New York State Academy of Family Physicians

Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Depression

Resources for helping your patients

This site provides you, the physician and your staff, with useful information on how to help your patients suffering from depression.

This document contains:

New York State Academy of Family Physicians

Screening, Brief Intervention, and Referral to Treatment (SBIRT) for DEPRESSION

Office Visit Protocol

Patient Name: _____ Age: _____ Doctor:_____

ENCOUNTERS	DATE	TASKS
PART I **SCREEN** For Depression (suggest 5-8 min)		The two screening questions (PHQ-2) in this part are valid, but if you wish to use a longer screening device, see "**Attachment A. Screening Devices and Techniques for Depression" pp 5-14. Otherwise, proceed …** "Over the past two weeks, ☐ Have you felt little interest or pleasure in doing things?" ___Yes ___No ☐ Have you felt down, depressed, or hopeless? ___ Yes __ No ☐ If the patient says, "YES" to both of these two questions, or scores high enough on a longer screening device you use to be considered depressed, then a thorough physical examination to rule out other causes of the depressive symptoms should be the next step. Certain medications as well as some medical conditions such as a viral infection, hypothyroidism, or low testosterone level can cause the same symptoms as depression, and you should rule out these possibilities through examination, interview, and lab tests. ☐ When screening indicates that depression may be present, the diagnosis should be confirmed with the DSM-V criteria for depression. **See p 14.** ☐ If treatment for depression is warranted, then proceed to ***"PART II, Treatment for Depression"***
PART II **TREATMENT** For Depression (suggest 5-8 min)		**Treatment** ☐ Explain to the patient who has just been diagnosed with depression that it is common and can be successfully treated with close collaboration between doctor and patient. ☐ Explain that Depression can be treated with medication, psychotherapy ("talk therapy"), or a combination of the two. ☐ Medications (See "**Attachment B, Medications," pp 15-16**). Unless the depression is minor, therapy is usually begun with an antidepressant medication. A description of medications used in the treatment of depression can be found at the National Institute of Mental Health (NIMH) Web site. ☐ Emphasize that: As a doctor, you need to know all medications, both prescribed and over-the-counter, vitamins, minerals, and herbal supplements being taken at present. You also need to be told of the use of alcohol and other substances. ☐ It usually takes several weeks to months to receive the full therapeutic benefit of the medication. Even if the patient feels better, he should stay on the medication until you mutually agree it is no longer needed, usually at least 4 to 9 months. The patient should never quit taking medication "cold turkey." It is best for you as the doctor, together with the patient, to work out a schedule of gradually discontinuing the medication. ☐ The "patient information inserts" that come with the medications are important and should be read. They will list possible side effects to look for. Side effects, even if they are very short-term, should be reported to you. Persistent sexual side effects should be reported. Such side effects are common during treatment with many but not all antidepressants, and will be a concern for many patients. These can be reduced with changes in type or dosage of antidepressant medication, or, in some cases, the addition of other medications. ☐ Talking Points. This section provides you or your staff suggested content for discussion with your patient. See "**Attachment C, Content for Discussion" on pp 17-18.** ☐ Refer to Psychotherapy (see "**Attachment D, Referral" p. 19**). If it is indicated, you will probably want to refer Pt to a mental health professional who works with one of the common types of psychotherapy. New "talk therapies" are often relatively brief, 6 weeks to a few months. Group therapy may be helpful as well. A therapy often used today is cognitive/behavioral therapy in which a primary focus is in changing negative styles of thinking. This often involves "homework" assignments between sessions. Many studies have shown that Cognitive Behavioral Therapy is a particularly effective treatment for depression, especially minor or moderate depression. Some people with depression may be successfully treated with CBT only. Others may need both CBT and medication. ☐ Schedule follow-up visit.

