Identification and Treatment of Depression in Primary Care for Adults Ages 18 and Older

Practice Guidelines and Principles: Guidelines and principles are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines and principles should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs.

Key Points
1. Depression is treatable.
2. There are 2 screening questions, which can be used to screen for depression.
3. Adequate dosing of antidepressant medication and patient compliance with medication is the key to favorable outcomes.

Purpose: To improve the identification, treatment and referral of patients with Major Depressive Disorder (MDD or Major Depression) in the primary care setting. Depressive symptoms which are not considered to reflect Major Depressive Disorder, and are related to other diagnoses e.g., Dysthymia, Seasonal Affective Disorder, Bipolar Disorder (Manic Depressive Illness), are not considered to be the focus of this guideline.

Distributed to: Primary care physicians including internists, family practitioners, general practice physicians, and pediatricians; specialists/sub-specialists including obstetricians/gynecologists, and psychiatrists; and psychologists, psychiatric nurse practitioners and other licensed independent practitioners.

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HARMONY
BEHAVIORAL HEALTH

Identification & Treatment of Depression in Primary Care

GRADING SYSTEM

Grades of Recommendations:

A = Good evidence to support the recommendation that the condition or intervention be specifically considered in a clinical practice guideline.

B = Fair evidence to support the recommendation that the condition or intervention be specifically considered in a clinical practice guideline.

C = Poor evidence regarding inclusion or exclusion of a condition or intervention in a clinical practice guideline, but recommendation made on other grounds.

D = Fair evidence to support the recommendation that the condition or intervention be specifically excluded from consideration in a clinical practice guideline.

E = Good evidence to support the recommendation that the condition or intervention be specifically excluded from consideration in a clinical practice guideline.

Quality of Published Evidence:

For Grade A:
I - Evidence from at least one properly randomized controlled trial.

For Grade B:

II – 1 Evidence from well-designed controlled trials without randomization.

II – 2 Evidence from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

II – 3 Evidence from comparisons between times or places with or without the intervention.
Dramatic results in uncontrolled experiments could also be included here.

For Grade C:

III - Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees.

Identification & Treatment of Depression in Primary Care *

Assess Family History

Common Symptoms

. Aches and Pains
. Low Energy
. Apathy, Irritability, Anxiety, Sadness
. Sexual Complaints
. Disrupted Sleep Patterns
. Vague GI Symptoms
. Appetite Changes
. Social Avoidances
. Headaches

Populations at High Risk
(untreated depression may interfere with recovery from co-morbid conditions)

. Heart Disease
. Diabetes
. Cancer
. Catastrophic Illness
. Pregnancy/Postpartum
. Thyroid
. Obesity
. Substance Abuse
. Anxiety
. Chronic Medical/ Psychiatric Conditions
. Marital Problems/ Domestic Violence
. Workplace Problems
. Dementia

Suicide/Homicide Risk Factors

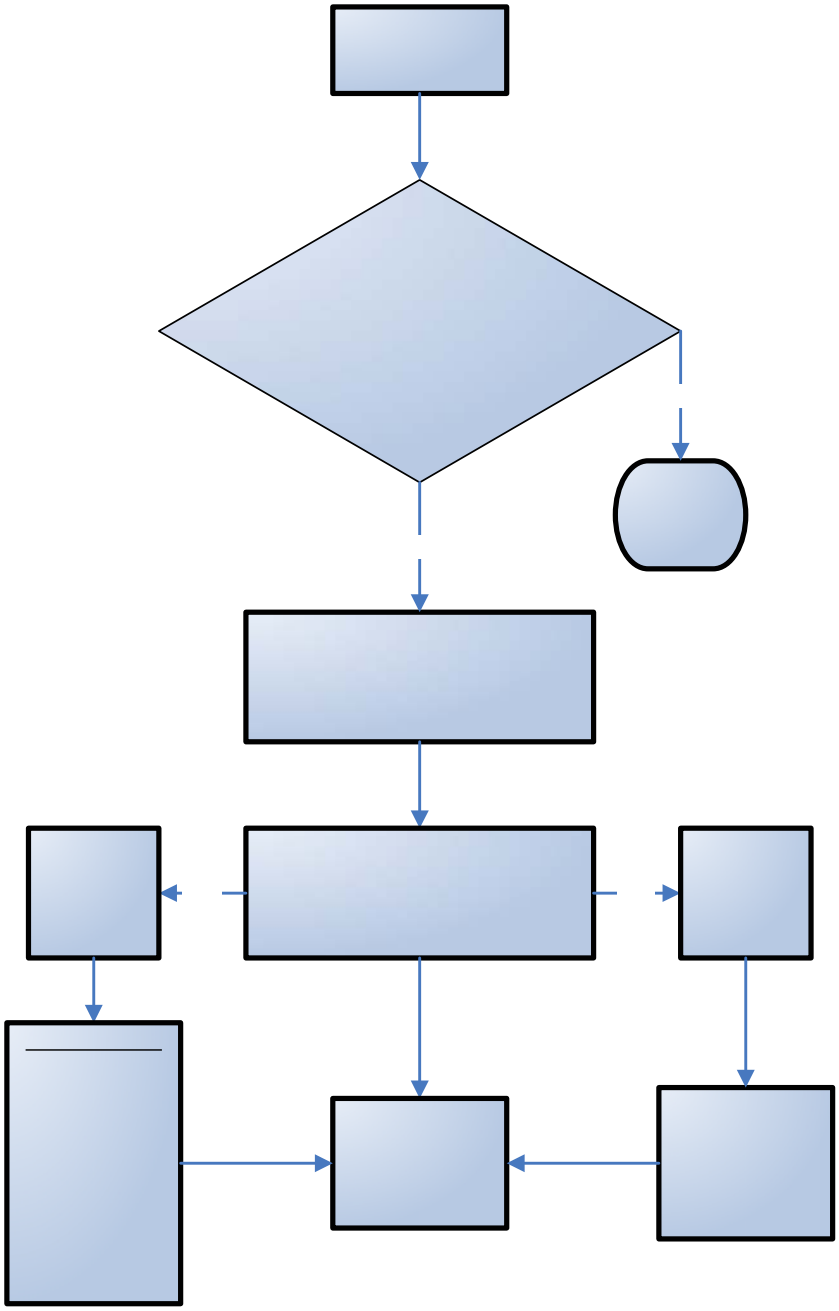
Does Your Patient Have the:

