VA PRACTICE Matters

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Collaborative Treatment for Depression

- *Nearly 10% of the population, or about 18.8 million Americans suffer from a depressive disorder at some time in their lives.*
- *The United States spends about $44 billion per year in both direct (i.e., medical care) and indirect (i.e. lost productivity) costs related to depression.*
- *About one out of every three veterans visiting primary care have some symptoms of depression, and one in eight to ten have major depression that requires treatment with psychotherapy or antidepressants. In addition, 40% of veterans with post-traumatic stress disorder (PTSD) also suffer from depression.*
- *Most patients with depression do not complete adequate care under usual VA or private sector conditions.*
- *Successful treatment of depression requires:*
  - *Collaboration between primary care and mental health*
  - *Screening and assessment to identify the condition, structured symptom monitoring to guide treatment, and brief care management (e.g., 10 minute nurse phone calls), emphasizing patient self-management support*
  - *Either psychotherapy and/or antidepressants*

VA HSR&D
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BACKGROUND

A depressive disorder is an illness with symptoms that can last for weeks, months, or years. Most people know a friend or loved one who has experienced the devastatingly vicious cycle of major depression, with symptoms that interfere with daily living. Yet despite the fact that depression is treatable, the helplessness and stigma that can accompany this condition make successful treatment difficult.

Imagine a busy primary care clinic, and a patient who either does not recognize or is ashamed to consider that his or her fatigue, apathy, insomnia, or chronic pain are related to depression. This patient also feels disorganized, forgetful, and hopeless - not the characteristics of an active health care consumer.

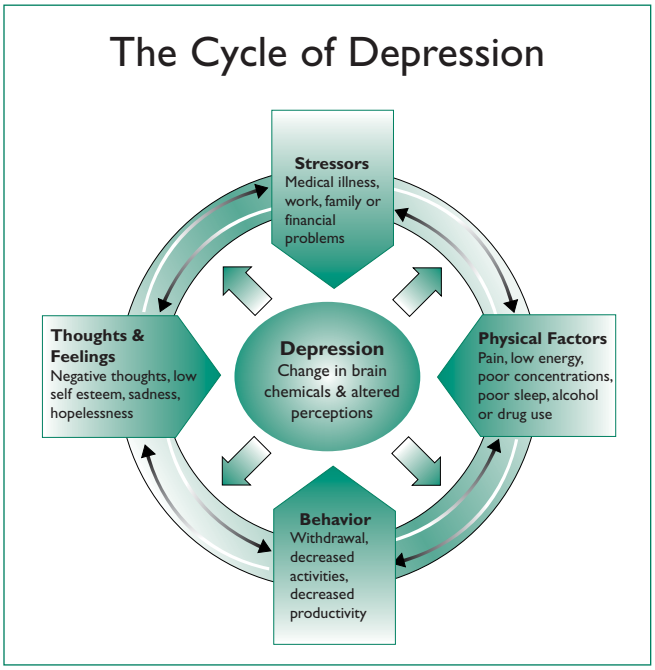
Even if the condition is detected and an antidepressant is prescribed, most patients will stop taking it before it has a chance to take effect, which can range from a few days to several weeks. If the clinician refers the patient to a VA mental health clinic, chances are that the patient will not show up for the first visit. Often, even if the patient completes one primary care or mental health visit, a second visit may not be available for a month or two — too long a gap for an uncertain patient who needs reassurance and reinforcement regarding how long medications may take to work. Research shows that a proactive, supportive team care approach is necessary before the benefits of depression treatment can be achieved.

TREATMENTS AND AVAILABLE THERAPIES

Experts agree on the key elements of depression care that are outlined in the Agency for Healthcare Research and Quality (AHRQ)[1,2] and VHA clinical guidelines for this condition. The information in the guidelines has been augmented by a variety of effectiveness studies on implementing the guidelines. The following treatment steps are based on both guidelines and subsequent implementation research.

Clinical Assessment: Once symptoms of depression are noticed, a systematic assessment by a trained clinician to confirm a diagnosis of depression and identify comorbidities is critical. Depressive symptoms characterize a variety of syndromes in addition to major depression, some of which do not require major depression-type treatments, such as grief reactions, adjustment reactions, and minor depression. Some medical illnesses and medications also can cause depression. In addition, depression or depressive symptoms can be accompanied by, or signal other major mental health comorbidities, most commonly post-traumatic stress disorder (PTSD), other anxiety disorders, substance use disorders, or bipolar disorder.