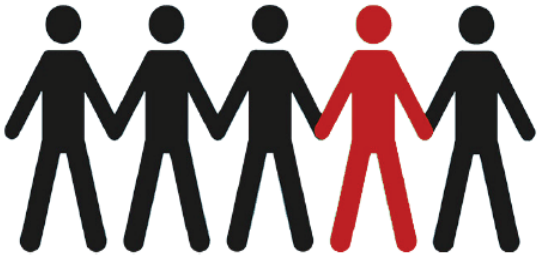
OVER

PART III **FOLLOW-UP WITH CONTINUED SUPPORT** For Depression (suggest 3-5 min)		☐ Review impact of medications and revise as indicated. If patient is not responding to medications, you may need to refer to a psychiatrist. ☐ Review impact of psychotherapy. ☐ Review **"Attachment C, Content for Discussion," pp 17-18.** ☐ ECT. If medications and psychotherapy do not reduce the symptoms of depression, after a reasonable trial, electroconvulsive therapy (ECT) may be an option to explore. See **"Attachment E" on p. 20**. ☐ If patient is suicidal, refer to a psychiatrist.

OVER

Overview

Why Should You Add Mental Health Screening and Counseling To Your Practice?
Most people with depression can benefit from some form of treatment no matter how severe the problem may seem.



Depression affects approximately 14.8 million American adults, or about 6.7 % of the U.S. population age 18 and older in a given year, and accounts for more than $43 billion in medical care costs. Depression causes myriad physical symptoms.

Minimal Time and Maximum Effect
You can improve your patients' health while lowering the health care costs associated with depression by asking a few simple questions. If the answers are positive, you can intervene briefly and most likely improve their health.

How does it work?
When patients see you for a health problem or an annual physical, you or your staff simply conduct a quick screen for depression and then, if indicated, provide brief interventions or referral to care.

Attachment A
Screening Devices and Techniques

TO BE USED FOR PART I of OV PROTOCOL
"Overview" (pp 5-6)
"Screen for Depression" (pp 7-14)

Short or Less Short
Screening can be simply, as noted on the OV Protocol, asking about Depression with just a few questions, such as listed on Part I of the Office Visit Protocol.

OR…..

Or, you can use slightly longer, "structured" questionnaires that contain up to 21 questions. They provide a broader picture of your patients' mental health condition. Note: As tablet computers or kiosk screening becomes more common, clinics may start with the longer screening instruments and skip the shorter, initial quick screens.

The More Popular Screening Tools
Several depression screening instruments are available, including the Patient Health Questionnaire (PHG-9), Beck Depression Inventory, the Zung Self-Depression Scale, and the Geriatric Depression Scale. Most of these instruments are easy to use and can be administered in less than 5 minutes. Shorter screening tests, including simply asking two questions seem to detect most depressed patients and, in some cases, perform just as well as longer instruments.

Who Do You Screen?
Screening should be conducted on an annual basis at a minimum.

Tips for Doctors and Staff Who Use Questionnaires

Asking Via Questionnaire
Screening questions can be in forms filled out by the patient in the waiting room OR asked quickly by a medical assistant or nurse when the patient is taken to an exam room. Computerized screening forms are being used increasingly. Asking about mental health helps reduce stigma and patient anxiety, and is becoming more accepted by patients.

Preparation
When trying a new screening instrument, read it aloud before administering it to patients. For example….. "Hi, I'm ____. Nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to mental health."

Precise Wording
Reading or repeating screening questions as they are written is important because these tests were validated using these words. Providers can repeat or clarify questions, but it is best not to modify them.

Communication to Build Patient Rapport
Effective communication skills can improve the effectiveness of screening. Patients who may have mental health issues may be reluctant to tell the truth. The following techniques from motivational interviewing may help establish rapport and get the patient to open up:

- Notify the Patient: Let the patient know you are going to ask a few questions and what they are about. "I have just a few questions regarding mental health that are helpful in finding out if it might be affecting your health. This will take only a few minutes." Putting the patient at ease before firing questions yields a less defensive response.

- Tone of Voice. Using a caring tone so that the patient understands you are on their side.

- Be Sensitive to the Patient's Need for Privacy: "Anything you say about your mental health stays between us, so please feel free to be honest when answering my questions."

- Empathize with the Patient: "I know this is not the easiest topic to talk about, and I appreciate that you are willing to talk with me about it."

- Listen Reflectively: Paraphrase what you heard from them to let them know you are listening carefully.

- Clarifications: You can clarify questions as needed, and ask further questions to clarify ambiguous responses. Also, you can provide some support for responding.

- Power of a Pause. Pauses are a powerful way to draw people out without asking further questions. After asking a simple question or making a reflective statement, pause and wait patiently. Most people will fill the pause.

