HRSA
Health Resources & Services Administration

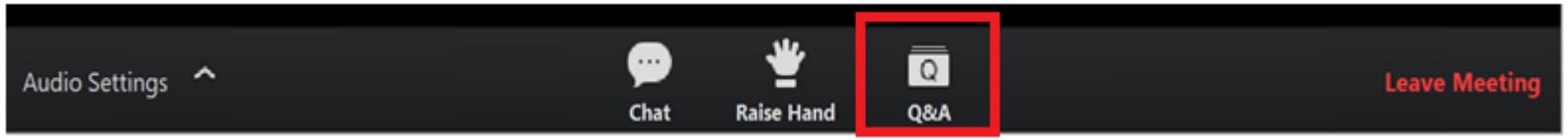
# Anxiety and Depression:
## Screening and Intervention within an Integrated Care Setting

**Wednesday, December 21, 2022**
**1:00 – 1:30 p.m. ET**

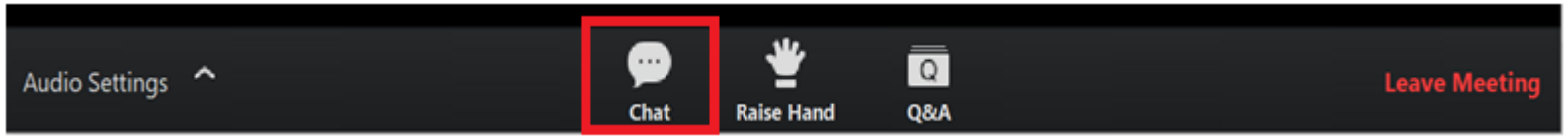
Vision: Healthy Communities, Healthy People

# Submitting Questions and Comments

- Submit questions by using the Q&A feature. To open your Q&A window, click the Q&A icon on the bottom center of your Zoom window.




- If you experience any technical issues during the information session, please message us through the chat feature, or email healthcenter_BHTA@jbsinternational.com.



# Continuing Education (CE)

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- You **must** complete the Health Center Satisfaction Assessment at the end of the workshop.
- We will provide more information about how to complete the Satisfaction Assessment and details about applying for CEs at the end of the workshop.

JBS International, Inc. has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6442. Programs that do not qualify for NBCC credit are clearly identified. JBS International, Inc. is solely responsible for all aspects of the programs.

# Presenter

Joseph Hyde, MA, LMHC, CAS
BHTA Project Director and Senior Technical Expert Lead
JBS International, Inc. (JBS)

## Anxiety and Depression:
Screening and Intervention within an Integrated Care Setting

# Objectives

Source: iStock

Participants of this webinar will be able to:

- State the prevalence of anxiety and major depressive disorder in the United States with respect to gender, ethnicity, and age
- Review recent USPSTF recommendations regarding anxiety screening
- Identify comorbidities associated with Anxiety & Major Depression
- Orient participants to the PHQ-9,(PHQ-3) and GAD-7 and use in risk stratification, treatment matching and monitoring
- Describe intervention strategies within an integrated care setting

# Polling Question 1

Which patients in your practice are more likely to be depressed or have issues of anxiety?

- Adolescents and Young Adults (10-19 y/o)
- Young Adults (18-24 y/o)
- Adults – Women (25-64 y/o)
- Adults --  Men (25-64 y/o)
- Older Adults 65+ years old
- Non-Hispanic African American
- Non-Hispanic White
- Hispanic

Source: iStock

# About Major Depression

- Relapsing and remitting illness
- Episodes may last a few months to years
- Half of episodes fully remit within 6 to 12 months with or without treatment
- Lack of treatment, however, often leads to chronicity
- Initial episode predisposes patients to subsequent episodes

Image by Pixabay

Source: Moore DP et al. Mood Disorders. In: Moore & Jefferson: Handbook of Medical Psychiatry, 2nd ed. Philadelphia: Mosby; 2004.

# Prevalence of Major Depression in the U.S.

- Lifetime prevalence: 16.2%[1]
  - Non-Hispanic whites: 17.9%[2]
  - Non-Hispanic blacks: 10.8%[2]
  - Hispanics: 13.5%[2]
- 12-month prevalence: 6.6%[1]
- Lifetime prevalence is increasing among both genders[3]

Image by Pixabay


Sources:

1. Kessler RC et al. The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). JAMA. 2003;289(23):3095-3105.
2. Breslau J et al. Specifying race-ethnic differences in risk for psychiatric disorder in a USA national sample. Psychol Med. 2006;36(1):57-68.
3. Kessler RC. Epidemiology of women and depression. Journal of Affective Disorders. 2003;74(1):5.

