
Depression & Anxiety Management

VOLUME

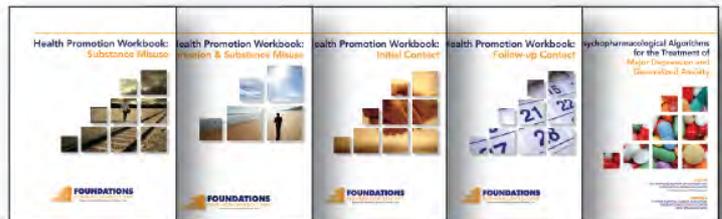
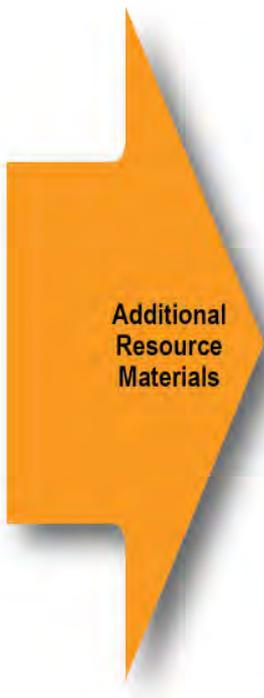
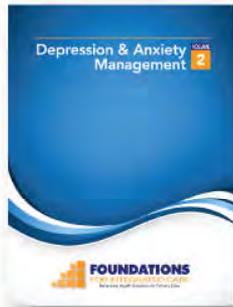
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FOUNDATIONS
FOR INTEGRATED CARE

Behavioral Health Solutions for Primary Care.

Foundations for Integrated Care LEARNING MAP



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Using This Training Manual

This training manual will provide you an overview of an evidence-based algorithm (or set of guidelines) for the delivery of Depression & Anxiety Management services appropriate for use in primary care and will serve as an ongoing reference guide. The target audience is behavioral health providers working in the primary care setting (integrated care providers), although the content may also be helpful for other members of the primary care team or providers wishing to better understand successful practices for primary care treatment of common mental health disorders. The first manual in this series “Building a Strong Foundation” lays the groundwork for integrated care treatment. This manual will build on the concepts and steps presented in the initial manual, thus presumes the reader has a basic understanding of initial manual content.

It is important to remember that this manual serves as a launching point; the training provided in this manual will not, in itself, result in expertise in the delivery of depression and anxiety management. It is expected that additional training will be required for all but the most experienced clinicians. Potential sources for additional training have been included in this manual to assist you in identifying potential opportunities for developing expertise in algorithm-appropriate skills.

As studies show that individuals demonstrate a higher level of retention when they can review their own notes later, if you are using this manual as part of a group training session, you are encouraged to make notes directly on the manual pages both to expand the content and to allow for increased future utility. The following icons are used as visual guides throughout this manual:

Graphic Icons/Cues		
		
<p>Key Points Course content that plays an important role in the overall learning experience.</p>	<p>Practice Dialogue Course content that contains dialog that is best practiced by speaking the text aloud.</p>	<p>Check it Out Course content specific to Health Technician level staff.</p>
		
<p>Practice Discussion Course content that depicts typical patient interactions, best practiced as a role play.</p>	<p>Procedure / Steps Course content that illustrates step-by-step instructions, procedures, or protocols.</p>	<p>Tips: Learning Course content that provides useful tips for enhancing the overall learning experience.</p>

Depression & Anxiety Management

This training manual provides a model of care for adults who suffer from anxiety or depressive symptoms in the setting that they are most likely to be identified and treated – primary care. The manual outlines the role of the integrated care clinician, or Behavioral Health Provider, in the delivery of integrated care services including 1) interventions aimed at prevention and/or health promotion and 2) the delivery of brief treatments, including behavioral interventions and/or medication management.

Learning Objectives

Completion of this training program will build clinical skills and achieve the following objectives:

- Understanding the theoretical framework for assisting patients seen in primary care to achieve successful, sustained engagement in the treatment of depression and anxiety symptoms and promote relapse prevention
- Learn the utility of using structured assessments to facilitate symptom measurement, tracking of patient outcomes, and allow for “down stream” program evaluation
- Develop a strategy to monitor patients with sub threshold depression symptoms for clinical worsening
- Learn how to effectively use telephone visits to enhance engagement in the clinical program
- Provide evidence-based interventions for depressive symptoms, consistent with delivery in the primary care environment

Brief Overview

The Depression & Anxiety Management program is designed to close the gap between identification of depression and anxiety in primary care, and access to the elements of care shown in studies to lead to improvement in symptoms and functioning [1]. Critical elements from research and clinical practice are combined to deliver time limited but effective treatment such as sustained use of antidepressant medication, symptom monitoring, and brief behavioral interventions, in a stepped care fashion. Key components include:

- Integration of behavioral health providers such as yourself with primary care providers;
- Emphasizing communication and shared responsibility for patients;
- Systematic follow-up care with a focus on routine assessment of symptoms and adherence to a treatment plan and algorithm;
- Active patient self-management;
- Systematic identification of indications for consultation and specialty referral.

This manual begins by describing the evidence base for management of depression and anxiety in primary care. The next section provides basic education on depression and anxiety disorders. Finally, the steps for Depression & Anxiety Management are described. Additional materials, including assessments, a medication algorithm, and patient handouts, can be found in the **Patient and Clinician Resources Volumes**. All interventions can be delivered either in-person or by telephone, as telephone management has been shown to be equally effective for this patient population.

The integrated care clinician is referred to in this manual as the Behavioral Health Specialist (BHS) and may include any licensed professional staff with mental health expertise working within primary care. This includes psychologists, licensed social workers, pharmacists, psychiatrists, and nurses. Basic competencies in motivational interviewing and problem-solving or goal setting are highly recommended. Other interventions used within the context of management, such as specific brief therapies, will vary based on the BHS's skill set and areas of expertise.

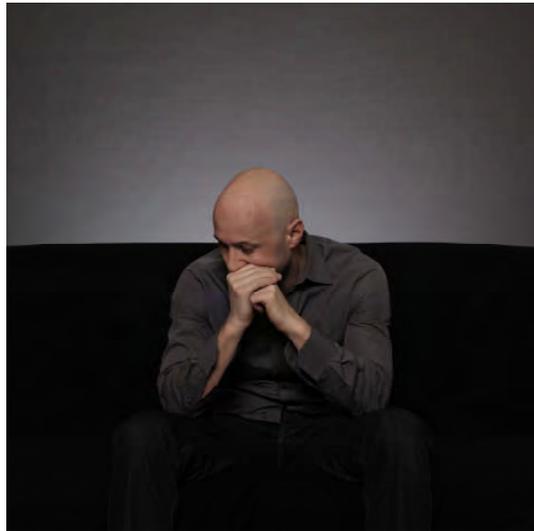
Understanding Depression

Before describing the steps of the depression and anxiety algorithm it may be helpful to begin with a brief overview of depression and anxiety. It may also provide a framework for presenting depression to primary care providers (PCPs) and other members of your integrated health care team. Depression is often not well understood by non-mental health professionals. A big piece of your role is helping providers and team members to expand their knowledge base and having a better understanding of mental health.

In 2010, the Centers for Disease Control and Prevention (CDC) released a report estimating the prevalence of current depression in adults from 2006-2008. Of 235,067 adults, 9% met the criteria for current depression, including 3.4% who met the criteria for major depression. Depression can be thought of as a disorder of mood regulation usually involving disturbances not only of the emotions, but of thought processes, behavior and physiological functioning [2]. Unlike many of the illnesses treated in primary care, depression cannot be diagnosed using a lab test or scan. Diagnosis relies entirely on an assessment of the presence, persistence, and effects on functioning of specific symptoms. Moreover, although there is evidence that depression is related to an imbalance of neurotransmitters in the brain, many non-biological factors interact with a person's physiology to produce the symptoms associated with depression.

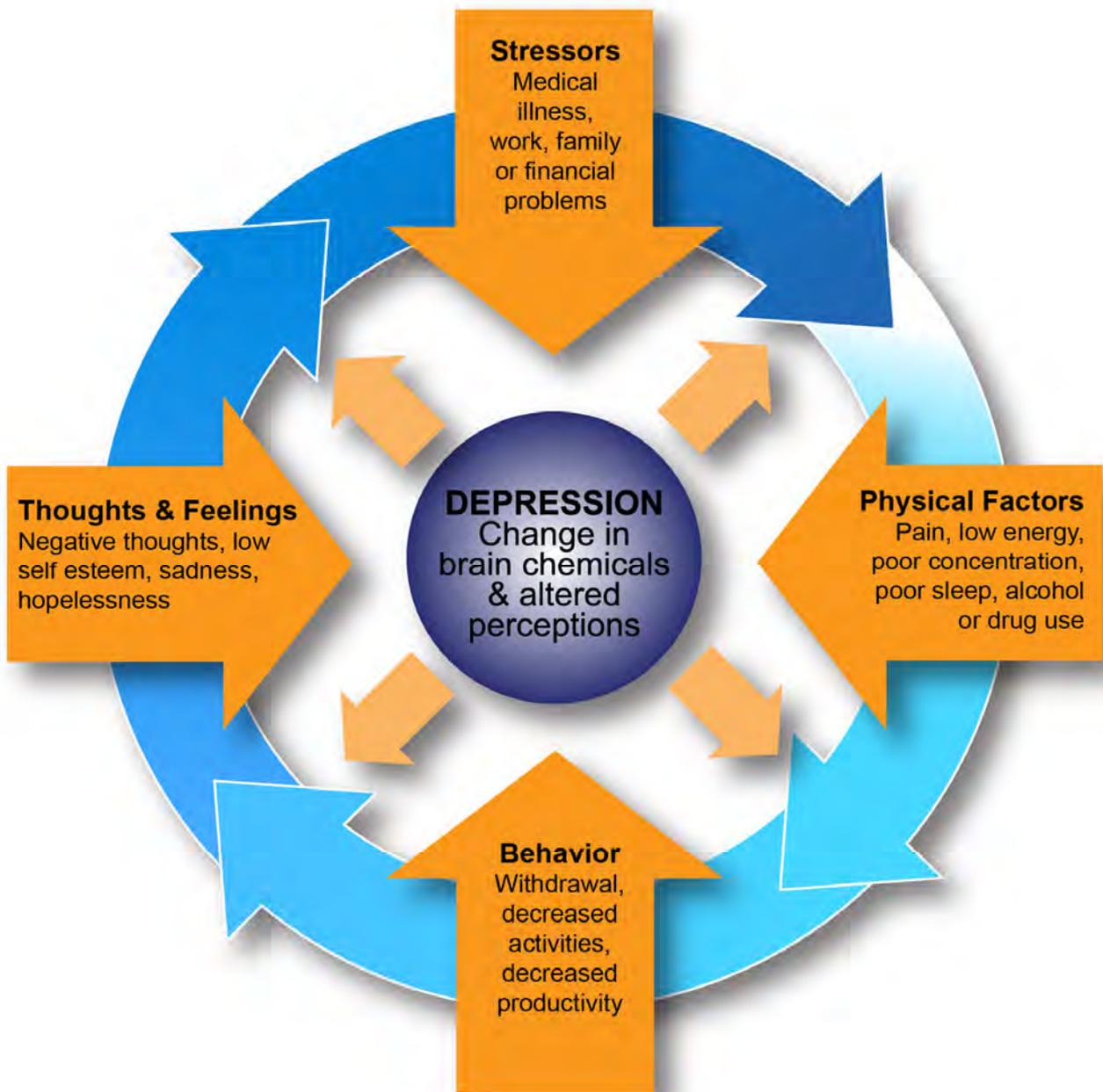
When speaking with patients it is important to be clear that the term "depression" as used by clinicians, has a different implication from the conversational meaning of feeling temporarily "down in the dumps." Clinical depression is not a matter of succumbing to a bad mood, and a person cannot cause depression from personal weakness, nor is it possible to will one's way out of its grip. Depression is a medical diagnosis referring to a state of body and mind in which a person's well being is profoundly affected. The name for the disorder fits its most common manifestations: a person's vitality and functional activity are lowered, or depressed, sometimes to the point of helplessness and seeming hopelessness. However, depression can also manifest as agitation and restlessness, or with a primary complaint of anhedonia – loss of interest in previously enjoyable activities of life.

In general, a variety of biological, genetic, psychological and other factors, including physical illness or medication, and drug or alcohol use are thought to contribute to the occurrence of depression. An episode can be triggered by a traumatic or stressful experience, or may occur when life seems to be going well with no obvious precipitating factors. As shown in the following graphic, the person feels caught in a cycle of physical and emotional problems that seem to interact to deepen the suffering.



Biopsychosocial Correlates of Depression

This diagram can also be useful to show to patients or as an educational tool



The following are possible depression diagnoses and the usual approach to treatment for each.

Major Depressive Disorder (Major Depression)

Major Depression is characterized by depressed mood or loss of interest or pleasure in almost all activities for more days than not for a period of at least two weeks. Treatment with antidepressant medication often has the fastest effectiveness, especially if there are significant somatic symptoms, such as insomnia. Psychotherapy requires additional time (e.g., twelve weeks) to substantially reduce symptoms. Short-term, manual based psychotherapy such as cognitive behavioral therapy, however, is as effective as antidepressants and may have especially enduring effects over the next two to ten years after treatment completion. Behavioral interventions such as Behavioral Activation have also been shown to be effective in reducing symptoms [3]. Combinations of antidepressant therapy and psychotherapy may have the best long-term outcomes in patients with severe or complicated depression[4].