. Thoughts
. Plan
. Means
. Intent

To Harm Himself/Herself or Others?

Treatment Options
. PCP Treatment
. Encourage Family / Support System
. Refer to Behavioral Health Specialist

Assessment and Identification



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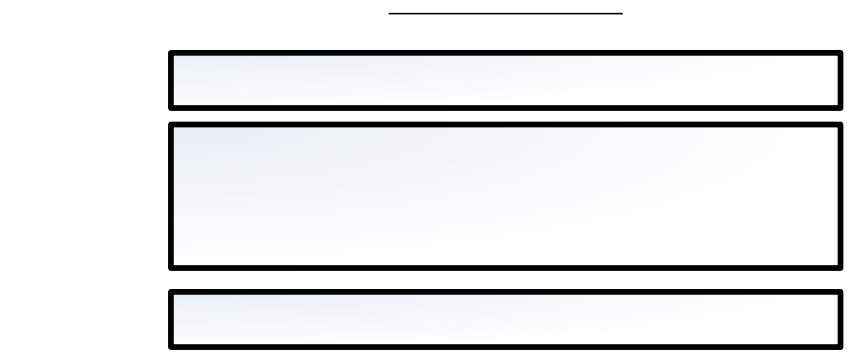
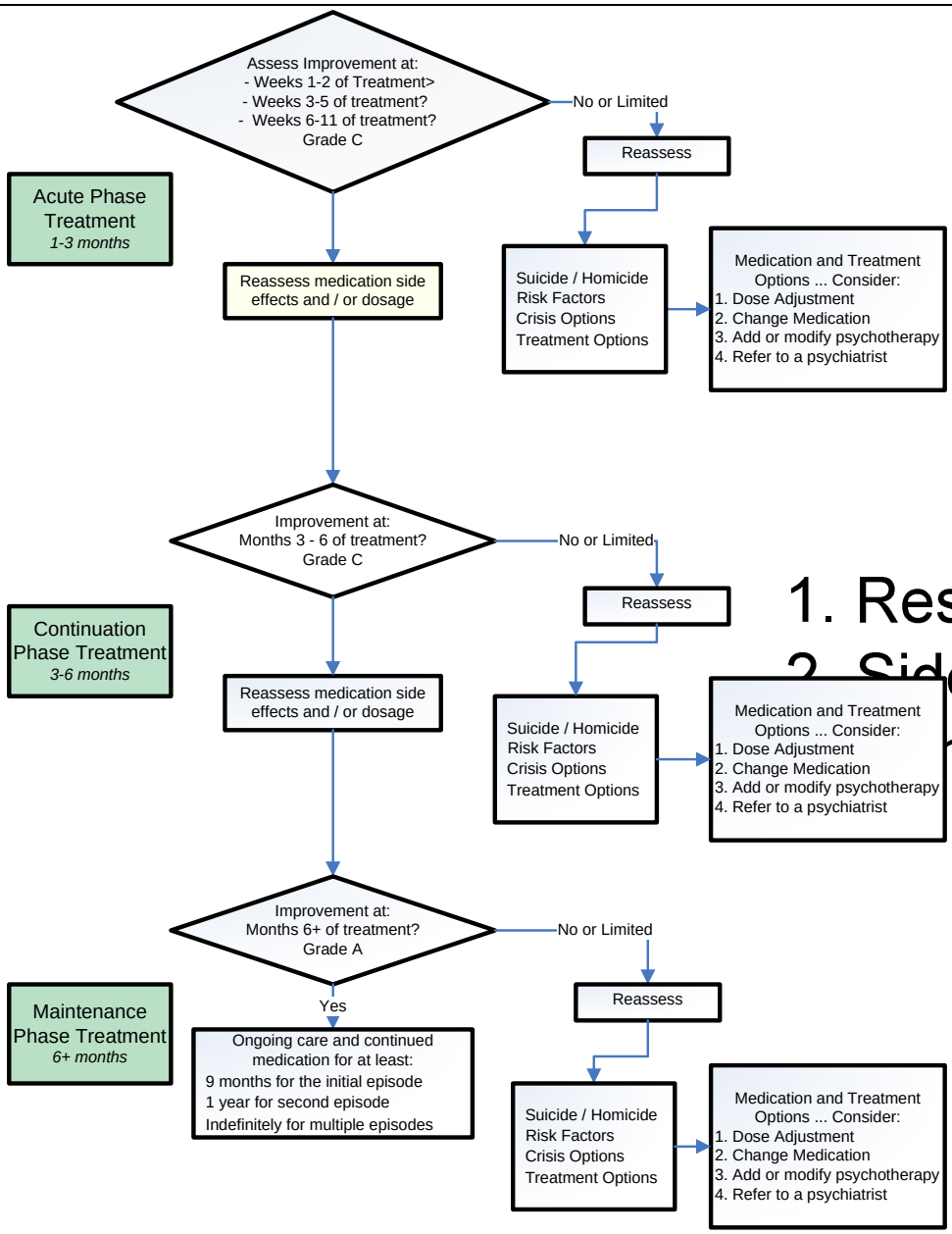
Identification & Treatment of Depression in Primary Care





