Value of Care Initiative
VOCI

Management of Depression

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This guideline is adopted for the general care of most patients, but may need to be modified to meet the needs of a specific patient as determined by the patient’s care giver.

Coverage of any medical intervention discussed in Value of Care guidelines is subject to the limitations and exclusions outlined in the patient’s healthcare benefit certificate.

The Dean Health System Clinical Practice Committee (CPC) has reviewed and approved this document for distribution.
**Two Question Depression Screener**

**ASK PATIENT:** “Over the last 2 weeks, how often have you been bothered by any of the following problems?”

1. Little interest or pleasure doing things
2. Feeling down, depressed, or hopeless

A SCORE OF 2 OR MORE INDICATES THE POSSIBILITY OF A DEPRESSIVE DISORDER. PROCEED WITH THE FOLLOWING SEVEN QUESTIONS ON THE REVERSE SIDE USING THE SAME RESPONSE OPTIONS.

**DIAGNOSIS**

<table>
<thead>
<tr>
<th>Score</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 4</td>
<td>None</td>
</tr>
<tr>
<td>5 – 9</td>
<td>Mild</td>
</tr>
<tr>
<td>10 – 14</td>
<td>Moderate</td>
</tr>
<tr>
<td>15 – 19</td>
<td>Mod/Severe</td>
</tr>
<tr>
<td>20 – 27</td>
<td>Severe</td>
</tr>
</tbody>
</table>

**Management of Depression**

1. Personal / family history of depression
2. History of unexplained, persistent physical symptoms.
   - fatigue
   - insomnia
   - pain
   - vague gastrointestinal symptoms
3. Medical conditions with high comorbidity:
   - cancer
   - chronic neurological disorders
   - circulatory disorders
   - coronary artery disease
   - dementia
   - diabetes
   - headache/migraine
   - hepatitis
   - multiple sclerosis
   - pain (back, chronic, myofascial)
   - perimenopause
   - pregnancy/postpartum
   - premenstrual conditions
   - stroke

Help patients understand:
1. Depression is a medical illness
2. Depression is no one's fault.
3. Treatment is effective
4. Personal and/or family support may be helpful in recovery.
5. Healthy lifestyle strategies may be helpful in the recovery process.

Key educational messages for patients using antidepressants:
1. Antidepressants work only if taken every day.
2. It may take 2-4 weeks before improvements begin.
3. It’s important to continue taking the medication.
4. Mild side effects are common and ease with time.
5. Abstain from alcohol use

Patient should be evaluated in a face-to-face meeting at least 3 times during the first 12 weeks following the initial diagnosis of depression to address:
1. medication compliance
2. treatment response and symptom remission
3. side effect tolerance
4. possible comorbid substance abuse or anxiety disorder

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VOCI Guidelines are reviewed and updated every two years (or earlier if needed) to assure information remains current.
PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ___________________________________________ DATE: ____/____/_____

ASK PATIENT: "Over the past 2 weeks, how often have you been bothered by any of the following problems?"

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

Add columns: ___________________________________________

TOTAL: ___________________________________________

TREATMENT OF DEPRESSION

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Depression Severity</th>
<th>Proposed Treatment Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild</td>
<td>Watchful waiting; repeat PHQ-9 at follow-up</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate</td>
<td>Consider counseling, follow-up and / or pharmacotherapy</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe</td>
<td>Immediate pharmacotherapy and / or psychotherapy</td>
</tr>
<tr>
<td>20+</td>
<td>Severe</td>
<td>Immediate pharmacotherapy. If severe impairment or poor response to therapy, expedited referral to mental health specialist for psychotherapy or co-management</td>
</tr>
</tbody>
</table>

- Consider referring patient to a mental health specialist if complicated by suicidal ideation, anxiety, mania, psychosis, pregnancy, or substance abuse.
- Patients expressing a preference for therapy or combination treatment should be referred to a mental health specialist.
- Communication between the PCP and the mental health specialist regarding coordination of care should occur at least once during the first 12 weeks of treatment, patient consent permitting. For provider to provider communication, please call Dean Direct at 1-888-302-3326.
I. Introduction

This guideline outlines the diagnosis and treatment of major depressive disorder (MDD). Atypical, bipolar, dysthmic and psychotic depressions are best treated by psychiatrists.

A. Major depressive disorder is a common illness affecting about 12 million Americans every year. Half of those affected have recurrent episodes. There is a 5-13% lifetime prevalence of depression, with estimated costs of $44 billion/year. Suicide is the eleventh leading cause of death in the U.S.; 70% of those who commit suicide see a physician within 6 weeks of death.

B. Risk factors for depression include:
   1. Family history of depression
   2. Gender (women 2X greater than men)
   3. Age (peak onset 20-40 years)
   4. Drug or alcohol use
   5. Marital status (single/divorced greater than married)
   6. Physical/sexual abuse history

C. Medical Conditions most frequently co-morbid with depression include:

<table>
<thead>
<tr>
<th>Cancer:</th>
<th>Circulatory Disorders:</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>Heart Attack</td>
<td></td>
</tr>
<tr>
<td>Leukemia</td>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Lymphoma</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gynecological:</th>
<th>Musculoskeletal Conditions:</th>
<th>Neurologic Disorders:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perimenopausal</td>
<td>Back Pain</td>
<td>Dementia</td>
</tr>
<tr>
<td>Pregnancy/Pospartum</td>
<td>Chronic pain</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>Premenstrual conditions</td>
<td>Myofascial pain</td>
<td>Headache</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Migraine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stroke</td>
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</tbody>
</table>

D. Somatization is one of the most common manifestations of depression.
   1. Many patients seen in primary care setting with major depression present with primarily somatic complaints including:
      a. Ill-defined functional disorders
      b. Pain of undetermined etiology after appropriate medical evaluation
      c. Complaints of tension or anxiety
   2. Research suggests that in the U.S. somatization correlates with lower socioeconomic class, traditionally ethnic groups which discourage expression of emotion, blue-collar workers, rural living, and lower educational achievement.