Dysthymia

Dysthymia is similar to major depressive disorder, except that, a diagnosis of dysthymia implies a chronic depressive condition. Depressed mood or loss of interest (called anhedonia) must be present at least half the time for at least two years. Many patients suffer with dysthymia their entire adult lives, and may come to accept depressed mood as a fact of life. A large majority of individuals with dysthymia will develop major depressive episodes. It is thus possible to have both dysthymia and major depression at the time of diagnosis. Dysthymia can be treated with antidepressants, psychotherapy and /or brief behavioral therapies/interventions.

Minor or Subsyndromal Depression

Minor depression is an acute depression that is less symptomatic than major depression, with less impairment in social and occupational functioning. The patient and clinician may consider treatment, but may prefer to adopt a watchful waiting attitude to see if the symptoms resolve without intervention. If the symptomatology changes, or does not remit, the depression should be reassessed and treatment considered.

Bipolar Disorder

With bipolar disorder, patients experience both depressive and manic states. A manic state involves a period of time where one feels unusually “up” or “high” or persistently irritable, and experiences increased energy or productivity, decreased need for sleep, racing thoughts, and increased risk taking or impulsivity. Though depression is a component of this disorder, treatment is complex and usually requires referral to specialty mental health care. Patients typically require mood-stabilizing medication in addition to, and usually before, taking an antidepressant. Patients who describe manic symptoms in addition to depression should generally not be treated for their depression in primary care.

Adjustment Disorder with Depressed Mood

All of the categories in this disorder (with depression, anxiety, disturbance of conduct or mixed) relate to the presence of a significantly more difficult adjustment to a life situation than would normally be expected considering the circumstances. The trigger may be a stressful life event like loss of a job, bereavement or severe physical illness. Patients with this type of depression should be observed carefully and supportive counseling

should be offered to help the person cope with the stressor. If the symptoms do not resolve or if they worsen over time, drug therapy, psychotherapy or brief interventions may be considered.

CHAPTER

5

Understanding Anxiety

Anxiety is a normal part of life. It can even be useful when it alerts us to danger. The body's natural response to danger is to prepare for "fight" or "flight". When the sympathetic nervous system activates to emergency situations, someone may experience feelings and body sensations such as:

- Increased heart rate
- Quick, shallow breaths
- Increased adrenaline
- Impending doom
- Increased muscle tension
- Increased perspiration
- Light headedness
- Chest pains

It is important to recognize that these reactions are a body's normal response to a perceived danger. None of these physical reactions to perceived danger can harm a person—they are designed to keep a person safe.

For some people, however, anxiety is a persistent problem that interferes with daily activities such as work, school or sleep. This type of anxiety can disrupt relationships and enjoyment of life, and over time it can lead to health concerns and other problems. Distressing, impairing anxiety affects approximately 19 million adults in the United States alone. One out of every 6 people will experience this type of anxiety at some time during their lives (that is nearly 45 million people). Once a medical cause is ruled out, an anxiety disorder may be the culprit.

Anxiety Disorders include a large number of disorders where the primary feature is abnormal or inappropriate anxiety. Symptoms of anxiety disorders may be somatic, such as the physical symptoms described above, and/or psychic, such as excessive worry about a range of things, difficulty controlling the worry, problems concentrating, feeling "on edge" or feelings of dread or panic. In anxiety disorders,



somatic and psychic anxiety symptoms occur without recognizable stimulus or when the stimulus does not call for such a reaction.

Medications, psychotherapy, counseling, psychoeducation, brief therapies, behavioral interventions, and lifestyle changes have all been found to be helpful in reducing the symptoms of anxiety disorders. Some of the common anxiety disorders include:

Generalized Anxiety Disorder (GAD)

In Generalized Anxiety Disorder or GAD, anxiety gets generalized to other situations, and can then become overwhelming or associated with life in general. This worry is associated with some of the symptoms such as feeling restless, problems concentrating, irritability, muscle tension, and insomnia. GAD is evidenced by general feelings of anxiety such as mild heart palpitations, dizziness, restlessness, irritability and excessive worry which are difficult for the patient to control and are not related to a specific event. Therapy and interventions aimed at teaching the patient how to gain control over the symptoms have been found to be especially effective in the treatment of GAD.

Panic Disorder

Panic Disorder involves a fear of having unexpected panic attacks. Panic attacks include distinct periods of discomfort with symptoms such as heart pounding, chest pain, trembling, shortness of breath, sweating, fear of losing control, stomach distress, and/or dizziness. Although medication can be useful, psychotherapy (especially behavioral and cognitive/behavioral approaches) have been demonstrated to be quite successful.

Post Traumatic Stress Disorder (PTSD)

Post Traumatic Stress Disorder may occur after a person is exposed to a traumatic experience. The patient may experience symptoms of re-experiencing the event in the form of distressing thoughts, dreams, and flashbacks, and/or distress at exposure to these and other reminders of the event. The patient may also experience avoidance behaviors with avoiding reminders of the events, decreased activity level, increased social isolation, and restricted range of emotions. Additionally, the patient may report symptoms of increased arousal in the form of insomnia, irritability/anger, problems concentrating, hypervigilance, and an exaggerated startle response. Psychological treatment is generally considered the most effective means to recovery from PTSD, although some medications (such as anti-anxiety medications) can help alleviate some symptoms during the treatment process. In patients with current severe PTSD symptoms, effective psychological treatment is likely to be beyond the scope



of the brief therapies that are appropriate for delivery in the integrated care setting.

Adjustment Disorder with Anxiety

As noted previously, adjustment disorders relate to a significantly more difficult adjustment to a life situation than would normally be given considering the circumstances. The key to recognizing an adjustment disorder is to look at (1) the issue that is causing the adjustment disorder and (2) the primary symptoms associated with the disorder, in this case anxiety symptoms. Patients with this type of anxiety should be observed carefully and supportive counseling should be offered to help the person deal with the stressor. If the symptoms do not resolve or if they worsen over time, drug therapy, psychotherapy or brief interventions may be considered.

Subsyndromal/Situational Anxiety

The presence of anxiety, in itself, may not be problematic. However some patients may report anxiety symptoms that are distressing for them, but do not meet the criteria for a specific disorder. As noted above, patients with subsyndromal anxiety should be monitored to assess the course of their symptoms. For those with situational anxiety, supportive counseling should be offered to help the person cope with the stressor. In either case, if anxiety symptoms do not resolve or if they worsen over time, drug therapy, psychotherapy or brief interventions may be considered.

Comorbid Depression and Anxiety

Possibly the most common presentation of anxiety is that which is comorbid with depression as opposed to a “pure” anxiety disorder. In mixed presentations, features of depression (sadness, decreased appetite, low energy etc.) coexist with anxiety (irritability, insomnia, muscle tension). Mixed presentations are associated with increased dysfunction and worse prognosis compared to “pure” anxiety. Depression with comorbid anxiety symptoms is associated with a higher rate of cardiovascular events, higher suicide rate, and lower or delayed response to antidepressants than “pure” depression.

Anxiety disorders commonly occur along with other mental illnesses, including alcohol abuse, which may mask anxiety symptoms or make them worse. In some cases, these other illnesses need to be treated in order to have full response to treatment directed at the target anxiety disorder. Patients with underlying anxiety disorders frequently display somatic complaints that are the subject of visits to the primary care office.



Depression

Depression is a disabling illness that is especially common among primary care patients [5-7]. Between 5 and 9 percent of adult patients in primary care suffer from depression. Depression increases health care utilization and costs \$17 billion in lost workdays each year [8]. Despite its high prevalence and its substantial economic impact, depression often goes unrecognized. For example, in primary care practice settings, depression alone affects 17% to 37% of older patients, but only one in six of these patients is diagnosed and treated appropriately [9-11]. Part of the problem in



identification is that depressive syndromes commonly seen in primary care settings are of mild to moderate severity and, as a general rule, occur in patients without comorbid psychopathology.

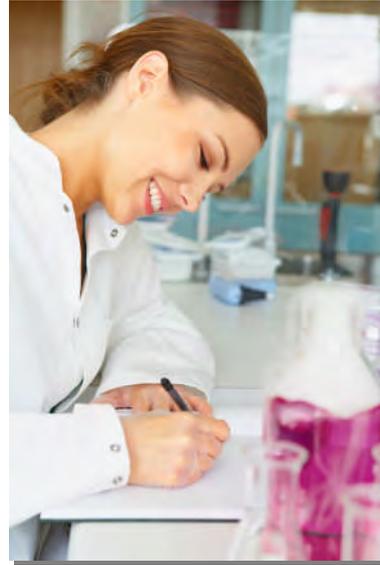
Primary care providers (PCPs) treat approximately two-thirds of depressed individuals. Practice guidelines for depression treatment have been developed as a way of making information

on efficacious treatment of depression available for PCPs. To view an example of an available practice guideline for the treatment of depression, the following link will take you to a well developed depression clinical practice guideline from the United States Department of Veterans Affairs and the Department of Defense (DoD):

http://www.healthquality.va.gov/mdd/mdd_sum09_c.pdf

Yet, as indicated by the low rates of depression recognition and treatment in primary care, the transfer of clinical research knowledge to primary care settings remains unsatisfactory. Depression care tends to be suboptimal and outcomes are sometimes poor. Controlled studies of the impact of different strategies to change PCP behavior consistently indicate that traditional educational methods (e.g., printed materials, lecture-style conferences) alone have little sustained impact on either PCP behavior or patient outcomes. One problem with traditional educational methods is that they are too general; generic information is detached from a specific patient's needs at a given time. Additionally, time constraints are a growing problem among primary care practices; PCPs' lack of time has been identified as a significant barrier to adequately treating depressed patients. Studies have demonstrated repeatedly that, in the absence of changing actual systems of care delivery, focusing purely on enhancing education may do little to impact quality [12].

Numerous clinical research studies have demonstrated the value of using integrated care strategies to enhance treatment outcomes for depression [1, 13-20] (for review see Williams et al, 2007; Gilbody, et al 2006 [1, 21]). Integrated care attempts to integrate mental health services along with other supports into the primary care setting. Positive outcomes include: greater engagement in care, improved treatment adherence, better symptom and function outcomes, and reduced mortality. These studies have mostly focused on enhancing outcomes from antidepressant treatment.



Studies of integrated care are heterogeneous, but active ingredients have begun to emerge [21]. Interventions that included primary care providers, behavioral health providers, and access to a mental health specialist tend to have better outcomes.

Other important components include systematic identification of patients with depression, the use of behavioral health providers with a mental health background to assist in managing care, and regular and planned supervision of behavioral care providers. An evidence-based synthesis report of key features of depression treatment found the core intervention features to be (Rubenstein et al, 2009):

- Primary care providers and behavioral health providers actively involved in patient management
- Behavioral health providers assess patient symptoms at baseline and at follow-up with a standardized measure
- Behavioral health providers assess treatment adherence at each follow-up
- The duration of care is at least 16 weeks of follow-up



The Department of Veterans Affairs has been a leader in researching and implementing care models for depression and other disorders. The Translating Initiatives for Depression into Effective Solutions (TIDES) program is one of the most studied models incorporating telephone care management for depression [22-24]. Implementation of the model in primary care settings with over 1,000 participants resulted in 8 out of 10 referred depressed patients being treated effectively in primary care. Primary care patients' compliance with medication was 85% and follow-up PCP visit attendance was 95%. Depression severity scores and functional status scores began showing improvement after 4 to 6 weeks, and 70% of patients followed in primary care scored below the major depression level at 6 months. In a very similar model, the Behavioral Health Laboratory (BHL) has also shown marked improvements in depression outcomes. These models have also added to the research base demonstrating that telephone care management is equally effective as in-person care management [1].

In addition to studies that include primarily medication management, there is evidence that brief therapies are also effective in primary care settings. Investigators at the VA Evidence-Based Practice Center in Durham, NC conducted a systematic review to examine brief psychotherapeutic interventions for depression in primary care [25]. Investigators evaluated two existing good quality systematic reviews and 15 randomized controlled trials (RCTs) conducted between 1982 and 2010. In the reviewed trials, treatment was delivered primarily in individual, face-to-face sessions, with one trial using telephone-based psychotherapy. Treatment providers included psychologists (majority), nurses, graduate students, and other professionals (i.e., social workers, general practitioners). Of the 15 RCTs, 11 trials were conducted in PC and 4 in MH outpatient clinics.

Findings include the following:

- Six to eight sessions of brief cognitive behavioral therapy (CBT) or problem solving therapy (PST) were more efficacious than control for the treatment of depression within the primary care setting
- Effects were modest: the number of sessions needed to treat for one additional responder was between five and eight in various studies
- CBT and PST were found to be similarly effective

Thus, a large evidence base exists for integrated medication management in the primary care settings, and an emerging literature also supports the delivery of brief treatments, including brief CBT and PST.