What To Do After Scoring
After scoring the screening tool, you can review or confirm the patient's responses with him/her and use the opportunity to explain why their answers make you concerned about their mental health.
"I looked over the health assessment that you completed with the nurse and a few things came to my attention. I have some concerns about some mental health issues and how they may impact your health."

Staff Role
Keep in mind that many of these steps can be completed by different staff: medical assistant, physician assistant, nurse practitioner, or counselor.

Make Sure You Have a System for Flagging Positive Responses
Each standardized screening tool includes instructions for administration and scoring so they can be administered and scored by staff with minimal training. If initial screening is self-administered or completed by a staff interview, a system for flagging responses of concern needs to be in place. "Flagging" positive responses can by a separate paper notice, a note at the top of the patient record, or electronic medical record alerts. It can be a quick, simple process once it is set up and becomes part of the routine.

Use of Electronic Health Records. Select an electronic medical record that has an expectation to screen for mental health. Choose EHRs where the user must go through this step in admitting a new patient and in periodic updating of the medical history.

Additional Considerations When Screening for Depression: Possibility of bipolar disorder instead of unipolar depression. Some people with symptoms of depression have in the past had episodes of increased energy and activity with inability to relax or sleep. Sometimes they describe these periods as "highs." Sometimes they describe a depression that "comes and goes." There is a possibility that they have bipolar disorder instead of unipolar depression. In such a case, a referral to a mental health professional should be considered. A patient who has bipolar disorder should first be prescribed a mood stabilizing medication. Then, if an antidepressant is needed, it can be given in addition. An antidepressant taken without a mood stabilizer can cause a swing into mania.

Severity Measure for Depression - Adult

Patient Health Questionnaire - 9 (PHQ-9)

Patient Name_____

Date of Assessment_____

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past seven days (circle the number).

	Not at All	Several Days	More than Half the Days	Nearly Every Day	Item Score
1. Little interest 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 TV	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 hurting yourself in some way	0	1	2	3	
Total/partial Raw Score:					
Prorated Total Raw Score (if 1-2 items left unanswered):					

SEE NEXT PAGE FOR SCORING KEY

Key to Scoring PHQ-9*

PHQ-9 Score	Depression Score	Proposed Treatment Actions
0-4	Non-minimal	None
5-9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10-14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15-19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20-27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

*From Kroenke K, Spitzer RL, Psychiatric Annals 2002;32:509-521TRANSLATIONS

The BDI-II
The Beck Depression Inventory

Instructions: This questionnaire consists of 21 groups of statements. Please read each one carefully, and then pick out the one statement in each group that best describes the way you have been feeling *during the past two week, including today.* **Circle** the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not chose more than one statement for any group, including Item 16 (Changes to Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
- 0 - I do not feel sad.
- 1 - I feel said much of the time.
- 2 - I am sad all the time.
- 3 - I am so sad or unhappy that can't stand it.

2. Pessimism
- 0 - I am not discouraged about my future.
- 1 - I feel more discouraged about my future than I used to be.
- 2 - I do not expect things to work out for me.
- 3 - I feel my future is hopeless and will only get worse.

3. Past Failure
- 0 - I do not feel like a failure.
- 1 - I have failed more than I should have.
- 2 - As I look back, I see a lot of failures.
- 3 - I feel I am a total failure as a person.

4. Loss of Pleasure
- 0 - I get as much pleasure as I ever did from the things I enjoy.
- 1 - I don't enjoy things as much as I used to.
- 2 - I get very little pleasure from the things I used to enjoy.
- 3 - I can't get any pleasure for the things I used to enjoy.

5. Guilty Feelings
- 0 - I don't feel particularly guilty.
- 1 - I feel guilty over many things I have done or should have done.
- 2 - I feel guilty most of the time.
- 3 - I feel guilty all the time.

6. Punishment Feelings
- 0 - I don't feel I am being punished.
- 1 - I feel I may be punished.
- 2 - I expect to be punished.
- 3 - I feel I am being punished.

7. Self-Dislike
- 0 - I feel the same about myself as ever.
- 1 - I have lost confidence in myself.
- 2 - I am disappointed in myself.
- 3 - I dislike myself.

