

THE MACARTHUR INITIATIVE ON *depression*  
& Primary  
Care AT DARTMOUTH & DUKE

## DEPRESSION MANAGEMENT TOOL KIT

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[www.depression-primarycare.org](http://www.depression-primarycare.org)

*Created by and for*

THE JOHN D. & CATHERINE T. MACARTHUR FOUNDATION'S  
INITIATIVE ON DEPRESSION & PRIMARY CARE

The John D. and Catherine T. MacArthur Foundation has supported the Initiative on Depression and Primary Care since 1995. The Initiative has pursued the mission of enhancing recognition and management of patients suffering from depression in primary care. We have studied current approaches to depression care, developed and tested educational and office system-based interventions that could improve these approaches, and established close working relationships with dissemination partners including specialty organizations, leaders interested in high quality depression care and other researchers.

This tool kit, revised in 2004, was developed through the Initiative to aid primary care clinicians in caring for their patients who suffer from depression. The care management process recommended here builds on the Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research) guidelines<sup>1,2</sup> and other evidence-based sources. Tools have been adopted from recently published and current studies. In addition, we are grateful to David Brody, Kathryn Rost and Jeffrey Smith for developing prototypes that guided this work. References to published work are provided on the bibliography page in the back of this Tool Kit.

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#### **LEGAL**

This Tool Kit is intended to provide helpful and informative material for clinicians on the subject of depression. ***This Tool Kit is not intended to provide medical advice to patients.*** The information provided here is general, and is not intended as clinical advice for or about specific patients. Before applying any of this information or drawing any inferences from it, clinicians should verify accuracy and applicability of the information. Any management steps taken with patients should include a discussion of risks and benefits as well as patient preferences.

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## MACARTHUR INITIATIVE DEPRESSION TOOL KIT

The MacArthur Foundation Initiative on Depression and Primary Care has created a Depression Tool Kit, which is intended to help primary care clinicians recognize and manage depression. The Kit includes easy to use tools to assist with:

- Recognizing and diagnosing depression;
- Educating patients about depression, assessing treatment preferences, engaging their participation and explaining the process of care;
- Using evidence-based guidelines and management tools for treating depression; and
- Monitoring patient response to treatment.

### OVERVIEW OF THE DEPRESSION CARE PROCESS

<i><b>Step I:</b></i> <i><b><u>Recognition &amp; Diagnosis</u></b></i>	The clinician suspects that a patient may be depressed. Some patients self-identify, but many others present with somatic complaints. Most clinicians rely on their general impression to recognize these patients; some clinicians use screening tools. Formal assessment follows to confirm diagnosis.
<i><b>Step I:</b></i> <i><b><u>Patient Education</u></b></i>	If diagnosis is confirmed, the clinician and staff educate the patient about depression and the care process, engage the patient and determine patient preference for treatment.
<i><b>Step III:</b></i> <i><b><u>Treatment</u></b></i>	The clinician and patient select a management approach for treating depression: <ul style="list-style-type: none"> <li>▪ Watchful waiting, with supportive counseling</li> <li>▪ Antidepressant medications</li> <li>▪ Mental health referral for psychological counseling</li> <li>▪ Combination of antidepressants and psychological counseling</li> </ul>
<i><b>Step IV:</b></i> <i><b><u>Monitoring</u></b></i>	The clinician and support staff monitor compliance with the plan and improvements in symptoms/function and modify treatment as appropriate.

## ATTACHED TOOLS FOR MANAGING DEPRESSION

### *APPENDIX I*

#### *Recognition and Diagnostic Information*

- Clinician Memory Aids
- PHQ-9 Patient Questionnaire
- Scoring PHQ-9

### *APPENDIX II*

#### *Patient Education Materials*

- Patient Handouts
- External Resources

### *APPENDIX III*

#### *Treatment Information*

- Treatment Fact Sheets
- Drug Administration Information

### *APPENDIX IV*

#### *Monitoring and Follow-Up Information*

- Monitoring Tools
- Referral Tools

### *APPENDIX V*

#### *Bibliography*

- List of useful references

## I. RECOGNIZING DEPRESSION AND DIAGNOSTIC EVALUATION

Some clinicians rely solely on their usual routines to identify depression. Some use memory aids to assure completeness. Others use a more formal approach to diagnosis by using a patient questionnaire. APPENDIX I contains memory aids and the PHQ-9, a screening instrument.

### OVERVIEW OF THE SCREENING PROCESS

<b>Step A</b>	Through interview and examination, the clinician may suspect depression.
<b>Step B</b>	Diagnostic criteria are explored and (if appropriate) a depression diagnosis is confirmed.
<b>Step C</b>	Rule out other causes of depressive symptoms.

#### *IA. RECOGNITION TOOLS: CLINICIAN MEMORY AIDS*

Clinician memory aids are briefly described below: (materials with \* are backed by specific evidence from the articles cited).

##### **Two Question Screen** <sup>18</sup>

During patient interview, two questions have been shown to be effective for identifying patients who may be depressed (page 14).

##### **Interview Questions** <sup>6</sup>

Direct questions about patient mood and function may help clinicians recognize patients who may be depressed (page 14).

##### **DSM - IV Criteria for Depression** <sup>3</sup>

A list of the 9 criteria for diagnosing Depression, with instruction of how to interpret patient responses (page 15).

##### **Assessment Checklist**

A list of measures and historical factors that are important when evaluating a depression diagnosis (page 15).

##### **Suicide Risk Questions**

Suicide risk needs to be assessed whenever a diagnosis of depression is made. Some scripted questions are provided (see page 15).

##### **Ruling Out Other Causes of Depressive Symptoms**

A list of medications and conditions to consider when diagnosing depression (page 16).

#### *IB. DIAGNOSTIC TOOLS: PHQ-9 PATIENT QUESTIONNAIRE* <sup>10,11,15</sup>

PHQ-9 may be used when a clinician suspects depression and/or the Two-Question Screen is positive. The PHQ-9 score also helps quantify the severity of depression. PHQ-9 can be self-administered by the patient before, during, or after the office visit. (A sample of the PHQ-9 can be found on page 17)

## II. PATIENT EDUCATION MATERIALS

One of the key components of depression management is helping the patient recognize that he/she is depressed, that treatment is needed to improve the quality of life for both the patient and his/her family, and to engage their participation in the care process. Tools have been developed to help the clinician educate the patient about depression, what effective treatments are available, what they can expect from treatment and the patient's role in managing depression. (See APPENDIX II, Patient Education Materials.)

### Approach to Patient Education

Many times patients may not be willing to accept a diagnosis of depression or may begin treatment but then not continue. Clinicians and their office staff can help patients by providing educational materials and support in terms that the patient can understand. For example, if the patient believes stress is a major factor, the clinician should be sensitive to the patients understanding and not over-emphasize the role of biological factors. The clinician can consider including these items in their discussion with the patient: <sup>6</sup>

- The cause, symptoms and natural history of depression.
- Treatment options, including indications, mechanisms of action, cost, risks and benefits.
- Anticipated outcomes in terms of symptom relief, functional ability and quality of life.
- Potential difficulties in complying with treatment and strategies to handle these problems.
- Early warning signs of relapse or recurrence.

<u>TOPIC OF HANDOUTS</u>	<u>TITLE</u>	<u>DESCRIPTION</u>
<i><b>UNDERSTANDING DEPRESSION</b></i>	What Is Depression	Concise, easy to understand understood information about depression and its treatment.
<i><b>MANAGING DEPRESSION</b></i>	Understand the Process for Managing Depression	List of steps involved in the treatment process.
<i><b>ANTIDEPRESSANT THERAPIES</b></i>	Persons Considering Medication Treatment	Explanations about how antidepressants work and steps the patient should take.
	Frequently Asked Questions About Antidepressants	Common questions and answers about antidepressant medications.
<i><b>PSYCHOLOGICAL COUNSELING</b></i>	Persons Considering Psychological Counseling Treatment	Explanations of types of mental health specialists, and what to expect from psychological counseling.
<i><b>WEB SITE MATERIALS</b></i>	Patient Education Materials	Links with national organizations for patient education materials.

### III. TREATMENT INFORMATION

The information in this section is based on AHCPR (AHRQ) <sup>2</sup> guidelines for Major Depressive Disorder as well as research in the field.

#### OVERVIEW OF THE TREATMENT PROCESS

<i>Step A</i>	Clinician selects treatment approach with the patient, then works with patient to set goals for treatment outcomes and discusses phases of treatment (acute, continuous and maintenance).
<i>Step B</i>	Clinician or support staff reassess patient symptoms and function after therapy has begun. Continues with therapies that reduce depressive symptoms or achieves remission. Adjusts therapies with partial or no response.
<i>Step C</i>	Follows Continuation/Maintenance guidelines to prevent relapse or recurrence.

#### Three Phases of Treatment

It may be useful to think of depression treatment as three phases. Each phase has a specific goal: <sup>2</sup>

Acute	Aims at <u>minimizing depressive symptoms and achieving remission.</u>
Continuation	Tries to prevent return of symptoms <u>during current episode.</u>
Maintenance	Focus is to prevent lifetime return of new episodes.