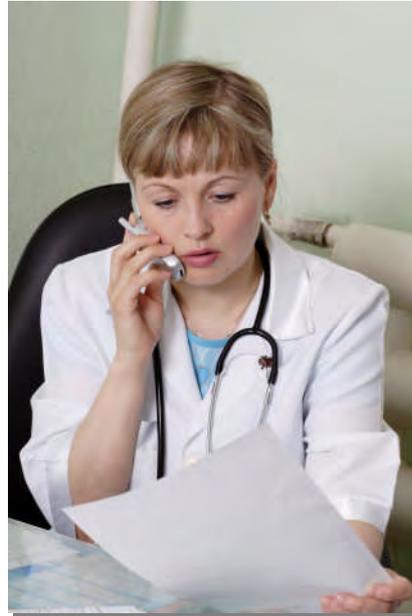
Minor Depression

While major depression has been widely researched, leading to the establishment of clear treatment guidelines, there has been less research on the treatment of minor and subsyndromal forms of depression. Minor and subsyndromal depression are almost twice as common in primary care (PC) as major depression [26-28], leading to greater health care utilization [29] and increased dysfunction and disability [30-32], and putting patients at risk for the development of major depressive disorder [33].



The challenge facing PCPs is made even more difficult by a lack of evidence about the optimal approach to treating patients with milder forms of depression. While some trials have shown pharmacotherapy to be efficacious for improving depressive symptoms [34, 35], others have shown no significant differences between response to placebo and active treatment [29, 36]. For example, a recent study of 30 years of antidepressant drug treatment data showed that the benefit of antidepressant medication compared with placebo might be minimal or nonexistent in patients with mild or moderate symptoms. Facilitating the dissemination and incorporation of such newly emergent findings relevant to the treatment of depression is a valuable role for the BHP.

These potentially conflicting findings have led to recommendations for a period of close monitoring before treatment of minor depression, with the initiation of treatment reserved for individuals who have persistent and/or disabling symptoms. The intention of this approach is to prevent the overprescribing of antidepressant medication and avoid exposure to potential side effects and risks of active treatment for patients whose symptoms would remit spontaneously. In a study in which patients with minor depression or distress were randomized to usual care or 8 weeks of telephone-based close monitoring, patients assigned to close monitoring exhibited less mental health problems at 6 months. These results support that interventions of close monitoring can be effective, feasible and valuable in the enhancement of clinical care and support the integration of mental health services and primary care [37]. This program intervention is referred to as Watchful Waiting (WW) and is outlined in more detail later in this manual.



Anxiety Disorders

While the evidence base is not as substantial as integrated care for depression, findings from a randomized control trial for use of a brief CBT intervention in the primary care setting found it to be significantly effective for the reduction of anxiety and depressive symptoms in patients suffering from panic disorder, generalized anxiety disorder, social anxiety, and post-traumatic stress disorder post interventions at 18 month follow-up [25]. Anxiety management can include medication and brief interventions (pleasurable events scheduling, relaxation techniques, exercise, problem-solving training) that can target the underlying anxiety or mixed presentation of anxiety and depression.

Summary

Integrated care programs provide the infrastructure for delivering evidence based treatments in the primary care setting with the goal of reducing depression and anxiety symptoms and improving patient self-management. Successful interventions support the primary care team by providing ongoing monitoring of symptoms and treatment adherence and feedback to allow for treatment modification. The findings cited above support a program of Depression & Anxiety Management that includes deliverability by a wide range of clinical providers, the potential role of the BHP in both pharmacotherapy and brief treatment protocols, and the required inclusion of measurement based assessment of outcome.

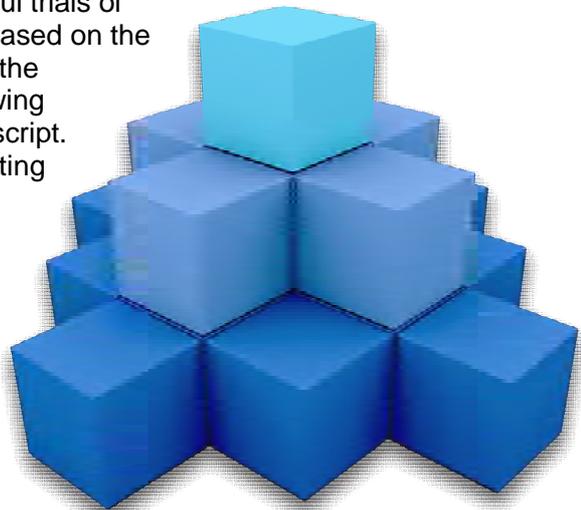
Steps of Depression & Anxiety Management

Preceding discussions have focused on the foundations of Depression & Anxiety Management in a primary care setting - the “why” and the “who”. The remainder of the manual will discuss the implementation of the Depression & Anxiety Management program. Again, this manual provides an introduction to Depression & Anxiety Management core competencies; however, you are strongly encouraged to seek out additional training to increase your effectiveness in meeting your program goals.

The first 3 steps, identifying patients, conducting the initial assessment and triage and treatment planning are mentioned briefly below and discussed in more detail in the first manual, **Building a Strong Foundation**. Beginning with Step 4, the management protocol will be discussed, focusing on essential elements and core competencies. The protocol is based on successful trials of primary care depression and anxiety treatment. Based on the patient’s presentation and needs, deviations from the protocol may make sense clinically; thus the following protocol may serve as a framework rather than a script. However, providers should be mindful when deviating from the evidence. This underscores the importance of evaluating treatment progress for the patient as well as the program over time.

Patient Tracking

Before beginning the Depression & Anxiety Management program, you need to establish a mechanism to document and track patient contacts and information. As this is a population-based and time-limited approach, the caseload of a BHP may be high and will be constantly evolving. A tracking mechanism that allows for increased efficiency and promotes delivery of measurement-based care is preferred. If you will be keeping a file outside of the medical chart for tracking purposes, for example an Excel spreadsheet, Word document, or Access database, check with your facility regarding charting regulations.



STEP 1 Identification of Patients

For a complete discussion on how to identify patients in the primary care setting as well as a discussion on marketing to your integrated team's staff, please refer to Volume 1, "Building a Strong Foundation."

As a quick review, mechanisms for identifying patients that have been successful for integrated programs include:

- Direct hand-off from providers or other primary care team members (e.g., warm hand-offs, walking the patient down the hall to you, via telephone, consults, fax, etc.)
- Self (patient) – referral
- Identification based on positive standardized screens, such as the PHQ-2, as discussed below
- Routine review of available records (for instance, reviewing pharmacy records for new antidepressant prescriptions)

PROGRAM ? DECISION

Depression and Anxiety management involves at minimum a BHP who is delivering structured, measurement-based follow-up for patients with depression and/or anxiety. The implementation of Watchful Waiting for subsyndromal depressive symptoms (described later in this manual) is supplemental and based on site resources and mission.

Screening for Depression: the PHQ-2

Identification of patients who may benefit from integrated care can be effectively streamlined by the incorporation of a brief standardized measure into the patient's visit with the PCP. The Patient Health Questionnaire (PHQ-2) screening measure is a two-item self-report measurement that inquires about the frequency of depressed mood and anhedonia over the last 2 weeks [38].

The purpose of the PHQ-2 is to screen for depression in a "first step" approach. The PHQ-2 includes the first two items of the Patient Health Questionnaire (PHQ-9) that screens for and provides a tentative diagnosis of depression based on DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition) criteria. Patients who screen positive with the PHQ-2 (total score of 3 or more) should be further evaluated with the PHQ-9, other diagnostic instrument(s), or direct interview. Many successful integrated care programs, including those implemented nationally across the VA system, have developed a process where all patients are screened for depression using the PHQ-2 and all patients with positive screens are followed up by the integrated behavioral health provider for additional assessment. This process becomes part of routine care, increasing screening and assessment, resulting in improved identification and access to care. From <http://www.innovations.ahrq.gov/content.aspx?id=2280>

PHQ-2				
Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half The Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

STEP 2 Initial Patient Baseline Assessment

For a more complete discussion on the baseline assessment, please refer to **Building a Strong Foundation**. Depending on your program's resources and resource allocation, the baseline assessment may be completed by yourself, another program clinician, or a Health Technician. Any standardized baseline assessment completed by a non-clinician must be reviewed by program clinician for appropriateness of outcome and any recommendations before being communicated to the primary care provider. The baseline assessment per se is not part of the Depression & Anxiety Management algorithm but rather the source of patient information, combined with clinical judgment that is used to identify patients who are appropriate for enrollment in Depression and/or Anxiety Management. This assessment guides treatment recommendations and provides information to support appropriate triage.

The goals in Step 2 are to:

- Confirm with the patient the reason for the hand-off to integrated care
- Build rapport with the patient
- Complete a baseline assessment utilizing standardized questionnaires

Keys to success include:

- Be prepared
 - Review available information such as presenting problem and patient chart if available
 - Have resources on hand
- Create a positive experience for the patient
- Remember that you do not need to know everything there is to know about a patient at this time but gather enough information to make an informed decision about next steps
- Balance the use of structured questionnaires with clinical skill and knowledge

As noted in the “Building a Strong Foundation” manual, the Foundations for Integrated Care program recommends the use of the PHQ-9 as the program standard measure for assessing depression as it is brief and validated for use over the telephone [39, 40]. In addition, the PHQ-9 provides clinicians with validated conventions for interpreting total score across the spectrum of severity of depressive symptoms, including subsyndromal depressive symptoms. The convention for measuring the severity of depressive symptoms based on PHQ-9 total score is as follows:

Convention: Total PHQ Score as Indicator of Depression Severity

- 1-4 Minimal Depression
- 5-9 Mild Depression
- 10-14 Moderate Depression
- 15-19 Moderately Severe Depression
- 20-27 Severe Depression

PROGRAM ? DECISION

When HTs are assisting with baseline assessments, they should use the standardized questions. The responses to the standardized questions can then be incorporated into additional unstructured evaluations of the patient by a BHS. In sites that use an HT to gather baseline data, the BHS reviews/edits the baseline assessment report (software generated report or templated report) and then communicates the baseline assessment to the PCP.

STEP 3 Triage decision and treatment recommendations, including subsyndromal monitoring

The goals in Step 3 are to:

- Make a triage decision based on the collected information
- Review recommendations with a program clinician (if the assessment was completed by non-clinician)
- Communicate the findings and the plan to the PCP

At this point, you have completed a baseline assessment with the patient. Next, the information collected, along with your clinical judgment, is used to determine if the patient is best treated in specialty mental health care or within integrated care in the primary care setting. Patients with mild to moderate severity problems are much more likely to engage in treatment that is delivered within the primary care setting. As previously discussed, PHQ-9 scores of up to 14 are considered to represent moderate severity of depressive symptoms while scores above a 19 are considered to represent severe depressive symptoms. Clinical judgment should also be incorporated into assessment of depression or anxiety symptom severity to guide treatment-setting recommendations. The program should also have available a site -specific Mental Health/Substance Abuse (MH/SA) referral mechanism for any patient with a baseline assessment outcome that is not appropriate for management in primary care, such as complex presentation of symptoms or severe cognitive impairment. The development of a site-specific MH/SA referral mechanism will also facilitate assisting

those patients who request specialty care treatment (See the Referral Management manual for more information).

PROGRAM ? DECISION

The following are recommendations for patients considered eligible for the Depression and Anxiety Management program. Site-specific resources, target population and mission may result in modification of these criteria. For example, an integrated program that has a clinician skilled in brief treatments for mild to moderate PTSD symptoms may elect to treat these patients in the primary care setting. An integrated program whose mission has been defined as offering services related to mood disorders may refer patients meeting criteria for a formal anxiety disorder to a specialty setting.

Primary care based Depression & Anxiety Management is appropriate for patients with the following disorders:

- Major Depressive Disorder
- Minor Depressive Disorder
- Dysthymia
- Depression NOS (partial remission or partial recurrence)
- Generalized Anxiety Disorder
- Panic Disorder
- Anxiety NOS (partial remission or partial recurrence)
- Sub threshold for meeting above diagnostic criteria but who could otherwise benefit from BHP contact

Patients who have depressive or anxiety symptoms complicated by any of the following criteria are considered in need of specialized care and should be referred to a specialty MH/SA provider:

- Severe Depression
- Bipolar Depression
- Drug Dependence (patients who are misusing alcohol may be followed in integrated care; see the Alcohol Misuse manual)
- Patients clinically judged to be at high risk for suicide
- Severe Cognitive Impairment
- Primary Psychotic Illnesses
- Post-traumatic stress disorder
- Severe personality disorders

For patients who are scheduled for an MH/SA appointment, part of your role as BHP is to facilitate that referral. For more information on enhancing MH/SA engagement, see Referral Management Volume 4.

A third set of patients who may be helped by program services are patients with subsyndromal or mild depressive symptoms. Monitoring these patient's symptoms rather than initiating depression management helps determine if treatment is appropriate, preventing the initiation of potentially inappropriate treatment as well as saving your program's resources. When patients' symptoms persist or

worsen, Depression & Anxiety Management may be offered. See the Watchful Waiting section of this manual for more information.

Convention: Total PHQ Score as Indicator of Depression Severity		
PHQ-9 Scores	Severity	Initial Strategies for consideration
1-4	Minimal Depression	Watchful waiting: Integrated Primary Care
5-9	Mild Depression	Watchful waiting, Integrated Primary Care; consider education and brief intervention. If no improvement after one or more months, consider use of an antidepressant or active depression and anxiety management
10-14	Moderate Depression	Active Depression management with medication and brief behavioral interventions: Integrated Primary care (Start with monotherapy of either antidepressants or psychotherapy, or a combination of both)
15-19	Moderately Severe Depression	May start with monotherapy of either antidepressants or psychotherapy, but should emphasize combination of both or multiple drug therapy
20-27	Severe Depression	Consider referral to more intensive services outside of primary care setting

NOTE: All treatment decisions should be based on a combination of assessment scores and clinical judgment.