8. Self-Criticism
- 0 - I don't criticize or blame myself more than usual.
- 1 - I am more critical of myself that I used to be.
- 2 - I criticize myself for all my faults.
- 3 - I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
- 0 - I don't have any thoughts of killing myself.
- 1 - I have thoughts of killing myself, but I would not carry them out.
- 2 - I would like to kill myself.
- 3 - I would kill myself if I had the chance.

10. Crying
- 0 - I don't cry anymore than I used to.
- 1 - I cry more than I used to.
- 2 - I cry over every little thing
- 3 - I feel like crying, but I can't.

11. Agitation
- 0 - I am no more restless or wound up than usual.
- 1 - I feel more restless or would up than usual.
- 2 - I am so restless or agitated that it's hard to stay still.
- 3 - I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest
- 0 - I have not lost interest in other people or activities.
- 1 - I am less interested in other people or things than before.
- 2 - I have lost most of interest in other people or things.
- 3 - It's hard to get interested in anything.

13. Indecisiveness
- 0 - I make decisions about as well as ever.
- 1 - I find it more difficult to make decisions than usual.
- 2 - I have much greater difficulty in making decisions than I used to.
- 3 - I have trouble making any decision.

14. Worthlessness
- 0 - I do not feel I am worthless
- 1 - I don't consider myself as worthwhile and useful as I used to.
- 2 - I feel more worthless as compared to other people.
- 3 - I feel utterly worthless.

15. Loss of Energy

0 - I have as much energy as ever.
1 - I have les energy than I used to have.
2 - I don't have enough energy to do very much.
3 - I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 - I have not experienced any change in my sleeping pattern. _____
1a - I sleep somewhat more than usual.
1b - I sleep somewhat less than usual.
2a - I sleep a lot more than usual.
2b - I sleep a lot less than usual.____
3a - I sleep most of the day
3b - I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

0 - I am no more irritable than usual.
1 - I am more irritable than usual
2 - I am much more irritable than usual
3 - I am irritable all the tie.

18. Change is Appetite

0 - I have not experienced any changes in my appetite
1a - My appetite is somewhat less than usual.
1b - My appetite is somewhat greater than usual.
2a - My appetite is much less than before.
2b - My appetite is much greater than usual.
3a - I have no appetite at all.
3b - I crave food all the time.

19. Concentration Difficulty

0 - I can concentrate as well as ever.
1 - I can't concentrate as well as usual.
2 - It's hard to keep my mind on anything for very long.
3 - I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 - I am no more tired or fatigued than usual.
1 - I get more tired or fatigued more easily than usual.
2 - I am too tired or fatigued to do a lot of the things I used to do.
3 - I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 - I have not noticed any recent change in my interest in sex
1 - I am less interested in sex than I used to be.
2 - I am much less interested in sex now.
3 - I have lost interest in sex completely.

SEE NEXT PAGE FOR SCORING KEY

Key to Scoring BDI-II

Each answer is scored on a scale of 0 to 3.

Scoring is:

0-13: Minimal depression;

14-19: mild depression;

20-28: moderate depression; and,

29-63: severe depression.

Zung Self-Rating Depression Scale

NOTE TO PHYSICIAN: you may administer the test or give a copy to the patient, who can self-administer the test.

The **Zung Self-Rating Depression Scale** was designed by Duke University psychiatrist William W.K. Zung MD (1929-1992) to assess the level of depression for patients diagnosed with depressive disorder.

Patient Name_____
Date of Assessment_____

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted & blue				
2. Morning is when I feel the best.				
3. I have crying spells or feel like it.				
4. I have trouble sleeping at night.				
5. I eat as much as I used to				
6. I still enjoy sex.				
7. I notice that I am losing weight.				
8. I have trouble with constipation.				
9. My heart beats faster than usual.				
10. I get tired for no reason.				
11. My mind is as clear as it used to be.				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still.				
14. I feel hopeful about the future.				
15. I am more irritable that usual.				
16. I find it easy to make decisions.				
17. I feel that I am useful & needed				
18. My life is pretty full.				
19. I feel that others would be better off if I were dead.				
20. I still enjoy the things I used to do.				