#### Treatment Section Format

The information in the treatment section is organized by treatment approach. The format of the treatment section and corresponding tools in APPENDIX III are described below:

- III-A. Supportive Counseling
- III-B. Antidepressants
- III-C. Referral to Psychological counseling
- III-D. Combined Treatment with Antidepressants & Psychological counseling
- III-E. Patient Response to Treatment

#### TREATMENT TOOLS IN APPENDIX III

- Supportive Counseling Guide Sheet - Clinicians who choose "office counseling" as a first line of treatment for patients will find this guide helpful. Information includes suggestions for approach, support strategies and coping strategies.
- AHCPR (AHRQ) Guidelines - Fact sheets with recommendations for depression treatment. Other information includes suggestions for monitoring and length of time to trial treatments.
- Information Guide to Antidepressants - Listing of common antidepressants used to treat depression. Information includes ranges of therapeutic dose, suggestions for initial dose and recommendations for titration. Also information is provided listing conditions/factors to consider when prescribing antidepressants.
- Antidepressant Fact Sheets - Information about elderly patients, non-responsive patients, contraindications, discontinuing antidepressants, and a side effect management guide, with alternative drug recommendations.

### ***III A. SUPPORTIVE COUNSELING AND PROBLEM SOLVING TREATMENT***

Primary care clinicians are well suited to provide supportive counseling and recommend coping strategies for depressive disorders. Patients with severe major depressive disorder require antidepressant therapy, with or without psychological counseling or supporting counseling. Counseling efforts focus on solutions. The clinician works with the patient using regular brief periods. The provider empathizes with the patient while moving the dialogue towards the construction of clear, simple, specific behavioral change plans. For clinicians who choose supportive counseling/coping strategies, a one-page fact sheet is located on page 30 in APPENDIX III to help with counseling sessions. Clinicians who would like more information about supportive counseling may find references such as the following to be useful: "The Medical Interview"<sup>4</sup>, "The BATHE Technique"<sup>17</sup>, "The SPEAK Technique"<sup>5</sup>, and "The Fifteen Minute Hour"<sup>16</sup>.

Problem Solving Treatment for Primary Care (PST-PC) is a psychological treatment for depression that may be performed by primary care clinicians or staff who are formally trained. It is based on the finding that depression is associated with life problems. Patients meet with the clinician four to six 30-minute sessions over a 6 - 10 week period. The focus of PST-PC involves a) identifying and clarifying problems; b) setting realistic goals and generating solutions; c) and evaluating progress and renewing problem-solving efforts if indicated. Patients who receive PST-PC tend to be more satisfied and more likely to complete treatment than patients receiving antidepressant medications.<sup>12,13</sup> Clinicians who are interested in learning more about PST-PC training for primary care clinicians may contact Mark Hegel Ph.D., via email: [Mark.T.Hegel@Dartmouth.edu](mailto:Mark.T.Hegel@Dartmouth.edu).

### ***III B. TREATMENT INFORMATION: ANTIDEPRESSANTS***

Treating depression with antidepressants is a decision made jointly with the patient. AHCPR (AHRQ) guidelines (pages 30-31) list recommendations for each treatment phase, timeframes and expected responses. The Information Guide to Antidepressants (page 32-34) is used to select type of antidepressant and dose, and describes advantages and disadvantages for the different medications. Recommendations for discontinuing antidepressants and strategies for managing side effects are on page 35-36. Other information for antidepressant treatment is listed below:

#### **Factors to Consider when Selecting Antidepressants**

- History of response to medication in patient or first-degree relative;
- Patient preference;
- Side effects;
- Out-of-pocket costs (tricyclics and generic SSRIs are more affordable);
- Potentially fatal drug interactions;
  - Avoid prescribing tricyclics in patients with cardiac conduction problems or CHF
  - Given the many complex interactions, MAOIs should only be prescribed by clinicians who are experienced in their use.

#### **ADD PSYCHOLOGICAL COUNSELING TO MEDICATIONS IF: <sup>2</sup>**

- Patient shows partial response to medication and residual symptoms are largely psychological.
- Patient shows partial or complete response to medication but other psychosocial problems remain significant.
- Patient has difficulty with adherence.

### ***III C. TREATMENT INFORMATION: REFERRAL TO PSYCHOLOGICAL COUNSELING***

Individuals with mild to moderate depression can be treated with time-limited psychotherapies. Cognitive Behavioral Therapy and Interpersonal Therapy (8-20 visits) have been shown to be equally efficacious to antidepressant medication, although improvement is initially slower than with medication. AHCPR (AHRQ) guidelines for psychological counseling treatment are listed on page 30-31.



### **Factors to Consider when Selecting Psychological counseling**

- Referred for medication management in addition to psychological counseling?  
**If yes:** consider referral to mental health specialist or other psychopharmacology expert or to therapist with close connections to psychopharmacology expert
- Patient preference
  - Has a specific therapist in mind
  - Prefers therapist of specific gender
  - May prefer therapist who counsels from a religious perspective
- Health plan restrictions
- Patient's out-of-pocket costs

#### **ADD MEDICATIONS TO PSYCHOLOGICAL COUNSELING IF:**

- Patient shows poor response to psychological counseling after 6 weeks or only a partial response after 12 weeks: If no response at all to psychological counseling after 12 weeks, antidepressant medication is recommended.

### ***III D. USING COMBINED TREATMENT: ANTI-DEPRESSANTS AND PSYCHOLOGICAL COUNSELING***

Combined treatment with psychological counseling and antidepressants are recommended for: <sup>2</sup>

- Patients who have partial response to either type of treatment alone;
- Patients with personality disorders;
- Patients with complex psychosocial problems;
- Patients who prefer psychological counseling, but have severe depression;
- Prior course of illness is chronic or characterized by poor inter-episode recovery.

### ***III E. TREATMENT INFORMATION: MONITORING PATIENT RESPONSE TO TREATMENT***

It is essential to monitor patient response to treatment. Management plans frequently need adjustment to optimize response. Many patients require significant support to maintain compliance.

Intervals for monitoring patients are dependent upon the severity of depression and the treatment approach taken.

Response to treatment can be categorized according to severity (number and intensity of symptoms) and duration <sup>8</sup>. Intervals for monitoring patients' treatment response are dependent upon the severity of depression and the treatment approach taken. Each patient differs in the timing of response to treatment. An initial response to treatment is usually seen in 2 to 8 weeks for medication and 2 to 12 weeks for psychological counseling. The goal of treatment, however, is to obtain not just a noticeable response but a full remission. A partial remission is a period during which a patient no longer meets syndromal criteria for the depression, but continues to experience more than minimal symptoms. When treatment response includes a partial remission, the clinician and patient may choose further observation rather than to change the treatment plan. If further observation does not result in full remission (an improvement of sufficient magnitude such that the patient no longer meets syndromal criteria and has no more than minimal symptoms) then a change in treatment is indicated. Clinicians may use AHCPR (AHRQ) recommendations for follow-up monitoring. Following scores on a symptom measure such as the PHQ-9 is highly recommended. Tools to support monitoring and monitoring intervals are provided in Appendix IV.

## IV. Implementing Systems for Monitoring and Referrals

An important part of depression management concerns office systems and staff roles in depression care. The systems used by clinician offices may include:

- 1) using support staff to help care for depressed patients,
- 2) establishing a monitoring schedule to track patient response to treatment at regular intervals, and
- 3) processing referrals for counseling.

Some tools for helping offices change systems are located in APPENDIX IV. The MacArthur Initiative has also developed a more comprehensive system including a depression care manager supervised by a mental health specialist. Details of this system and its implementation are located at the RESPECT website ([www.depression-primarycare.org](http://www.depression-primarycare.org))

### *IV A. USE OF SUPPORT STAFF*

Primary care clinicians can benefit by asking a nurse or support staff to help educate and monitor patients with depression. Functions that can be delegated include:

- Administer and score the PHQ-9 instrument;
- Share educational resources with patients and answer questions;
- Explain the steps involved in the process of care that will be used to treat the patient and what he/she can expect;
- Review side effect strategies and discuss when the clinician needs to be notified;
- Schedule follow-up visits and establish systems for maintaining patient compliance and monitoring response to treatment;
- Assist with the referral process for psychological counseling services.

### *IV B. ESTABLISHING A MONITORING SCHEDULE*

Depression is often a chronic condition and requires close initial monitoring until symptoms are eliminated and then periodic monitoring to make sure a relapse or recurrence doesn't occur. Depression is like other chronic conditions, diabetes, heart disease, or hypertension and can benefit from establishing regularly scheduled visits with the patient.

#### **Recommendations for Follow Up Visits**

The AHCPR (AHRQ) guidelines provide recommendations for Major Depressive Disorder. Specific frequencies depend on many factors, including the severity of depression. The following consensus guidelines may be useful for establishing intervals of follow up, until more evidence about specific frequencies is available.

If treatment is initiated, the patient should be contacted by phone or office visit within **1-2 weeks** of diagnosis as a first step, regardless of severity. Contact with the patient early after treatment begins may foster better patient compliance. Conversation with the patient may include:

- Answering any questions the patient may have about his/her diagnosis or treatment;
- Verifying if the patient has followed recommendations;
- Supportive counseling;
- Referral to counseling or psychological counseling;
- Compliance with medication.
- Identifying problems with medications and either:
- Give support to continue with known side effects;
- Have clinician prescribe another medication.

## SCHEDULING FOLLOW-UP APPOINTMENTS AFTER INITIAL MANAGEMENT

(DEPRESSION SYMPTOMS PRESENT)

<b>Minor</b>	Watchful waiting, with a re-evaluation in 4 to 8 weeks
<b>Mild</b> - Major Depressive Disorder (PHQ-9 score of 5-14 and less than 5 symptoms endorsed as present "more than half the days")	Visit or phone contact <u>every month</u> .
<b>Moderate</b> - Major Depressive Disorder (PHQ-9 score of 15-19 or 5 or 6 symptoms endorsed as present at least "more than half the days")	Visit or phone contact <u>every 2 weeks</u>
<b>Severe</b> - Major Depressive Disorder (PHQ-9 score of $\geq 20$ or 7 to 9 symptoms endorsed as present at least "more than half the days")	Visit or phone contact <u>at least every week</u> .