Offering Treatment

Treatment decisions are based on assessment scores and clinical judgment, but also patient and PC preference. Once you determine primary care based treatment is a good fit for the patient, talk with the patient about the service. If they are interested, schedule a time for your first visit or if the patient will be working with another member of the integrated care team, ask for the best time to reach the patient and best telephone number. If the patient is not interested, discuss alternative options. Example of presenting your treatment plan:

“Based on what we spoke about today, what I’d like to do is work with you and your primary care provider over the next few months to improve (symptoms to work on). We will meet every few weeks for about 20 to 30 minutes – you can come in or we can talk over the phone. How does that sound to you?”

Communicating the Results

You should communicate the outcome of the baseline assessment to the patient’s primary care provider in the form of a progress note (see Clinician Resources Volume for an example). Depending on provider preferences, additional communication may be appreciated in the form of in-person follow-up,

telephone or secure email. For a more thorough discussion on collaborating with PCPs, please refer back to Volume 1.

Subsyndromal Depression Monitoring- the Watchful Waiting Intervention

Consistent with the stepped care approach recommended in this integrated care program, the Depression & Anxiety Management program can also include the intervention of Watchful Waiting (WW) which monitors patients with subsyndromal depressive symptoms to assess for worsening of symptoms and desire for engagement in treatment. As noted in Table 1 above, this intervention may be an appropriate initial strategy for patients with minimal or mild symptoms, especially in the absence of significant patient distress. The recommended intervention tracks the trajectory of patient symptoms by systematic monitoring over the course of up to 8 weeks [41]. Those patients who demonstrate clinical worsening or request initiation of treatment for their symptoms are offered additional treatment using pharmacotherapy or brief therapies. A WW trial is one based on the decision to not to begin either medication or therapy, but rather to mindfully observe whether the depression improves, persists, or worsens over time, with the intention of reassessing treatment options later. The program-recommended WW algorithm discussed below is based on positive research findings supporting its utility in improving outcomes when compared to usual care.

Identification of patients appropriate for the WW intervention is based on the outcome of the initial assessment. Good candidates for WW include patients who:

- Report current depressive symptoms but do not meet criteria for Major Depression and
 - a. Do not currently meet criteria for other Axis I diagnoses
 - b. Are not taking a psychotropic medication
 - c. Are not currently participating in psychotherapy
 - d. Are not endorsing high risk factors (e.g. suicidal or homicidal thinking)

Patients who are enrolled into WW receive weekly phone calls for up to 8 weeks to monitor symptoms of depression with the use of the PHQ-9 (or other structured depression instrument that was completed at the baseline assessment). Weekly calls may be conducted by a health technician, if available. At each contact, patients are also asked if they are interested in receiving treatment for their depressive symptoms. If the WW contact is conducted by a clinician, the contact may also provide support and work with the patient to set self-management goals.

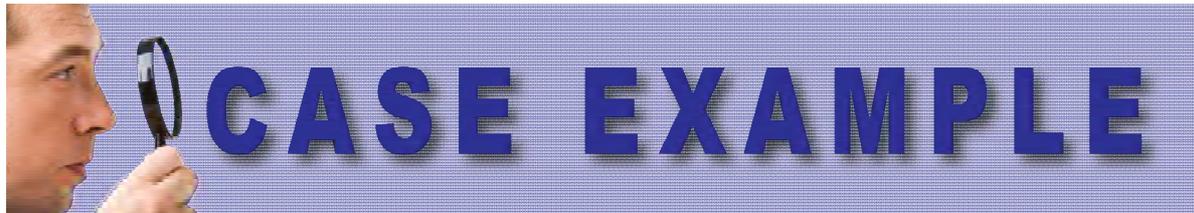
However, the calls are meant as a check-in on the person's well-being and not necessarily as goal directed or content driven. Indeed, many patients prefer the brief check compared to a therapy visit or bibliotherapy. Any patient who indicates he/she wants to receive treatment is offered treatment as part of your evolving treatment plan. Patients are also referred to active management based on persistent or worsening depressive symptoms, as defined by the following:

- 2 consecutive PHQ scores > 9 and meeting criteria for major depression at any point during monitoring,
- 4 consecutive PHQ scores > 4 and meeting criteria for minor depression; or
- 4 consecutive PHQ scores > 4 and a past history of depression

At the end of the patient's participation in WW, send a summary report to the patient's PCP. The report generally indicates one of the following outcomes:

1. For those who remain subsyndromal: Over the course of 8 weeks, the patient's level of symptoms never reached the point of recommending treatment and the monitoring is complete
2. For those who were offered treatment: The patient completed X weeks of monitoring, depressive symptoms have worsened (or the patient requested treatment) and the treatment plan has been adjusted to include (medication / brief therapy)

It is expected that some planned weekly contacts will not be completed due to patient unavailability; however, all 8 contacts should be attempted. It is helpful to include in the final report to the PCP how many of the 8 planned calls were completed by the patient as well as the range of the measured PHQ-9 scores for future reference.



Patient monitored in Watchful Waiting

Mr. Brown is a 66-year-old patient who comes to his annual PCP check-up with Dr. Jones. During the visit, Dr. Jones uses the PHQ-2 to screen for depression and the screen is positive. Dr. Jones asks the patient if he has been feeling down lately. Mr. Brown explains that he had a fight with his wife this morning and got stuck in traffic on the way to the clinic, but otherwise is doing okay.

Dr. Jones decides to refer Mr. Brown to your team for further evaluation. You call him the next day to complete the Baseline assessment.

Baseline results: PHQ9=6 and no other symptoms are reported.

Plan: He agrees to be contacted weekly over the next 8 weeks to monitor his mood (Watchful Waiting)

Scenario 1: You contact Mr. Brown by telephone for the 5-minute call to monitor his symptoms. His PHQ9 increases to 8. He continues to complete the monitoring calls each week, and you do not see improvement in his symptoms. You offer to talk to Dr. Jones about starting a medication and to work with him improving his mood. He agrees saying "I guess I've been feeling down for awhile. Probably be good to talk to someone about it."

Scenario 2: You contact Mr. Brown weekly by telephone for the 5-minute call to monitor symptoms. His PHQ9 is 5 one week due to trouble sleeping when there is construction next door. Then it goes down to 3 for the next several weeks. At the end of the 8 weeks Mr. Brown says, "Thanks for calling - it's good to know someone cares." He says knows he can call or talk to his PCP if he ever needs treatment.

Reflecting on the Case: Watchful Waiting helped you to distinguish between patients how can benefit from treatment (Scenario 1:) and patients who do not need treatment (scenario 2), thus preventing overtreatment. It also helps you to save resources.

STEP 4

Providing Clinical Services: Initiating Management of Depression and Anxiety in Primary Care

At this point, you have completed your baseline assessment and have decided on the locus of care (e.g., referral to specialty clinic or initiation of Depression & Anxiety Management program). The remainder of the steps will outline specifically the protocol a BHP can use in the collaborative management of depression and anxiety that is based on effective collaborative care trials. The protocol is based on an algorithm, but at the same time the treatment plan is collaborative and patient-centered. As you read the remainder of the steps, be mindful of the current understanding of the critical components as discussed in the evidence base section including:

- Collaboration with primary care providers in the treatment plan
- Access to a mental health specialist for regular supervision/medication consultation (we refer to this specialist as the Medication Consultant (MC) for the remainder of this manual). This is a critical role if you are not a prescribing provider
- Regular assessment of symptoms (measurement-based care) and treatment adherence

The goal of Step 4 is to solidify and enact a treatment plan that is based on the information gathered already, patient preferences and available resources. At the beginning of the protocol, and at all subsequent contacts, it is important to create a positive experience for the patient. Good communication skills, including active listening, empathy, patience, flexibility, and a positive conviction that the patient can get better are all qualities of an effective BHP that cannot be scripted. The use of good communication skills contributes to the establishment of rapport and, in turn, fosters trust and a belief that your main goal is to see that the patient feels better. The resulting rapport might well contribute to the patient's adherence to treatment and willingness to communicate with you if questions, concerns, or feelings of ambivalence over treatment arise.

Preparing for Your Visits

Prior to each visit, you should try to review what you know about the patient. If you access to the clinical chart, perform a chart review. Because the baseline assessment is often done quickly as a warm handoff or over the telephone, you may not have had time to thoroughly review the chart during the baseline visit. Now that treatment is about to start, it is a good point in time to review what you know about the patient before facilitating the start of the treatment plan.

Beginning BHPs may find completion of an initial contact form or template helpful to ensure relevant information is collected. Examples of templates for recording this information can be found in the Clinician Resource Volume.

The following information should be collected:

- History of psychiatric and medical conditions
- List of current medications
- History of use of psychotropic medications or psychotherapy, including:
 - 1) Tolerance and response
 - 2) Contraindications for antidepressant medication and
 - 3) Adequate versus inadequate treatment for depressive/anxiety disorder
 - a) Determine dosage and duration of all antidepressant medication trials

The definition of an adequate antidepressant trial is at least 6 weeks of medication at an effective dose for that antidepressant. Table 2 below lists effective doses for more commonly prescribed antidepressant medications. Information related to low dose use of medications such as tricyclic antidepressants for pain management or trazodone for sleep should be collected but should not be considered treatment for behavioral health disorders. Assessing medication response may be new to you but is critical in supporting the primary care team. Most often the PCP is the prescribing provider and your role is to support him or her to make sure the dose, duration and response are measured and that the treatment plan is fully embodied. Reviewing this outside of the clinical visit also gives you a chance to ask your supervisor questions, or look up information about medications or issues that you aren't familiar with. Don't be afraid to seek out assistance.

- History of other treatment for psychiatric symptoms
- Lab Results: Thyroid Profile, Liver Enzymes, or Electrolyte Panel that are not noted on the chart in the last 6 months. The Clinician Resources Volume discusses suggested laboratory tests for depression. You should notify the PCP of the need for these tests, as appropriate



Citalopram	20 mg
Escitalopram	10 mg
Fluoxetine	20 mg
Fluvoxamine	150 mg
Paroxetine	20 mg
Sertraline	100 mg
Trazodone	300 mg
Nefazodone	200 mg
Bupropion	200 mg
Mirtazapine	30 mg
Venlafaxine	150 mg
Duloxetine	40mg
	<i>or a minimum plasma level of nortriptyline 50 ng/ml</i>
Desipramine	100 ng/ml

Goals for Patient Contact(s)

Each time you meet with the patient there are certain goals to keep in mind:

1. Establish rapport with the patient in order to build a supportive and therapeutic relationship. The focus should be on motivating the patient for treatment throughout the contact. Remember you can't help someone if they are not willing to talk to you again.
2. Review the purpose of the contact and the reason for the referral. Confirm the baseline assessment. This could be done as follows:

"When we last spoke, you reported problems with sleep difficulties, poor concentration, loss of interest and feeling down over the past two weeks. Is that accurate? These are problems we can work on together over the next several months, as well as other concerns you may have about your emotional health".

3. Stay on top of changes in the patient's medical and psychiatric condition and medication use. If you gather this information from a chart, briefly review the information with the patient. Depending on whether or not the chart was available, this could be introduced as follows:

"Before I contacted you, I was able to review your medical history from [Dr. _____] records. I would like to confirm that you have a medical history of _____. Is that correct? Am I missing anything? I also noted that you are currently taking _____. Is that correct? Am I missing any prescription or over-the-counter medications that you are taking? And according to his/her records, you have never had any mental health medication or therapy treatment in the past? Is that correct?"

or

"I'd like to begin by asking you about your medical history, your current medications, and about any mental health treatment you may have had in the past. This will help me get to know you and will also assist us as we work together thinking about to what potential treatment options make sense for you to improve your symptoms."

4. Use a mix of open-ended clinical questions combined with structured assessments. The use of measurement based assessments has been demonstrated to improve care [42] . The structured items may include the completion of any standardized instrument that will be used to assess/track patient symptoms over the course of management, such as the GAD-7 for anxiety symptoms, or the completion of a standardized template for the collection of medical and psychiatric history. If more than a week has elapsed since the completion of the baseline assessment, the BHP may also re-administer the relevant baseline interview structured assessments to re-establish baseline symptom level.

The content of the unstructured clinical interview will largely be driven by patient-specific concerns solicited through generalized inquiries of what the patient's perceptions are as well as what issues are of highest concern/priority to him/her. The unstructured, unscripted piece of this clinical interview is also the place where your interpersonal skills can be the most effective in engaging the patient by building rapport and promoting trust through expression of empathy and enthusiasm for working together and conveying conviction that the treatment plan will be successful. It really doesn't matter at what point during the interview the structured piece is completed, but a standardized, structured, validated measure should be included at all contacts. See below for a suggestion as to how to introduce the measurement-based assessment.

An introduction to the structured piece could be:

“Over the course of our working together, I will be regularly completing a quick survey of specific questions to help monitor your symptoms. This will help us make sure that things are going in the right direction or suggest that we should think about making a change. Let me ask you those questions now.”

