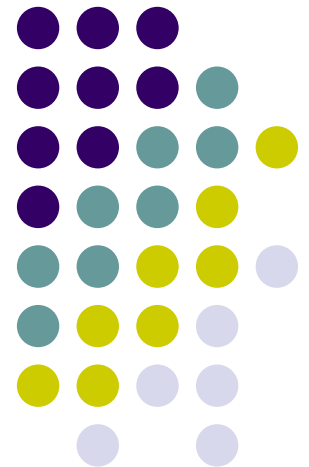


# Depression, Kidney Disease and the Role of Primary Care

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Dr. Ellen Anderson  
October 12 2007



# Full disclosure & Acknowledgments



- I am a practicing family doc
- My work is funded by the BC Medical Services Plan, the Vancouver Island Health Authority, UBC, the BCMA and the Ministry of Health
- I do not receive any pharmaceutical funding
- Although I've never been depressed or had kidney disease, in my practice there are lots of people with one or both conditions—these brave people have been my teachers. I thank them for encouraging me to learn to really listen and understand



# Today's topics:

- Why is major depressive disorder (MDD) a problem for people who live with chronic kidney disease (CKD)?
- What are the consequences of this?
- How can people who live with CKD take care of their mental health?
- Why does an ongoing relationship with a family doctor matter so much for a CKD patient, and how can we improve it?



# What is depression?

- A medical illness that impairs a person's ability to **work, love, and play**.
- A depressed person usually experiences persistent **low mood, lack of interest** in usual activities and a constellation of **physical symptoms** which impair quality of life
- A 'spectrum' disorder:
  - MDD can range from mild to severe
  - People can have single episode, recurrent episodes or a chronic illness