At follow up visits, typical functions the clinician and/or support staff will perform include:

- Re-assessing the diagnosis of depression;
- Measuring changes in symptom severity (depression scores) and patient function;
- Making changes in treatment recommendations if improvements are not noted.

### Scheduling Follow-Up Appointments (After Symptom Resolution)

Patients need regular contact with their primary care clinician after their symptoms have remitted to assure that they complete the course of recommended treatment and that there is no relapse of symptoms:

For all patients-those, with no active treatment, those on antidepressant medications and/or psychological counseling, a visit or phone contact should occur every 2-3 months following remission

### Periodic Monitoring

Major depression is often a chronic disease. Continuation of antidepressants for 4 to 9 months after achieving remission considerably reduces relapse<sup>2,9</sup>. As many as 40 - 50% of depressed patients may experience a new episode of depression within two years of a first episode of major depression. Once depression has recurred, the subsequent recurrence rate approaches 75%. Long-term maintenance for patients with recurrent episodes significantly reduces recurrence<sup>9</sup>. Many patients with recurrent depression do not seek help from their primary care clinician as soon as symptoms reappear. This makes it important for the primary care clinician or office to actively monitor the status of patients with a history of depression, for example in periodic check-ups once a year. It is also useful to have an increased level of suspicion regarding depression when these patients are seen in the interim for other problems.

### Documenting Progress in the Medical Record

A flow sheet is located on page 38 for documenting patient symptoms, functions, PHQ-9 scores and treatment. Ongoing monitoring is an important step in depression care. For high risk patients (multiple episodes, dysthymia) clinicians may choose to keep the flow sheet on top of other medical record documents, such as the inside flap of the manila folder.

#### ***IV C. PSYCHOLOGICAL COUNSELING REFERRALS***

Two functions the office staff can perform in this area include:

- 1) coordinating referrals for psychological counseling, and
- 2) monitoring the status of referrals:

<p><b>COORDINATING REFERRALS FOR PSYCHOLOGICAL COUNSELING</b>  <i>Types of tasks the office helps with for referrals and the tools used in the process:</i></p>	
<p><b><u>Tasks for Monitoring</u></b></p> <ul style="list-style-type: none"> <li>• Was the referral able to accept patient?</li> <li>• Did patient schedule appointment?</li> <li>• Did patient keep appointment?</li> </ul>	<p><b><u>Tool to Assist Process</u></b> Office Monitoring Systems</p>
<p><b>FACILITATING COMMUNICATION - PRIMARY CARE CLINICIAN AND CONSULTANTS</b>  <i>When depressed patients require psychological counseling, the primary care clinician needs to talk with the mental health specialist. Types of monitoring tasks and tools to help monitor the process includes:</i></p>	
<p><b><u>Support Staff Monitoring</u></b></p> <ul style="list-style-type: none"> <li>• Did the clinician obtain patient consent for communication with the therapist?</li> <li>• Did the clinician establish initial communication with the mental health specialist?</li> <li>• Has the mental health specialist's impression been communicated back to PCP?</li> <li>• Is patient continuing with psychological counseling session as scheduled?</li> <li>• Is patient improving?</li> </ul>	<p><b><u>Tool to Assist Process</u></b> Signed release of information form  Referral for Psychological counseling Form  Psychological counseling Communication Form</p>
<p><b>MONITORING STATUS OF MENTAL HEALTH REFERRALS</b>  <i>Office systems in the clinician office need to monitor patient activities when referrals are made to mental health specialists. These tracking systems:</i></p>	
<ul style="list-style-type: none"> <li>• can be manual, (such as a tickler file) or;</li> <li>• can be computerized, where reminders and communications are printed out and reviewed.</li> </ul>	

## APPENDIX I

### *Recognition and Diagnostic Information*

1. Clinician Memory Aids
2. Assessment Fact Sheets
3. PHQ-9 Patient Questionnaire

## RECOGNITION TOOLS

### Clinician Memory Aids

#### Page 1 of 3

#### TWO QUESTION SCREEN <sup>18</sup>

A quick way of screening patients you think may be depressed requires asking patients these two questions:  
During the past month, have you often been bothered by:

1. Little interest or pleasure in doing things  Yes  No
2. Feeling down, depressed or hopeless?  Yes  No

- If the patient's response to *both* questions is "no", the screen is negative.
- If the patient responded "yes" to *either* question, consider asking more detailed questions or using PHQ-9 patient questionnaire.

#### THE INTERVIEW APPROACH

As an alternative or enhancement to the two-question screen, the medical interview is a powerful tool for recognizing depression. Using open-ended questions, addressing emotional issues in some way at each visit (how are things at home), and having a high index of suspicion for depression when patients present with certain complaints (headache, fatigue, nonspecific aches) are all effective. Consider also asking these questions during your interview with patients whom you suspect are depressed.

##### Depressed mood

How's your mood been lately?

##### Effects of Symptoms on Function

How are things at home/work?

How have (the symptoms) affected your home or work life?

##### Psychological Symptoms/Suicidal Ideation

How's your concentration?

Do you ever feel like life is not worth living?

Have you been feeling down on yourself?

Do you have any plans to hurt yourself?

How does the future look to you?

##### Anhedonia

What have you enjoyed doing lately?

##### Physical Symptoms

How have you been sleeping?

What about your appetite?

How's your energy?

#### DSM-IV DIAGNOSTIC CRITERIA FOR DEPRESSION 3

For major depressive disorders, at least five of the following symptoms must be present most of the day, nearly every day, for at least two weeks. At least one of the first two **bolded** symptoms must be present.

- 1 **Depressed mood**
- 2 **Markedly diminished interest in usual activities**
- 3 Significant increase/loss in appetite/weight
- 4 Insomnia/hypersomnia
- 5 Psychomotor agitation/retardation
- 6 Fatigue or loss of energy
- 7 Feelings of worthlessness or guilt
- 8 Difficulty with thinking, concentrating, or making decisions
- 9 Recurrent thoughts of death or suicide.

## Clinician Memory Aids

Page 2 of 3

### DSM DYSTHYMIA

<ol style="list-style-type: none"> <li>1. Depressed mood for most of the day, for more days than not, for at least 2 years</li> <li>2. Two or more of the following:             <ul style="list-style-type: none"> <li>▪ Poor appetite or overeating</li> <li>▪ Insomnia or hypersomnia</li> <li>▪ Low energy or fatigue</li> <li>▪ Low self-esteem</li> <li>▪ Poor concentration or difficulty making decisions</li> <li>▪ Feelings of hopelessness</li> </ul> </li> <li>3. Not more without 1 and 2 above for more than two months at a time</li> <li>4. Symptoms cause clinically significant distress or functional impairment</li> </ol>
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### ASSESSMENT CHECK LIST

<ol style="list-style-type: none"> <li>1. Quantify Severity of Depression</li> <li>2. Assess and document Impairment of Function</li> <li>3. Evaluate Pertinent History/Comorbid Conditions             <ul style="list-style-type: none"> <li>▪ Past history of depression</li> <li>▪ Past history of other mental health problems</li> <li>▪ Past history of mental health treatment</li> <li>▪ History of suicide attempt *</li> <li>▪ Family history of depression and other mental health problems (especially bipolar)</li> <li>▪ Stressful life events</li> <li>▪ Social isolation</li> <li>▪ Substance abuse</li> <li>▪ Bipolar illness</li> <li>▪ Current medications</li> </ul> </li> <li>4. Evaluate Suicide Risk             <ul style="list-style-type: none"> <li>▪ High Risk/Suicide Risk Assessment Guidelines</li> </ul> </li> </ol> <p><i>*Indicates risk factor for suicide</i></p>
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### Suicide Screening Questions

When a diagnosis of Depression is made, suicide risk requires assessment. For all depressed patients the following questions may be asked:

- Have these symptoms/feelings we've been talking about led you to think you might be better off dead?
- This past week, have you had any thoughts that life is not worth living or that you'd be better off dead?
- What about thoughts about hurting or even killing yourself? IF YES, what have you thought about? Have you actually done anything to hurt yourself?

### ASSESSMENT OF SUICIDE RISK

Risk	Description	Action
<input type="checkbox"/> Low Risk	No current thoughts, no major risk factors * See risk factors above and helplessness.	Continue follow-up visits and monitoring
<input type="checkbox"/> Intermediate Risk	Current thoughts, but no plans, with or without risk factors	Assess suicide risk carefully at each visit and contract with patient to call you if suicide thoughts become more prominent; consult with an expert as needed.
<input type="checkbox"/> High Risk	Current thoughts with plans	Emergency management by qualified expert.