5. Assess adherence and side effects for those currently being treated with a psychotropic medication (See Patient Resources Volume). This can be accomplished through general inquiry:

“How are things going with your sertraline? Are you taking it [as prescribed]? Any negative effects you think might be related to the medication?” - as well as specific inquiry for common adverse effects known to be associated with that particular medication- “Any problems with upset stomach? Headaches? Sexual problems?”

6. Ask the patient if he/she would like educational materials addressing the management of specific symptoms. If by telephone, ask if the materials can be mailed to him/her. You will not do this every week but don't forget to ask later in the course of treatment as well as at the beginning of treatment. Know what materials you have available to send and the program mechanism for mailing materials to patients. In many programs, the BHP role includes the development and updating of a “library” of program patient education materials.

Suggested topics include:

- Understanding of depression/ anxiety
- Understanding of treatment options
- Symptoms Management
- Other educational printed materials appropriate for the patient and/or family

7. Continuously work with the patient to choose a treatment plan based on the outcome of each interview and your clinical impression (see below “Determining a Treatment Plan”). Appropriate Action Plan(s) or Goal Setting worksheets may be used to help guide this process. Examples of Action Plans for Depression, Anxiety, Sleep, and Pain are found in the Patient Resources Volume. These are also available electronically and can be adapted as appropriate. An example of this could be:

“As we have been talking, you have reported several problem areas that we could work on together. Perhaps one way to start is to target the symptom that is most distressing to you. You indicated that your sleep difficulties are the most troubling to you at this point, is that correct? Some of the ways shown to be helpful in improving sleep are making specific changes in your daily routine to promote good sleep habits, short-term use of medication, and learning techniques to promote relaxation and stress reduction. I would like to send you educational materials about improving sleep. The next time we talk, we can review the materials, discuss what you may already have tried or be doing currently, and then make a plan of action to try to help you improve your sleep. How does that sound to you as a place for us to start?”

8. Schedule follow-up contacts with the patient (phone or in person). Those patients who are taking a psychotropic medication should be contacted 1 week after initiating or changing existing medication treatment. All others should be followed up within 3 weeks. An example of arranging a follow-up contact for a patient changing antidepressant dose could be:

“I understand that Dr. [PCP] wants you to increase your sertraline to 100 mg. Have you done that yet? When did/will you make the change? I would like to briefly talk with you on (one week from increase) to check how you are doing on the increased dose. What time on [day] would be convenient for me to call?”

Again, it is more important to have a visit than to worry about where the visit takes place. If a patient is on vacation or if it is a burden to make trips to your office, schedule a phone session.

The follow-up contacts should reflect the delivery of the agreed upon treatment plan. The program algorithm outlines specific timelines/content for patient contacts in those patients receiving psychotropic medication. In patients whose primary integrated care treatment includes brief therapies, behavioral interventions, and/or education regarding prevention/health promotion the time/number of contacts are not specifically set by the program but should reflect the general principle of multiple contacts conducted over the course of the program’s 12 week acute treatment period.

9. Continuously discuss/communicate treatment options/recommendations with the PCP as appropriate.

- If the patient is taking or considering psychotropic medication, you are strongly encouraged to discuss the case with the program's medication consultant (MC) before making medication-related recommendations to the PCP. Even if your program BHP role does not include active participation in the management of psychotropic medication as part of its mission, it is very likely that you will incidentally uncover patient medication issues in your Depression & Anxiety Management activities. You need be aware of and utilize program resources to ensure that information you obtain about medication issues are addressed by a clinician within the integrated team.

An example of this could be:

"I spoke with your patient Mrs. X on Monday. She is taking the citalopram 10 mg a day that you ordered several months ago, not having side effects, but continues to report significant depressive symptoms. I consulted with [MC], and she recommended that you consider increasing Mrs. X's dose to 20 mg. If you do increase the dose, I'll monitor Mrs. X to see how it goes and report back to you."

- You may recommend to the PCP to order any appropriate laboratory testing if not done in the last 6 months (thyroid panel, liver enzymes, and electrolyte panel). For the BHP with limited prior exposure to this area of knowledge, program prescribing clinicians are a potential resource for you regarding the rationale/approach for making these recommendations to the PCP. Suggested laboratory tests for depression can also be found in the Clinician Resources Volume.

An example of this could be:

"I spoke with your patient Mrs. X on Monday as she agreed to depression management services. She reported worsening depression symptoms over the past several months. In my chart review, I noted you have been treating her for hypothyroidism. Would it be possible to re-check her thyroid levels at this point to see if they may be contributing to her recent increase in depressive symptoms? The levels I found in her record are within normal limits but appear to be 10 months old."

- If the PCP agrees to recommended lab studies, you need to confirm with the PCP and facilitate with the patient the plan to draw the blood.

- Include any plans to engage the patient in specific behavioral interventions and/or prevention/wellness activities.

An example of this could be:

“Mrs. X and I discussed possible treatment options for managing her anxiety and she would like to learn problem solving techniques and specific relaxation exercises. I will be working with her on developing both of these skills.”

- Remind the PCP of the BHP collaborative role in patient follow-up. The occasional tactful verbal reminder of the added value of your role in patient management can go a long way toward maintaining a collegial, respectful collaboration. The suggested example regarding making a medication recommendation to increase a patient’s citalopram noted above serves as an example of a brief, targeted verbal communication to the PCP that reinforces the program principle of collaboration and tactfully highlights added value.
10. Document the details of each patient contact and the treatment recommendations. Send/post/forward a report for the PCP that summarizes this information according to site- specific procedures.

Determining a Treatment Plan

As introduced in Volume 1, the principles of Integrated Care include the concept of patient-centered care which allows patients to have a more active role in their health care. Therefore, the treatment plan should be determined collaboratively with the patient to encourage self-efficacy and engagement, though you may offer guidance and education. In patients with mild symptoms, or symptoms around an event that are predicted to naturally subside relatively quickly, monitoring of the patient with the provision of health promotion education may represent the best first approach.

Establishing a treatment plan is likely to vary in approach from patient to patient depending on the patient’s symptomatology, her/his readiness to accept treatment, the treatment s/he is willing to accept, his/her level of knowledge of the diagnosed condition, and other individual concerns. Medication treatment plans are likely to reflect the practice preferences of your Medication Consultant (MC) and any known preferences of the PCP. The treatment plan will likely also reflect your skill set, including your expertise in delivering primary care setting-appropriate brief behavioral interventions. Suggested guidelines about patient education for treatment choice can be found in the Patient Resources Volume. Patient, and possibly family, education is likely to be an integral part of the treatment decision-making process.

As previously discussed, Action Plans or Goal Setting may be used when appropriate to develop initial treatment goals using a problem-solving style and to promote patient activation. Ambivalence about committing to the proposed treatment plan needs to be addressed on an individual basis and can include unscheduled follow-up contacts, increased education, or eliciting support from the PCP or the MC.

In general, initial treatment for depressive/anxiety disorders will be a combination of support and education provided by you and appropriate medication and/or brief therapy modalities. Medication recommendations need to be made in consideration of any precautions made evident by review of the patient's past history and current clinical status.

Initial treatment options include:

1. Monitoring (but not treating) some patients (See Watchful Waiting (WW) at end of Step 3 above)
2. Treatment by the PCP and BHP within program guidelines for patients with select depressive/anxiety disorders, including medication management
3. Initiation of BHP delivered core program strategies including education, pleasurable event scheduling (Patient Resources Volume), symptom-targeted Action Plans (Patient Resources Volume), and training in problem solving techniques (Patient Resources Volume). As a BHP, you are expected to have competency in the delivery of these interventions. Additional information on these interventions is described in Building a Strong Foundation, Volume 1.
4. Delayed initiation of medication treatment pending further medical stabilization, diagnostic assessment or further consultation
5. Time-limited behavioral interventions such as Problem-Solving Therapy or Brief Cognitive Behavioral Techniques, behavioral activation, and relaxation training when within BHP expertise
6. Referral to a specialty behavioral health clinician for a consultation and/or treatment. It is recommended that this option be utilized for patients who reveal complicated diagnostic presentations, chronic benzodiazepine use, severe cognitive impairment, need for hospitalization, or primary psychotic illnesses. Other program-specific situations for which the recommendation is referral of a patient to a specialty provider may exist for your program based on program resources and mission.

If you are a non-prescribing clinician, the MC should participate in any medication treatment recommendations made to the PCP. Regular planned time to present cases for medication consultation is often important and beneficial as well as the availability of ad hoc consultation. Primarily ad hoc consultation may also be appropriate for smaller programs.

Even in programs whose planned services do not include active medication management by the BHP, it is unrealistic to assume that medication "issues" will not come up during the delivery of depression and anxiety management. Information deliberately or inadvertently collected during BHP contacts needs to be appropriately responded to and communicated to the MC. Programs that utilize BHP staff from a non-medical setting/tradition may especially benefit from the availability of a clearly identified program MC. While not ideal, programs with limited access to experienced psychiatric prescribers may need to designate the primary care provider as the MC.

Patient Education for Treatment Choice

Some patients will enter Depression & Anxiety Management already taking an antidepressant or engaged in “talk therapy”, while others will discuss their treatment preferences and concerns with you, guiding your treatment recommendation to the provider. The first step of helping a patient participate in deciding upon his or her course of treatment is to educate the patient about the treatments available for depression and to dispel any misconceptions the patient may have about the treatments. For instance, the patient may be resistant to taking antidepressant medications because he or she is afraid of becoming addicted to the medication. Once the patient learns that antidepressants do not cause a high or lead to addiction, he or she may be more willing to try an antidepressant. When discussing treatment options, patient preferences are key, but other factors such as prior depression treatment, depression severity, stress, and contraindications to medications are also important.

Antidepressants

- In general, patients can be told that antidepressants are usually an effective choice under the following circumstances:
- The patient prefers antidepressants.
- The patient’s depression score is in the severe range.
- The patient has vegetative depression, meaning the following symptoms are present:
 - Sleeplessness
 - Trouble concentrating
 - Lack of appetite
 - Severe constipation
 - Psychomotor retardation
 - Psychomotor agitation
 - Disheveled appearance
- The patient has had 3 or more episodes of depression.
- The patient has a family history of multiple depressions.
- The patient has had a prior response to antidepressants.
- Many antidepressants are also approved for the management of anxiety symptoms.

If the patient is interested in a medication trial, the factors to be considered in choosing a first-line agent can be discussed. Since the PCP will make the final choice with the patient, you may not know what the final decision will be, but can tell the patient what kinds of general side effects are possible, and what features of their particular case may be relevant in choosing a drug. Sexual side effects might be especially concerning for some patients, for example. Older patients might need to avoid the side effects of a tricyclic agent (TCA). Patients should also know the cost and time commitment that each treatment requires before making a decision. A full course of psychotherapy will last from eight to twelve weeks. A full course of medication lasts about nine months unless the patient has a history of prior depression episodes or dysthymia in which case treatment lasts about 2 years.

Reinforce the following education points with patients who choose medication: **the importance of being patient** during the trial and error process of finding the right drug and dosage. Education should include that it can take four to six weeks to reach full therapeutic effect, and it might take several attempts to find the best medicine.

The need to follow instructions to get the full benefit of the medication. Education should include the importance of not skipping or altering the dose, and not stopping the medicine as soon as the patient feels better. Relapse is common, and relapse prevention awareness should be taught as soon as improvements are apparent.

The importance of paying attention to side effects and reporting physical and emotional changes during treatment. Education should include directives to not stop the medication before discussing side effects as there may be other ways to manage the discomforts until they pass, and there can be significant discontinuation symptoms if medications are stopped suddenly. If side effects are intolerable, patients should be educated that there are many different types of antidepressants, and though it is not understood why, people respond differently to different medications and side effects of each drug vary from person to person. Information provided by you that unacceptable side effects from one antidepressant doesn't mean a different antidepressant will also cause unacceptable side effects will provide encouragement to continue investment in possible medication treatment of his/her symptoms. In any case, report the side effects to the MC/provider to determine whether another treatment choice may be better.

Treatment planning: Starting/modifying a psychotropic medication

The patient may have recently been started on a medication by the PCP, in which case you will follow this patient to assess symptoms and treatment adherence as part of the treatment plan. For patients who have been on a medication and are still symptomatic or are not on a medication but could benefit, the MC should be consulted and then recommendations discussed with the PCP who then makes the final decision about the medication. The PCP may also want to schedule an appointment to meet with the patient within the first six weeks of new antidepressant treatment.