Patient Education and Self-Management Support: The first step in the recovery process is to help the veteran understand the vicious cycle of depression.



As the cycle illustrates, adverse events, physical illness, and environmental circumstances, such as social isolation, can affect the brain's chemistry (center of the cycle), which in turn alters a person's view of the world and affects behavior. The effects of altered brain chemistry on thoughts and behavior further perpetuate social withdrawal and decrease physical activity, resulting in difficulties at home and work that feed back and worsen brain chemistry.

Clinical Treatment Choice: Breaking this cycle of depression generally requires medication, psychotherapy, or both. This choice should take into account patient preferences and key symptoms. The most evidence-based psychotherapies for this condition are short-term, action-oriented psychotherapies, such as cognitive-behavioral therapy that optimally requires eight to twelve visits. Medications are necessary for a minimum of four to five months, and more typically for about nine months, to achieve optimal results. The length of initial antidepressant treatment is dependent upon the speed with which depression symptoms resolve; treatment should be continued for at least four months after symptom resolution.

If symptoms do not resolve within one to three months of the initial antidepressant or psychotherapy regimen, an active stepped-care approach to changing or adding to current treatment should be initiated. Even after resolution, patients on antidepressants who have had two or more prior episodes of major depression should be continued on their medication for at least two years.

Both medications and psychotherapy act to change the brain's chemistry, helping patients make additional positive behavioral and cognitive changes. Research shows that patients' stress and physical symptoms improve as their brain chemistry, cognition, and behavior move out of the depressed state. Further detail on treatments is available on a variety of websites including:

- VA TIDES - "Translating Initiatives for Depression into Effective Solutions" at www.va.gov/tides_waves/;
- VA's Office of Quality and Performance (OQP), "Clinical Practice Guidelines for Major Depressive Disorder" at www.oqp.med.va.gov/cpg/MDD/MDD_Base.htm;
- RAND Health, "Overview of the Partners in Care Study" at www.rand.org/health/pic.products/overview.html;
- MacArthur, Research - Human and Community Development "Initiative in Depression and Primary Care" at www.depression-primarycare.org
- AHRQ's "National Quality Measures Clearinghouse" at www.qualitymeasures.ahrq.gov

Care Management Support: Because of the propensity of depressed patients to drop out of treatment, it is critical to support their adherence through education about depression, as well as problem solving and encouragement, especially during the early weeks of treatment. Although new classes of medication have made depression easier to treat, in many cases adjustments to the initial plan will be required to determine the correct medication and dosage. This treatment issue, combined with concerns about side-effects and suicide risk among patients receiving antidepressants, indicates that close monitoring is imperative. Guidelines suggest three to six visits either by telephone or in person with a trained clinician over the first three months of treatment, with visits concentrated in the first month. Research shows that in order to provide successful care management, primary care settings generally require the involvement of a care manager, often a nurse, who carries out initial assessment and patient education, and then meets visit guidelines through additional brief contacts interspersed with the patient's visits to their usual primary care clinician. Research also shows that care manager functions (i.e., assessment, support, and symptom

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monitoring) can be successfully carried out by telephone for patients who have telephones using validated protocols and trained clinical staff.

Objective symptom monitoring through the administration of depression symptom indices has proven to be central to care management. These indices produce scores that can be graphed to show whether the patient is improving. Like blood pressure or blood sugar readings, depression symptom scores are used as the basis for proactive management, monitoring, and treatment adjustment. Current validated symptom indices like the PHQ-93 are easy to use, reliable and valid, and can be scored as part of CPRS. As care managers review patient progress with mental health specialists and primary care clinicians, these scores become the basis for tracking and communicating treatment progress.

Depression Treatment in Primary Care Settings: Most depressed patients seek depression care first in primary care settings. Extensive research shows that depressed patients can be cared for very successfully in these settings, if the primary care environment has the capability to provide the kinds of care outlined above, and when primary care clinicians collaborate with mental health specialists — one of the most important ingredients in successful depression treatment in primary care. This collaboration may incorporate ongoing education of primary care clinicians, back-up or supervision of primary care nurse care managers, quality review of depression care in primary care, and joint primary care and mental health specialty care for more severe, complex, or difficult to treat problems.