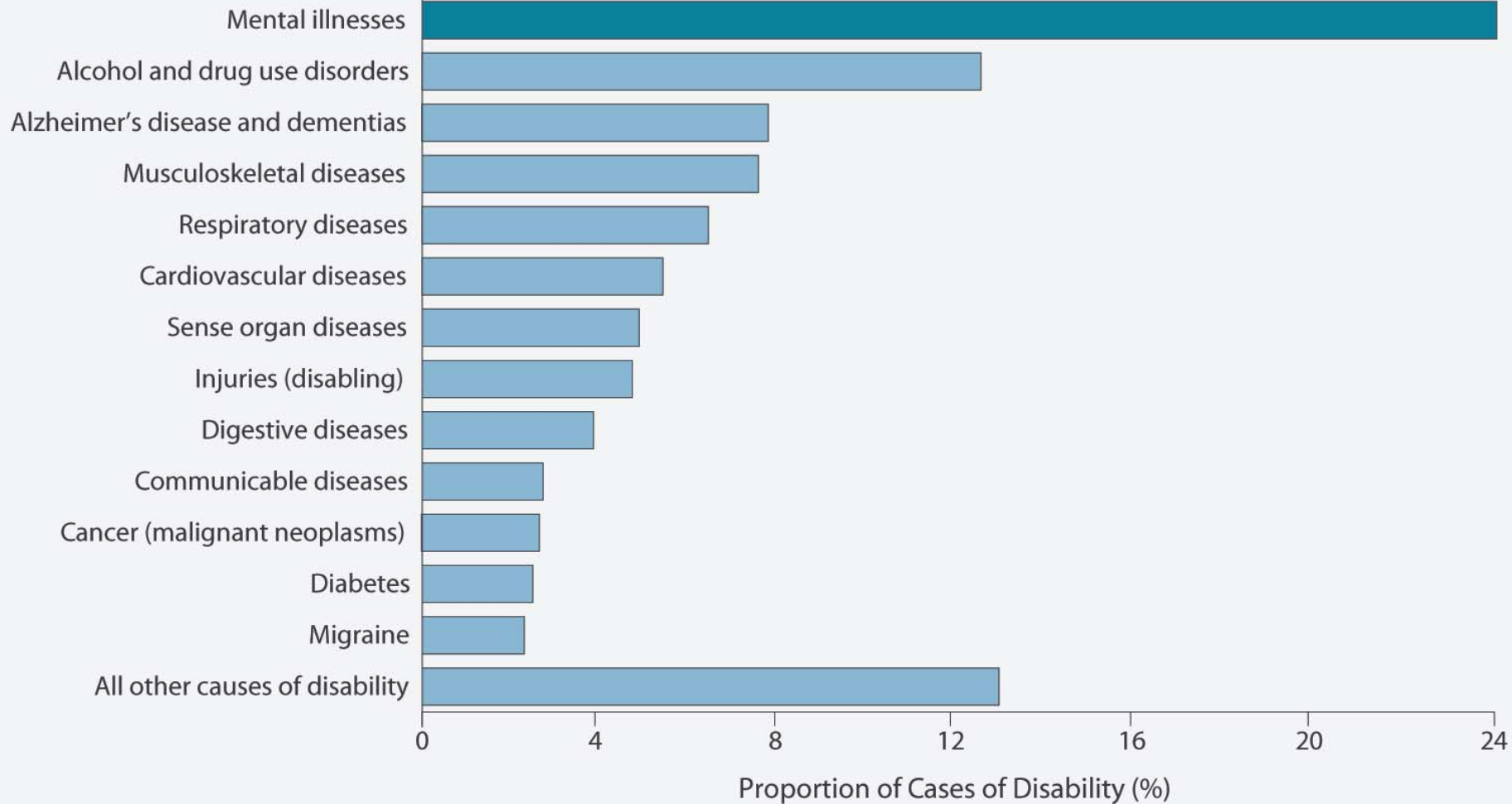


# What depression isn't:

- It is not transient unhappiness caused by life experiences or stress
- It is not normal grief associated with loss
- It is not a sign of weakness or 'giving up'
- It is not a personal choice



# The burden of disability:



**Figure 1.** Causes of Disability in the United States, Canada, and Western Europe in 2000.

Data are from the report by the President's New Freedom Commission on Mental Health. <sup>2</sup>



# How common is MDD in BC?

- **1 in 20** BC residents suffers from MDD at any one time
- **1 in 5** BC residents will suffer from MDD throughout their lifetime
- 10% of the adult population in BC is currently taking antidepressants
- 20% of BC health care providers are currently taking antidepressants
- **20-30% of people with Chronic Kidney disease presenting for dialysis will have MDD– many of them will be untreated**

# Why is the diagnosis often missed?



- $\frac{3}{4}$  of people with MDD come to their doctor with complaints of physical symptoms (eg fatigue, sleep problems, headache, etc)
- Stigma
- Mistrust
- Competing co-morbid illness
- Fragmentation of care
- Cultural issues

# How are chronic diseases and MDD related?



- MDD increases mental health co-morbidities: anxiety, alcohol or other substance use disorders are more common
- MDD makes it harder for a person to live a healthy lifestyle
- Long lasting physical illnesses of all kinds are linked to increased rates of MDD
- MDD increases the risk of developing other chronic illness
- MDD reduces a person's capacity to manage other chronic illness

# What do we know about CKD and Depression?



- Depression is more frequent in people with CKD, particularly ESRD\*
- People with mild CKD who have NO other health problems may have NO higher risk of depression
- Depression may predate the development of CKD

\*ESRD=end stage renal disease

# What do we know about ESRD\* and Depression?



- As the number of co-morbid health problems increases so does the likelihood of having MDD
- People with ESRD and MDD have increased morbidity and mortality
- 20-30% of dialysis patients present with depression
- In dialysis patients, no association of MDD with age, gender or frequency of dialysis
- Rx of MDD in ESRD improves patient outcomes and reduces side effects of Rx

\*ESRD=end stage renal disease

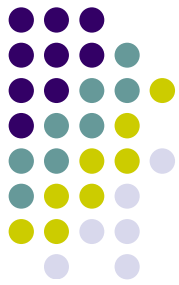
# Why might people with CKD become depressed?