SEE NEXT PAGE FOR SCORING KEY

Key to Scoring the Zung Self-Rating Depression Scale

PHYSICIAN: Consult this key for the value (1-4) that correlates with the patient's response to each statement. Add up the numbers for a total score.

- 20-44 Normal Range
- 45-59 Mildly Depressed
- 60-69 Moderately Depressed
- 70 and above Severely Depressed

	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted & blue	1	2	3	4
2. Morning is when I feel the best.	4	3	2	1
3. I have crying spells or feel like it.	1	2	3	4
4. I have trouble sleeping at night.	1	2	3	4
5. I eat as much as I used to	4	3	2	1
6. I still enjoy sex.	4	3	2	1
7. I notice that I am losing weight.	1	2	3	4
8. I have trouble with constipation.	1	2	3	4
9. My heart beats faster than usual.	1	2	3	4
10. I get tired for no reason.	1	2	3	4
11. My mind is as clear as it used to be.	4	3	2	1
12. I find it easy to do the things I used to	4	3	2	1
13. I am restless and can't keep still.	1	2	3	4
14. I feel hopeful about the future.	4	3	2	1
15. I am more irritable that usual.	1	2	3	4
16. I find it easy to make decisions.	4	3	2	1
17. I feel that I am useful & needed	4	3	2	1
18. My life is pretty full.	4	3	2	1
19. I feel that others would be better off if I were dead.	1	2	3	4
20. I still enjoy the things I used to do.	4	3	2	1

Further Diagnosis of Depression

When screening indicates that depression may be present, you may wish to further diagnose using the DSM-V criteria for depression.

DSM-V Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others.

2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.

3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

4) Insomnia or hypersomnia nearly every day.

5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6) Fatigue or loss of energy nearly every day.

7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.
Note: Criteria A-C represnt a major depressive episode.
Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disbility) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a signficant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgement based on the individual's history and the cultural norms for the expression of distress in the content of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.
Note: The exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Attachment B
Medications for Depression

TO BE USED FOR PART II of OV PROTOCOL

"Treatment for Depression"

Medications

- Young adults aged 18-29 years: second-generation antidepressants (mostly selective serotonin reuptake inhibitors [SSRIs]) increase suicidal behaviors in adults aged 18 to 29 years, especially those with major depressive disorder (MDD) and those who receive paroxetine. Thus, clinicians may want to select a psychotherapeutic approach or medications other than SSRIs.

- The United State Preventive Services Task Force found at least fair-quality evidence that SSRI use is associated with an increased risk for upper gastrointestinal (UGI) bleeding in adults older than 70 years, with risk increasing with age.

- Adults 65 years or older: clinicians may want to select a psychotherapeutic approach or medications other than SSRIs because of the increased risk for UGI bleeding associated with the use of SSRIs.

- Adults aged 40 to 79 years: the concurrent use of SSRIs with a nonsteroidal anti-inflammatory drug (NSAID) or low-dose aspirin increases the risk for UGI bleeding in although the increase in risk is less with aspirin. The risk for UGI bleeding is greater for medications that feature a moderate to high degree of serotonin reuptake inhibition. Perform a brief intervention with all patients who screen positively for at-risk drinking

Depression, especially in midlife or older adults, can co-occur with other serious medical illnesses, such as diabetes, cancer, heart disease, and Parkinson's disease. These conditions are often worse when depression is present. Sometimes medications taken for these physical illnesses may cause side effects that contribute to depression.

KEY RECOMMENDATIONS FOR PRACTICE*

CLINICAL RECOMMENDATION	EVIDENCE RATING
Antidepressants are most effective in patients with severe depression.	A
Selective serotonin reuptake inhibitors are more likely than placebo to produce depression remission in the primary care population.	B
Serotonin-norepinephrine reuptake inhibitors are slightly more likely than selective serotonin reuptake inhibitors to improve depression symptoms, but they are associated with higher rates of adverse effects such as nausea and vomiting.	B
For treatment-naive patients, all second-generation antidepressants are equally effective. Medication choice should be based on patient preferences, with adverse effect profiles, cost, and dosing frequency taken into consideration.	C
Preferred agents for older patients with depression include citalopram (Celexa), escitalopram (Lexapro), sertraline (Zoloft), mirtazapine (Remeron), venlafaxine, and bupropion (Wellbutrin). Because of higher rates of adverse effects in older adults, paroxetine (Paxil) and fluoxetine (Prozac) should generally be avoided.	C
Treatment for a first episode of major depression should last at least four months. Patients with recurrent depression may benefit from prolonged treatment.	C

A = consistent, good-quality patient-oriented evidence;
B = inconsistent or limited-quality patient-oriented evidence;
C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series.

