

Help and Healing:

Resources for Depression Care and Recovery

Section 1: Identification, Education and Talking Points

PHQ-9

Talking Points

Strategies for Patient and Family Education

Patient Education - Depression Fact Sheet

Example Suicidality Screening Flow

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
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 or staying asleep, or 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

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, 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

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Talking Points

Team Care for Depression

About the Team Approach:

I would like to tell you about how we care for clients/patients with depression here. We use a team approach, which means you (the client/patient), the clinician and the care coordinator are a team. It is important that you are actively involved in the process.

About the Care Coordinator:

The care coordinator is part of the treatment team. I want you to work with her/him.

The care coordinator helps us keep in touch and monitor your progress in between visits. He/she is the physician's eyes and ears since the visit time with him/her is limited.

He/she supports you in making sure the treatment is well tolerated and effective and lets us know when it is time to change treatment.

Your first visit with the care coordinator will give you a chance to meet and ask any question you may have about what will happen/occur moving forward.

To Describe the PHQ-9:

Each time you and I touch base, I'll ask you some questions that will help us to see how you are doing and where you and I need to focus our efforts to improve your symptoms and daily functioning.

The tool I will be using is called a PHQ-9. It is an objective way to determine the main symptoms you are having that relate to your depression. It is very much like when your clinician checks your blood pressure.

Instead of asking you, "How does your blood pressure seem today?" an actual measurement is taken that gives the clinician accurate information to help in determining your treatment. The same is true when assessing depression. Instead of only asking you "How are you feeling today?" we ask you a set of questions that assists us when making treatment decisions.

This tool cannot summarize everything about you. Yet it serves as a way to gather additional information so we can make treatment decisions.

If you've already taken the PHQ-9 in the last 2 weeks, has anything changed since then? If not, let's take that one out and use it again today.

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Internal Communication/Questions to Implement the PHQ-9:

Who will give out the tool?

Will the tool be in paper or electronic form?

Who will score the tool?

Who will document the score and where will the full tool's responses be documented and filed?

Who will trigger the need for a repeat PHQ-9?

About Depression Treatment:

In depression treatment, the first thing we try is often helpful, but if it is not we have to be systematic about making adjustments. This can take time and this is where the care coordinator comes in. The care coordinator will work with you on some other aspects of your care such as goal setting and establishing healthy behaviors.

Care Coordinator/Manager First Contact with Patient:

Hello, my name is _____, we met on (state the day) when Dr. _____ introduced us. He/she asked that I follow-up with you regarding your depression care.

Hello, my name is _____, I am a depression care manager/coordinator here at _____ clinic. I work with Dr. _____. He/she asked that I follow-up with you.

What is a Care Manager/Coordinator and what to they do?

I am responsible for overall coordination of your depression care. I'll follow-up with you on your treatment plan, work with you on setting goals, and update your physician/therapist/clinician on your progress.

Will I still be able to see my Care Provider?

Yes. I stay in close contact with your doctor/therapist/provider, keeping him/her current on your treatment and how you are doing. If either you or I feel at any time you should see your Care Provider, we'll arrange an appointment. He/she may also request to see you for a follow up.

Talking Points

Next Steps:

You may not know a lot about your condition now, however, we will teach and work with you so you can be actively involved in your care.

Will you ask questions, communicate problems or issues, and share good things that happen along the way? (Wait for response.)

Will you come with me to meet the care coordinator (or other staff person for warm hand off)? (Wait for response.)

To improve likelihood of follow-up (commitment influences behavior):

Your next appointment with me is (date/time). Will you call if you need to reschedule?

What barriers do you anticipate could get in the way of making our next scheduled appointment?

What is a back-up phone number you would like me to call if I can't reach you at this number?



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Strategies for Patient and Family Education

It is important to remember that no one makes it through a serious illness by himself or herself. This is true for depression as well. People need the support and help of family and friends who provide practical assistance, comfort and hope. When asked, families reported their most-valued provider attributes included compassion, respect, flexibility, accessibility, candor, helpfulness, and commitment.

Helpful strategies

Refrain from imposing a “therapeutic agenda” on families who are in crisis or pain.

Ask “what can we do today that would be most helpful?”

Provide a “no fault” explanation – relieve the family of the burden of guilt and shame.

Share information about depression, treatment, medications and side effects, and dealing with practical issues.

Remember that families go through stages of coping and may be facing a number of burdens including emotional and financial.

Seek information from families about the history, background and day-to-day progress.