# Global Burden of Major Depression

**Today**

- Leading cause of disability
- Fourth leading contributor to global burden of disease
- Second leading burden of disease for those 15 to 44
- 877,000 deaths from suicide annually worldwide

**By 2030**

- Major Depression is projected to be second leading burden of disease for all ages and both genders


Sources:

1. Mental health: Depression. World Health Organization web site. http://www.who.int.db.usip.edu/mental_health/management/depression/definition/en/. Accessed May 2, 2007.
2. Mathers CD et al. Projections of global mortality and burden of disease from 2002 to 2030. PLoS Med. 2006;3(11):e442

# Comorbidity, Anxiety and Depression

Image by Pixabay

- 72.1% of those with lifetime depression and 64% of those with 12-month major depression have at least one additional behavioral health condition
- Most commonly anxiety disorder, substance abuse disorder, or trauma
- Anxiety and Depression are frequently comorbid with health conditions such as Type 2 diabetes, Hypertension, Cardiovascular disease and chronic pain

Source: Kessler RC et al. The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). JAMA. 2003;289(23):3095-3105.

# Anxiety and Depression in the Age of COVID

2018 Annual Incidence of depression in adult 6.6%. (CDC)

2020 Annual Incidence of depression in adult 12.4%. (CDC)

2021 Incidence of depression in adult 24%. (Kaiser Family Foundation)

2021 Incidence of suicidal ideation in adult 11%. (Kaiser Family Foundation)

- 2019 Incidence of Anxiety in adults 19.5% (CDC)
- 2021 Incidence of Anxiety in adults 34.4% (Kaiser Family Foundation)
- What does this mean? The disruption in our social fabric caused by the pandemic has (to quote the NYT) created a second pandemic!

# Polling Question 2

Who is most likely to first identify anxiety and depression?

- Primary care physician
- Ob/Gyn
- Psychiatrist
- BH Clinician (social worker)

Source: iStock

# Major Depression in Primary Care

Common in primary care

- >60% of antidepressants prescribed by PCP[1]

- Depression is often underdiagnosed
- Depression is often undertreated

Image by Pixabay

# Why Bother Screening?

- In 2022 the US Preventative Services Task Force has recommended universal screening of children for anxiety
- In 2022 the US Preventative Services Task Force has recommended universal screening of adolescents for depression and suicidality
- In 2022 the US Preventative Services Task Force has recommended universal screening of adults for depression and suicidality
- Because screening for anxiety and depression can significantly improve the early detection and treatment of anxiety and depressed patients, and patients with suicidal risk thus improving health outcomes and decreasing clinical morbidity.

Sources:
1. US Preventive Services Task Force. Screening for depression: recommendations and rationale. Ann Intern Med. 2002;136(10):760-764.
2. MacMillan HL et al. Screening for depression in primary care: recommendation statement from the Canadian Task Force on Preventive Health Care. Cmaj. 2005;172(1):33-35.

# Why aren’t medical providers addressing anxiety and depression?

Image by Pixabay

- Providers may not have the training they need in medical school and during their residency.
- Patients often don’t exhibit the readily detectable symptoms providers are trained to focus on.
- The provider may not have the interpersonal skills necessary to elicit sensitive information required for diagnosis.
- An integrated team approach can significantly assist in identification and intervention.

Source: Hirschfeld RM et al. The National Depressive and Manic-Depressive Association consensus statement on the undertreatment of depression. JAMA. 1997;277(4):333-340.

# Patient Presentation can be a barrier

- Patients rarely self identify anxiety and/or  depression (or other behavioral health) condition. This is especially true for men.
- Internalized stigma prevents acknowledgement.
- Many patients will not bring up concerns unless they are directly asked.

Remember… **If you don’t ask, you don’t know!**

Source: Hirschfeld RM et al. The National Depressive and Manic-Depressive Association consensus statement on the undertreatment of depression. JAMA. 1997;277(4):333-340.