When to Refer to a Behavioral Health Specialist

- Active Suicide
- Potential Psychotic Symptoms
- Lack of Response to Treatment
- Need for Psychotherapy/ Counseling
- Substance Abuse
- Poor Adherence/ Compliance
- Diagnostic Consultation (Treatment/Medication Management)
- Need for Hospitalization or Electroconvulsive Therapy (ECT)
- Recurrent or Chronic Depression
- Patient or Family Request

Resource Materials

1. US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. (1993) Depression in Primary Care: Volume 1, Diagnosis and Detection and Volume 2, Treatment of Major Depression. Clinical Practice Guideline, No. 5, Rockville, Maryland

2. American Psychiatric Association Clinical Resources, April 2000. Practice Guidelines for the Treatment of Patients with Major Depression, Washington, DC.

3. Texas Medication Algorithm Project (TMAP), Depression Module Physician Algorithm Implementation Manual, 12/21/98.

4. US Preventive Services Task Force. Screening for Depression: Recommendations and Rationale. Ann Internal Med. 2002;136:760-764.

Treatment Options

. PCP Treatment
. Encourage Family / Support System
. Refer to Behavioral Health Specialist

Identification & Treatment of Depression in Primary Care

1A. **Untreated depression may interfere with recovery from co-morbid conditions** Prevalence of depression in medical co-morbidities: • Coronary Artery Disease 18% • Myocardial Infarction 16% • Cancer 20-25% • Diabetes 25% • HIV 36% • Alzheimer's Disease 17-31% • Migraine 22-32% • MS up to 50% • Post Partum 10-20% **Reference**: Kessler 1999; Carney 1987; Frasure-Smith 1993; AHCPR Guidelines 1993; Anderson 2001; Bing 2001; Reifler 1986; Rovner 1989; Breslau 1991; Minden 1987; Joffe 1987.	**1. Suspect Depression** Many patients with depression do not complain of depressed mood, and physicians need to suspect depression based on a profile of risk factors and common presentations. *Common Presentations for depression may include:* • Multiple shifting somatic complaints; headaches, abdominal pain or other body aches, often multiple (>5 per year) medical visits • Fatigue, low energy, or reduced capacity for pleasure • Sleep disturbance • Non-adherence to a treatment regimen for a chronic illness • Moods of apathy, irritability, anxiety, or sadness • Work or relationship dysfunction • Multiple worries, helplessness, hopelessness • Complaints of sexual dysfunction or lack of desire • Rapid fluctuations in weight • Alcohol or substance abuse
2A. 2 Question Assessment: During the past month have you often been bothered by: • little interest or pleasure in doing things and / or • feeling down, depressed or hopeless 2B. Screening Tools are: - PHQ9 (see attachment) <u>Other Examples:</u> - Zung - Beck - Ham D - Edinburgh Post Natal Depression Scale	**2. Interview for Key Symptoms of Depression** Depressed mood or anhedonia (diminished interest or pleasure in activities) is necessary to diagnose depression. If you suspect depression, ask about underlying depressed mood or anhedonia. Remain cognizant that depression is expressed differently in each age group and cultural group. Sometimes depressed patients will initially deny depressed mood and anhedonia, so ask about vegetative symptoms (sleep disturbances, changes in appetite and energy level). If vegetative symptoms are present, ask again about underlying depressed mood and anhedonia. If either is endorsed, proceed to a full clinical interview. Depression in the elderly may be indicated by somatic complaints, especially constipation, chronic pain, and/or pseudo-dementia.