For information about the "Strength of Recommendation Taxonomy" rating system, go to http://www.aafp.org/afpsort.

*Heather Kovich, MD and Amanda DeJong, PharmD. "Common Questions About the Pharmacologic Management of Depression in Adults." Am Fam Physician. 2015 Jul 15;92(2):94-100.

Attachment C
Content for Discussion with Patients about Depression

YOU MAY WISH TO GIVE YOUR PATIENT THESE 2-PAGES OF TALKING POINTS

TO BE USED FOR PART II of OV PROTOCOL
"Treatment for Depression" and for PART III "Follow-up Continued Support"

- Depression is a condition in which a person feels discouraged, sad, hopeless, unmotivated, or disinterested in life in general.

- Most people feel depressed at times. Losing a loved one, getting fired from a job, going through a divorce, and other difficult situations can lead a person to feel sad, lonely, scared, nervous, or anxious. These feelings are normal reactions to life's problems.

- When these feelings last for a short period of time, it may be a case of "the blues". But when such feelings last for more than two weeks and when the feelings interfere with daily activities such as taking care of family, spending time with friends, or going to work or school, it's likely a major depressive episode.

- It is not uncommon for someone with an anxiety disorder to also suffer from depression or vice versa. Nearly one-half of those diagnosed with depression are also diagnosed with an anxiety disorder. The good news is that these disorders are both treatable, separately and together.

- You are not alone. Depression is one of the most common mental disorders in the U.S. Major depression is a treatable illness that affects the way a person thinks, feels, behaves, and functions. At any point in time, 3%-5% of people suffer from major depression; the life time risk is about 17%. Based on the 2014 NSDUH data, 6.6% of adults aged 18 or older had a major depressive episode (MDE) in 2014.

- Current research suggests that depression is caused by a combination of genetic, biological, environmental, and psychological factors.

Treatment and Therapies

- Depression, even the most severe cases, can be treated. The earlier that treatment can begin, the more effective it is. Depression is usually treated with medications, counseling, or a combination of the two.

- No two people are affected the same way by depression and there is no "one-size-fits-all" for

treatment. It may take some trial and error to find the treatment that works best for you.

Medications

- Antidepressants are medicines that treat depression. They may help improve the way your brain uses certain chemicals that control mood or stress. You may need to try several different antidepressant medicines before finding the one that improves your symptoms and has manageable side effects. A medication that has helped you or a close family member in the past will often be considered.

- Antidepressants take time – usually 2 to 4 weeks – to work, and often, symptoms such as sleep, appetite, and concentration problems improve before mood lifts, so please give medication a chance before reaching a conclusion about its effectiveness.

- If you begin taking antidepressants, do not stop taking them without the help of a doctor. Sometimes people taking antidepressants feel better and then stop taking the medication on their own, and the depression returns. When you and your doctor have decided it is time to stop the medication, usually after a course of 6 to 12 months, the doctor will help you slowly and safely decrease your dose. Stopping them abruptly can cause withdrawal symptoms.

- If you are considering taking an antidepressant and you are pregnant, planning to become pregnant, or breastfeeding, talk to your doctor about any increased health risks to you or your unborn or nursing child.

- Avoid drugs and alcohol. Both can cause dangerous side effects with antidepressant medicine.

Counseling (for more information on referral, see Attachment D, p 19)

- Several types of psychotherapy (also called “talk therapy” or counseling) can help people with depression.

Some Tips. Here are other tips that may help you during treatment for depression:

- Try to be active and exercise.
- Get involved in activities that make you feel good or like you’ve achieved something.
- Set realistic goals for yourself and a realistic schedule.
- Try to spend time with other people and confide in a trusted friend or relative.
- Try not to isolate yourself, and let others help you.
- Postpone important decisions, such as getting married or divorced, or changing jobs until you feel better. Discuss decisions with others who know you well and have a more objective view of your situation.
- Eat nutritiously and get enough sleep.
- Avoid drugs and alcohol; they can make depression worse.
- Continue to educate yourself about depression.
- Don’t blame your self for your depression because you didn’t cause it. Don’t expect to fail. Don’t give up.
- Expect your mood to improve gradually, not immediately.

