Depression

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Today we have far greater knowledge and awareness of the prevalence of mental illness, including depression, in primary care settings than ever before. As many as 25% of primary care patients have a significant mental health disorder (most often anxiety or depression). All too often, mental health conditions are neither diagnosed nor adequately treated in primary care settings. The costs associated with untreated mental disorders in primary care are considerable. For example, the annual health care cost for untreated patients with depression is nearly twice that for patients who do not have depression. According to a study supported by the Agency for Healthcare Research and Quality (HS09397), the proper diagnosis and timely treatment of these mental health disorders can prevent many costly acute care hospitalizations and save significant health care dollars.

Depressed patients in primary care settings commonly present with somatic symptoms rather than complaints of depressed mood. Therefore clinicians must be proficient in the assessment and management of depression. However, the diagnosis and treatment of depression in the adult homeless population can be very challenging for primary care practitioners. This is generally due to the complex set of bio-psycho-social factors experienced by homeless adults. These factors may include chronic alcohol and substance abuse, various forms of physical and emotional trauma (e.g., PTSD), persistent poverty with limited access to affordable housing, lack of access to and continuity of medical and mental health services, and the formidable task of survival on the streets or in the emergency shelter system.

In the *Homeless Survey of 2000 in Hartford, Connecticut*, 27 of 66 (41%) homeless individuals who completed the survey reported having depression as a medical issue. Only drug abuse (other than alcohol) was reported higher (42%) by homeless respondents to the survey. The National Institute of Mental Health and the Federal Task Force on the Homeless also estimate that roughly one-third of homeless persons suffers from mental illness. Various studies have estimated the prevalence of co-occurring disease (both mental illness and substance abuse) in the adult homeless population to be from 30% to 60%.

This man suffered from lifelong and untreated depression. His depression improved with medication prescribed by a psychiatrist who had observed him in the shelter and on the streets. Photo by Norma Laurenzi

Signs and Symptoms of Depression

Clinical depression can be very difficult to diagnose in the homeless population. Depression is often viewed as a normal response to the situation of living in a "state of homelessness", and the typical manifestations are considered the result of trying to survive life on the streets or the turmoil of the emergency shelter system. Depressive symptoms in the adult homeless population may also accompany chronic substance abuse, and clinicians should be cautioned about making a diagnosis of clinical depression when patients are impaired. A diagnosis of depression should be made cautiously during short-term periods of sobriety, as "rebound" sadness and other depressive symptoms can occur during withdrawal periods in persons who suffer from chronic substance abuse.

Clinical depression is a syndrome with biological changes characterized by a specific cluster of signs and symptoms. Three common forms should be recognized by primary care clinicians: major depression, chronic depression, and minor depression. According to the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV), chronic depression is also known as "dysthymia". Minor depression is classified as "adjustment disorder with depressed mood" or "depressive disorder not otherwise specified (NOS)."

Major Depression

DSM-IV identifies nine signs and symptoms of major depression that can be categorized into four groups:

- *depressed mood*: subjective feelings of sadness or emptiness most of the day, nearly every day;
- *anhedonia*: markedly diminished interest or pleasure in all or almost all activities;
- *physical symptoms*: fatigue, significant change in appetite or weight, sleep disturbances, and psychomotor retardation or agitation;
- *psychological symptoms*: feelings of worthlessness, inappropriate guilt, inability to concentrate, and recurrent thoughts of death or suicidal ideation.

For a diagnosis of depression, the patient must exhibit either a depressed mood or anhedonia, as well as four of the physical or psychological symptoms noted above. If both depressed mood and anhedonia are present, then only three other symptoms are necessary to make the diagnosis. These symptoms must be present for at least two weeks and occur nearly every day for most of the day.

Chronic Depression

Chronic depression, or dysthymia, is characterized by a persistently depressed mood, present for more days than not, for at least a two-year period of time. Depressed mood must be accompanied by two other depressive symptoms (see above list). These symptoms must be present for at least two years with no major depressive episode.

Dysthymic disorder is not a major depressive episode in partial remission. Many patients have suffered with dysthymia for their entire adult lives, and some may have come to accept depressed mood as a part of life. A large majority of individuals with dysthymia, however, will develop major depressive episodes.

Minor Depression

Sadness is an appropriate response to stressful life events, such as job loss, death of a family member, loss of a close friend, health impairment, marital difficulties, or financial hardship. When the reaction appears excessive or continues for longer than two months, these patients are considered to have an adjustment reaction with depressed mood. Other patients may have mixed depressed mood and anxiety symptoms, some of which recur on an intermittent basis.

Patients suffering from one of these depressive disorders that do not fit well into any other category can be diagnosed with the syndrome of minor depression or, according to DSM-IV, "depressive disorder not otherwise specified (NOS)."

These minor forms of depression are distinguished from major depression by the absence of a full complement of five depressive symptoms and from chronic depression by their shorter duration. If at any time, however, the symptoms change, the diagnosis and management strategies should be adjusted accordingly.

The BPHC's Depression Collaborative and Worcester's HOAP

In July of 2002, the Bureau of Primary Health Care's (BPHC) Health Disparities Collaborative included depression in its list of chronic illnesses, along with diabetes, cardiovascular disease, and asthma. The goal of the Bureau's Health Disparities Collaboratives is to develop improvements in chronic disease management in underserved populations who receive primary care services across

all health center programs. Teams focusing on one of the four chronic illnesses were selected through a competitive process based on their readiness to engage in a "redesign" of chronic illness care in their health centers. Among the health centers selected to engage in the process were a number of HCH programs. Depression care was adapted to the Care Model, and teams were assembled across the country by region and by disease to discuss the implementation of both the Care and Improvement Models in each setting.