# What to Do?

- In universal screening include questions about depression (PHQ3)* and anxiety conditions into general set of wellness questions presented to all patients. (universal screening)
- Incorporate screening for anxiety and depression as standard of care.
- Use the screening tool results to start conversation with patients.

- **PHQ Q1, Q2, Q9*

Source: Practical strategies for diagnosing and treating depression in women at midlife and beyond. Changing Lives CME Series. Fort Worth, Texas: University of North Texas; 2007.

# Major Depression Contributing Risk Factors

- Family problems
- Family history (alcoholism, mood disorders, IPV)
- Social isolation
- Personality factors
- Exposure to stressful life experiences (ACEs)
- Comorbid health conditions such as diabetes, arthritis, cancer and chronic pain


Image by Pixabay

Source: Kessler RC. Epidemiology of women and depression. Journal of Affective Disorders. 2003;74(1):5.

# Contributing Risk Factors for Anxiety

Medical Conditions

- Heart disease
- Diabetes
- Thyroid problems, such as hyperthyroidism
- Respiratory disorders, such as chronic obstructive pulmonary disease (COPD) and asthma
- Drug misuse or withdrawal
- Withdrawal from alcohol, anti-anxiety or other medications
- Chronic pain or irritable bowel syndrome

- **Trauma. Stress due to an illness.** Having a health condition or serious illness can cause significant worry about issues such as your treatment and your future.
- **Stress buildup.** A big event or a buildup of smaller stressful life situations may trigger excessive anxiety **Personality.** People with certain personality types are more prone to anxiety disorders than others are.
- **Other mental health disorders.** such as depression, family History.

# Anxiety Disorders

Image by Pixabay

- They affects over 50 million people over age 18 in the United States
- Median onset as early as 13 years of age
- May interfere with being able to form in school, work sustain relationships

# Many Faces of Anxiety Disorders

- Panic attack
- Panic Disorder without agoraphobia
- Panic Disorder with agoraphobia
- Obsessive-Compulsive Disorder
- Substance induced Anxiety Disorder
- Post-traumatic Stress Disorder
- Generalized Anxiety Disorder
- Anxiety Disorder due to a general medical condition
- Anxiety Disorder Not otherwise specified

# Universal Screening

## SBIRT

- Screening, brief intervention, and referral to treatment (SBIRT) is a comprehensive, integrated, **public health approach** to the delivery of identification, early intervention and treatment services.
- Although originally developed for early identification of risky or harmful substance use, the protocol today commonly includes depression and anxiety screening.
- Pre-COVID, triage screening was conducted in the waiting room. Today, triage screening is increasingly performed virtually using technology or telehealth.

Let us get well acquainted or re-acquainted with the PHQ-9.

- There is a PHQ-9 for adults
- There is a PHQ-9a for adolescents
- A PHQ adaptation – The PHQ – 3 (Q1, Q2 and Q9)
- The tool is validated and in the public domain (free).
- It is the most commonly used depression screening tool used.
- One of its greatest values is stratifying risk and severity that aligns with suggested clinical intervention.

# Know the scoring

- 1-4 minimal depression
- 4-9 mild depression
- 10-14 moderate depression
- 14-19 moderate severe depression
- 20-27 severe depression

**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 |

# How do PHQ-9 scores inform care

- 1-4 minimal depression – Normal, no intervention indicated
- 4-9 mild depression – Monitor or explore brief counseling
- 10-14 moderate depression – Psychosocial intervention (MI/CBT)
- 14-19 moderate severe depression - Psychosocial intervention and consider pharmacologic intervention
- 20-27 severe depression – Pharmacologic Intervention and psychosocial intervention
- ***A positive response to question 9 (self harm) regardless of score should trigger intervention by behavioral health.***

- **Generalized Anxiety Disorder 7-item (GAD-7) scale**
-
- Date: _____
- Name: _____
- DOB: _____
- If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

## Generalized Anxiety Disorder 7-item (GAD-7) scale

| Over the last 2 weeks, how often have you been bothered by the following problems? | Not at all | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it's hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |
| Add the score for each column | + | + | + | |

**Total Score (add your column scores) =**

Score 0-4: Minimal Anxiety. Score 5-9: Mild Anxiety. Score 10-14: Moderate Anxiety. Score greater than 15: Severe Anxiety