- Personal losses (roles relationships, responsibilities)
- Lack of exercise
- Poor nutrition
- Chronic pain
- Poverty
- Other disabilities
- Generally being in poor health
- Physical limitations, lifestyle differences, and other illnesses can make people more susceptible to depression
- Getting older *can* put us at increased risk of depression

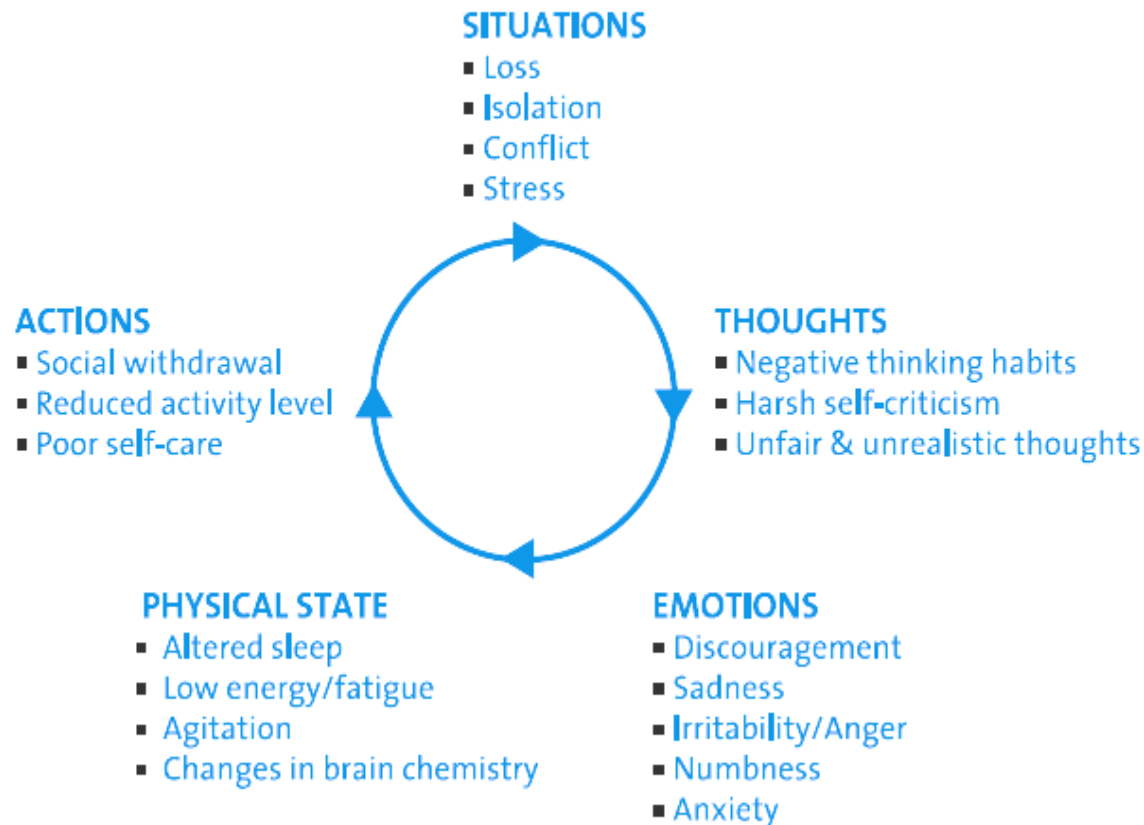
# A cognitive depression model\*

\*Dr Dan Bilsker CARMHA