Encourage the patient to sign a privacy release, or the family involvement privacy release so that basic information can be shared. (Remember: families don’t want access to the medical records, they want to know what is going on and how to help their loved one.)

Validate the family’s early warning signs of relapse.

Refer the families to resources and support groups.

Remember that a family’s desire to remain connected is normal - an expression of loyalty and support - not their trying to keep their family member “dependent.”

Families need help with subjective burden, objective burden; help with management of symptoms and family education.

Avoid the words such as enabling, co-dependency, denial, rock bottom, dysfunctional and hopeless.

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Depression Fact Sheet

Major Depression

What is major depression?

Major depression is a serious medical illness affecting 15 million American adults, or approximately 5 to 8 percent of the adult population in a given year. Unlike normal emotional experiences of sadness, loss, or passing mood states, major depression is persistent and can significantly interfere with an individual's thoughts, behavior, mood, activity, and physical health. Among all medical illnesses, major depression is the leading cause of disability in the U.S. and many other developed countries.

Depression occurs twice as frequently in women as in men, for reasons that are not fully understood. More than half of those who experience a single episode of depression will continue to have episodes that occur as frequently as once or even twice a year. Without treatment, the frequency of depressive illness as well as the severity of symptoms tends to increase over time. Left untreated, depression can lead to suicide.

Major depression, also known as clinical depression or unipolar depression, is only one type of depressive disorder. Other depressive disorders include dysthymia (chronic, less severe depression) and bipolar depression (the depressed phase of bipolar disorder or manic depression). People who have bipolar disorder experience both depression and mania. Mania involves unusually and persistently elevated mood or irritability, elevated self-esteem, and excessive energy, thoughts, and talking.

What are the symptoms of major depression?

The onset of the first episode of major depression may not be obvious if it is gradual or mild. The symptoms of major depression characteristically represent a significant change from how a person functioned before the illness. The symptoms of depression include:

- persistently sad or irritable mood
- pronounced changes in sleep, appetite, and energy
- difficulty thinking, concentrating, and remembering
- physical slowing or agitation
- lack of interest in or pleasure from activities that were once enjoyed
- feelings of guilt, worthlessness, hopelessness, and emptiness
- recurrent thoughts of death or suicide
- persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

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When several of these symptoms of depressive illness occur at the same time, last longer than two weeks, and interfere with ordinary functioning, professional treatment is needed.

What are the causes of major depression?

There is no single cause of major depression. Psychological, biological, and environmental factors may all contribute to its development. Whatever the specific causes of depression, scientific research has firmly established that major depression is a biological, medical illness.

Norepinephrine, serotonin, and dopamine are three neurotransmitters (chemical messengers that transmit electrical signals between brain cells) thought to be involved with major depression. Scientists believe that if there is a chemical imbalance in these neurotransmitters, then clinical states of depression result. Antidepressant medications work by increasing the availability of neurotransmitters or by changing the sensitivity of the receptors for these chemical messengers.

Scientists have also found evidence of a genetic predisposition to major depression. There is an increased risk for developing depression when there is a family history of the illness. Not everyone with a genetic predisposition develops depression, but some people probably have a biological make-up that leaves them particularly vulnerable to developing depression. Life events, such as the death of a loved one, a major loss or change, chronic stress, and alcohol and drug abuse, may trigger episodes of depression. Some illnesses such as heart disease and cancer and some medications may also trigger depressive episodes. It is also important to note that many depressive episodes occur spontaneously and are not triggered by a life crisis, physical illness, or other risks.

How is major depression treated?

Although major depression can be a devastating illness, it is highly treatable. Between 80 and 90 percent of those diagnosed with major depression can be effectively treated and return to their usual daily activities and feelings. Many types of treatment are available, and the type chosen depends on the individual and the severity and patterns of his or her illness. There are three well-established types of treatment for depression: medications, psychotherapy, and electroconvulsive therapy (ECT). For some people who have a seasonal component to their depression, light therapy may be useful. These treatments may be used alone or in combination. Additionally, peer education and support can promote recovery. Attention to lifestyle, including diet, exercise, and smoking cessation, can result in better health, including mental health.

Medication. It often takes two to four weeks for antidepressants to start having an effect, and 6-12 weeks for antidepressants to have their full effect. The first antidepressant medications were introduced in the 1950s. Research has shown that imbalances in neurotransmitters like serotonin, dopamine, and norepinephrine can be corrected with antidepressants. Four groups of antidepressant medications are most often prescribed for depression:

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Selective serotonin reuptake inhibitors (SSRIs) act specifically on the neurotransmitter serotonin. They are the most common agents prescribed for depression worldwide. These agents block the reuptake of serotonin from the synapse to the nerve, thus artificially increasing the serotonin that is available in the synapse (this is functional serotonin, since it can become involved in signal transmission, the cardinal function of neurotransmitters). SSRIs include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), escitalopram (Lexapro), and fluvoxamine (Luvox).