An example of successful VA collaborative care within the primary care setting is the TIDES (Translating Initiatives for Depression into Effective Solutions) project — a partnership of researchers in Seattle and Los Angeles, and network leaders and clinicians in VISNs 10, 16, and 23. A key feature of this project is the collaboration between primary care providers and mental health specialists, with support from a depression care manager, all working together to assess and manage the care of depressed patients. The implementation of TIDES at seven demonstration clinics achieved successful clinical outcomes. Primary care patients' compliance with medication and follow-up visits was outstanding. Not surprisingly, depression severity scores and functional status scores began showing substantial sustained improvement after four to six weeks, and early results of this ongoing project show even more striking improvement after six months. The project web site (www.va.gov/tides_waves/) provides information for patients, clinicians, and those wishing to implement collaborative care for treatment of depression.

Another example of successful VA collaborative care is PROJECT IMPACT (www.impact.ucla.edu), a multicenter randomized trial with 1,801 depressed older adults in eight cities around the country, including two VA outpatient clinics. Like TIDES, this project supported the care given by patients' regular primary care physicians. In the IMPACT model, patients and their physicians had access to a care manager in the primary care office who could: educate patients about depression, track symptoms and side effects, support treatment with antidepressant medications, and/or provide a brief form of psychotherapy or counseling for up to 12 months. Patients assigned to IMPACT felt better, were less depressed, had less impairment in their day-to-day functioning, and experienced greater improvements in quality of life than those in usual care.

FUTURE DIRECTIONS IN VA DEPRESSION CARE

Collaborative care models improve recognition and treatment of major depressive disorder in primary care settings, substantially improving the health outcomes of affected veterans. The VA has proven to be an outstanding environment for implementing collaborative care models. The type of implementation research carried out in projects like TIDES and IMPACT fosters the adherence of clinical programs to the research evidence base by

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CLINICAL OPINION

There is growing awareness of the mismatch between the needs of patients with chronic illness and our acute care oriented delivery system. Patients with chronic illness and their loved ones must respond daily to the demands of the illness, the treatment, and the disruptions and uncertainties of a fluctuating course with a modicum of skill and confidence. These demands are challenging enough when one has energy and perceives the world accurately. But the challenges of coping with their illness often overwhelm the patient with depression, who, even if diagnosed and treated, may be incapable of sustaining treatment without more intensive follow-up and support than most medical practices can provide. The usual intermittent interactions with health care to deal with urgent problems don't help much.

However, evidence is now overwhelming that the rate of recovery from major depression will increase by 50% or more if practice is redesigned to: 1) assure effective treatment, and 2) provide ongoing surveillance and support. This issue of *Practice Matters* nicely summarizes the research, much of it done within the VA, that has clarified the critical features of effective depression care:

- Intensive monitoring of symptoms (using standardized measures like the PHQ-9), medication adherence, and experience of treatment;
- Ongoing support of the patient's self-management skill and confidence; and
- Adjustment of therapy if the clinical response is inadequate.

Providing care with these features requires access to and integration of resources and expertise not often resident in primary care-nurse care managers, psychiatrists, and psychotherapists. Integration that makes sense to both patients and health care professionals is the more daunting task.

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KEY RECOMMENDATIONS

- Primary care clinicians should be aware of the high incidence of depression in their patients and should be prepared to assess severity, deliver first-line treatment, and make use of collaborative care resources.
- Mental health care directors should be aware of the critical role their services can play in reducing disability and distress in the primary care population through collaborative care arrangements.
- Health care practice directors should develop systems for supporting and encouraging collaborative care for depression.
- Practice systems should devote resources to the treatment of depression and other mental health disorders to achieve parity with other less stigmatized chronic conditions.

FUTURE DIRECTIONS IN VA DEPRESSION CARE

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bridging the gap between literature and existing clinical and administrative procedures. It is expected that programs developed through action research partnerships like these will endure past the formal project demonstration period and provide veterans with cost-effective, targeted care for a wide range of often under-diagnosed, under-treated problems, including common mental health problems like depression.

AUTHORS

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