**Clinician Memory Aids**  
**Page 3 of 3**  
**Assessing Alternative Sources of Depressive Symptoms**

**CONCURRENT MEDICATIONS?<sup>19</sup>**

Depressive-like symptoms may be an idiosyncratic side effect of some medications, such as reserpine, glucocorticoids, and anabolic steroids. The drugs listed below have been implicated in the development of depression.	
<b>Antihypertensives and cardiovascular drugs</b>	Methyldopa, reserpine, clonidine, beta-blockers, digoxin, diuretics (hypokalemia or hyponatremia).
<b>Sedative-hypnotic agents</b>	Alcohol, benzodiazepines, barbiturates, chloral hydrate, meprobamate
<b>Anti-inflammatory agents and analgesics</b>	Opioid (narcotic) analgesics
<b>Hormones</b>	Corticosteroids, oral contraceptives, estrogen withdrawal, anabolic steroids

**ALCOHOL?**

<p><b>CAGE QUESTIONNAIRE<sup>7</sup></b></p> <ol style="list-style-type: none"> <li>1. Have you ever felt you ought to <b>C</b>ut down on your drinking?</li> <li>2. Have people <b>A</b>nnoyed you by criticizing your drinking?</li> <li>3. Have you ever felt bad or <b>G</b>uilty about your drinking?</li> <li>4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (<b>E</b>ye-opener)?</li> </ol> <p><i>Two or more "Yes" responses yield a positive screen test for alcohol.</i></p>
--

**MANIA (R/O BIPOLAR DISORDER)?**

<p>Has there ever been a period of at least four days when you were so happy or excited that you got into trouble, or your family or friends worried about it, or a clinician said you were manic?</p> <p>A "Yes" response indicates potential bipolar disorder. Assess further for mania. Diagnostic criteria for mania include the concurrent presence of at least four of the following symptoms, one of which must be the first symptom listed (<b>bolded</b>).</p> <ol style="list-style-type: none"> <li>1. <b>A distinct period of abnormal, persistently elevated, expansive, or irritable mood.</b></li> <li>2. Less need for sleep.</li> <li>3. Inflated self-esteem/grandiosity.</li> <li>4. More talkative (pressured speech) than usual.</li> <li>5. Distractibility.</li> <li>6. Increased goal-directed activity or psychomotor agitation.</li> </ol> <p>Excessive involvement in pleasurable activities without regard for negative consequences (e.g., buying sprees, sexual indiscretions, foolish ventures).</p>
---

**GRIEF REACTION?**

<ol style="list-style-type: none"> <li>1. Did your most recent period of feeling depressed or sad begin just after someone close to you died?</li> <li>2. IF YES TO QUESTION 1, ASK: Did the death occur more than two months ago?</li> </ol> <p><b>If 'No' to first question, or if 'Yes' to <u>both</u> questions, treat the patient for depression.</b></p>
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# PATIENT HEALTH QUESTIONNAIRE - PHQ-9 <sup>15</sup>

## Nine Symptom Depression Checklist

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	<i>Not at all</i>	<i>Several days</i>	<i>More than half the days</i>	<i>Nearly every day</i>
	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Total # Symptoms:** \_\_\_\_\_ **Total Score:** \_\_\_\_\_

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## The Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire contains a brief, 9-item, patient self-report depression assessment specifically developed for use in primary care (PHQ-9). The PHQ-9 has demonstrated usefulness as an assessment tool for the diagnosis of depression in primary care with acceptable reliability, validity, sensitivity, and specificity. The nine items of the PHQ-9 come directly from the nine DSM-IV signs and symptoms of major depression. Patients should not be diagnosed solely on the basis of a PHQ-9 score. The clinician should corroborate the score with clinical determination that a significant depressive syndrome is present. After making a provisional diagnosis with the PHQ-9, there are additional clinical considerations that may affect decisions about management and treatment. (Tools for these considerations are found in the Recognition and Assessment Memory Aids of this Appendix.)

In addition to its use as a diagnostic instrument, the PHQ-9 can also be used as a depression severity tool for monitoring treatment. With possible scores ranging from 0 to 27, higher scores are correlated with other measures of depression severity.

### Using PHQ-9 for Diagnostic Assessment

Of the 9 items in question 1, include only those that are checked *at least "More than half the days"*, except count the suicide item if present "at all"

At least one of item 1a or item 1b must be endorsed as more than half the days for a depression diagnosis. Also question 2 for functional impairment must be 3 answered *at least "Somewhat difficult."*

### Using PHQ-9 For Severity of Depression Measure

Of the 9 items in question 1, also include items checked *"Several days."* Count one point for each item checked several days, two points for checked items more than half the days, three points for items checked nearly every day, and sum the total for a severity score.

## DIAGNOSTIC CATEGORIES FOR DEPRESSION

<i>PHQ-9 Symptoms &amp; Impairment</i>	<i>PHQ-9 Severity</i>	<i>Provisional Diagnosis</i>	<i>Treatment Recommendations**</i>
1 to 4 symptoms, functional impairment	< 10	Mild or Minimal Depressive Symptoms	- Reassurance and/or supportive counseling - Education to call if deteriorates
2 to 4 symptoms, question a or b +, functional impairment	10-14	Moderate Depressive Symptoms (Minor Depression)*	- Watchful waiting - Supportive counseling - If no improvement after one or more months, consider use of antidepressant or brief psychological counseling
≥ 5 symptoms, question a or b +, functional impairment	15-19	Moderately Severe Major Depression	-Patient preference for antidepressant and/or psychological counseling
≥ 5 symptoms, question a or b +, functional impairment	> 20	Severe Major Depression	- Antidepressants alone or in combination with psychological counseling

\*If symptoms present for > 2 years, Chronic Depression, or functional impairment is severe, remission with watchful waiting is unlikely, immediate active treatment indicated for moderate depressive symptoms (minor depression).

\*\*Referral or co-management with mental health specialty clinician if patient is a high suicide risk or has bipolar disorder, an inadequate treatment response, or complex psychosocial needs and/or other active mental disorders.

## USING THE PHQ-9 TO ASSESS PATIENT RESPONSE TO TREATMENT

<b>Initial response after Four weeks of an Adequate Dose of an Antidepressant</b>		
<i>PHQ-9</i>	<i>Treatment Response</i>	<i>Treatment Plan</i>
Drop of $\geq 5$ points from baseline	Adequate	No treatment change needed. Follow-up in four weeks.
Drop of 2-4 points from baseline.	Possibly Inadequate	May warrant an increase in antidepressant dose
Drop of 1-point or no change or increase.	Inadequate	Increase dose; Augmentation; Switch; Informal or formal psychiatric consultation; Add psychological counseling
<b>Initial response after Six weeks of Psychological Counseling</b>		
<i>PHQ-9</i>	<i>Treatment Response</i>	<i>Treatment Plan</i>
Drop of $\geq 5$ points from baseline	Adequate	No treatment change needed. Follow-up in four weeks.
Drop of 2-4 points from baseline.	Possibly Inadequate	Probably no treatment change needed. Share PHQ-9 with psychotherapist.
Drop of 1-point or no change or increase.	Inadequate	If depression-specific psychological counseling (CBT, PST, IPT*) discuss with therapist, consider adding antidepressant.  For patients satisfied in other type of psychological counseling, consider starting antidepressant  For patients dissatisfied in other psychological counseling, review treatment options and preferences

\* CBT-Cognitive-Behavioral Therapy; PST-Problem Solving Treatment; IPT-Interpersonal Therapy

*The goal of acute phase treatment is remission of symptoms so that patients will have a reduction of the PHQ-9 to a score  $< 5$ . Patients who achieve this goal enter into the continuation phase of treatment. Patients who do not achieve this goal remain in acute phase treatment and require some alteration in treatment (dose increase, augmentation, combination treatment). Patients who do not achieve remission after two adequate trials of antidepressant and/or psychological counseling or by 20 to 30 weeks should have a psychiatric consultation for diagnostic and management suggestions.*

## APPENDIX II

### *Patient Education Tools*

#### Handouts

1. What is Depression
2. Process for Managing Depression
3. Persons Considering Medication Treatment
4. Frequently Asked Questions About Antidepressants
5. Persons Considering Psychological counseling Treatment

#### External Resources

1. Depression & Mental Health Education Materials

## PATIENT HANDOUT - WHAT IS DEPRESSION

### **General Facts**

Depression is a very common, yet highly treatable, medical illness that can affect anyone. About 1 of every 20 Americans get depressed every year. Depression is not a character flaw, nor is it a sign of personal weakness. Depression is a treatable medical illness. Unfortunately, many persons with depression do not tell their clinician how they are feeling. This is very regrettable since effective treatments are available for depression, and most people with depression can begin to feel better in several weeks when they are adequately treated. Talking with a clinician about how they are feeling is the depressed person's first important step toward getting better.

### **What is Depression?**

Depression isn't just feeling "down in the dumps". It is more than feeling sad following a loss or hassled by hard times. Depression is a medical disorder (just like diabetes and high blood pressure are medical disorders) that affects your thoughts, feelings, physical health and behaviors. People with major depression experience a number of symptoms all day, nearly every day, for at least 2 weeks. Symptoms of depression include:

- Feeling sad, blue, or down in the dumps
- Loss of interest in things you usually enjoy
- Feeling slowed down or restless
- Having trouble sleeping or sleeping too much
- Loss of energy or feeling tired all the time
- Having an increase or decrease in appetite or weight
- Having problems concentrating, thinking, remembering, or making decisions
- Feeling worthless or guilty
- Having thoughts of death or suicide

### **If I'm Depressed, What Can Be Done About It?**

The good news is that **depression is treatable**. Your primary care clinician can effectively treat depression by supportive counseling, prescribing an antidepressant medication and/or referring depressed persons to a mental health specialist for counseling. Talking with your clinician about how you are feeling is a very important first step. You can further help your clinician treat you most effectively by participating actively in treatment by (a) asking questions and (b) following through with the treatment that both you and your clinician decide is best for you.