Serotonin and norepinephrine reuptake inhibitors (SNRIs) are the second-most popular antidepressants worldwide. These agents block the reuptake of both serotonin and norepinephrine from the synapse into the nerve (thus increasing the amounts of these chemicals that can participate in signal transmission). SNRIs include venlafaxine (Effexor) and duloxetine (Cymbalta).

Bupropion (Wellbutrin) is a very popular antidepressant medication classified as a norepinephrine-dopamine reuptake inhibitor (NDRI). It acts by blocking the reuptake of dopamine and norepinephrine.

Mirtazapine (Remeron) works differently from the compounds discussed above. Mirtazapine targets specific serotonin and norepinephrine receptors in the brain, thus indirectly increasing the activity of several brain circuits.

Tricyclic antidepressants (TCAs) are older agents seldom used now as first-line treatment. They work similarly to the SNRIs, but have other neurochemical properties which result in very high side effect rates, as compared to almost all other antidepressants. They are sometimes used in cases where other antidepressants have not worked. TCAs include amitriptyline (Elavil, Limbitrol), desipramine (Norpramin), doxepin (Sinequan), imipramine (Norpramin, Tofranil), nortriptyline (Pamelor, Aventyl), and protriptyline (Vivactil).

Monoamine oxidase inhibitors (MAOIs) are also seldom used now. They work by inactivating enzymes in the brain which catabolize (chew up) serotonin, norepinephrine, and dopamine from the synapse, thus increasing the levels of these chemicals in the brain. They can sometimes be effective for people who do not respond to other medications or who have “atypical” depression with marked anxiety, excessive sleeping, irritability, hypochondria, or phobic characteristics. However, they are the least safe antidepressants to use, as they have important medication interactions and require adherence to a particular diet. MAOIs include phenelzine (Nardil), isocarboxazid (Marplan), and tranylcypromine sulfate (Parnate).

Non-antidepressant adjunctive agents. Often psychiatrists will combine the antidepressants mentioned above with each other (we call this a “combination”) or with agents which are not antidepressants themselves (we call this “augmentation”). These latter agents can include the atypical antipsychotic agents [aripiprazole (Abilify), olanzapine (Zyprexa), quetiapine (Seroquel), ziprasidone (Geodon), risperidone (Risperdal)], buspirone (Buspar), thyroid hormone (triiodothyronine, or “T3”), the stimulants [methylphenidate (Ritalin), dextroamphetamine (Aderall)], dopamine receptor agonists [pramipexole (Mirapex), ropinirole (Requip)], lithium, lamotrigine (Lamictal), s-adenosyl methionine (SAME), pindolol, and steroid hormones (testosterone, estrogen, DHEA).

Consumers and their families must be cautious during the early stages of medication treatment because normal energy levels and the ability to take action often return before mood improves. At this time - when decisions are easier to make, but depression is still severe - the risk of suicide may temporarily increase.

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Psychotherapy. There are several types of psychotherapy that have been shown to be effective for depression including cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT). Research has shown that mild to moderate depression can often be treated successfully with either of these therapies used alone. However, severe depression appears more likely to respond to a combination of psychotherapy and medication.

Cognitive-behavioral therapy (CBT) – helps to change the negative thinking and unsatisfying behavior associated with depression, while teaching people how to unlearn the behavioral patterns that contribute to their illness.

Interpersonal therapy (IPT) – focuses on improving troubled personal relationships and on adapting to new life roles that may have been associated with a person’s depression.

Electroconvulsive therapy (ECT). ECT is a highly effective treatment for severe depressive episodes. In situations where medication, psychotherapy, and a combination of the two prove ineffective, or work too slowly to relieve severe symptoms such as psychosis or thoughts of suicide, ECT may be considered. ECT may also be considered for those who for one reason or another cannot take antidepressant medications.