2C.
Significant Risk Factors for Suicide
- Suicidal Ideation/ Plans
- Prior suicide attempts
- Family History of suicide
- Hopelessness
- Recent major loss
- Serious medical condition
- Coexisting Substance abuse
- Psychosis

Medications Reportedly Associated with Depression

Cardiovascular Drugs
- Alpha-methyldopa
- Propranolol *
- Guanethidine
- Clonidine
- Digoxin

Anticancer Agents
- Cyclosporine
- Tamoxifen*

Hormones
- Oral Contraceptives*
- Glucocorticoids
- Anabolic Steroids

Psychotropics

- Benzodiazepines
- Anti-psychotics

Withdrawal Syndromes

- Cocaine
- Tranylcypromine (MAO Inhibitor)
- Fenfluramine

This is a partial list.

- Source: Psychotherapy and Psychosomatics, Drug Induced Depression, 1997; 66:63-73

*Controversial

You should assess depressed patients' risk of suicide by asking them about thoughts they may have had about suicide, impulses and their personal history of suicide attempts. Is there a specific plan? Does the patient have access to weapons? If so, a behavioral health practitioner and a family member need to be contacted.
If suicide is a distinct risk consult a behavioral health practitioner immediately. This may indicate the need for a direct referral to the psychiatric emergency department.

Remember:
•Suicide is the second leading cause of death for men 18-24.
•Men over 55 are also at significant risk for suicide.

3. Evaluate for Other Causes of Depressive Symptoms
Bipolar Disorder (Manic Depressive Illness):
During the interview, inquire about any past history of manic episodes. Suggested Screening Question: Have you ever been through a spell of a few weeks where you felt overly happy, hyperactive, talkative, impulsive, invincible, and need very little or no sleep, but still had tons of energy?

Psychosocial Stressors:
A patient with an Adjustment Disorder may only need time and support. However if symptoms are persistent or debilitating, medication and/or psychotherapy should be considered:

- Stressful life events including loss (death of a loved one, divorce)
- Traumatic events (car accident, sexual or physical abuse)
- Major life changes (job change, retirement, migration, cultural transition)

Emotional and behavioral reactions to these psychosocial stressors may include symptoms of depression, which can mimic Major Depression.

Since these adjustment reactions can develop into a major depression or anxiety disorder, follow-up and re-evaluation are necessary.

In the elderly, difficulties that may interfere with treatment include conflicts about dependency, prolonged or unresolved grief/loss and social isolation.

	Medical Illness: The close relationship of mind and body results in the presentation of medical illness with depression in various forms: • Medical illnesses may be the cause of depression (e.g. hypothyroidism, stroke, sleep apnea) • Medical illness may trigger a psychological reaction to prognosis, pain or disability (e.g. in a patient with cancer, diabetes) • Medical illness may exist concomitantly in a patient with primary mood disorder. • Untreated depression may interfere with recovery from co-morbid condition. Untreated depression may interfere with recovery from co-morbid condition. A past medical history, medication list (including over the counter and herbal remedies) and brief review of symptoms is generally sufficient to rule out medical disorders causing depression. Depression may be a side effect of many medications. It is also important to evaluate for alcohol and/or substance abuse as this is very frequently a co morbid condition. The practitioner should administer the CAGE Questionnaire if indicated. Alcohol dependence is likely if a patient gives 2 or more positive answers: • Have you ever felt you should CUT down your drinking? • Have people ANNOYED you by criticizing your drinking? • Have you ever felt bad or GUILTY about your drinking? • Have you ever had a drink first thing in the morning to steady your nerves to get rid of a hangover (EYE-opener)? Perform a focused physical examination and laboratory testing as indicated by the review of systems. The benefit of screening laboratory tests including thyroid tests to evaluate depression in the absence of indicators of possible metabolic abnormalities has not been established. Reliance on laboratory tests should be increased if: • The medical review of systems detects symptoms of possible medical illness • The patient is older • The first depressive episode occurs after the age of 40 • The depression does not respond fully to routine treatment • The depression is due to medications • The depression is due to alcohol and/or substance abuse **4. Cultural Factors:** • Depression is more prevalent in women than men (almost 2:1 due to hormones) • African Americans are treated less often than Caucasians, however they are 40% more likely to experience depression than Hispanics or Caucasians. • African Americans may mistrust conventional treatment and prefer to discuss care with their pastor. • Poverty and low socio economic status contribute to depression.

6A.