Attachment D
Referral Process for Psychotherapy

TO BE USED FOR PART II of OV PROTOCOL
"Treatment" for Depression

Patients who screen positive for depression probably also need psychotherapy. In these cases, you must refer them to a provider. This section will provide you some pointers on making those referrals.

Make a referral in every instance that it is indicated because patients do not tend to self-refer. If you do not make the referral, treatment is not likely to happen.

Create a List of Treatment Providers
In compiling your list of providers, conisider obtianing referral information from employee assistance programs, local health departments, behavioral health program counselors, and local hospitals.

Establishing Office Protocol for Referrals. Have a clear, standard, complete protocol in place for referral and make all staff aware of it if they are involved in referral activities. The elements of a referral strategy are described below:

Starting the Conversation.

- Conduct the interview in private and do not bring up the referral around others without the patient's permission.
- Empathetic interviewing is key. Sensitive approaches can reduce resistance.

Now, tell your patients:

- Why you are recommending a referral for psychotherapy.
- What to expect. Provide as much information as possible about the provider where you are referring the patient. If you speak with confidence and knowledge about the therapist, patients are more likely to respond positively.

Encouragement. It is important to encourage patients to comply with treatment in order to raise the likelihood that the patient will follow-through with the treatment plan.

Schedule the Appointment Immediately. If possible, schedule referral appointments while the patient is in the office. Asking them to make the appointment themselves, in your presence, encourages the patient to start taking responsibility while at the same time provides support. Provide the name and phone number, and a phone if necessary. Facilitating the patient's request for treatment will increase their likelihood of following through. Making the call immediately takes advantage of the momentum and provides the opportunity to support the patient. Obviously, the physician or staff member can make the initial call for the patient in the patient's presence.

Confirm Referral. It is important to make sure the patient followed through on a referral.

Your office can support the patient by calling to ask whether they kept the referral appointment and how it went, or your office can call the treatment provider.

After Referral. Steps after referral include:

- Become familiar with the treatment plan.
- Establish an agreement between members of the treatment team that describes the care each will provide. Develop common goals and a shared understanding of roles. Disagreements on treatment need to be identified and openly discussed.
- Develop a protocol for maintaining effective, ongoing, two-way communication.
- Check to make sure that follow-up messages are received from the therapist.
- Conduct a periodic review of the co-management process.
- Follow up with the patient to make sure the referral was successful.

Attachment E
Notes to Doctors on Electroconvulsive Therapy

TO BE USED FOR PART III of OV PROTOCOL for Depression
"Follow-Up with Continued Support for Depression"

If medications and psychotherapy do not reduce the symptoms of depression, electroconvulsive therapy (ECT) may be an option to explore. In this case, you may wish to refer the patient to a psychiatrist.

Based on the latest research:

- ECT can provide relief for people with severe depression who have not been able to feel better with other treatments.

- Electroconvulsive therapy can be an effective treatment for depression. In some severe cases where a rapid response is necessary or medications cannot be used safely, ECT can even be a first-line intervention.

- Once strictly an inpatient procedure, today ECT is often performed on an outpatient basis. The treatment consists of a series of sessions, typically three times a week, for two to four weeks.

- ECT may cause some side effects, including confusion, disorientation, and memory loss. Usually these side effects are short-term, but sometimes memory problems can linger, especially for the months around the time of the treatment course. Advances in ECT devices and methods have made modern ECT safe and effective for the vast majority of patients.

- ECT is not painful, and the patient cannot feel the electrical impulses. Before ECT begins, a patient is put under brief anesthesia and given a muscle relaxant. Within one hour after the treatment session, which takes only a few minutes, the patient is awake and alert.

Other more recently introduced types of brain stimulation therapies used to treat medicine-resistant depression include repetitive transcranial magnetic stimulation (rTMS) and vagus nerve stimulation (VNS). Other types of brain stimulation treatments are under study. You can learn more about these therapies on the NIMH Brain Stimulation Therapies webpage.