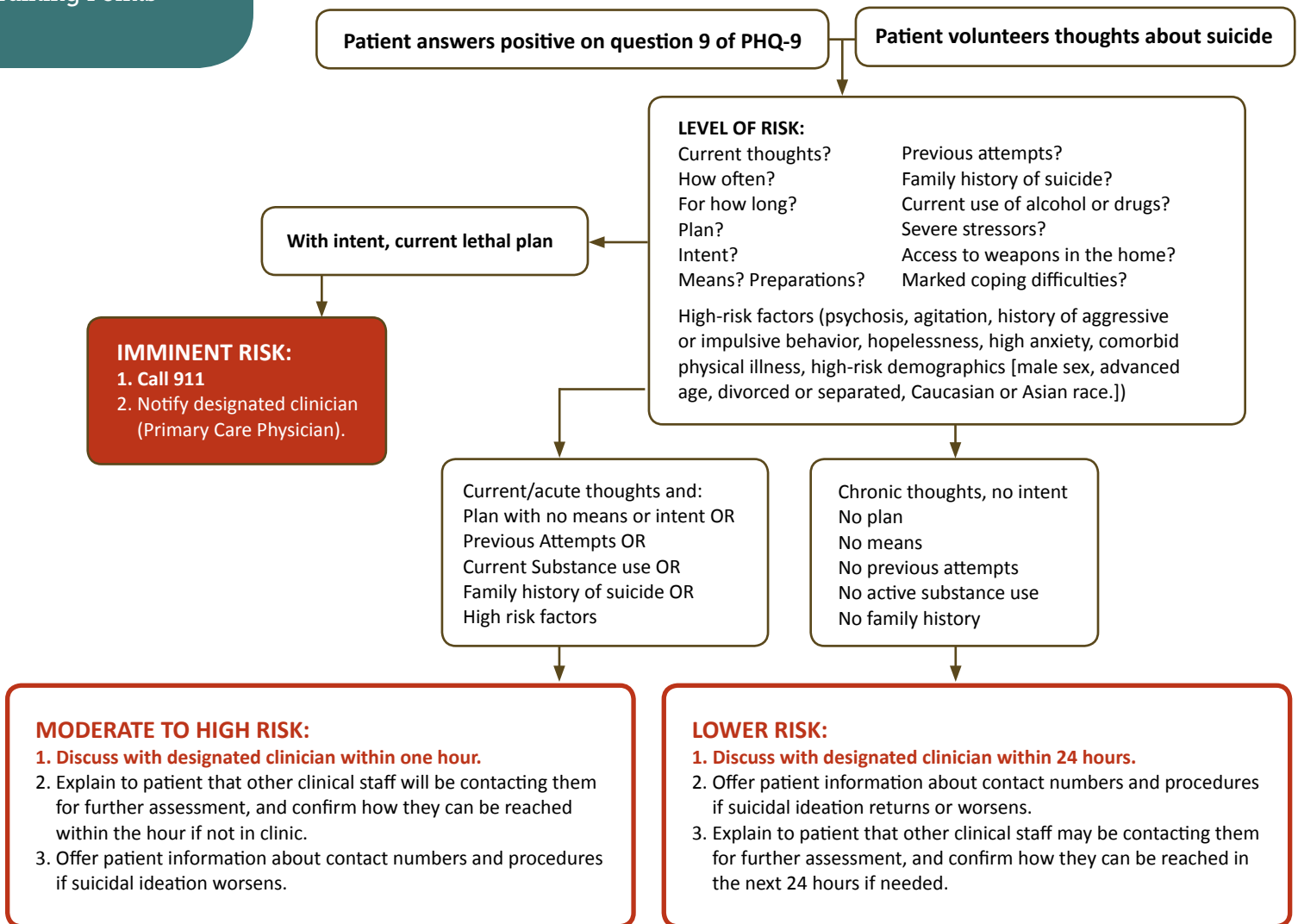
What are the side effects of the medications used to treat depression?

Different medications produce different side effects, and people differ in the type and severity of side effect they experience. About 50 percent of people who take antidepressant medications experience some side effects, particularly during the first weeks of treatment. Side effects that are particularly bothersome can often be treated by changing the dose of the medication, switching to a different medication, or treating the side effect directly with additional medications. Rarely, serious side effects such as fainting, heart problems, or seizure may occur, but they are almost always treatable.

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Example Suicidality Screening Flow*



*A clear process for contacting the patient and next steps in assessing risk should be determined by the individual clinics. Many clinics may already have a protocol for the triage of suicidal patients; this is intended to guide how the Integration Specialist interfaces with that system.

A recommended resource for how to establish a clinic-based protocol to assess and minimize suicide risk is: Bonner, L., et al. Suicide Risk Response: Enhancing Patient Safety through Development of Effective Institutional Policies. *Advances in Patient Safety: From Research to Implementation*. 2005;3.