*Adapted from Rost K. Depression Tool Kit for Primary Care NIMH grant MH54444*

## PATIENT HANDOUT - PROCESS FOR MANAGING DEPRESSION

A diagnosis of depression is a chronic condition and it requires your participation in making decisions about your care, setting realistic goals for improvement and helping your clinician monitor your condition.

### **The Steps Your Clinician Will Follow To Treat Your Condition**

#### ***At the Office Visit***

After your clinician has diagnosed your depression, he/she will talk with you about

- The severity of your condition.
- The possible choices for treatment and give you educational materials.
- An initial treatment which is one of four possible choices: 1) encourage you to wait a couple of weeks to see if symptoms decrease, 2) recommend an antidepressant, 3) recommend psychological counseling with a mental health specialist, or 4) recommend both antidepressant and psychological counseling.

#### ***Following the Office Visit***

You will be either scheduled for a follow-up appointment or contacted by telephone. Follow-up appointments or telephone contacts may be as frequent as every 1 to 2 weeks initially. The purpose is to see if your symptoms are improving, staying the same or getting worse.

- If you've ***selected psychological counseling*** with your clinician, he/she will continue to talk with you, listen, give advice, add perspective, and try to address your concerns. He/she may recommend other types of treatment if your symptoms are getting worse or not improving after a period of time.
- If you've ***selected psychological counseling with a mental health specialist***, your clinician will ask you about your symptoms and your daily routines at work, at home and with family and friends. With your permission, he/she will communicate with your mental health specialist to understand if treatment is helping and address any medical issues that relate to your depression.
- If you've ***selected antidepressant treatment or a combination of antidepressant and psychological counseling***, your clinician will check to make sure that the medication is working and whether you are having any side effects or difficulties. Since your symptoms may relapse if treatment is discontinued, it is important to call your clinician if you are thinking about stopping your medication.

#### ***Scheduling Periodic and Annual Check-Ups Visits***

Your clinician needs to monitor your depression over time, to make sure that it doesn't recur, and to make sure your treatment continues to be effective. Depression requires periodic check-ups with your clinician, just like hypertension, diabetes, or heart disease. Your clinician will use a check-up schedule that is just right for your specific condition.

## PATIENT HANDOUT - PERSONS CONSIDERING MEDICATION TREATMENT FOR DEPRESSION

### **Quick Facts about Antidepressant Medications**

- Antidepressant medications work by helping to correct an imbalance of chemicals in the brain.
- Antidepressant medications are not addictive or habit forming; they are not uppers; and they are not tranquilizers.

### **Treating Depression with Antidepressant Medications**

Your clinician will consider several factors in selecting an appropriate antidepressant medication for you from the many that are available. Most people respond well to medication. Some antidepressant medications are started at low doses to allow your body time to adapt; your clinician will then gradually increase the dose until you begin to feel better. After about 3-6 weeks of taking antidepressant medications, most people with depression begin to feel more like their usual self. It may take time for you and your clinician to find the medication that works best for you with the least number of side effects.

**It is *very important* that you continue to take the medication exactly as the clinician prescribed even if you feel better.** For the first 6-8 weeks after you begin treatment, your clinician will want to see you often (possibly every week) to check how much and how often you take the medication, to watch for and address any side effects you may experience, and to see how the medication is working on your depression. If your depression is significantly improved after 12 weeks, you will continue taking the medication for an additional 4-9 months to prevent your depression from returning. People who have had 2 or more previous episodes of depression may need to continue taking their medication for longer periods.

### **What Can You Do to Help Your Clinician Treat Your Depression With Medication?**

- Keep all of your appointments.
- Speak to your clinician about questions or concerns you have about the medication.
- Take the medication exactly as your clinician prescribes.
- Tell your clinician immediately about any side effects you have to the medication.
- Tell your clinician how the medication is working (e.g., whether you are feeling better or worse).

*Adapted from Rost K. Depression Tool Kit for Primary Care NIMH grant MH54444*

**PATIENT HANDOUT**  
**FREQUENTLY ASKED QUESTIONS ABOUT ANTIDEPRESSANT MEDICATION**

**Page 1 of 2**

**How do antidepressants work?**

Antidepressants help restore the correct balance of important chemicals (called neurotransmitters) in the brain that affect a person's mood.

**Are antidepressants addictive?**

No, absolutely not. Antidepressants are not addictive or habit-forming, and they do not provide a "high".

**Will I get better if I take the antidepressant?**

Between 50% and 80% of people with depression recover completely with an adequate trial of medication. If you do not feel better after taking an adequate trial of one antidepressant, there is an excellent chance that you will respond more favorably to a different antidepressant.

**How long will the antidepressant medication take to work?**

People with depression usually start to feel better after taking an antidepressant medication for two to six weeks. In many cases, sleep and appetite improve first. It may take a little longer for your mood and energy to improve. If the depression is not improved after about six weeks, your clinician may want to increase the dose of the medication you are taking or switch you to another antidepressant.

**How long will I have to take the antidepressant?**

Once you have completely recovered from your depressive episode, you should stay on the medication for another four to nine months to prevent your depression from returning. Some people who have had previous episodes of depression should stay on antidepressant medication for longer periods of time to prevent new episodes of depression.

**What should I do if I forget to take a dose of the medication?**

Do **not** take a double dose to correct for the dose you forgot without asking your clinician. Take your next dose at the regular time.

**Should I drink alcohol when I'm taking an antidepressant medication?**

Alcoholic beverages can produce side effects in some persons taking antidepressants. Therefore, if you intend to have any alcohol-containing drinks while taking antidepressants, it is important you discuss this with your clinician.

**Is it safe to take antidepressants with other medications?**

In general, antidepressants can be taken safely with other medications. However, it is very important for you to tell your clinician exactly which other medications you are taking (including over-the-counter medications) so s/he can assure that there are no potentially dangerous interactions.



**PATIENT HANDOUT**  
**FREQUENTLY ASKED QUESTIONS ABOUT ANTIDEPRESSANT MEDICATION**

**Page 2 of 2**

**Can I stop taking the medication once I start feeling better?**

No. You should not stop taking the medication without first talking with your clinician. If you stop taking the medication too soon, you would be at high risk for having your depression return. In addition, some medications must be stopped gradually to give your body time to adjust. In most cases, you should expect to continue taking the medication for four to nine months after all of your depressive symptoms have gone away.

**My problem is inability to sleep. How can an antidepressant help with this?**

In many cases, poor sleep is a primary symptom of depression. Once the depression lifts, sleep improves as well.

Some antidepressants can help restore normal sleep, even in people who do not have depression. They are advantageous over other sleeping pills in that they are not habit-forming, and they usually do not impair concentration or coordination.

**I have a problem with pain. How can an antidepressant help with this?**

Some antidepressants have been shown to be successful (even in the absence of major depression) in a number of pain conditions such as diabetic neuropathy, postherpetic neuralgia, and phantom limb pain. Antidepressants may also help restore normal sleep and 'reverse' a vicious cycle of pain and poor sleep.

**I have low energy and feel tired a lot of the time. How can an antidepressant help with this?**

Low energy and fatigue commonly occur in people with depression. Once the depression improves, their energy starts to return as well. Antidepressants can help restore energy in patients who are depressed. With successful treatment, patients will feel less tired and more able to do their usual activities.

**I have a lot of stress in my life. How can an antidepressant help with this?**

Life stress can cause or worsen the symptoms of depression. The depression can then worsen the impact of stress (such as work stress, family problems, physical disabilities or financial worries) and your ability to cope with them. Treating depression can help some patients break out of this vicious circle.

**My problem is anxiety or panic attacks, not depression. How can antidepressants help?**

In many cases, anxiety is a by-product of depression. Once the depression lifts, the anxiety improves as well. Some antidepressant medications are also among the most effective medical treatments for anxiety disorders, including panic disorder and generalized anxiety disorder.

**Are there any dangerous side effects?**

Side effects from antidepressants are usually mild. You should ask your clinician what to expect and what to do if you have a problem.

In many cases, your body will get used to the medication and you won't be bothered with the side effect for long. In other cases, your clinician may suggest that you lower the dose, add another medication, or change to another antidepressant. If used properly, there are no dangerous or life-threatening side effects.

*Adapted from Rost K. Depression Tool Kit for Primary Care NIMH grant MH54444*

**PATIENT HANDOUT**  
**PERSONS CONSIDERING PSYCHOLOGICAL COUNSELING TREATMENT FOR DEPRESSION**

**Quick Facts about Psychological Counseling**

- In psychological counseling, patients with depression work with a qualified mental health care specialist (mental health specialist) who listens to them, talks, and helps them correct overly negative thinking and improve their relationships with others.
- Psychological counseling for depression is not talking about your childhood.

**Treating Depression with Psychological Counseling**

Psychological counseling has been shown to be just as effective as antidepressant medication in treating many people with depression. Psychological counseling can be done individually (only you and a mental health specialist), in a group (a mental health specialist, you, and other people with similar problems), or it can be family or marriage therapy where a mental health specialist, you and your spouse or family members participate. More than half of the people with mild to moderate depression respond well to psychological counseling. While the length of time that persons are involved in counseling differs, people with depression can typically expect to attend a weekly hour-long counseling session for 8-20 weeks. If your depression is not noticeably improved after six to twelve weeks of counseling, this usually means that you need to try a different treatment for your depression. Psychological counseling by itself is not recommended as the **only** treatment for persons whose depression is more severe. Medication is needed for this type of depression, and it can be taken in combination with psychological counseling.

