

# Self-Management Support to Control Depression

It is important to effectively screen and treat depression in patients with diabetes.

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Compared with the healthy population, the incidence of depression in people with diagnosed medical conditions is heightened. Depression may amplify medical symptoms and increase impairment as well as mortality. Some studies show that between 11% and 15% of the diabetic population experiences major depression. As practitioners, we must screen our diabetic patients for depression, and when necessary, treat the patient for depression.

According to the Pathways study — an epidemiologic study enrolling 4,225 HMO prescribing patients with diabetes — 12% of the patients experienced major depression. Depression was noted more often in patients with diabetes in the following demographic categories: women, younger age, less education and not married. With this many patients susceptible to depression, one would assume that it should be easy to receive care. Unfortunately, there are many barriers to the care and treatment of depression, and only 33% to 50% of patients are treated for their condition. Barriers may be related to the patient (eg, stigma regarding mental health diagnosis, lack of insurance coverage for mental health care) or the health care system (eg, suboptimal outcomes in 40% of patients, interruptions in treatment, frequency of contact).

## PRIMARY OR MENTAL HEALTH SETTINGS

When treatment does occur, it takes place most often in primary care or mental health settings. In the primary care setting, visits — performed largely by the primary care physician — are infrequent and approximately 15 minutes long. There may be limited access to clinical information on depression, resulting in a decreased ability to monitor patient progress or offer care from mental health specialists or personnel. If care for depression is

## SYMPTOMS OF DEPRESSION

- Depressed mood
- Anhedonia or loss of interest/pleasure
- Weight loss or weight gain
- Insomnia/hypersomnia
- Psychomotor agitation/regardation
- Fatigue/loss of energy
- Feelings of worthlessness/guilt
- Inability to concentrate
- Recurrent thoughts of death

taking place in the primary care setting, it is important for the physician to know the symptoms of depression (see above).

It is also important to have a diagnostic and monitoring tool in place. The Patient Health Questionnaire-9 (PHQ-9; Pfizer, New York, NY) is one method to monitor health in patients with a chronic illness, unexplained physical complaints, who appear sad or stressed or who have lost interest in pleasurable things. This nine-question test is self-administered. From its results, patients may be categorized into one of three clinical depression categories:

- **Major depression.** If a patient is experiencing five of the nine symptoms of depression that persist for a majority of days in a 2-week period of time, it is safe to say they have major depression. The patient is experiencing a depressed mood or anhedonia.

- **Dysthymia.** If a patient has been depressed for 2 years and is experiencing at least two symptoms of depression on most days, then the diagnosis is dys-

Score	Level of Depression	Treatment Recommendations
0-4	None	Monitor
5-9	Minor	Watchful waiting/ SMS/Reassessment
10-14	Moderate/ Clinically significant	Meds and/or psychoTx; SMS
>15	Major Depression	Meds primary, SMS, consider psychoTx

Figure 1. Chart shows treatment recommendations for each category of depression.

THE CHRONIC CARE MODEL
<ul style="list-style-type: none"> <li>• Delivery system redesign: Assure delivery of effective and efficient clinical care and self management</li> <li>• Decision support: Promote self-management support consistent with scientific evidence and patient preferences</li> <li>• Clinical information systems: Organize patient and population data to facilitate self-management support</li> <li>• Health care organization: Create a culture, organization and mechanisms that promote self-management support</li> <li>• Community: Mobilize community resources to promote self-management support</li> </ul>

PHQ-9	Treatment Response	Treatment Plan
Drop of >5 pts from baseline or PHQ<5	Adequate	No Tx change. F-u monthly until remission, then q 6 mos.
Drop of 2-4 pts from baseline	Possibly Inadequate	Consider increase dose or change medication; increase intensity of SMS, psychotherapy
Drop of 1 pt, no change or increase	Inadequate	Obligate change in plan, specialist consultation, collaboration, referral

Figure 2. Chart shows follow-up plan for each level of depression, according to the PHQ-9.

memory among patients with depression.

The physician must also conduct regular follow-up examinations. The guide for follow-up exams is found in Figure 2. One component of follow-ups is collaborative self-management support. The chronic care model is a beneficial tool for providing support to patients with depression. The five chronic care model points (ie, delivery system redesign, decision support, clinical information systems, health care organization and community) are outlined above.

Establish rapport with patients; educate them about depression and help to set goals for managing and treating depression. Regular follow-ups allow for consistent monitoring and assessing the patient’s progress and goals. One strategy is to encourage adherence and relate the goals or treatments to the patient’s social and/or cultural environment. Sometimes, patients find it easier to reach their goals with the help of support programs or teams, which may be available through their health care facility. If this option is available, be sure to offer it to the patient. Furthermore, track patients’ progress and make sure they are following through with their action plans.

Too many patients are not receiving adequate information and treatment for depression. By following a self-management support model, physicians may be better equipped to help patients with diabetes overcome depression. ■

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thymia. The patient is at an increased risk of major depression.

• **Minor depression.** If a patient is experiencing between 2 and four symptoms of depression, lasting for at least 2 weeks, then minor depression is the diagnosis. These patients must also have anhedonia or depressed mood as well.

A PHQ-9 score of 0 to 4 signifies no depression, while a score of 5 to 9 signifies minor depression, 10 to 14 signifies moderate or clinically significant depression and >15 signifies major depression. Figure 1 lists the treatment recommendations for each category.

### TAKE NOTE OF WITHDRAWAL, COGNITIVE FUNCTION

Each patient must understand that self-management is a crucial part to managing depression. They should continue checking their blood glucose levels and exercise regularly. Patients should also make sound dietary choices. Physicians should take note of increased withdrawal or social isolation and a reduction in cognitive function and