## Causes of Low Mood & Depression

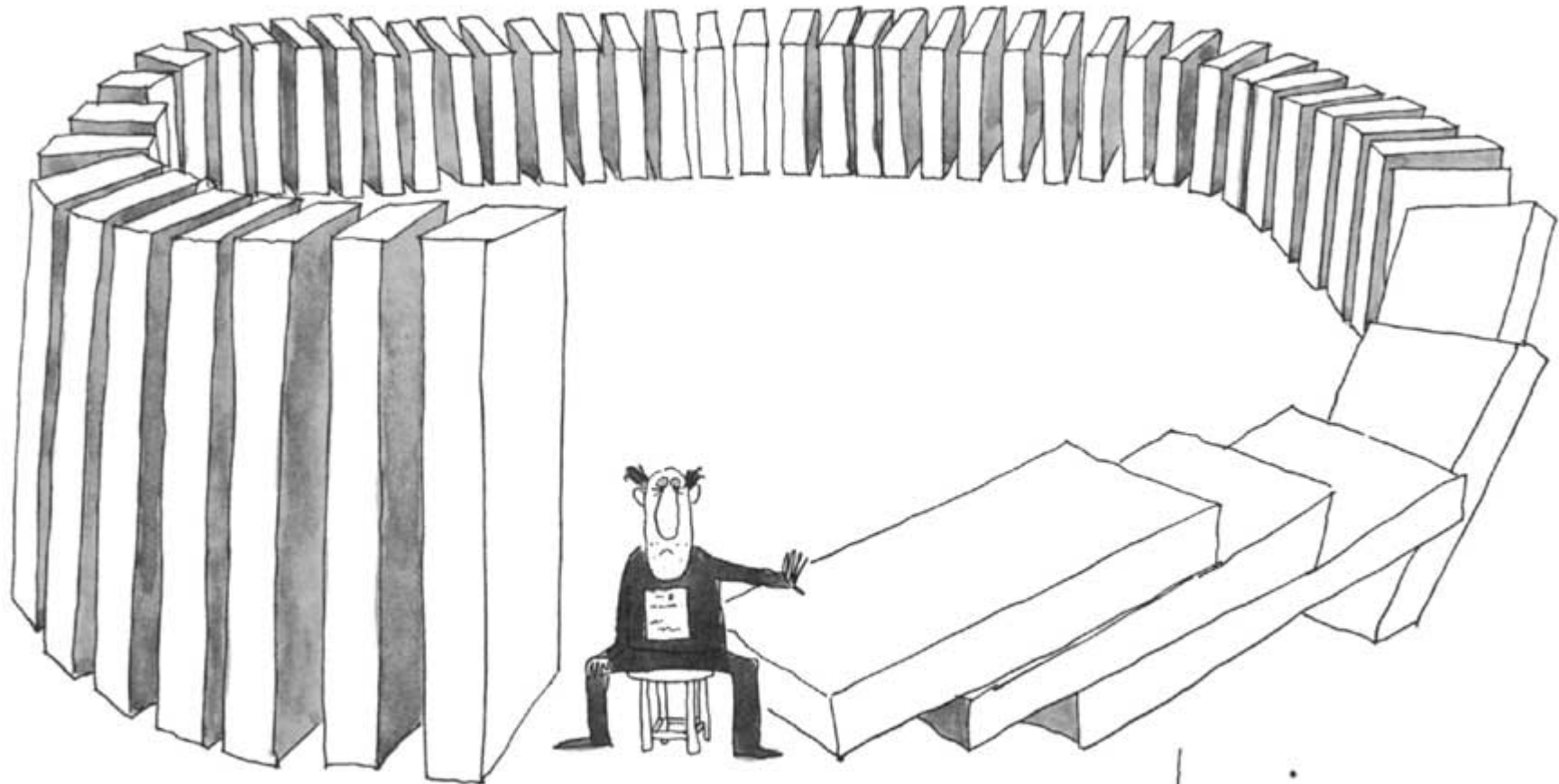
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## It turns out that:

- Depression itself is a significant risk factor for developing diabetes, heart disease, kidney disease and stroke
- Depression increases the cardiovascular risks associated with most chronic illness
- Depression can make it difficult to manage both CKD and other cardiovascular disease
- Depression occurs more frequently after a heart attack or stroke



