Depression Care: Distress and Crisis Management Issues

New York State – Collaborative Care Initiative
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Goals of Webinar- Learns Ways to

• Assess depression causes/ contributing factors and tailor treatment for different needs

• Distinguish distress from depression and use evidenced-based treatments for these

• Plan for use of PST and BA within crisis situations

• Consider how to use case management within this model of care
PHQ9

Not the Whole Story
PHQ9 as a Screening Tool

• Importance of first two items - scores above 2 tell you more

• Number 10 gives extra information
History Taking - Other Factors

- Onset of depression
- Environmental factors
- Past history of depression
- Family history
- Past effective and ineffective treatments
- Patient treatment preferences
Depression/Distress

- Chronic Pain
- Housing
- Heart Disease
  - diabetes
  - cancer
- Finances
- Safety
- Job-feeling useful

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Is it a Mental Health Disorder?

• How long has the patient been feeling this way?
  ▪ Less than 2 months?

• Did something specific happen?
  ▪ Grief, bereavement?
  ▪ Adjustment reaction?
  ▪ Stress?

• Normal reaction to a bad situation?
  ▪ Feeling upset, unhappy, distressed can be normal
Provisional Diagnosis: Internal vs. External Causes of Depression

Two patients may have the same PHQ9 score

1) Patient lost job creating stress on marriage, feels overloaded by financial problems

2) Patient has been depressed most of their life with some periods of worse symptoms
Stress and Relapse

• One study found that stress came before a relapse in 70% of exogenous depression

• 30% of endogenous had a stress before depression
Fallacy of Good Reasons

“You would be depressed too if…”

Many people assume that if there is a good reason for the person to be depressed that it doesn’t need to be treated
• Can have both types of depression

• Patients may need medications even when environmental factors have started the cycle of depression for them
Customizing Care: Distress and Depression

- Customizing means to target treatment to the cause of depression and to patient preference
- External causes - case management, problem solving
- Internal causes - medications, behavioral activation, PST
Discussing Treatment Options

• The treatment that WORKS is the best one
  ▪ Person-centered care means selecting treatments based on client preference, not clinician preference
    • Try to be unbiased when offering treatment options
  ▪ Be eclectic: “One size fits few”
    • Medication therapy is not right for everyone
    • Psychotherapy is not right for everyone; Different therapies

• Supporting whole person treatment is important
  ▪ This may include medication therapy
    • You can support medication therapy within scope of practice
    • Ask questions and collect information
    • Support the patient being informed and active about all aspects of treatment plan
PHQ9 - Monitoring Tool

- Useful in distress and depression to see results
- Patients who have scores up and down - respond a lot to environmental issues
Traditional CBT with Low Income

• Research shows that it may not be effective

• Some things asked to do but didn’t help - changing negative thoughts but patient really is in a difficult environment

• PST is synergistic with case management
Models for Treating Environmental Causes of Distress

- Clinical case management:
  - Advocacy model - taking on the problems by the case manager

- Solving problems for patients with intent for independence

- Help patient advocate for self - PST
Pep - UP

• Compared: Clinical case management, CBT - group therapy or combination of both

• 70 pts, Over 60

• At poverty line

Outcomes

• Clinical care management and most improvement in depression

• PST is synergistic with clinical case management
CARED - unpublished

• Included PST with case management vs. just case management

• Divide lists of problems – which one does the patient want to start on?

• Truly combined approach

• Conclusion: Start with environmental issues first before other interventions
REDEEM

- 392 type 2 diabetics
- PHQ 8 was 10-15 no major depression
- Diabetes distress score $\geq 1.5$
- Randomized to informational video
- Computer assisted self management CASM
- CASM plus 4 PST sessions - not therapists
Crisis Management

Is every patient who cries or has a positive PHQ9 number 9 in need of your immediate help?

Helping the clinic know when to call you
PHQ-9 Follow-up Questions for Patients Scoring 1-3 on Question #9

The final assessment of whether immediate action is needed is up to licensed professionals within their scope of practice.

1: Do you feel like life isn't worth living?
   • Yes = Go to Follow-up Question #2
   • No = Write down what patient was thinking when they answered Question #9.
     ▪ A warm handoff would be useful but no urgent need for immediate assessment if behavioral health staff not available for warm handoff.

2: Do you have thoughts about harming yourself?
   • Yes = Go to Follow-up Question #3
   • No = Write patient's comments
     ▪ Warm handoff still best but no need for immediate behavioral health staff assessment if not available.

3: Do you have plans for how you would harm yourself?
   • Yes = Go to Follow-up Questions 4 and 5

4: Do you plan to act on this soon?

5: Do you have the means to harm yourself?

Yes on items 3, 4, or 5 should be reported to behavioral health staff before patient leaves the clinic so a decision can be made regarding actions to take.

2012 AIMS Center created by Rita Haverkamp, CNS, MS, APRN
What if there’s a crisis during PST?

- By all means, address it
- Add it to the agenda
- Use PST and have them tell you what is going on with the crisis
- Show them HOW PST can be helpful in a crisis
Suicidal Patients

• Assess suicide

• May address what to do when feeling suicidal as a PST session

• Solving other problems can help people feel less hopeless

• Staying with process after assessment can help
PST - Examples

• Brother-in-law dying - ways to be comfortable around him and family rather than withdrawing

• Take better care of self - eat, take meds, communicate

• Daughter OD - getting groceries
What if they have 100’s of awful things that all seem important?

• Take a deep breath

• Help them focus

• Emphasize that by focusing on one problem, others often fall into place

• Have them prioritize

• Look for opportunities where case management would be appropriate
What if they confess to a horrible thing from their past during PST?

• Again, add it to the agenda
• Listen to them
• Ask them what their goal is in sharing the information with you
• Use that information for problem solving
• What if it comes up in the middle of a session?
Horrible past - discussing re-traumatizes patient

- Body responds as if it happening now
- Abandonment case, past as reason
- Questions to ask self
  - Are they stable enough for this?
  - Do I have a strong evidenced-based treatment?
  - Will they come long enough?
  - Do I have enough sessions?
- Changing current life for most people is most effective
- Look for opportunities where case management would be appropriate
Distress Scales and Diabetes

• Many patients with diabetes and high levels of depressive symptoms are not clinically depressed

• This may apply to other health issues as well
• Non-clinically depressed patients display a high level of distress

• This distress is related to diabetes and its management.

• There are tools to assess this.
Diabetes Distress Scale 2

Feeling Not a Problem, Moderate Problem, Serious Problem

1. Feeling overwhelmed by the demands of living with diabetes.

   1   2   3   4   5   6

2. Feeling that I am often failing with my diabetes regimen.

   1   2   3   4   5   6
Diabetes Distress Scale
Full scale

http://www.ncbi.nlm.nih.gov/pubmed/17327318

http://familymedicine.medschool.ucsf.edu/pdf/bdrg/scales/DDS_all.pdf

Brief scale

http://www.annfammed.org/content/6/3/246.full
Distress of Pain

- Integrated care for pain and depression
- Cycle of pain and depression
- BA for pain
- Pain management medication support
- Medication management may not work for everyone
- Use of mindfulness, relaxation tools

Q&A