Once the PCP has accepted medication recommendations, you should re-contact the patient to provide agent specific and general medication education. Such information may include (where appropriate):

- Name of medication (generic and trade), class of med, and why it is being prescribed, if new
- Review of dosing instructions for patients starting on medication or for those whom changes are being made to ongoing psychopharmacological management
- What to do if adverse effects are associated with the medication; may include common known "nuisance" side effect information with reassurance that these often resolve with continued use
- Under what circumstances the patient should contact you or the prescriber
- When you will be following up with the patient

The Clinician Resource Material Volume provides some reference materials for the BHP about depression and anxiety medication management. Included in the reference materials are:

- Dose recommendations, common and rare side effects for specific antidepressants
- An overview of different classes of antidepressants and benzodiazepine use with comprehensive patient teaching points
- Specific benzodiazepine dosing guidelines and general precautions and side effects associated with benzodiazepine use
- Commonly used herbal medications and any known interaction with prescription medication
- An evidenced-based psychopharmacological algorithm for the treatment of Major Depression and Generalized Anxiety

Information that the BHP should review with the patient regarding specific as well as generalized principles of effective and safe use of psychotropic medications can be included in the case discussion with the MC, based on BHP current level of expertise. Whenever possible, supportive medication education materials should be mailed to the patient. The Patient Resource Volume contains two medication-targeted patient sheets, one outlining potential factors if medication treatment is being considered and a second sheet outlining general guidelines in taking antidepressant medications. In addition, many national pharmacy chains have patient-oriented medication-specific materials available electronically which, in addition to being provided at the time of prescription by the dispensing pharmacy, can be accessed by you online as a supplemental training aid to help you remain updated and knowledgeable about specific agents as well as offer guidance about how to present this type of information to patients in relatively simple, straightforward language. It is also important to develop a sense of balance between providing information without “scaring” the patient from starting the medication, a problem often encountered when patients actually do read the package insert that pharmacies now routinely include with prescriptions. Patients should be encouraged to call you or the prescriber if they have any concerns about the medication based on written materials they receive, so that their concerns can be addressed. An introduction to starting a medication could be:

“Dr. [PCP] is going to be prescribing the antidepressant citalopram for you. You should be receiving a bottle of 10 mg pills from your pharmacy labeled with the instruction to take one pill in the morning. It does not matter if you take this medication with or without food. Citalopram has been shown to be generally well tolerated, and any side effects tend to be mild and brief, but if you have any new or worsening problems after you start the medication, please call me so that we can talk about what is happening. Do you have any questions?”

You can't be expected to know everything about a particular psychotropic medication, either from a patient education perspective or a clinical perspective. Your most important role in medication management is to solicit information from the patient and encourage the patient to express concerns/questions. Once identified, you have available resources, including consultation with the program MC, to potentially address these issues and get back to the patient or PCP. If the patient has a question or concern that is beyond your current expertise, a response could be:

“Thank you for mentioning that. I want to check with the team before I give you specific advice/information about [concern/question]. I should be able to get an answer in [provide appropriate timeframe] and give you a call back. In the meantime, [suggest plan in regards to managing medication until you re-contact patient, if appropriate].”

Additional Resources

Several resource materials are included in the Clinician Resources Volume that are directed toward assisting you and the MC in the monitoring and management of psychotropic medication. Additionally, you can use this information to help educate the patient's PCP on psychotropic medication recommendations. As mentioned previously, the Clinician Resources Volume lists antidepressant medications along with dosing and side effect information, provides an overview of patient education for patients prescribed SSRIs, TCAs, and benzodiazepines, contains information about select herbal medications including potential interactions with specific prescription medication(s) and contains the Psychopharmacological Algorithm.

Using the Psychopharmacological Algorithm

The psychopharmacological algorithm is intended to be an educational guide for you, the MC, and the PCP. The algorithm is broken down into three parts. The first section provides the general principles for using the algorithm. The second section provides a table of minimum, “adequate” and maximum doses for listed antidepressants. The final section is a diagram of the Depression and Anxiety antidepressant (AD) medication algorithm. The algorithm begins at the point that the patient has been on the AD for at least 6 weeks, regardless of dose. The algorithm also assumes you know the patient's baseline PHQ-9 score as well as his/her 6 week PHQ-9 score. Decision points throughout the algorithm are based on change in PHQ-9 score compared to baseline. As noted in the manual's principles, clinical judgment can always override the algorithm based on individual patient circumstances.

Patients on an Antidepressant Medication at the Initiation of Management

Some patients will already be on an antidepressant at the time that you first see them. Guidelines for these patients are as follows:

- If the patient remains symptomatic despite adequate treatment for depression (adequate dosage of antidepressant with duration greater than 6 weeks), then you should, with MC support, consult with the PCP about the recommended changes to treatment as outlined in the algorithm.

- If the patient is depressed and receiving an adequate dosage of an antidepressant, but the duration is less than 8 weeks, then you should monitor the patient on the current dose. If the patient is still not responding at 6 weeks, you should consult with the PCP, again with MC support, regarding the algorithm recommendations.
- If the patient is depressed and not receiving an adequate dosage of antidepressant, you should consult with the PCP regarding the patient's treatment, regardless of the duration of previous treatment. In most cases, the algorithm would recommend increasing the dosage in patients who are tolerating the medication.

The Management of Sub-Optimal Antidepressant Medication Treatment Response

The algorithm makes several suggestions regarding potential “next steps” in the management of patients who have achieved sub-optimal clinical response from an adequate trial, both in terms of dose and length of time of treatment of antidepressant medication. The first of these algorithm strategies is to “optimize” the dose of the current agent, if the patient is not experiencing side effects on the current dose. The next strategy suggested by the algorithm is to “augment” treatment with a different class of AD medication, psychotherapy, or with an atypical antipsychotic. In general augmentation with another antidepressant or psychotherapy is the next step if the patient has some response but not an adequate response. However, several atypical antipsychotic medications, such as quetiapine and aripiprazole, have received FDA approval as an adjunct medication in the treatment of depression. It is very important for you to appreciate that atypical antipsychotics have a much more potentially troublesome side effect profile when compared to conventional ADs and for this reason, augmentation with such agents should be carefully considered. If augmentation of AD with an atypical antipsychotic is implemented, it is especially important for you to evaluate the outcome by regularly performing a measurement-based depression assessment, such as the PHQ-9, to ensure that the risk-benefit ratio for the patient is acceptable. Atypical antipsychotic medications are not approved to be used for use as the sole treatment for depression and should only be considered as an adjunct to a therapeutic AD trial in which depressive symptoms are partially remitted but remain distressing to the patient. In addition to augmenting ongoing antidepressant treatment with another class of AD or an atypical antipsychotic, other medication agents such as mood stabilizers or the addition of formal psychotherapy may also be appropriate augmentation options. The strategy to “switch to a different class of AD” is also presented in the algorithm and is the clear choice if there has been no response or very limited response to the first medication. If augmentation or switching medications continues to demonstrate sub-optimal treatment of symptoms that are distressing to the patient, the algorithm recommends referral to specialty care.

Treatment planning: Brief “Behavioral Therapies” Appropriate for Delivery in Integrated Care

In addition or separate from medications, patients may be interested in engaging in brief behavior therapy. Brief Behavioral Therapy is often useful under these circumstances:

- The patient prefers brief non-pharmacological treatment available in primary care
- The patient’s depression score is in the mild to moderate range
- The patient is experiencing severe life stress
- Medications are not advised because of other conditions (pregnancy, breastfeeding, already on many medications with possible interactions).
- The patient has had a prior positive response to psychotherapy

Individuals seeking intensive, (e.g., 12+ sessions) traditional, structured psychotherapies such as prolonged exposure therapy, or interpersonal therapy, are likely best served in a mental health specialty clinic. The issue of referring patients interested in more intensive psychotherapy to a specialty provider is one of being integrated and collaborative. As discussed in volume 1, if you focused on traditional therapy, your caseload would quickly fill and thus you become unavailable to the PC team. These latter aspects of primary care based interventions are considered critical to the program. Brief time-limited behavioral therapies, however, are very appropriate to be considered in a primary care setting, as are the incorporation of specific techniques from more intensive interventions.

Your role may also include the delivery of brief therapy, based on your clinical expertise. Clinical guidelines recommend that both pharmacotherapy and psychotherapy should be considered as first-line treatments for depressive and anxiety disorders. However, because primary care settings are often the frontline of treatment, pharmacological treatments often take precedence. The perception that psychotherapy is time intensive may contribute to its under-utilization, but recent studies suggest that psychotherapies that are briefer in duration and intensity may be effective in treating depressive disorders. These briefer psychotherapies, such as Problem Solving Therapy or Brief Cognitive Behavioral Therapy, may be more easily integrated in primary care settings.

As discussed within Volume 1, motivational interviewing, goal setting/action planning, problem solving techniques, brief CBT and behavioral activation are specific brief interventions that are appropriate for delivery within integrated care. Specifically, a recent systematic review of controlled trials of brief CBT and problem solving therapy found these interventions efficacious for depression in primary care (Nieuwsma et al., 2011). Brief behavioral activation has also recently been identified as having promising results for use within the primary care setting [43]

In addition, specific elements of CBT, such as “thought stopping”, through identifying and disputing negative cognitions, self-monitoring, assertive communication as well as relaxation training are useful tools that can be used in this setting and are consistent with service delivery in an integrated care setting.

The inclusion of brief therapy by programs with licensed clinicians who have received specialized training in specific brief therapies allows for a meaningful increase in the available treatment options for patients.

The incorporation of the delivery of brief therapy should not exclude the completion of the expected measurement-based assessments or monitoring/management of psychotropic medications. Further, it is important that skills are developed within these areas and that additional training and competencies in these interventions are developed prior to implementation.

Resources for additional information on implementation for brief Cognitive Behavioral Therapy and Problem Solving Therapy include:

Cully & Teten's (2008) A Therapist's Guide to Brief Cognitive Behavioral Therapy. Department of Veterans Affairs South Central MIRECC, Houston.

Beck, J.S. (1995). Cognitive therapy: Basics and beyond. New York: Guilford Press. Greenberg, D. & Padesky, C.A. (1995). Mind over mood: Change the way you feel by changing the way you think. New York: Guilford Press

D'Zurilla, T.j., & Nezu, A.M, (2007). Problem-Solving Therapy: A positive Approach to Clinical Intervention. New York, Springer

Formal Psychotherapy

Patients who prefer intensive psychotherapy, meaning psychotherapy with a specialty care provider as opposed to brief therapies offered in your integrated care program, need to understand that even “talk therapy” is not without side effects. As problems are discussed and focused upon in treatment, negative feelings can become worse initially, but then gradually improve. So, like with medication treatment, the need for patience should be emphasized. It can take several weeks for improvements to become noticeable, and patients will need to persevere through any early reluctance to attend sessions. Enlisting help from caring, nonjudgmental family members in getting to appointments can help.

When discussing the option of formal psychotherapy treatment with a patient, you may encounter certain barriers to accepting a trial of therapy. While the final decision is up to the patient, you can address some of the patient's concerns, possibly helping the patient become more comfortable giving psychotherapy a try.

Following are some helpful responses to patients' concerns:

“Research has shown that psychotherapies such as Cognitive Behavioral Therapy is effective for depression and many other mental health conditions.”

“Psychotherapy can help people identify and change negative thought patterns. It does not mean you are “crazy” or have a psychotic disorder.”

“Many types of psychotherapies, such as CBT, focus on current problems and effective changes to relieve one's symptoms.”

“The therapy I am suggesting lasts for 8 weeks (or whatever is appropriate). It is a time commitment, but it is important for your health and well-being. The benefits have the potential to last for a long time.”

“Most psychotherapy involves talking about solutions, not just problems.”

“Medications are a good option for many people, but because of (circumstance related to patient) I am suggesting psychotherapy instead/in addition.”

“I am suggesting an 8-12 week investment of your time. This has been shown to be effective for many people.”

“Therapy is not going to cure all of your problems, but you and the therapist will work together to find ways of dealing with your problems. And it may help you break down problems into more manageable issues.”

“It sounds like you’ve had some bad experiences in the past with therapy. Let’s talk about that.”

“Just like anything else, therapy can be done in many different ways and by different people. I can help you find a therapist who’s approach is a good match with your preferences.”

The BHP should have knowledge of potential patient resources for initiating psychotherapy and prepare the patient for understanding the referral and/or consultation process, and any possible delays. The BHP can tell the patient that his or her preference for treatment will be reported to the PCP who will make the appropriate referrals (or if co-located psychotherapy is available, the BHP will make the referral personally, but will keep the PCP informed). For a further discussion on engaging patients into specialty mental health care, please refer to the Referral Management Volume.

Facilitate engagement

Patients with depression and anxiety have a tendency to isolate themselves from others, decrease positive activities, and engage in other maladaptive behaviors that maintain or exacerbate their symptoms. Techniques drawn from Motivational Interviewing (MI) are thus appropriate for Depression & Anxiety Management to 1) help facilitate engagement in treatment and positive behavior change and 2) to help address any ambivalence about change.

Please refer to Volume 1, Building a Strong Foundation for an in-depth discussion of the principles and techniques associated with MI.

STEP 5 Active or Acute Phase Depression and Anxiety Management

The active or Acute Phase of the Depression & Anxiety Management program occurs during the first 12 weeks during which the BHP and the patient are actively engaged in the implementation of the treatment plan. In general, patients should be contacted at least 3-4 times to assess symptoms and assess progress towards treatment goals. In addition to clinical content (goal setting, education, brief

therapy for example), structured assessments should also be included to evaluate progress and assist with treatment decisions.

For patients receiving psychotropic medication management, the program has well defined, evidence-based planned contacts with the patient. Other patients may be engaged in a brief therapy as well as medication management services, and your planned contacts will need to be adjusted over the course of the 12 weeks to meet recommended timelines for both interventions as appropriate. For those patients who are not receiving psychotropic treatment for their symptoms, the timing and frequency of contacts should be based on best practices for the specific intervention they are receiving, obtainment of the goals established at the initiation of the intervention, guided by symptom severity/fluctuations and coupled with clinical judgment. For example, a patient may have 4 contacts to engage in a specific problem-solving intervention interspersed systematically throughout the 12-week period, based on patient preference, need, and structure of the specific problem solving protocol. In planning acute phase contacts for your patients who are not receiving medication treatment, you need to ensure that your planned contacts for providing Depression & Anxiety Management retain fidelity to this program's principles, specifically that the intervention includes multiple contacts with routine measurement based assessment over the 12 week period.