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**What can we do to better  
PREVENT, DIAGNOSE and TREAT  
depression in CKD patients?**

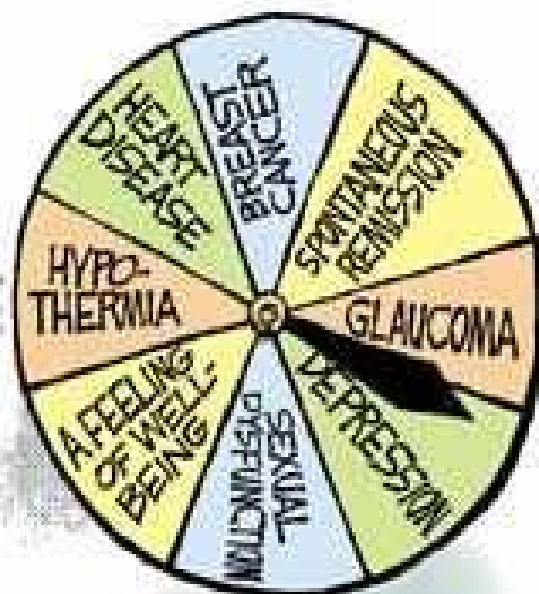
# Today's Random Medical News

from the New England  
Journal of  
Panic-Inducing  
Gottliebbooks

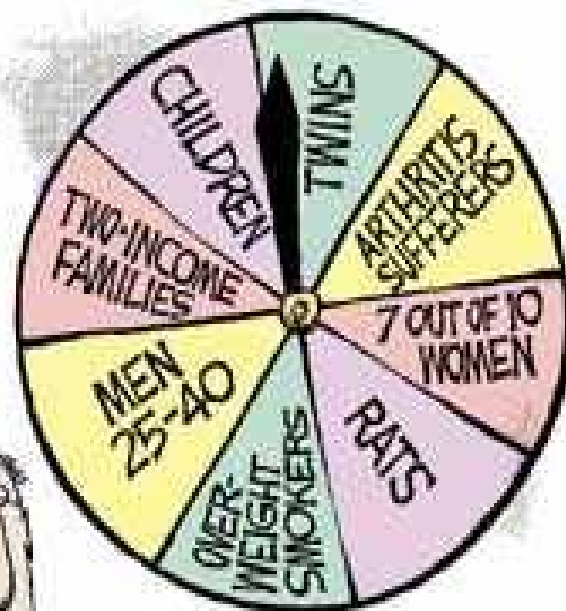
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# Community

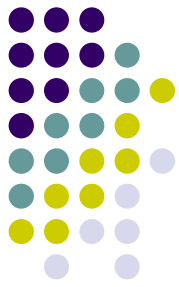


**Population Health Outcomes/  
Functional and Clinical Outcomes**

# Planned pro-active care needs to be tailored to specific conditions



- Good CKD care requires a careful diet, regular exercise, monitoring BP and blood tests, taking medicine as prescribed
- Good depression care requires a careful diet, regular exercise, monitoring mood and sleep, taking medicine as prescribed, and engaging in pleasurable activities



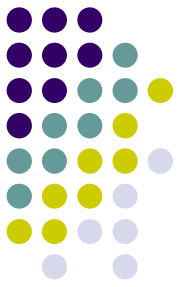
# Disease specific care...

- Depression care management improves depression related outcomes and quality of life.
- CKD care management improves CKD outcomes and quality of life
- Depression care management may improve CKD management and outcomes

# Depression IS a Primary Care Problem



- A GP is the only health provider seen by 85% of adult patients with major depressive disorder\*.
- GPs often know their patients for a long time and patients trust them
- GPs offer “whole person” rather than “disease-specific” care
- Patients who start dialysis often become ‘lost’ to their family doctor for regular follow up
- \* BC MSP linked data



*"Ah-ha! You are not happy."*

# How to quickly and accurately screen for depression?



- The 1 question screen:  
“What do you do to have fun in your life?”
  