# GAD Scoring and Care Recommendation

| Score | Severity | Recommendations |
|---|---|---|
| 0-4 | None to minimal | No follow-up is warranted at this time. |
| 5-7 | Mild | It is recommended to monitor symptoms and follow-up as indicated. |
| 8-9 | Mild | This individual is likely to be diagnosed with an anxiety or related disorder. Repeat administration of the GAD-7 every 4 weeks to monitor symptoms. Follow up to determine if current symptoms warrant a referral to a mental health professional. |
| 10-14 | Moderate | This individual is likely to be diagnosed with an anxiety or related disorder. Their symptoms are clinically significant and warrant further assessment (including diagnostic interview and mental status examination) and/or referral to a mental health professional is recommended. |
| 15-21 | Severe | This individual's symptoms of anxiety likely warrant active treatment. This individual is likely to be diagnosed with an anxiety or related disorder. Further assessment (including diagnostic interview and mental status examination) and/or referral to a mental health professional is recommended. |

Mild to Moderate anxiety is often treated with behavioral therapies, behavioral activation and complementary interventions such as physical exercise, yoga and mindfulness/meditation.

SSRI medications are often prescribed for moderate/severe anxiety with companion behavioral therapy.

# Behavioral Health and Physical Comorbidity

- Depression, anxiety and sleep disturbance often co-occur with chronic conditions such as pain, diabetes and cancer (and other chronic health conditions).
- Behavioral health conditions poorly managed, negatively impact treatment for the physical health condition.
- Conversely,  reasonably managed behavioral health conditions positively impact care.
- An integrated team approach supports whole person care.
- A range of evidence based nonpharmacologic interventions should be considered to maximize care planning…relaxation training, mindfulness, motivational interviewing, cognitive behavioral therapy, yoga.

# Key Takeaways for Today

Screening for depression, suicidality and anxiety should be a standard of care because:

**If you don't ask, you don't know!**

- Untreated or poorly managed anxiety and depression impacts physical health, especially patients with chronic health conditions
- An integrated approach between physical health and behavioral health yields better results for patients with chronic health conditions
- There are a range of evidence based behavioral health interventions that can be employed to support patient health and wellbeing

# Polling Question 3

As a result of this webinar, in what ways might we further support your health center?

- Better engage and intervene with depressed or anxious patients
- Better engage and intervene with patients experiencing suicidal ideation
- Strengthen clinical skills for behavioral therapy
- Enhancing cultural relevance in clinical practice

Source: iStock

# Q&A

# Accessing Additional T/TA Opportunities

**BPHC BH TA PORTAL ONLINE REQUEST FORM**

https://bphc-ta.jbsinternational.com/ta-request-form

**EMAIL**

healthcenter_BHTA@jbsinternational.com

**BH TA WEEKLY UPDATE**

healthcenter_BHTA@jbsinternational.com

# Upcoming TA Opportunities in December 2022/January 2023

## WEBINARS

**12/21/2022 1:00-2:00 p.m. ET**

**"Addressing Anxiety and Depression in Primary Care"**

*Registration coming soon*

## BROWN BAG SESSIONS

**12/13/2022 11:00 – 12:00 p.m. ET**

**"Integrated Care for Patients Who Consume Cannabis"**

https://us06web.zoom.us/meeting/register/tZMvc-utqDgoE9PB_wMZQWm1Fu6mGAfRj1tf.

## COMMUNITIES OF PRACTICE (CoPs)

Eight Sessions Each (12 CEs)

**2:00 – 3:30 PM ET, every other Tues.**

**CoP 1: "Workforce Resiliency and Retention"**

**1/10/2023 – 4/25/2023**

*Registration coming soon*

**CoP 2: "Treatment of Anxiety and Depression in the Health Center Setting"**

**1/10/2023 – 4/25/2023**

*Registration coming soon*

**2:00 – 3:30 PM, every other Thurs.**

**COP 3: "Transition-aged Youth – Addressing BH Needs"**

**1/19 /2023 – 4/27/2023**

*Registration coming soon*

# CE Revisited

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- We will also email you a link to the Satisfaction Assessment.

***Please take  2–3 minutes to complete the Satisfaction Assessment directly following this session.***

THANK YOU!

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# Thank You!

## Joe Hyde, BHTA Project Director and JBS Senior Technical Expert Lead