Your role during the Acute Phase is to promote and monitor adherence to the treatment plan, monitor symptoms, support the patient's self-management of their illness/symptoms, and problem-solve around treatment goals. As a guideline, the follow-up contacts are generally to be 15-25 minutes in length. Patient contacts may be in person or over the telephone. If introducing a specific skill, such as relaxation training or problem solving, these contacts may take a little more time. However, it is critical that the contacts remain brief, ranging from 25-30 minutes. Follow the risk management guidelines for patients who endorse suicidal thinking and/or behavior that is specific to your program. If the patient drinks any alcohol, they should be advised to abstain from alcohol and illicit drugs while taking medication for depression or anxiety. The BHP should provide education about specific strategies that may support the patient's self-directed efforts to reach their goal of relieving their symptoms including:

1. Setting SMART goals
2. Pleasurable events scheduling
3. Exercise
4. Learning problem solving skills
5. Increasing social interactions
6. Use of antidepressants

Both Problem Solving Techniques and the setting of SMART goals are discussed in Volume1. Additional information on these strategies and patient handouts can be found in the Patient Resources Volume. All program BHP personnel are expected to have competency with these techniques.

OVERVIEW of the Acute Phase of Depression and Anxiety Management –

Example Contact Timeline						
	Initial Contact	Week 3	Week 6	Week 9	Week 12	1 week post-medication or change
Depression measure	X [^]	X	X	X	X	X
Side Effect/adherence (if on med) Inquiry	X	X	X	X	X	X
Alcohol use measure	X [^]		*		*	
Anxiety measure	X	*	*	*	*	*

[^] = *Expected to be in Baseline Assessment*

* = *As Appropriate, if prominent anxiety*

Follow-up contacts (telephone or in person):

- **For those receiving psychotropic medication management through integrated care:**

Follow-up contacts should occur at approximately weeks 3, 6, 9, and 12. Additional contact(s) are to be made approximately 1 week after any change in psychiatric medication, if any. Such changes include change in dose (increase or decrease) or type of medication as well as the discontinuation of a psychotropic medication.

- **For those patients who are not receiving medication management through integrated care:**

Depending on the patient's treatment plan, the above schedule of telephone or in-person contacts may also be appropriate for the delivery of depression and anxiety management. However, for patients not receiving psychotropic medication management through integrated care, the timeline and number of planned BHP contacts is flexible to allow fidelity to the principles recommended in the delivery of specific behavioral interventions.

Note that, even if patients are not receiving medication management services through your program, you should still periodically conduct the medication inquiry described below in those patients known to be receiving psychotropic medications. This will allow you to include this valuable information in the feedback provided to the PCP.

Conducting Acute Phase Patient Contacts

1. Prior to contacting or meeting with the patient, review the patient's clinical chart, if available, to learn if s/he was seen by any providers since last contact.
2. Conduct a semi-structured interview, including the completion of the standardized depression/anxiety measure (e.g. PHQ-9 and GAD-7), and, for those patients on psychotropic medications, an adherence/side effect inquiry (see below). If the patient reports suicidal intent and/or plan, the BHP is required to follow the site High Risk Management protocol. The content of the unstructured part of the clinical interview will largely be driven by patient-specific symptoms and concerns being targeted by your treatment plan and may include goal directed, action-oriented activities, the delivery of behavioral interventions, and /or health and wellness education. The unstructured, unscripted piece of this clinical interview is also the place where your clinical skills can be the most effective in keeping the patient focused, motivated and engaged. It doesn't matter at what point during the interview the structured piece is completed, but completion of a standardized, structured, validated measure should be included all scheduled follow-up contacts.
3. Conducting the medication inquiry: ask about adherence and potential side effects from the medication. One strategy is to begin the contact by asking patients a structured inquiry regarding side effects (see Patient Resources Volume) focusing on the past 7 days and targeting headache, nausea, vomiting, diarrhea, and sexual dysfunction (the most common side effects for antidepressants) and inquiring whether the patient is having any problems with their medication in an open-ended fashion. The patient should be given the chance to elaborate on any symptoms that are interfering with his/her functioning. After each contact, any significant report of side effects should be promptly discussed with the MC and reported to the PCP. Reports to the PCP should also include any recommendations made to the patient to help manage the side effect(s). The Clinician Resources Volume includes a resource for recommendations for common side effects of SSRIs as well as information related to potential side effects associated with medication discontinuation.

Side effect monitoring through direct inquiry is particularly important in the first week after any medication change as many so-called nuisance side effects appear at this time and can lead to non-compliance if not addressed. You are to contact the patient 1 week after a psychotropic medication is started, discontinued, or the dose is increased/decreased.

4. Periodically review alcohol use (e.g. on weeks 6 and 12), using the same measure used in the baseline assessment; 7 day time-line follow-back and AUDIT-C are recommended (see Patient Resources Volume).
5. Review with the patient any changes in medications, including OTC medications, vitamins, and nutritional supplements. Ask if he/she was seen by medical or psychiatric professional(s) since your previous contact. Document any positive findings.
6. Include efforts to foster trust and engage/motivate patient for treatment if ambivalence or resistance to treatment recommendations are present.
7. Conduct goal-setting, behavioral activation, problem solving, or other brief therapy intervention, if appropriate.
8. Schedule the next appointment with the patient.
9. Document contact and assessment findings in a format to be sent to the PCP.

Key Acute Phase Decision Points for those with Depression

Additional Tasks at 6 weeks:

At week 6, a re-evaluation of the patient is conducted to assess the need for modifications in the treatment plan. Modification may include re-introducing the possibility of medication treatment as well as the initiation or stepping up of behavioral or other psychosocial interventions.

In conjunction with the guidelines found in the medication algorithm, consult with the MC prior to making recommendations related to psychotropic medication management to the PCP.

For patients who are already receiving medication treatment, the following recommendations are made in the medication algorithm:

- If the patient has had a 50% or greater improvement (50% or more reduction in PHQ-9 score), continued monitoring is sufficient.
- If the PHQ-9 score has decreased by at least 30%, but not as much as 50%, then the current medication dose, if any, should be optimized to the maximum recommended dose (this may require titration over several days).
- If the PHQ-9 score has not decreased by at least 30%, the BHP needs to consider a treatment modification, such as augmentation (the addition of another medication to enhance the response to the current antidepressant or initiation of BHP-delivered brief therapy), switching to a different class of antidepressant, or referral for formal psychotherapy.
- If at any time during the Acute Phase of treatment there is a change of medication brand or an augmentation of medication, the patient is to receive a 1 week post-initiation or change contact from the BHP and then may be restarted in the Acute Phase monitoring schedule, if appropriate.

Discuss the pertinent assessment findings with the PCP and inform him/her of any recommendations. Include in the communication with the PCP any changes you are planning to recommend to the patient that will be delivered as part of your BHP role in integrated care.

Charting and documenting your work

The BHP documents the outcome of the sessions and provides this information to the PCP. The format of clinical notes, and the route of communication to the PCP, is expected to be highly specific to site, provider, and your preference. Issues related to charting and documenting your work are discussed in Volume 1.

Additional Tasks at Week 12

At week 12, if the patient's PHQ is less than 10, the patient enters the Maintenance Phase of the Depression & Anxiety Management program. If the PHQ-9 score is 10 or greater, consider alternative treatment plans by first discussing potential options with the patient. Consult with the MC regarding implementation of further treatment options, if the patient is currently on medication or is now willing to consider an antidepressant trial. Discuss the pertinent assessment findings with the PCP, communicate the patient's preferences, and inform him/her of any recommendations. The approach to patients who continue to be symptomatic at the end of 12 weeks of treatment includes the possible re-enrollment in the Acute Phase of treatment. The decision to do this is a clinically driven decision, based on current symptoms as well as patient motivation to actively work toward goals, and must include support from both the PCP and the patient. For example, a patient who has made significant improvement in symptoms and function but still has a few minor symptoms may not want to risk changing treatments or augmenting treatment or may report satisfaction with their current mental health status. To keep the management time-limited and goal-driven, patients should not repeat the Acute phase more than 3 times (9 months). Patients who are still symptomatic after 9 months of active treatment are likely best served by a referral to specialty care. Provide documentation to the PCP regarding the patient's clinical status at week 12 and the planned post-Acute Phase patient management plan.

Anxiety Disorders

The treatment of anxiety disorders follows the same principles established for depressive disorders. Differences in approach are indicated in the assessment instrument used, the initial pharmacologic recommendations, and possible interventions used to target anxiety (such as relaxation techniques and recommended behavioral changes such as increasing exercise or reducing caffeine consumption.) The anxiety measure should be administered at each contact and the depression measure should be performed at baseline and as clinically indicated. It is recommended that the GAD -7 be used, a validated anxiety measure with response set and scoring identical to the PHQ-9.

It is not uncommon for patients to present with both significant depression and significant anxiety symptoms. Potential interventions for managing patients with mixed presentations are listed below.

Setting SMART goals and Problem Solving therapy are discussed in the first manual, Building a Strong Foundation. More information and patient handouts on the following techniques can be found in the Patient Resources Volume and the Clinician Resources Volume:

1. Setting SMART goals
2. Pleasurable events scheduling
3. Relaxation techniques
4. Exercise
5. Problem-solving techniques
6. Use of social support
7. Use of antidepressants are also potentially effective in targeting underlying anxiety symptoms

As there is no clear evidence demonstrating differential efficacy of benzodiazepines versus selective serotonin reuptake inhibitors (SSRIs) for Panic Disorder or GAD, program recommendations are biased toward long-term treatment of anxiety with an SSRI, while benzodiazepines are best as a short-term adjunct to symptom management during SSRI titration.

“Pros” of benzodiazepine use:

- Efficacious in short-term treatment of anxiety
- No delay in onset of action
- Do not appear to interfere with antidepressant actions

“Cons” of benzodiazepine use:

- Potential for dependence and abuse
- Increased risk of falls and fractures
- Sedation
- Cognitive impairment (short-term)
- Cognitive decline (long-term)

Most of the listed well-known “cons” are likely to be of particular consequence in older adults, especially those already demonstrating cognitive disability. It is recommended that patients with known substance dependence problems be preferentially treated with an SSRI.

For patients who enter the anxiety management already on benzodiazepine treatment, and are unwilling to discontinue the medication, a “harm reduction” approach is recommended.

A harm reduction approach includes:

- Avoidance of use of very long or very short acting benzodiazepines
- Working toward the use of the lowest effective dose
- The promotion of ongoing patient education aimed at the potential anxiolytic effect of initiating/continuing treatment with AD

However, as in the medication management of depression, medication recommendations are up to the discretion and clinical judgment of the MC and PCP, allowing for incorporation of prior treatment success or failure and other individual factors.

Clinical Worsening During the Acute Phase

Patients who have demonstrated significant clinical worsening, especially those who are reluctant to consider changes in the current treatment plan, should be considered for referral to a specialty care MH provider. It is expected that once the patient becomes engaged in specialty care, the patient has concluded their participation in your care.

IF CLINICAL MANAGEMENT INCLUDES PSYCHOTROPIC MEDICATION DISCONTINUATION

Side-effect symptoms are sometimes associated with discontinuation. In placebo-controlled studies of SSRIs, the most common events (>1 %) associated with discontinuation and considered drug related have included the following:

Side-Effect Symptoms associated with discontinuation of antidepressant medications that effect Serotonin (e.g. SSRIs)		
CNS	Gastrointestinal	Other
Somnolence	Nausea	Sweating
Insomnia	Dry Mouth	Abnormal Ejaculation
Tremor		

Side effects associated with discontinuation can often be avoided or minimized by gradual discontinuation of antidepressant medication, rather than abrupt withdrawal.

Similar issues regarding documentation and adverse effects apply to the treatment of anxiety. When using benzodiazepines, the most common adverse effects include sedation, psychomotor retardation, and the potential to worsen gait problems. Again, side effects associated with discontinuation can often be avoided or minimized by gradual discontinuation of benzodiazepine medication, rather than abrupt withdrawal.

STEP 6

Maintenance Phase of Depression and Anxiety Management

During the Maintenance Phase, follow-up with the patient once a month to obtain a PHQ-9 and/or GAD-7 score, monitor clinical status/changes, and educate about relapse prevention. If a patient becomes more symptomatic (scores 10 or greater), reassess in 1 week to determine if s/he is relapsing. If the score remains at 10 or greater, the patient may be relapsing; therefore, the treatment plan needs to be addressed and discussed with the patient, and then with the MC and/or PCP as appropriate. The patient may need to restart the Acute Phase of treatment. Pharmacotherapy may be recommended for those patients who entered the Maintenance Phase not receiving an antidepressant. Brief therapy may be recommended or added as augmentation to pharmacological management.

Pharmacotherapy patients who are asymptomatic or minimally symptomatic (score of 10 or less) at the completion of the Acute Phase week 12 assessment are encouraged to continue pharmacotherapy during the 3 month Maintenance Phase.