Major Depressive Episode DSM-IV Criteria
To diagnose major depressive disorder, one of the following symptoms must be present:
Depressed mood:

Loss of interest or pleasure in most activities most days

In addition, four of the following symptoms must be present for at least two weeks:
- Significant weight loss/gain
- Insomnia/hypersomnia
- Psychomotor agitation/retardation
- Impaired concentration or decisiveness
- Feelings of worthlessness or guilt
- Recurrent thoughts of death or suicide
- Fatigue or loss of energy

5. Address secondary causes and re -evaluate

6. Reasons for Consultation and Referral Consultation:
- The practitioner or patient wants a second opinion
- Practitioner unsure of diagnosis or treatment
- Patient's co-morbid conditions raise medication dilemmas
- Patient not interested, not responding to, or noncompliant with medication

Referral to a Behavioral Health Practitioner

Emergent Referral:
- The patient is actively suicidal/homicidal (consider emergency department)
- The patient has acute psychotic features or bipolar depression

Urgent Referral:
- The patient has significant suicide risk factors (but not currently suicidal)

Routine Referral:
- The patient's symptoms suggest a multiple complex psychiatric illness
- The patient does not respond fully to one or two medication trials
- The patient shows persistent psychosocial problems
- The patient has a family history of suicide, and/or a family history of Bipolar Disorder (Manic Depressive Illness)
- The patient has a personal history of substance abuse

Communication
Effective, timely and confidential communications must be exchanged between medical practitioners and behavioral health practitioners.

7. Diagnose
- Refer to DSM-IV Criteria

The clinical interview is the most effective method for detecting Major Depression. Self-report scales cannot be solely used to formulate a diagnosis of depression. There is insufficient evidence to recommend for or against the routine use of questionnaires to screen for depression in asymptomatic primary care patients.

8A

Available Options

- Medication
- Consultation
- Psychotherapy
- ECT

SOURCE: Depression Guideline Panel, Depression in Primary Care, 1993 (AHCPR)

Duration of Drug Therapy

Treatment: The goal of treatment is complete symptom remission, not just symptom improvement. All patients who are prescribed antidepressants should remain on medication through symptom resolution (six to twelve weeks) and should have continuation treatment for six to twelve additional months.
Decisions should then be made about who needs maintenance therapy.

All patients on antidepressants should be seen at least three times in the 84 days following initial diagnosis and start of treatment.
Recommendation:
Visits at 2-3week intervals.

Treatment consists of three Phases per NCQA HEDIS® guidelines:

1) Acute treatment (six to 12 weeks) This treatment aims to put a patient's symptoms into remission. All antidepressants require six to eight weeks of therapy to show symptom resolution.

2) Continuation treatment (six to twelve months) This phase is designed to prevent a relapse. During this phase, medication should be continued at the full dosage.

8. Treatment

The following guidelines assume that a diagnosis of major depression has been made, and that guidelines for referral to a behavioral health practitioner have been reviewed.

Once the diagnosis is made, treatment should begin. There is strong evidence to show the benefit of medication as a first line treatment for moderate to severe major depression. There is evidence to support the use of psychotherapy as a first line treatment for mild to moderate major depression.

If psychotherapy is chosen, refer the patient to a behavioral health practitioner.
If psychotherapy alone is used and there is no symptom improvement within six weeks, or if symptoms remain after 12 weeks, medication should be reconsidered. If the patient does not respond to routine treatment, re-evaluate history/ physical.

Factors to consider when starting medication:

- severity of symptoms
- prior response to medication
- family history of depression and their medication responses
- patient age
- possible drug interaction
- presence of other psychiatric and general medical conditions
- incomplete response to psychotherapy alone
- history of medication non-compliance

Important Things to Know:

- Co-morbid depression with chronic medical illness worsens the medical prognosis
- Co-morbid psychiatric disorder with depression is common. Examples include substance abuse, eating disorder and anxiety disorder
- Consider an EKG if the patient has thyroid or cardiac dysfunction, or is presently taking multiple medications. Special consideration should be made for those patients presently on anti-arrhythmics, phenothiazines or sympathomimetics.

Treatment options should be discussed with the patient at the time of diagnosis and during treatment planning.

Compliance/Adherence:
Active participation by patients, along with patient education is essential for successful treatment. Patient compliance can be influenced by side effects and the patient's ability to afford the prescribed medication.

The following information should be emphasized to your patients :

- Depression is a medical illness, not a weakness.
- Recovery is the rule, not the exception.
- Treatments are effective, and there are many options, including adjusting the dosage or considering evening dosage to avoid initial side effects such as drowsiness.