- The 2 question screen:  
“In the past month have you felt down depressed or hopeless much of the time?”  
“In the past month have you lost interest or enjoyment in your usual activities and relationships?”

# The PHQ-9 is used to screen, confirm diagnosis and follow response to Rx



- Patient-rated primary care tool with a QOL question
- Helps grade severity of MDD: mild mod severe
- Takes ~3 minutes to complete
- It is the 'HBA1c' of depression
- Useful for patients >16yrs with Grade 4 English reading comprehension
- Not as good for older people with many other co-morbidities (GDS 7 is better) or cognitive impairment

# Suicide risk assessment



- Suicide is a rare event
- Thoughts of suicide or self-harm are common, particularly in people with depression
- Asking about suicidal thoughts or plans does NOT 'give people ideas' or increase the likelihood of a patient 'doing something'
- Patients find it helpful for a trusted care provider to raise a subject they often cannot.

# How to ask about suicide

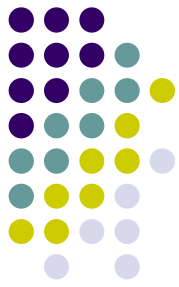


- The PHQ-9 asks for you. (Any answer of more than 0 on the suicide question requires further discussion with your patient and a written plan in the chart)
- “Sometimes when people feel the way you are feeling they feel hopeless and have thoughts that life may not be worth living, or thoughts of harming themselves. Have you ever felt like that?”
- “Have you ever had a time when you felt like hurting yourself or have tried to hurt yourself?”
- “How do you cope with those thoughts when they happen?”

# How to manage suicide risk



- Distinguish clearly between thoughts, intent and a plan
- Thoughts are common and usually transient
- Intent with a plan requires urgent referral and a documented care plan
- Make sure you and the patient identify and notify their personal supports
- “Contracts” not effective.



# How to treat depression?

- Lots of different drugs are available
  - Medication can be a lifesaver for many
- AND
- Talk therapies are as effective as drugs for mild to moderate depression
  - Talk therapies are a useful adjunct to medication
  - Talk therapy can help with relapse prevention
  - Group therapy is safe and cost effective

# What about Antidepressant meds in CKD?



- Concerns re safety of meds in the medically ill counterbalanced by the benefits of Rx
- Start low and go slow
- Choose a drug with a short half-life and inactive metabolites
- Be aware of drug-drug interactions
- Choose Rx based on therapeutic benefits, adverse/side effects, and CYP interactions with current meds

# What sort of talk therapy?



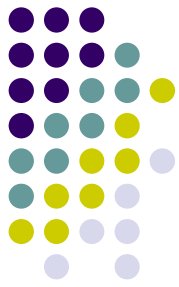
- **Cognitive behavior therapy** helps people develop healthy ideas, thoughts, and lifestyle, and learn new coping skills
- **Interpersonal therapy** helps people resolve family and relationship conflicts
- **Brief problem solving therapy** can help people learn to resolve some of their own problems



# Other considerations

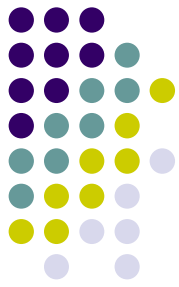
- Client/patient capacity/strengths
- Removing our 'deficit' focus
- Health literacy issues
- Cultural issues: MDD doesn't always 'Map' onto other cultures
- Utilizing existing support systems effectively

# What advice can we offer to people to prevent low mood?



- Tell someone who cares about you if you are feeling down
- Cultivate loving relationships, friendships, and social contacts
- Stay connected to others through volunteer work, service clubs or social activities.
- Laugh and joke whenever you can, watch funny movies, listen to comedy shows, read the comics
- Don't listen to the news every single day
- Enjoy the small pleasures in life

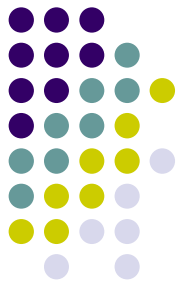
# What else can people do to help themselves?