The Maintenance Phase offers the opportunity to educate the patient about relapse prevention. During the Maintenance Phase, you can use the following strategies which aim to help patients achieve learning goals related to relapse prevention:

- **Understanding relapse risk** – The review of relapse prevention can be started by first clarifying that management is coming to an end and there will be no further formal BHP contacts after the final maintenance call. This, however, does not mean that a patient's depression care is over, or that you cannot be contacted in the future should the need arise. Since you will no longer be following up regularly, it is important for patients to be reminded that depression has a recurrence rate of about 50%, and the rate is even higher for people who have dysthymia or have had multiple past episodes of depression. Thus, it is important to make a plan for relapse prevention treatment, and to reinforce self-monitoring skills for signs of recurrence.
- **Monitoring symptoms** – Patients can learn to “check in” with their symptoms once a month to notice whether they are getting worse (or better) or maintaining the improvements gained in treatment. The Clinician Resources Volume includes a sample relapse prevention patient letter and the Patient Resources volume includes a copy of the PHQ-9 as well as the GAD-7 designed for patients which can be provided to the patient.
- **Monitoring personal early warning signals of depression** – Personal warning signs are those that you and the patient together have identified as early signals of returning depression for that patient. For some people, unusual irritability or a return of disinterest in social encounters may be warning signs. Others may find themselves crying easily again. Often such signals are noticed by family members before the patient even recognizes them. Patients can be encouraged to enlist help from those close to them to help catch relapses early.

- **Monitoring and managing trigger situations and stressful events** – For some people, certain situations, such as unpleasant social encounters, can trigger or worsen depression or anxiety. Patients can learn to anticipate such events and plan ways to deal with them if they arise. Stressful life situations, such as illnesses, or family problems, can also trigger or worsen an episode of depression or anxiety. For events that can be foreseen, patients can be encouraged to prepare a coping plan, using skills learned during depression and anxiety management.
- **Reinforcing self-care skills** – Self-care may include calling friends or relatives, preparing for stressful events by writing down a coping plan, pursuing interests, and continuing to take medication as prescribed. An important strategy for all patients is to participate in healthful pleasurable activities as frequently as possible. Strategies agreed upon during the conversation should be incorporated into the patient relapse prevention letter. Particular emphasis should be placed on prompting the patient to use effective self-care strategies that were developed during management calls.
- **Knowing when to get professional help** – Patients need to know when to come back for more help. If patients find themselves scoring worse on the PHQ-9/GAD-7 (and particularly if they score higher than 14), are unable to do their daily activities, or have thoughts of suicide, they should be taught to seek help right away, thus preventing a downward spiral. Patients should be aware that there are many people ready to help if they have suicidal thoughts, including the National Crisis Line [800-273-TALK or 800-273-8255], 911, the local Emergency Room, their primary care provider or BHP.

Introducing the availability of self-monitoring skills as a way to extend clinical gains should begin as soon as the patient begins to demonstrate clinically meaningful reduction of their symptoms and certainly no later than the patient's enrollment into the Maintenance Phase. Once the patient is beginning to feel better, with PHQ-9/GAD-7 scores falling and close to remission, you can weave discharge preparation education into every call. Patients should understand early that the goal is not only to bring their depression and anxiety under control, but to teach them how to manage their own health, and how to work effectively with their provider. Patients are encouraged to continue using the tools and knowledge gained during their time with you in order to stay healthy. Education about relapse prevention ideally begins during follow-up calls prior to the discharge of your patient. The last follow-up call, then, reinforces the principles of relapse prevention and prepares the patient to continue management without your regular support, knowing he/she can call you if a need comes up. Because of the relationship patients have forged with you, you may be the first person the patient wants to speak with if unpleasant feelings return. You can help the patient sort out what kind of help is needed, and help ensure that he/she accesses an appropriate resource.

Documentation for End of Maintenance Phase

At the completion of the Maintenance Phase, a letter/clinical note for the PCP's review should be posted/sent that summarizes the relevant case details and includes any recommendations.

Procedure for End of Maintenance Phase for Those Receiving Pharmacotherapy

At the completion of the Maintenance Phase (3 months symptom free), discuss with the patient his/her interest in continuing to take medication for relapse prevention. Provide the patient with education informing patients that those who respond to medication and continue taking it are less likely to have a relapse than those who discontinue it.

Inform the PCP of the patient's preference by incorporating this information into the post-Maintenance Phase clinical note that summarizes the patient's clinical course and makes follow-up recommendations. For those receiving psychopharmacology, the PCP note should also routinely include the information that patients who respond to antidepressants and who continue on them demonstrate a significantly lower relapse rate than patients who discontinue them.

Early Entry into the Maintenance Phase

While the patients typically begin the Maintenance Phase at the completion of the Acute Phase with minimal/remitted symptoms, the program does permit the decision to enroll patients into the Maintenance Phase at an earlier point of time. This is most likely to occur when the patient has consistently refused to establish treatment goals or consider treatment recommendations for their symptoms, and therefore active treatment is not likely to be productive. In this case, the patient is followed by three brief monthly telephone contacts, primarily for monitoring and encouragement to engage in treatment, and a final report is sent to the PCP. If the patient decides to accept treatment recommendations over this period, he/she can be re-entered into the Acute Phase.

STEP 7 Discharging patients

Discharge from the Depression & Anxiety Management program usually occurs after 6 full months of patient participation, when many patients have few or no symptoms, or can occur earlier if a patient has low follow-up PHQ-9/GAD-7 scores (score of less than 5 twice in a row, at least 2 weeks apart). Patients who feel well often think they've overcome their illness for good. Being well at the time of discharge, however, does not provide assurance of continued good health. Teaching patients relapse prevention is the best way to promote good long-term outcomes. Though many patients will feel well at the time of discharge, other patients may have continued significant symptoms, and additionally need a plan for managing their ongoing treatment.

Discharge Dispositions

Because patients may be in varying states of symptom resolution at the time of discharge, the discharge care plan should be individualized to the patient's condition. In general:

- If the patient is doing well, the PCP can follow-up with the patient and re-refer to you if any problems arise
- If the patient has moderate symptoms at discharge (PHQ-9 or GAD-7 is over 10), mental health specialty follow-up or other adjustments in the treatment regimen are likely to be required

- Appropriate steps, including educating the patient about options for improving results, should definitely be initiated by the BHP prior to discharge from care
- For a limited number of patients, re-enrollment for a second 6 -month course of management can be considered. For example, some patients refuse antidepressant treatment when they begin, but after 2 or 3 follow-up contacts or appointments decide to give it a try. Such patients might benefit from another 6 months.

For patients on antidepressants at discharge:

- **If depression is resolved or there is low risk of relapse** (fewer than two prior episodes and no dysthymia) – Patients should complete at least 6 to 9 months of the successful pharmacotherapy. The average patient on antidepressants achieves remission in 3 to 5 months. Pharmacotherapy should continue for 4 to 9 months after their depression symptoms have remitted (e.g., reached a PHQ-9 of less than 5). Most patients will thus be on antidepressants for about a year from when they began a successful pharmacotherapy course. Many patients will not have completed this entire duration of pharmacotherapy at the time of discharge from management, so education about the importance of continuing pharmacotherapy, as prescribed by their primary care provider, is crucial. Research evidence shows that if a patient's depression has not been fully stabilized, relapse will occur when antidepressants are discontinued. Stopping medication too soon seems to adversely affect brain chemical balance. The expected continued duration of pharmacotherapy should also be indicated to the primary care clinician. Both the patient and PCP should expect a trial of discontinuation of antidepressants after the recommended pharmacotherapy duration has been achieved. After discontinuing the medication, the provider can do a PHQ-9 during the patient's primary care visits to monitor for returning symptoms.
- **If there is high risk for relapse** (history of dysthymia or more than two prior depressive episodes) – Patients should be encouraged to stay on current treatment (usually full dose of the pharmacotherapy that led to clinical response) for at least 2 years. This information should also be shared with the patient's primary care clinician.
- **If mild persistent symptoms** – Patients with PHQ-9 scores between 5 and 9 at the time of discharge have mild persistent symptoms and the goal for most of these patients should be complete symptom resolution. If the PHQ-9 has been improving over time, and the patient is adherent to treatment, continuation of the same pharmacotherapy treatment in primary care without treatment adjustment is appropriate. If the symptoms have remained unimproved over 1 to 2 months, however, consideration should be given to recommendation of adjusting pharmacotherapy treatment and /or augmentation of treatment with psychotherapy.

Summary of Discharge Dispositions	
<p>Low relapse risk (less than two previous episodes and no dysthymia)</p>	<ul style="list-style-type: none"> • Continue initial treatment until 6-9 months of post-remission treatment complete • Discontinuation trial after completion of treatment
<p>High relapse risk (two or more prior episodes or dysthymia)</p>	<ul style="list-style-type: none"> • Maintenance treatment for 2 years post-remission – usually the same treatment that led to remission at full dose • Discontinuation trial after completion of treatment
<p>PHQ-9 between 5 and 9 and has not been improving over time</p>	<ul style="list-style-type: none"> • Continue current treatment until remission • Consider re-enrollment in limited cases where patient may benefit • Implement relapse prevention according to risk category after remission
<p>PHQ-9 between 5 and 9 and has been improving over time</p>	<ul style="list-style-type: none"> • Consider treatment adjustment. • Consult MC • Consider re-enrollment in limited cases where patient may benefit from BHP contact during implementation of modified treatment plan
<p>PHQ-9 between 5 and 9 and has not improved in last 1 – 2 months</p>	<ul style="list-style-type: none"> • Consider Mental Health Specialty follow-up • Consult MC • Consider other treatment adjustments • Consider re-enrollment in limited cases where patient insists on care but not in a specialty care environment

Common Challenges in Depression and Anxiety Management

This treatment manual describes a straightforward and patient-centered protocol to provide Depression & Anxiety Management to patients enrolled in primary care and to provide on-time, on-target information to the collaborating PCP. One of the challenges facing the BHP is how to coordinate and accomplish these activities and goals across multiple stakeholders, all of whom may have complicating factors such as competing needs, limited availability, etc. The MC can be a resource in problem solving when scheduled assessments, activities, or communications do not proceed smoothly. In addition, sharing experiences with peers may suggest strategies for commonly encountered barriers and obstacles.

Below are some of the more common patient issues and potential strategies for handling them:

- **The patient is not interested in pursuing any potential strategies/changes in managing his/her symptoms, despite agreeing to actively work with you** – Consider transitioning the patient to the Maintenance Phase (brief monthly assessments). This should be discussed with the PCP if appropriate.
- **Trouble keeping contact within the recommended time limits** – This can be a real challenge for which there is no specific strategy that is universally effective. For those patients with whom it is difficult to focus and target the interaction, you may need to utilize limit-setting techniques, for example stating the time limit at the start of the contact and setting an agenda with the patient that can be referred to. After developing specific treatment goals (for example using an appropriate Action Plan), you can also re-direct the contact back to the targeted goals. Also see the section in Volume 1 on 30-minute interviews.
- **Patient is not attending scheduled appointments with you (phone or in-person)** – If a patient fails to show for an appointment, the BHP should reach out by telephone and be prepared to conduct the contact by telephone. As mentioned, telephone-based interventions have been shown to be equally effective, and patients may prefer this type of contact for logistical reasons. If patients are being followed by phone and numerous (>4) attempts to reach them are unsuccessful, or if patients fail to attend an appointment and are not reachable, a letter can be sent that addresses your efforts and provides contact information for the patient to reach you if they wish to continue. This information should also be shared with the patient's PCP.
- **Patient is only available outside of your normal working hours** – if your site allows flexible hours, a strategy would be to adjust work hours allowing a greater portion of non-business hour contacts.
- **Challenges with the collaborating PCP and other members of your primary care integrated team** – Difficulties in contacting the PCP, lack of consensus regarding treatment recommendations, and varying provider beliefs about mental health issues/psychiatry in general are all issues that can be routinely encountered during your collaboration with your primary care integrated team.

Again, sharing experiences with peers may elicit strategies for commonly encountered barriers and obstacles or may support you in coping with obstacles. Utilize the support and expertise of the integrated care program director and/or MC as much as possible while continuing to keep the needs of the patient and his/her effective management the paramount issue. Refer back to Building a Strong Foundation for a further discussion on this topic. Briefly, some effective strategies include:

- Being visible in primary care
- Attending team meetings
- Providing brief educational talks on mental health issues or your program
- Eliciting feedback from providers
- Developing a list of individual provider preferences
- Fostering primary care provider “champions”

A Final Critical Piece: Program Evaluation/Monitoring

Program level monitoring is just as important as patient level monitoring. Program level monitoring facilitates quality measurement, the ability to adjust and improve the program, and communication with all stakeholders including hospital administrators, insurance companies or others responsible for budgeting of the program. A successful program needs to be able to demonstrate success over many patients. This is only done with appropriate informatics.

Key parameters to monitor for Depression & Anxiety Management include:

- Number of referrals
- Proportion of referrals assessed or pending an assessment
- Proportion of referrals assessed as appropriate for the depression/anxiety program
- Number of patients who accept treatment within the depression/anxiety program
- Number of patients who engage in treatment
- Average number of contacts within the first 3 months of treatment (active phase)
- Change in depression and anxiety symptoms over time

Tracking these outcomes can be accomplished in a number of ways. There is commercially available software (BHL software) that facilitates the baseline assessment, progress note creation, as well as patient, provider, and program level evaluation. A more in depth discussion regarding program monitoring and evaluation can be found in manual 1, Building a Strong Foundation.

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