**What Can You Do to Help Your Clinician Most Effectively Treat Your Depression With Psychological Counseling?**

- Keep all of your appointments with the mental health specialist.
- Be honest and open, and ask questions.
- Work cooperatively with the mental health specialist (e.g., complete tasks assigned to you as part of the therapy).
- Keep appointments with your primary care clinician and tell him/her how the therapy is working (e.g., whether your depression is getting better or worse).

*Adapted from Rost K. Depression Tool Kit for Primary Care NIMH grant MH54444*

## **PATIENT HANDOUT - DEPRESSION & MENTAL HEALTH PATIENT EDUCATION MATERIALS**

### **Listing of Patient Resources**

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#### **Agency for Health Care Policy and Research**

- *Depression is a treatable Illness NO5*
- <http://www.AHRQ.gov/consumer>
- Information about depression, its causes, treatment options, professionals who treat the disease, national programs and assistance.

#### **American Academy of Family Physicians**

- *Patient Educational Information*
- <http://familydoctor.org/handouts/587.html>
- Description of depression, how it's treated, how antidepressants are selected and common side effects.

#### **American Medical Association**

- *Consumer Health Information on Depression*
- Overview:  
[http://www.medem.com/MedLB/article\\_detailb.cfm?article\\_ID=ZZZGKPMOACC&sub\\_cat=128](http://www.medem.com/MedLB/article_detailb.cfm?article_ID=ZZZGKPMOACC&sub_cat=128)
- Treatment:  
[http://www.medem.com/MedLB/article\\_detailb.cfm?article\\_ID=ZZZLMLUOACC&sub\\_cat=128](http://www.medem.com/MedLB/article_detailb.cfm?article_ID=ZZZLMLUOACC&sub_cat=128)
- Depression information, including what causes it, how to get help, treatment options, help for family and friends, risk factors, suicide prevention and how to reach out and get support.

#### **American Psychiatric Association**

- *Let's talk about...Depression*
- [http://www.psych.org/public\\_info/depression.cfm](http://www.psych.org/public_info/depression.cfm)
- General depression information, including causes, symptoms, types of therapy, and national organizations that offer assistance with depression.

#### **National Alliance for the Mentally Ill**

- *Index of Patient Educational Resources*
- <http://www.nami.org/index.html>
- Information for depression and other mental health illness. State and federal laws, journal articles, fact sheets about depression and more.

#### **Depression and Bipolar Support Alliance**

- *Patient Information*
- <http://www.ndmda.org/>
- An excellent resource and service site where patients with depression can go for help. Well-developed information about the different types of depression, adolescent depression, success stories from patients and clinical trials that are available. Provides details about chapters in local areas, educational programs, new releases, calendar of events and more.

#### **National Mental Health Association**

- *Public Educational Material*
- <http://www.nmha.org/ccd/index.cfm>
- Excellent information and resources including methods for screening depression, symptoms, commonly asked questions, types of treatment, women depression issues, geriatric depression and an events calendar.

## APPENDIX III

### *Treatment Tools*

1. Supportive Counseling Fact Sheet
2. AHCPR (AHRQ) Treatment Guidelines
3. Information Guide to Antidepressant
4. Clinician Antidepressant Fact Sheets

## ***SECTION I. SUPPORTIVE COUNSELING FACT SHEET FOR CLINICIANS***

### **Clinician Approach to Office Counseling**

Some patients benefit from supportive counseling with the clinician and/or knowledgeable support staff. Brief sessions where counseling is provided using these techniques:

- Active listening
- Advice giving
- Adding perspective
- Confirmation of appropriateness of patient concerns

### **Focus on Solutions**

Empathize with the patient, while moving the dialogue towards the construction of clear, simple, specific behavioral change plans:

- Work
- Home
- Finances
- Health

### **Focus on Coping Strategies**

Coping strategies can be divided into problem focused, which are directed at situations that can be changed, and emotion focused, which are directed at situations that cannot be changed. After helping a patient recognize whether a situation can be changed or not, some helpful coping strategies that may be suggested to patients are listed below.

#### *Problem Focused*

Gather facts  
Use problem-solving techniques...  
Notice negative thoughts and replace them

#### *Emotion-Focused*

Participate in pleasurable activities...  
Participate in activities that boost...  
Participate in activities that relax...

### **Process for Developing/Monitoring Coping Strategies**

1. Identify two to three coping strategies that may be helpful for the patient and clarify if the strategies will be consistent with their personality and lifestyle.
2. Create a list of these coping strategies, giving one to the patient and the other to keep in the medical record.
3. Have the patient keep track of both the problems and coping strategies that occur over the next week/couple of weeks. Have patient bring a summary to the next office visit.
4. Assess coping strategies the patient used, reinforcing strategies that are effective and making suggestions when improvements are needed.

## SECTION II. AHCPR (AHRQ) TREATMENT GUIDELINES - TABLE FORMAT

### ANTIDEPRESSANT TREATMENTS<sup>2</sup>

#### ACUTE PHASE TREATMENT - AIM: REMOVING ALL SYMPTOMS

<i>Acute Phase – Expected Response</i>	<i>Continue Treatment</i>	<i>Modify Treatment</i>
<p><b>Every 1 - 2 weeks:</b> monitor patient compliance /symptoms;</p> <p><b>4 - 6 weeks:</b> ≥ 5 point reduction in PHQ-9 score</p> <p><b>8 - 10 weeks:</b> 50% reduction in PHQ-9 score</p> <p><b>10 - 12 weeks:</b> near 100% reduction in symptoms, score &lt; 5 points on PHQ-9</p>	<p>If <b>partial response by 5 - 6 weeks</b>, continue with same antidepressant for another 5 - 6 weeks</p>	<p>* If <b>no response by 6 weeks</b>- increase dose or switch drugs</p> <p>* If <b>partial response by 12 weeks</b> - increase dose or switch drugs</p>

#### CONTINUATION/MAINTENANCE PHASE TREATMENT- PREVENTING RELAPSE/RECURRENCE

<i>Type of Patient</i>	<i>Continuation Treatment</i>	<i>Maintenance Treatment</i>
<b>Initial Episode</b>	<b>4 to 9 months</b> after return to well state	Discuss with patient the Pros/Cons of continuing antidepressant therapy based on severity of episode
<b>Recurrent Episode</b> (2 or more episodes of depression in a 5 year period)	At least <b>9 months</b>	Continue long-term maintenance therapy. Consult AHCPR (AHRQ) guidelines for details about maintenance treatment

### PSYCHOLOGICAL COUNSELING TREATMENTS<sup>2</sup>

#### ACUTE PHASE TREATMENT - AIM REMOVING ALL SYMPTOMS CONTINUATION/MAINTENANCE PHASE TREATMENT- PREVENTING RELAPSE/RECURRENCE

<i>Severity of MDD</i>	<i>Initial Psychological counseling</i>	<i>Continue Psychological counseling</i>	<i>Modify Treatment Plan</i>
<b>Mild or Moderate</b>	<b>6 - 8 week trial</b> - partial remission of symptoms	If psychosocial function has not been fully restored	No improvement after <b>6 - 8 weeks</b> Only partial improvement <b>after 12 weeks</b>
<b>Severe</b>	Psychological counseling should be used <b>only in conjunction with antidepressants</b>	Prevents subsequent relapses and recurrences once treatment with antidepressants ends	Prevents subsequent relapses and recurrences once treatment with antidepressants ends

## AHCPR (AHRQ) Treatment Guidelines - Narrative Format

1. Initially, the patient should be evaluated every 1 - 2 weeks to monitor patient compliance, symptom improvement, and medication side effects.
2. The patient should have at least a partial response ( $\geq 5$  point reduction in PHQ-9 score) by 4 - 6 weeks, 50% reduction in PHQ-9 score by 8 - 10 weeks and full remission of symptoms by 10 - 12 weeks (PHQ-9 score of  $< 5$  points).
3. The medication dose should be increased (or, if this is ineffective, the antidepressant should be changed) if there is not a partial response by 4 - 6 weeks or full remission by 10 - 12 weeks.
4. The antidepressant should be continued at least 4 to 9 months after depressive symptoms have remitted.
5. Patients who have two or more episodes of major depression in a 5-year period may be considered for maintenance antidepressant therapy.
6. Psychological counseling may be used alone (if the patient prefers this to medication) in cases of mild to moderate depression. As with antidepressants, the patient should have at least a partial response by 4 - 6 weeks and full remission by 10 - 12 weeks.
7. In more severe depression, psychological counseling should only be used in conjunction with antidepressants. In some patients, such adjunctive psychological counseling may prevent subsequent relapses and recurrences once treatment with antidepressants ends.