3) Maintenance treatment: This is designed to prevent depression from recurring in patients with prior episodes. A full dose of medication can prevent a new episode and maintain effective stability in patients prone to recurrence. **Assessing Progress** • Reduce/remove presenting signs and symptoms' • Absence of suicidal ideation • Normalization of sleep patterns • Restore occupational and psycho-social functioning **The risk of recurrence is significant:** • 50 percent after one episode • 70 percent after two episodes • 90 percent after three episodes Major causes of recurrence: • inadequate dose of medication • insufficient duration of treatment	**If medication is prescribed, remind your patients that:** • There are possible side effects of medication. Most of the possible side effects are transient and many are reversible and can be treated with other medications, which allows the patient to continue with antidepressant therapy. • Medication should be taken as directed; however, patient should discuss lifestyle with physician to determine time of day for medications. • Patients should call their prescribing practitioner before discontinuing their prescription. • It will take two to four weeks before the benefits from medication are noticeable • It may take up to eight weeks for medication to work fully • Patients should call their prescribing practitioner if there are any questions • The prescribing practitioner must monitor response to treatment **PHARMACOLOGICAL TREATMENT OF DEPRESSION** **Choose the first and second line of treatment from the following list:** • Previously effective agent • Selective serotonin reuptake inhibitors (SSRIs), such as sertraline, paroxetine, fluoxetine, or citalopram • Secondary amines, such as desipramine or nortriptyline • Selective norepinephrine reuptake inhibitors (SNRIs) such as venlafaxine • Others, such as bupropion, and mirtazapine **Alternative agents:** • Tertiary amine, tricyclic antidepressants (TCAS) **Treatment choice may depend on the side effect profile of the medication** Trazodone may be considered for sleep disturbance

Discontinuation Syndrome

Discontinuing antidepressant medication requires systematic tapering. There are physical and psychological symptoms that often occur when abruptly stopping an antidepressant. These reactions usually start within a few days of stopping antidepressant therapy, usually resolve within two weeks, and are more common with longer courses of treatment. All these characteristics are short lived, may be suppressed by reintroduction of the antidepressant and are distinct from either relapse or reoccurrence of the primary disorder.

Tricyclic Antidepressants:
Gastrointestinal symptoms such as nausea, vomiting, abdominal cramps and diarrhea, general somatic distress such as headaches, lethargy and sweating; sleep disturbance, such as insomnia, excessive dreaming and nightmares; and affective symptoms, including anxiety, agitation and low mood.

Selective Serotonin Reuptake Inhibitors:
In addition to the symptoms listed above: Balance and sensory abnormalities, dizziness, lightheadedness being the most common; numbness and the unusual sensation of electric shocks, particularly in the head, neck, upper limbs.

Advise your patient not to stop taking their antidepressant abruptly.
Using the mnemonic **FINISH** may help patients understand symptoms that may occur if an antidepressant is discontinued abruptly:

- **F**lu-like symptoms - **N**ausea - **S**ensory Disturbance
- **I**nsomnia - **I**mbalance - **H**yper-arousal (anxiety/agitation)

Antidepressant Fact Sheet

All antidepressants may be started at a lower dose to decrease side effects

Generic Name	Brand Name	Dosage Forms ++ *liquid*	Usual Daily Dose
SSRI's			
Citalopram	Celexa	10, 20,40mg ++	20-60mg
Paroxetine	Paxil*	10,20,30mg ++	20-50mg
Sertraline	Zoloft	25, 50,100mg ++	50-200mg
Fluoxetine	Prozac*	10,20,40mg ++	20-60mg
	Prozac Time Release Capsule	90mg weekly	90mg weekly
Escitalopram	Lexapro	5,10,20mg ++	10-20mg
Others	Wellbutrin* Wellbutrin SR* Wellbutrin XL	75,100mg 100,150mg 150, 300mg	225-450mg 150-400mg 300-450mg
Bupropion**			
SNRIs			
Venlafaxine	Effexor Effexor XR	25,37.5,50,75,100mg 37.5mg,75,150mg	75-375mg 75-225mg
Mirtazapine	Remeron*	15,30,mg	15-45mg
	Remeron SoluTabs	15, 30, 45mg	15-45mg
Tricyclics			
Amitriptyline	Elavil*	10,25,50,75,100,150 mg	75-300mg
Desipramine	Norpramine*	10,25,50,75,100,150mg	75-300mg
Doxepin	Sinequan*	10,25,50,75,100,150mg	75-300mg
Imipramine	Tofranil*	10,25,50mg	75–300mg
Nortriptyline	Pamelor*	10,25,50,75mg	50-150mg

For a full range of drug interactions and side effects, see the Physician's Desk Reference (PDR). Some medications may cause excessive weight gain and sexual problems, which may be substantial.

Do not use Sarafem with Prozac, as both are Fluoxetine.

* Available in Generic

Bupropion is contraindicated in patients with history of seizures or eating disorders, and should be used with caution with agents that lower seizure threshold. **Do not use Zyban with Wellbutrin, as both are bupropion.

*******FDA Issues Public Health Advisory on Antidepressant Use: On March 22, 2004 the FDA asked manufacturers to add a warning statement indicating the possibility of worsening depression or emergence of suicidal tendencies in adults and pediatric patients on the labels of the following drugs*:

- Celexa® (citalopram)
- Effexor® (venlafaxine)
- Lexapro® (Escitalopram)
- Luvox® (fluvoxamine)
- Paxil® (paroxetine)
- Prozac ® (fluoxetine)
- Remeron® (mirtazapine)
- Serzone® (nefazodone)
- Wellbutrin® (sertraline)
- Zoloft® (bupropion)

*Prescribers should carefully monitor patients on the above medications especially at the beginning of treatment or when doses are adjusted.