- Get out every day for a walk or some sort of exercise, activity or socialization
- Eat a healthy nutritious diet and take a multivitamin
- Avoid alcohol and other mood depressants
- If your sleep is not good, talk to your doctor about how to improve your sleep hygiene
- If you have pain, talk to your doctor about the best way to manage it.

# Are General Practitioners good for you?

(The population perspective)



- A 6% increase in supply of GPs directly increases the % of the population who report very good or excellent health by ~10%\*
- No comparable benefit is observed for an increased supply of specialist physicians
- That doesn't mean that specialists aren't important—they are—but they usually don't offer continuity of care or preventive services.

\* Are GPs good for you? University of York Centre for Health Economics

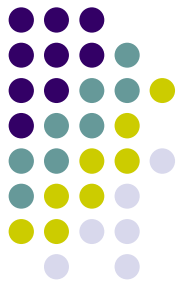
# Why does having a relationship with a personal physician matter?\*



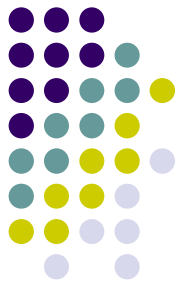
- It increases continuous care
- It increases preventive services
- It provides better control of chronic medical conditions
- It mitigates the health related quality of life disparities based on income
- It reduces the number of work days lost to illness

\* Unpublished data from the 2003 US Behavioral Risk Factor Surveillance System, on 264,864 citizens

# Maintaining a good working relationship with a family doctor is important...for pts and care providers

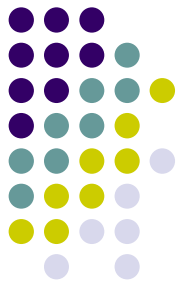


- It takes time and repeated visits to develop trust and a good working relationship
- A GP has no magic wand or crystal ball: they need information and involvement to know how to help
- Recognize the importance of self care and actively nurture this
- Communicate: GPs appreciate timely, brief, factual communication that is easily summarized



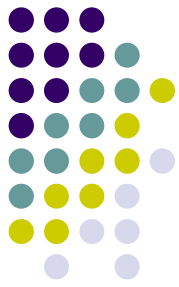
## And for patients...

- If you have a problem and don't feel comfortable discussing it in person, try writing a note or getting someone you trust to help you talk about it.
- Bring any information you need to discuss (blood tests, prescriptions, etc) to each visit
- If you are not clear about something that affects you make sure you ask



# The constraints:

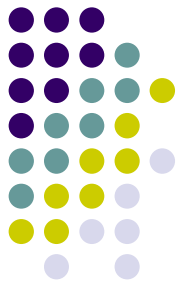
- GPs are paid piecework
- Average appointment times are 10-15 minutes
- Staff salaries and overhead increases have regularly exceeded fee increases for the past 25 years.
- Most paperwork (referrals, etc) is unpaid.
- 4 hours of seeing patients=1 hour paperwork
- Always more to do in a day than there is time available...
- The 'tyranny of the urgent' rules our lives
- We now get paid a small sum to take time to communicate with other care providers and attend team conferences



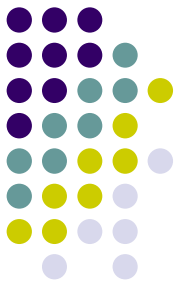
# You can help...

- Give family docs the gift of clear communication and realistic expectations
- Just because someone is involved in dialysis or pre dialysis teaching doesn't mean their family doc isn't still important to them
- In order to work as an effective team with a GP, communication needs to be explicit, thoughtful and timely

# Some problems we need to address..



- How can we increase linkage and support for patients with both their kidney care team and their GP?
- How can we nurture the lines of communication between hospital and community?
- How can we ensure that our shared patients experience 'seamless care' when they need help with their mental health?



Thank You  
Questions or Comments?