<b>ACUTE PHASE: PATIENT RESPONSE TO TREATMENT</b> (Monitor every 1 - 2 weeks to assess response to treatment)	
<b><i>Antidepressants</i></b>	
<b>4 - 6 weeks:</b> $\geq 5$ point reduction in PHQ-9 score <b>8 - 10 weeks:</b> 50% reduction in PHQ-9 score <b>10 - 12 weeks:</b> near full response, remission of symptoms, score of $< 5$ on PHQ-9	Continue with same treatment
<b>5 - 6 weeks:</b> partial response to treatment	Continue with treatment another 5 - 6 weeks
No response by 6 weeks or partial response by 12 weeks	Use alternative drug and/or combined treatment
<b><i>Psychological counseling</i></b>	
<b>6 - 8 week:</b> partial remission of symptoms	Continue with psychological counseling
No improvement at 6 - 8 weeks or only partial improvement at 12 weeks	Add antidepressants

### SECTION III – INFORMATION GUIDE TO ANTIDEPRESSANTS

*revised June 2004*

Antidepressant *	Therapeutic Dose Range (mg/day)	Initial Suggested Dose	Titration Schedule**	Advantages	Disadvantages
<i>Serotonin Reuptake Inhibitors (SSRIs)</i>					
Citalopram (Celexa)	20 – 40	20 mg in morning with food (10 mg in elderly or those with panic disorder).	Maintain 20 mg for 4 weeks before dose increase. If no response, increase in 10 mg increments every 7 days as tolerated.	Probably helpful for anxiety disorders. Possibly fewer cytochrome P450 interactions. Generic soon.	
Escitalopram (Lexapro)	10 - 20	10 mg for escitalopram	Increase to 20mg if partial response after 4 weeks	s-enantiomer more potent than racemic, 10mg dose usually effective for most	
Fluoxetine (Prozac)	10 - 80	20 mg in morning with food (10 mg in elderly and those with comorbid panic disorder)	Maintain 20 mg for 4-6 weeks and 30 mg for 2-4 weeks before dose increases. Increase in 10 mg increments at intervals of 7 days. If significant side effects occur within 7 days, lower dose or change medication.	Helpful for anxiety disorders. Long half-life good for poor adherence, missed doses. Generic available. Less frequent discontinuation symptoms.	Slower to reach steady state. Sometimes too stimulating. Possibly more cytochrome P450 interactions.
Paroxetine (Paxil)	10 – 50 (40 in elderly)	20 mg once daily, usually in morning with food (10mg in elderly and those with comorbid panic disorder)	Maintain 20 mg for 4 weeks before dose increase. Increase in 10 mg increments at intervals of approximately 7 days up to a maximum of 50 mg/day.	FDA approved for most anxiety disorders. Generic soon.	Sometimes sedating. Occasionally more anticholinergic-like effects. Possibly more cytochrome P450 interactions. May have more frequent discontinuation symptoms.
(Paxil CR)	25 – 62.5 (50 in elderly)	25 mg daily (12.5mg in elderly and those with panic disorder)	Increase by 12.5 mg at weekly intervals, maintain 25 mg for 4 weeks before dose increase	May cause less nausea and GI distress	
Sertraline (Zoloft)	25 - 200	50 mg once daily, usually in morning with food (25mg for elderly)	Maintain 50 mg for 4 weeks. Increase in 25-50 mg increments at intervals of 7 days as tolerated. Maintain 100 mg for 4 weeks before next dose increase.	FDA approved for anxiety disorders. Safety shown post MI.	
<i>Serotonin and Norepinephrine antagonist</i>					
Mirtazapine (Remeron)	15 - 45	15 mg at bedtime (7.5 mg for those in need of sedation / hypnotic)	Increase in 15 mg increments (7.5 mg in elderly) as tolerated. Maintain 30 mg for 4 weeks before further dose increase	Few drug interactions. Less or no sexual dysfunction <u>Less</u> sedation as dose increased. May stimulate appetite.	Sedation at low dose only. May initially stimulate appetite.



Antidepressant *	Therapeutic Dose Range (mg/day)	Initial Suggested Dose	Titration Schedule**	Advantages	Disadvantages
<i>Norepinephrine- and dopamine-reuptake inhibitor</i>					
Bupropion† (Wellbutrin SR, Wellbutrin XL)	300 - 400	150 mg in morning	Increase to 150 mg b.i.d. after 7 days. Increase to 200mg bid if insufficient response after 4 weeks. 8 hours between doses and initially not at bedtime. With hepatic disease only 100 mg total per day.	Stimulating. Less or no sexual dysfunction.	At higher dose, may induce seizures in persons with seizure disorder. Stimulating. Usually b.i.d. dosing, unless more expensive XL.
<i>Serotonin and Norepinephrine reuptake inhibitor</i>					
Venlafaxine (Effexor, Effexor XR)	75 - 375	75 mg with food; if anxious or debilitated, 37.5 mg	Dose should be divided b.i.d. or t.i.d. unless XR. For extended release (XR) give 37.5 in a.m. then increase to 75 mg in a.m. after 1 week, 150 mg in the a.m. after 2 weeks. If partial response after four weeks increase to 225 mg in the morning. Norepinephrine effect only occurs above 150mg.	XR version can be taken qd Helpful for anxiety disorders. Possibly fewer cytochrome P450 interactions.	May increase blood pressure at higher doses. Bid dosing unless use XR. Expensive.
<i>Primarily Norepinephrine reuptake inhibitor</i>					
Desipramine‡ (Norpramin, Pertofrane)	100-300 (25-100 in elderly)	50 mg in the morning	Increase by 25 to 50 mg every 3 to 7 days to initially target of 150mg for 4 weeks.	More effect on norepinephrine than serotonin, less sedating. Generic available.	Like all TCAs, anticholinergic. Caution with BPH. <u>Can exacerbate cardiac conduction problems or CHE.</u>
Nortriptyline‡ (Aventyl, Pamelor)	25-150	25 mg (10mg in frail elderly) in the evening	Increase in 10-25 mg increments every 5 days as tolerated to 75mg. Dosing too high may be ineffective. Obtain serum drug levels after 4 weeks if not effective.	Availability of reliable, valid blood levels. Lower orthostatic hypotension than other tricyclics. Generic available.	Like all TCAs, anticholinergic. Caution with BPH. <u>Can exacerbate cardiac conduction problems or CHE.</u>

\*There are more antidepressants than those listed in this table; however, this list provides a reasonable variety of drugs that have different side effects and act by different neurotransmitter mechanisms. Treatment of Parkinson's disease may include selegiline (Eldepryl), which is a selective monoamine oxidase inhibitor at low doses only. Because the use of many antidepressants is contraindicated in conjunction with a nonselective MAOI, caution with or discontinuation of Eldepryl may be in order. For pregnancy, TCAs and SSRIs (particularly fluoxetine, because of more data collected) are not associated with congenital malformations or developmental delay. SSRIs in the third-trimester are associated with a slight decrease in gestational age and correspondingly lower weight, and occasionally with neonatal withdrawal symptoms. Diarrhea, drowsiness, and irritability are occasionally seen in breast fed infants of mothers taking antidepressants. The risks of maternal depression on child development should be balanced against the effects of antidepressants on an individual basis.

\*\*For SSRIs, generally start at beginning of therapeutic range. If side effects are bothersome, reduce doses and increase slower. In debilitated or those sensitive to medications, start lower. For all antidepressants, allow four weeks at a therapeutic dose, assess for a response. If a partial or slight response then increase the dose. If no response or worse symptoms then consider switching drugs.

†Generally avoid bupropion in patients with a history of seizures, significant central nervous system lesions, or recent head trauma.

‡Tricyclic antidepressants (TCAs) have lower costs but somewhat higher discontinuation rates compared to SSRIs due to side effects and are more lethal in overdose. TCAs may be contraindicated

in patients with certain physical comorbidities such as recent myocardial infarction, cardiac conduction defects, urinary retention, narrow angle glaucoma, orthostatic hypotension, and cognitive impairment.

## SECTION IV.

### Clinician Antidepressant Fact Sheet Page 1 of 2

#### Anxiolytics

- Anxiolytic medications (benzodiazepines and barbiturates) have not been shown to be effective in treating depression. Anxiolytics may be useful as an adjunctive, short-term medication (e.g. 12 weeks) for patients with pronounced anxiety. Benzodiazepines may be useful for short-term treatment (e.g., 2-6 weeks) for pronounced insomnia.

#### Treating Elderly Patients With Antidepressants

- More sensitive to side effects, particularly to those of tricyclics; start with SSRIs.
- Are often on multiple other medications (beware of drug interactions).
- Metabolism is slower; may need lower doses, increase doses slowly.

#### Discontinuing Antidepressant Therapy

While antidepressant medications are generally considered safe, they should be discontinued if they are not required. For first episodes of depression, it is appropriate to discontinue medication after 4-9 months of continuation phase treatment. Tricyclic antidepressants and other drugs listed on page 3 of the administration schedule should be tapered if the patient has had exposure at therapeutic dosages for 3 months or more. A tapering schedule of over 2 to 4 weeks is recommended.

#### Expected Course for Patients Who are Non-Responsive to Antidepressants <sup>2</sup>

The following approaches may be useful with non-responsive patients:

<u>Phases</u>	<u>Patient Response</u>	<u>Expected Outcome</u>
Acute Phase	Partial symptom reduction	More symptoms during Continuation Phase
Continuation Phase	Poor symptom control	Higher chance of earlier relapse & higher recurrence once treatment is discontinued

#### Managing Side Effects

Clinicians may elect to refer to the table on page 36, which lists strategies for managing antidepressant side effects. This tool provides information about types of side effect, suggestions to minimize or eliminate the side effect and alternative drugs to consider if the patient cannot tolerate the side effect.

**Clinician Antidepressant Fact Sheet**  
**Page 2 of 2**

**ANTIDEPRESSANT SIDE EFFECTS**

Side effects account for as many as two-thirds of all pre-mature discontinuations of antidepressants. Most side effects are early onset and time limited (e.g. SSRI decreased appetite, nausea, diarrhea, agitation, anxiety, headache). These can be managed by temporary aids to tolerance. Some side effects are early-onset and persistent or late onset (e.g. SSRI apathy, fatigue, weight gain, sexual dysfunction) and may require additional medications or a switch in antidepressant.