References: www.fda.gov/cder/drug/antidepressants

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12 FL Rx facts. April 2004: Volume 6, Number 4.

Name _____

Date _____ ID # _____

Date of Birth _____

Patient Health Questionnaire – PHQ-9

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

	Column 1	Column 2	Column 3	Column 4
	Not at all	**Several days**	**More than half the days**	**Nearly every day**
	0	**1**	**2**	**3**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

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10. If you checked off <u>any</u> problem on this questionnaire so far, how <u>difficult</u> 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
❒	❒	❒	❒

For office use only:
Total # Symptoms: _____ Total Score: _____

Nombre: _____

Fecha de hoy _____ Número del identificación # _____

Fecha de nacimiento _____

Cuestionario sobre Salud del Paciente– PHQ-9

En las últimas dos semanas, ¿cada cuando frecuencia le han molestado estos problemas?

	Para Nada	Varios Dias	Mas de medio dia/Cada dia	Casi todos los dias
	0	1	2	3
1. Tener poco interés o placer en hacer las cosas	0	1	2	3
2. Sentirse desanimado/a, deprimida/o, o sin esperanza	0	1	2	3
3. Problemas de dormir, mantenerse dormida, o dormir demasiado	0	1	2	3
4. Sentirse cansado/a o tener muy poca energía	0	1	2	3
5. Tener poco apetito o come en exceso	0	1	2	3
6. Sentir falta de amor propio – ser un fracasado/a o se siente decepcionado/a con sigo mismo/a o con su familia	0	1	2	3
7. Tener dificultad para concentrarse en cosas tales como leer el periódico o mirar la televisión	0	1	2	3
8. Se mueve o habla tan lentamente que otra gente lo podría dar cuenta – o de lo contrario, está tan agitado/a o inquieto/a que se mueve mucho más de lo acostumbrado	0	1	2	3
9. Se le han ocurrido pensamientos de que sería mejor estar muerto/a o de hacerse daño de alguna manera	0	1	2	3

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10. ¿Si usted marcó afirmativo en cualquiera de las preguntas de arriba ¿que tan difícil se le ha hecho cumplir con su trabajo, atender su casa, o relacionarse con otras personas debido a estos problemas.

Nada en absoluto	Algo difícil	Muy difícil	Extremadamente difícil
❒	❒	❒	❒

For office use only:
Total # Symptoms: _____ Total Score: _____

PHQ-9 SCORING INSTRUCTIONS

DIAGNOSTIC SYMPTOMS

Count total boxes checked in all shaded areas. Enter # of boxes checked as "Symptoms"

SEVERITY SCORE

Multiply the boxes checked in each column by the number at the top of the column, then total all columns. Enter total in "Total Score"

PHQ-9 Symptoms & Impairment	PHQ-9 Severity Score	Depression Severity
1 to 4 symptoms, functional impairment	<10	Mild or Minimal Depressive Symptoms
2 to 4 symptoms, question 1 or 2 +, functional impairment	10-14	Moderate Depressive Symptoms (Minor Depression)*
≥ 5 symptoms, question 1 or 2 +, functional impairment	15-19	Moderately Severe Major Depression
≥ 5 symptoms, question 1 or 2 +, functional impairment	≥20	Severe Major Depression

*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:

- High suicide risk
- Bipolar disorder
- Inadequate treatment response
- Complex psychosocial needs and/or
- Other active mental disorders

Understanding Major Depression

What is Major Depression? Depression is an illness that affects the way you think and act as well as the way you feel. Being overwhelmed by the problems in your life and fixating on these problems can cause changes in the chemistry of your nervous system, which can interfere with your daily activities and relationships at home and at work.

How do I know if I am suffering from major depression? You should talk to your physician if you've had problems sleeping, if your eating habits have changed, or if you are losing interest in things you've always enjoyed in the past. You may have a difficult time concentrating or remembering things. You may be tired more often and you may have thoughts of death or suicide. Frequent outbursts of anger or sadness are also symptoms of depression.

How does my physician make a diagnosis of depression? The best way to find if you are suffering from depression is to discuss your symptoms with your physician. He or she will ask you certain questions about how you've been feeling, or ask you to complete a questionnaire that can help in making an accurate diagnosis.

What causes Major Depression? Changes like menopause or childbirth, changes in medication, major surgery or illness, or an event such as the loss of a loved one can trigger depression. Sometimes depression seems to appear suddenly, with no apparent reason. Many depressed people can recall a family member who has been affected by the illness. People who are depressed may abuse alcohol or drugs to avoid the feelings of depression but alcohol and drug abuse make the depression worse.

