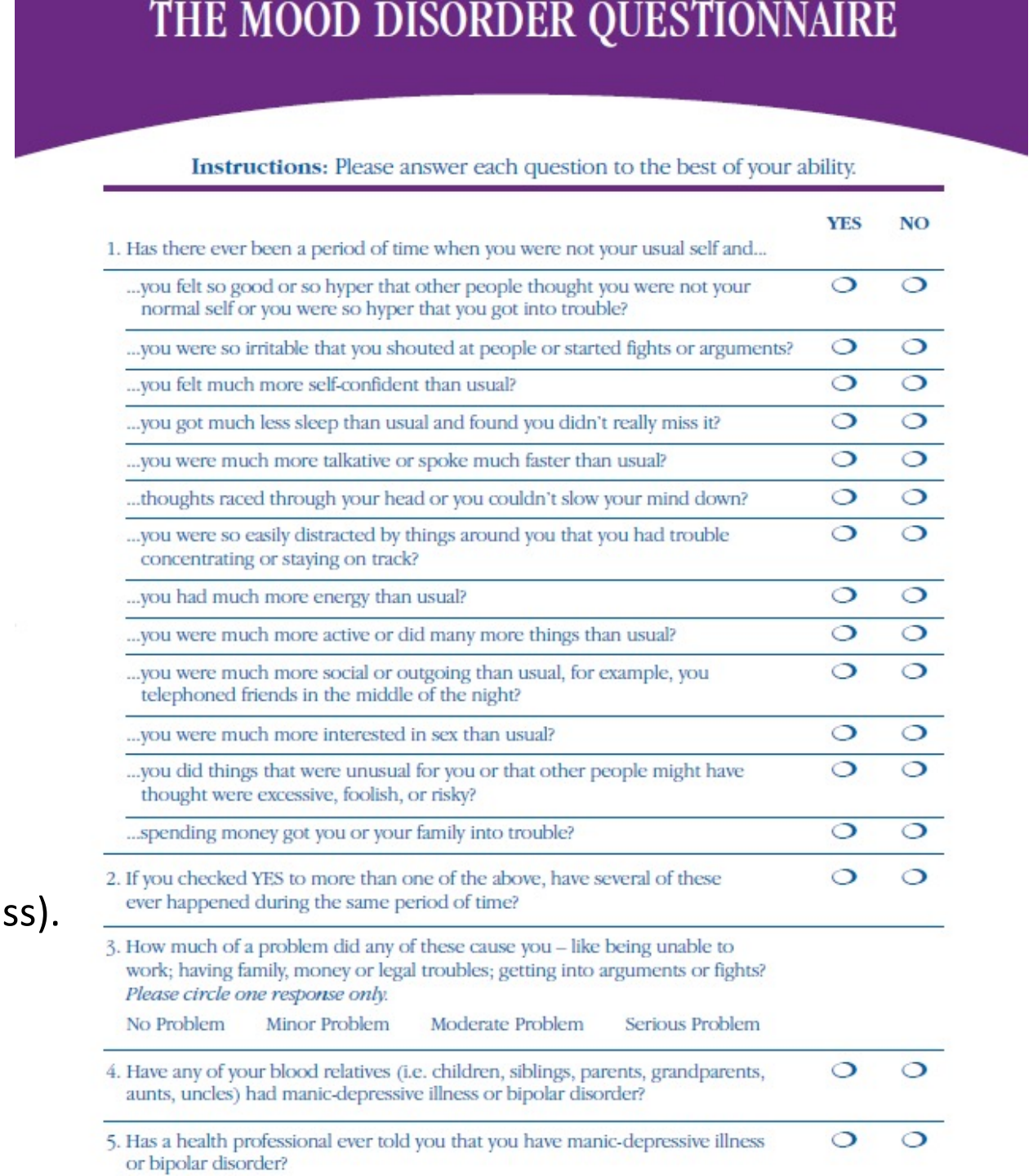
A “positive screen” is when:

--“Yes” to 7 or more questions in section 1

--“Yes” to section 2

--“Moderate” or “Serious” to section 3

Fair at sensitivity (+ when those have the illness),
Better at specificity (- when those don’t have the illness).



THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	❍	❍
...you were so irritable that you shouted at people or started fights or arguments?	❍	❍
...you felt much more self-confident than usual?	❍	❍
...you got much less sleep than usual and found you didn't really miss it?	❍	❍
...you were much more talkative or spoke much faster than usual?	❍	❍
...thoughts raced through your head or you couldn't slow your mind down?	❍	❍
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	❍	❍
...you had much more energy than usual?	❍	❍
...you were much more active or did many more things than usual?	❍	❍
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	❍	❍
...you were much more interested in sex than usual?	❍	❍
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	❍	❍
...spending money got you or your family into trouble?	❍	❍
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	❍	❍
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	❍	❍
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	❍	❍

Tools

- "No Substitute for Good Clinical Skills"
- Longitudinal information
- Collateral information

SBIRT (screening, brief intervention, referral to treatment)

- **SBIRT CONSISTS OF THREE MAJOR COMPONENTS:**

- **Screening** — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting

- **Brief Intervention** — a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice

- **Referral to Treatment** — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services

Occupational Hazard

Physician suicide compared to the general population

- Twice the rate of the general population.
- For female physicians, four times the rate (same rate as male physicians)
- More substance abuse issues, historically
- More likely to have had emotional problems prior to college
- 1/3 had prior psychiatric hospitalization and were more likely to l had prior attempts
- More likely to be seeing mental health provider (depends on specialty)

Additional Training Opportunities

RRSR-PC specifically addresses the U.S. Surgeon General's 2001 *National Strategy for Suicide Prevention's* Objective 7.2 to develop and promote effective clinical and professional practices in primary care settings, and Objectives 6.1 and 6.2 to implement training for recognition of at-risk behavior and delivery of effective treatment by nurses, physician assistants, and medical residents.

The RRSR-PC was developed by the American Association of Suicidology (AAS) with funding from the Irving and Barbara C. Gutin Charitable Fund to provide physicians, nurses/nurse practitioners, and physician assistants with the knowledge they need in order to include suicide risk assessments in routine office visits, to elicit risk where it exists, and work with patients to create treatment plans to reduce risk.

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

For pricing information, please contact AAS.

American Association of Suicidology

5221 Wisconsin Ave. NW 2nd Floor
Washington, DC 20015-2032

Phone (202) 237-2280
Fax (202) 237-2282

www.suicidology.org
info@suicidology.org

Recognizing and Responding to Suicide Risk in Primary Care

Information Brochure

20% of those who died by suicide visited their PCP within 24 hours prior to their death.

You could be the last medical professional seen by a patient on the brink of a life or death decision.

Sponsored by

American Association

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COLLEGES OF MEDICINE & PHARMACY

Resources

- https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.healthcare.english

- https://suicidology.org/training-accreditation/rrsr-primary-care/

Resources

Suicide Prevention Resources

Be a lifesaver

Visit
Your Primary Care Provider
Mental Health Professional
Walk-in Clinic
Emergency Department
Urgent Care Center

Suicide Prevention Lifeline
1-800-273-TALK (8255)
Veterans: Press 1

911 Call 911 for emergencies

Find a mental health provider
findtreatment.samhsa.gov
mentalhealthamerica.net/finding-help

CrisisChat.org

Text TALK to 741741
Text with a trained crisis counselor from the Crisis Text Line for free, 24/7

American Foundation for Suicide Prevention

afsp.org/resources

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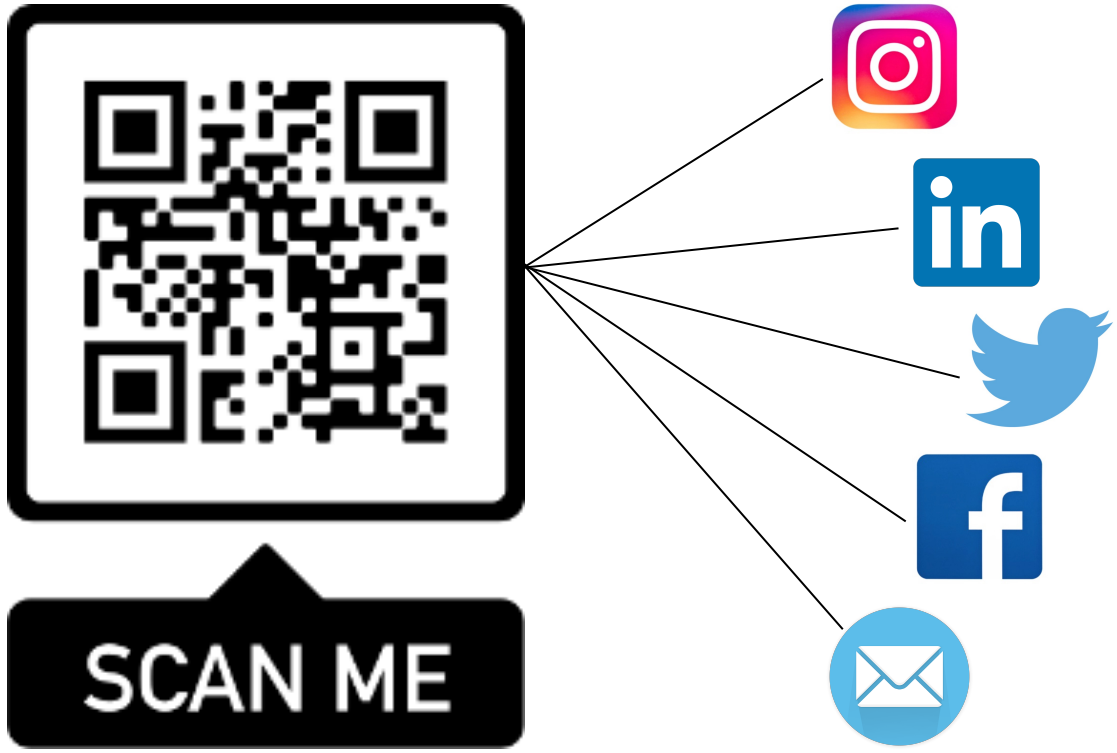

Questions? Comments?