**Strategies for Managing Antidepressant Side Effects:**

1. Allow patient to verbalize his/her complaint about side effects.
2. Wait and support. Some side effects (i.e. GI distress) will subside over 1-2 weeks.
3. Lower the dose temporarily.
4. Treat the side effects (see table).
5. Change to a different antidepressant.
6. Discontinue medications and start psychological counseling.

SIDE EFFECT	SSRIs & EFFEXOR	TRICYCLICs (nortriptyline, amitriptyline, imipramine)	BUPROPION	MIRTAZAPINE	MANAGEMENT STRATEGY
Sedation	+/-	++	-	+	*Give medication at bedtime. <u>Increase</u> Remeron dose. *Try caffeine.
Anticholinergic - like symptoms: Dry mouth/eyes, Constipation, Urinary retention, Tachycardia	+/-	+++	-	+/-	*Increase hydration. *Sugarless gum/candy *Dietary fiber. *Artificial tears. *Consider switching medication.
GI distress Nausea	++	-	+	+/-	*Often improves in 1-2 weeks. *Take with meals. *Consider antacids or H2 blockers.
Restlessness Jitters/Tremors	+	+/-	++	-	*Start with small doses, especially with anxiety disorder. *Reduce dose temporarily. *Add beta-blocker (propranolol 10-20 mg bid/tid. *Consider short trial of benzodiazepine.
Headache	+	-	+	-	*Lower dose. *Acetaminophen.
Insomnia	+	-	+	-	*Trazodone 25-100 mg po qhs (can cause orthostatic hypotension and priapism). *Take medication in A.M.
Sexual Dysfunction	++	-	-	-	*May be part of depression or medical disorders. *Decrease dose. *Consider a trial of Viagra. *Try adding bupropion 100 mg qhs or bid. *Try adding buspirone 10-20 mg bid/tid. *Try adding cyproheptadine 4 mg 1-2 hrs. before sex.
Seizures	-	-	+	+/-	*Discontinue antidepressant.
Weight gain	+/-	+/-	+/-	++	*Exercise *Diet *Consider changing medications
Agranulocytosis	-	-	-	+/-	*Monitor for signs of infection, flu-like symptoms *Stop drug, check WBC

**Key:**    - Very unlikely            +/- Uncommon            + Mild            ++ Moderate

## APPENDIX IV

### *Monitoring Tools*

1. Depression Monitoring Flow Sheet
2. Processing Referrals for Psychological Services
3. Referral to Mental Health Services Form
4. Model Communication Form  
(Mental Health Specialist – Primary Care Clinician)

## Depression Monitoring Flow Sheet

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Symptoms	<i>DATE</i>	<i>DATE</i>	<i>DATE</i>	<i>DATE</i>	<i>DATE</i>
	<i>Week</i>	<i>Week</i>	<i>Week</i>	<i>Week</i>	<i>Week</i>
Mood					
Interest					
Appetite/weight					
Sleep					
Psychomotor					
Fatigue					
Self-Esteem					
Concentration					
Death/Suicide					
PHQ-9 Score (# Symptoms/Score)					
Suicidality (Question "i" score)					
Functioning (PHQ-9 #2 Question)					
Patient Impression					
Contact With Patient/ Phone = P Visit = V					
MH Referral					
Medications/ Dosage					
Patient Compliant With Recommendations					

## Processing Referrals for Psychiatric Services

### Sequence in Referral Process

1. Primary Care Clinician (PCC) recognizes need for mental health referral.
2. PCC explains reasons for mental health referral and recommends appropriate level of care and type of psychological counseling services (i.e. counselor, psychologist, psychiatrist).
3. Patient may not agree to seek help from a mental health specialist. If patient resists, clinician and/or office staff provides education, support and counseling, and reinforce need for mental health referral.
4. Referral form is completed and mental health specialist is selected by the patient depending upon many factors, such as geographic location, insurance coverage, goals of treatment, and if combined therapy with antidepressants are being used.
5. Communication from the PCC is sent to the mental health specialist on the "Referral to Mental Health Form" when the referral is made. The PCC includes his/her office information, such as address, phone and fax numbers on the form, to facilitate communication.
6. Mental health specialist begins treating the patient and communicates response and recommendations back to the primary care clinician, using the "Model Communication Form Mental Health".
7. Primary care clinician and mental health specialist continue to communicate and coordinate patient treatment, until problems are resolved.

## Referral to Mental Health Services

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### 1. Goal(s) of Treatment as Identified by Patient:

- A. \_\_\_\_\_
- B. \_\_\_\_\_
- C. \_\_\_\_\_
- D. \_\_\_\_\_

### 2. Primary Care Clinician Recommendations for Psychological counseling Treatment

Type of Therapist:  Counselor  Psychologist  Psychiatrist

Reason for Referral:

\_\_\_\_\_

\_\_\_\_\_

### 3. Medical History Related to Psychiatric Diagnosis

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 4. Previous Treatment for Psychiatric Problems

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 5. Current Medications

<b>Drug</b>	<b>Dose</b>	<b>Frequency</b>
-------------	-------------	------------------

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Note to MH Specialist:* **Primary Care Clinician Information:**

Please communicate with Name: \_\_\_\_\_

Address:

Phone:

Fax:

\_\_\_\_\_  
Signature – Patient Consent



## Model Communication Form - Mental Health to PCC

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Mental Health Specialist Providing Patient's Care: \_\_\_\_\_

Week \_\_\_\_\_ of Treatment

Name & Title:

Address:

Phone:

Fax:

### 1. Diagnostic Impression:

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### 2. Treatment Information:

<u>Treatment</u>	<u>Patient Response to Treatment</u>
Type/dosage of Antidepressants	Type of Therapy(s) Initiated
_____	<input type="checkbox"/> Cognitive Behavioral Therapy
_____	<input type="checkbox"/> Interpersonal Psychological counseling
_____	<input type="checkbox"/> Marital Therapy
	<input type="checkbox"/> Brief Dynamic Psychological counseling
	<input type="checkbox"/> Other _____

### 3. Patient Response to Treatment and Recommendations for PCC Treatment

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## APPENDIX V

### *Bibliography*

## BIBLIOGRAPHY

1. AHCPR Depression Guideline Panel. Depression in Primary Care: Volume 1. Detection and Diagnosis of Depression. Clinical Practice Guideline, Number 5. Rockville, MD. U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, 1993
2. AHCPR Depression Guideline Panel. Depression in Primary Care: Volume 2. Treatment of Major Depression. Clinical Practice Guideline, Number 5. Rockville, MD. U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, 1993
3. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition revised. Washington DC. American Psychiatric Association, 2000.
4. Cole S, Bird J: The Medical Interview: The Three-Function Approach, St. Louis, MO, Mosby; 1990.
5. Cole S, Christensen FJ, Raju MA et al: Depression, in Feldman M, Christensen J (eds): Behavioral Medicine in Primary Care. Stamford, CN, Appleton & Lange; 1997:177-192.
6. Cole S, Raju M, Barrett J, Gerrity M, Dietrich A. MacArthur Foundation Depression Education for Primary Care Physician: Background, Participant's Workbook, and Facilitator's Guide. General Hospital Psychiatry 2000, 22(5):299-358.
7. Ewing JA. Detecting Alcoholism. The CAGE Questionnaire. Journal of the American Medical Association 1984;252:1905-1907
8. Frank E, Prien R, Jarrett R, Keller M, Kupfer D, Lavori P, Rush J, Weissman M. Conceptualization and rationale for consensus definitions of terms in major depressive disorder. Remission, recovery, relapse, and recurrence. Archives of General Psychiatry 1991;48:851-855.
9. Geddes JR, Carney SM, Davies C, Furukawa TA, Kupfer DJ, Frank E, Goodwin GM: Relapse prevention with antidepressant drug treatment in depressive disorders: a systematic review. Lancet 2003;361:653-651.
10. Kroenke K, Spitzer RL, Williams JB: The PHQ-9: validity of a brief depression severity measure. Journal of General Internal Medicine 2001;16:606-13,
11. Kroenke K, Spitzer RL. The PHQ-9: A new depression and diagnostic severity measure. Psychiatric Annals 2002;32:509-521.
12. Mynors-Wallis L, Gath D, Lloyd-Thomas A Tomlinson D. Randomised controlled trial comparing problem solving treatment with amitriptyline and placebo for major depression in primary care. British Medical Journal. 1995 February; 441-5.
13. Mynors-Wallis, L. Problem-solving treatment: evidence for effectiveness and feasibility in primary care. International Journal of Psychiatry in Medicine 1996;26:249-62.
14. Rost K, Smith J: Retooling multiple levels to improve primary care depression treatment. Journal of General Internal Medicine 2001;16:644-645
15. Spitzer R, Kroenke K, Williams J: Validation and utility of a self-report version of PRIME-MD: the PHQ Primary Care Study. Journal of the American Medical Association 1999;282:1737-1744
16. Stuart M, Lieberman J. The Fifteen Minute Hour. Praeger Publishers, Westport, CT 1993.

17. Stuart MR: The BATHE Technique in Rakel RE. (eds.): Saunders Manual of Medical Practice. Philadelphia. PA. W.B. Saunders, 1996 pp. 1108-9.
18. U.S. Preventive Services Task Force: Screening for Depression: Recommendations and Rationale. Annals of Internal Medicine 2002;136:760-764
19. Webb MR, Dietrich AJ, Katon W, Schwenk TS. Diagnosis and Management of Depression. American Family Physician. Monograph No. 2, 2000.
20. Williams JW, Noel PH, Cordes JA, et al: Is this patient clinically depressed? Journal of the American Medical Association 287:1160-1170, 2002