Teams are required to report monthly and to maintain a confidential database or "registry" of patients participating in the Collaborative. These patients are described as a "population of focus" who belong to a designated team of providers and support staff (nurse educators, care managers, etc.). Teams of providers report patient progress compared to a set of national "key measures" on a monthly basis to the Bureau through 10 Regional Cluster coordinators. Sites can also select specific measures that are unique to their population of focus. Goals of the project include improving patient care and quality of life, reducing the overall cost of chronic illness care in primary care settings, helping patients become more active in managing their illness, and "redesigning" patient visits to better meet the needs of patients. The model supports the use of a wide spectrum of health center and community resources.

Community Healthlink (CHL) is a community-based mental health facility located in Worcester, Massachusetts, and is the site of a 330(h) HCH program. The HCH program at CHL, the Homeless Outreach and Advocacy Project (HOAP), has been operating since 1985. HOAP serves between 2300-2400 unduplicated homeless adults annually. HOAP provides a broad range of services to Worcester's adult homeless population, including: primary care; mental health and substance abuse services; transitional and permanent housing services; emergency case management; and a small respite program. The majority of HOAP's patients are single adult homeless males (65%) between the ages of 25 and 55, with the largest single group of male patients falling within the specific age range of 39-44.

The initial screening for depression takes place via a self-administered tool called the Patient Health Questionnaire (PHQ-9). In a multi-center study of 8 family practices and internal medicine sites with 3000 patients and 62 physicians, the instrument was found to have 73% sensitivity and 98% specificity for the diagnosis of major depression. The instrument is easy to administer and can be scored quickly (1-2 minutes for 85% of patients). The PHQ-9 is administered on regular follow-up visits in order to monitor a patient's response to treatment.

The PHQ-9 provides screening, diagnostic, and outcome data for patients with depression through a series of questions (11 in total) that measure the signs and symptoms of clinical depression. Recording the number of overall symptoms and a severity score correlates to a specific diagnosis of depression. The greater the frequency of depressive symptoms reported by the patient, the higher the severity score. Patients with a severity score of 10 or greater are classified as having a "Clinically Significant Depression" (CSD) and are engaged in the program.

The original national key reporting measures required for all depression teams are listed below. These key measures have been discussed at length with current depression teams at several of the National Learning Sessions, and modifications are frequently made. The measures are:

- number of patients with a diagnosis of depression;
- number of patients with a CSD;
- CSD patients with PHQ score less <5;
- CSD patients with documented follow-up within 2 weeks of initial assessment;
- CSD patients with 2nd PHQ within 6 weeks of initial assessment;
- patients with self-management goal within 12 months;
- number of patients with documented PHQ score at six months.

New homeless patients seen at the HOAP main clinic site in Worcester were given the PHQ-9 questionnaire beginning in July 2002. The HOAP primary care team is relatively small and includes one physician (0.6 FTE) and two nurse practitioners (2.0 FTEs). As of May 2003, the collaborative patient database was capped with 73 patients entered into the registry. Of these 73 initial patients, 48(66%) were male and 25(34%) were female. Sixty-one patients (84%) had a PHQ severity score of 10 or greater, indicating a Clinically Significant Depression (CSD). One of the national key measures being tracked is follow-up after the initial or index assessment. There is a two-week standard for the first follow-up appointment. Despite often high rates of no-shows in homeless populations, HOAP found that 73% of patients were seen within 2 weeks of the initial assessment.

Components of Change

Treating depression in the homeless adult population presents many challenges. Clinical depression has often gone untreated for many years or may have been treated only episodically in emergency settings. More often than not, homeless individuals receive only emergent or acute treatment for a variety of mental illnesses and then return to the community with incomplete follow-up care.

HOAP has a significant mental health and substance abuse treatment component as a part of its core services. Depression was often relegated to a "low level" priority in comparison to other mental illnesses among HOAP's homeless patients, such as schizophrenia, bi-polar disorder, schizo-affective disorder, and psychotic disorders. HOAP primary care providers often prescribe anti-depressant medications but are much more comfortable referring patients to the HOAP psychiatrist and mental health team for medication and ongoing psychotherapy. The collaborative did raise the "visability" of depression in our population, and patients participating in the collaborative were referred for mental health treatment much more quickly. Also, substance abuse disorders were present in a significant number of patients, making the diagnosis of clinical depression more difficult.

Self-Management Issues

One of the major goals of the collaborative process is the active involvement of patients in the overall management of their illness. For illnesses such as diabetes, CVD, and asthma, patients can often participate by making changes in life-style, exercise, or choices about reducing the consumption of foods high in fat or salt content. Depressed individuals in most settings have opportunities to make changes such as practicing stress reduction techniques, going for walks, or talking to a sympathetic friend. Homelessness limits such choices and opportunities, and therefore self-management goals must be adapted to other than "ideal" circumstances. For example, patient adherence with medication regimens is often a goal for providers working with homeless patients. Although 100% adherence is usually the target, this may be an unrealistic expectation for many homeless individuals who may not have a place to store or refrigerate medicines and who may have great difficultly remembering to take medicines at prescribed times throughout the day. As a direct result of our provider team conferences, we have decided that a "harm reduction" philosophy is more realistic for homeless individuals. Patients are reminded that their use of substances such as alcohol or drugs directly contributes to overall feelings of depression. For patients who are depressed and continue to use substances, a self-management goal might be to commit to using less alcohol or heroin or to use less frequently. We have found that self-management goals tailored to each individual work more effectively in the homeless population. ■

References

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