What is the treatment for Major Depression? The most common ways to treat depression are with antidepressant medication, counseling, or a combination of both. The choice of treatment depends on how severe your symptoms are, your medical history, and what you think will work best for you. Your physician can help you decide which treatment option is the best for you. If your physician starts you on antidepressant medication, it is very important for you to see your physician *at least 3 times within the first three months*. Your physician will monitor your progress and watch for any possible side effects of the medication. Antidepressant medication must be taken every day to work properly. It may take two to four weeks before the medication begins to work, and up to eight weeks for the medication to reach full effect. Many people suffering from depression remain on the medication for nine to twelve months before the physician begins to decrease the dosage. **Please remember: you should never stop taking medication without talking to your physician. If you are planning on becoming pregnant, talk to your physician about the best medication for you to take during your pregnancy.**
Should your physician refer you to a Mental Health Expert? Your physician may wish to consult a psychiatrist, psychologist or psychiatric social worker that is a specialist in mental health care. This may help your physician to clarify the diagnosis, or determine the best treatment for you. An *urgent* referral is required if you are having thoughts of harming yourself or others.

What else can I do? Talk to someone you trust. When someone believes in you, it's easier to believe in yourself. Find a support partner to help you speed up you recovery. This partner should be someone you know, trust and can count on – a family member or close friend who can understand you feelings and remind you of your value and strengths.
♦ **Remember: It is very important to immediately tell your physician if at any time you are having thoughts about harming yourself or others.**

Lo que debe saber sobre depresión severa

¿Cómo puedo saber si estoy sufriendo de una depresión severa? Si tiene problemas para dormir, ha notado cambios en sus hábitos de comida o falta de interés en cosas que siempre disfrutaba en el pasado, usted debería hablar con su médico. Quizás tenga dificultad para concentrarse o recordar cosas. O se siente cansado con frecuencia y tiene pensamientos sobre la muerte o el suicidio. Éstos, y también recuentes explosiones de ira o tristeza pueden ser síntomas de depresión.

¿Cómo puede diagnosticar mi médico la depresión? La mejor forma de saber si estásufriendo una depresión es discutir sus síntomas con el médico. Él o ella le hará preguntas en relación a como se siente, o le pedirá que complete un cuestionario que le ayudará a hacer un diagnóstico certero.

¿Qué causa una depresión severa? Cambios como la menopausia o dar a luz, un cambio de medicamento, una operación quirúrgica o enfermedad seria, o un evento como la muerte de un ser querido pueden provocar una depresión. A veces la depresión aparece repentinamente y sin motivo aparente. Muchas personas deprimidas recuerdan que hay un miembro de su familia que padece esa enfermedad. Las personas con depresión beben a veces alcohol en exceso o usan drogas para no sentirse deprimidas pero éstos empeoran la depresión.

¿Cuál es el tratamiento para la depresión severa? La forma más común de tratar la depresión es con medicamentos antidepresivos, terapia o la combinación de ambos. El tratamiento varía de acuerdo con la gravedad de sus síntomas, su historia médica y lo que usted piensa que será mejor para usted. Su médico puede ayudarle a decidir qué tratamiento es el indicado para usted.
Si su médico lo pone en un tratamiento de medicamentos antidepresivos, es muy importante que usted vea al médico *por lo menos 3 veces en el transcurso de los primeros tres meses*. El médico controlará su progreso y vigilará si aparece alguno de los posibles efectos secundarios del medicamento. Los medicamentos antidepresivos deben tomarse todos los días para que actúen correctamente. Y pueden demorar de dos a cuatro semanas en comenzar a hacer efecto, y hasta ocho semanas en alcanzar el efecto completo. Muchas personas que sufren de depresión permanecen medicadas de nueve a doce meses antes de que el médico comience a disminuirles la dosis. **Por favor recuerde: usted no debe interrumpir nunca la medicación sin hablar con su médico. Si usted está tratando de quedar embarazada, hable con su médico para que le recomiende la medicación que le conviene tomar durante el embarazo.**

¿Debe su médico hacer un referido para que consulte a un especialista en salud mental?
Es posible que su médico consulte a un psiquiatra, psicólogo o trabajador social psiquiátrico que sea un especialista en el cuidado de la salud mental. Esto podría aclararle a su médico el diagnóstico, y ayudarle a determinar cual es el mejor tratamiento para usted. Un referido *urgente* deberá hacerse si usted tiene pensamientos sobre lastimarse a sí mismo o a otros.

¿Qué otra cosa puedo hacer? Hable con una persona de su confianza. Saber que alguien cree en usted, le puede ayudar a creer en sí mismo-autoestima. Busque un compañero que le ayude a acelerar su recuperación. Este compañero debe ser alguien que usted conoce, en quien puede confiar y con quien puede contar, un miembro de la familia o un amigo cercano que entiende sus sentimientos y puede hacerle apreciar sus valores y fortalezas.

♦ **Recuerde: Es muy importante que le comunique a su médico si en algún momento se le cruzan por la mente pensamientos sobre hacerse daño a sí mismo u otros.**