II. Screening and Diagnosing Depression

There are a variety of instruments available for screening and identification of patients with depression in the primary care setting. The Patient Health Questionnaire (PHQ) is a practical tool which is designed and validated for use in this clinical setting. This tool is available for Dean Health System clinicians using EpicCare as a SmartForm named “Depression Screen”. It may also be used in paper form.
Use of the PHQ uses an efficient two-step approach. *(Please refer to page 3.)*

1. Patient Health Questionnaire-2 (PHQ-2)
   i. These two questions are used to screen and assess dysphoria and anhedonia. If positive, additional follow-up questions are asked.
   ii. This screening tool has sensitivity of 83% and specificity of 92%.

2. Patient Health Questionnaire-9 (PHQ-9)
   i. This includes the previous 2 questions, plus 7 additional follow-up questions.
   ii. It outlines the diagnostic criteria for diagnosis of depression in the DSM-IV.
   iii. This tool has sensitivity of 88% and specificity of 88%.

Use of the PHQ-2 and PHQ-9 can be applied in a number of helpful ways in clinical practice.
- The tool is brief and can be administered by the patient him/herself or by the clinician *(Please refer to Attachments E & F.)*
- Use of the tools increases the provider’s ability to diagnose depression
- Severity of depression can be rated
- Treatment response can be quantified

**A PHQ-2 score of 3 or more is positive, and warrants finishing with the following 7 questions that complete the PHQ-9. Treatment recommendations based on score are below.**

<table>
<thead>
<tr>
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Other important patient health information to obtain includes:

1. Other active medical problems
2. Current medications
3. Prior history of depression including any prior use of antidepressant medications and response
4. Presence of anxiety and/or panic symptoms
5. Psychomotor agitation or retardation
6. It is extremely important to ask about current alcohol and drug use. Alcohol abuse in particular is very common amongst patients with depression and it is a frequent cause of failure of therapeutic interventions.
7. Always ask about suicidal ideation and intent as well as family history of suicide.

VOCI Guidelines are reviewed and updated every two years (or earlier if needed) to assure information remains current.
8. **Rule out bipolar disorder.**
   a. Patients with manic-depressive illness usually have a history of depression but also have episodes of abnormally and persistently elevated, expansive or irritable mood lasting at least a week.
   b. These patients can be grandiose, have decreased perceived need for sleep, be hyperverbal, have racing thoughts, be distractible and hypersexual.
   c. Pharmacologic treatment of depression in patients with bipolar disorder not on a mood stabilizer (i.e., lithium, valproate, carbamazepine) can precipitate manic episodes.
   d. Family history is a good clue to bipolar disorder.
   e. Referral to a psychiatrist for medication management is appropriate.

9. **Rule out psychosis.**
   a. Psychotic symptoms include hallucinations, delusions, thought disorder, illusions and paranoia.
   b. These symptoms almost always indicate serious illness and usually require neuroleptic therapy.
   c. Referral to a psychiatrist for medication management is appropriate.

### III. Medical Evaluation of Patients with Depression

A. Depression often accompanies many ailments seen in the primary care setting. When depression has an onset after 45 years of age or occurs in the absence of personal or family history, be especially vigilant for medical illness.

B. Consider depression when the review of systems elicits:
   1. Multiple somatic complaints
   2. Pain
   3. Weight loss or gain
   4. Cognitive complaints
   5. Fatigue
   6. Sleep disturbance

C. 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 major depression has not been established. The prevalence of unidentified thyroid disease in patients with major depression is the same as in the general population.

D. Be mindful of the possibility of pregnancy in women of child bearing age.

### IV. Acute Treatment of Depression

Therapeutic options for patients with depression include psychotherapy, education, and medication. Patients with bipolar disorder, psychosis, or who are suicidal warrant psychiatric consultation. The PHQ-2 and PHQ-9 should be utilized to screen and assess the effectiveness of treatment. *(Please refer to page 3.)*

A. **Psychotherapy**

Untreated depression in medical patients can adversely impact self-care behaviors and prognosis associated with certain medical conditions. Psychotherapy can play an important role in treatment response, treatment adherence, and prevention of both relapse and recurrence. As such,
referral to a psychotherapist should be an option presented to primary care patients at the outset of treatment rather than reserved for non-responders to medication or for complicated cases only.

Effective psychotherapy is targeted and structured. Clinical research studies have supported the use of cognitive behavioral therapy and interpersonal therapy. Cognitive therapy provided by an experienced clinician can be as effective as pharmacotherapy in the initial treatment of moderately to severely depressed patients. Provision of cognitive therapy in the acute treatment of depression can have enduring effects in the prevention of relapse after successful treatment. *(Please see attachment A.)*

**B. Depression Education**

Patient education is an essential part of the acute treatment plan for depression. Patients with depression often suffer from difficulties with memory, concentration and abstract reasoning. These cognitive issues, as well as resistance to the diagnosis, may make it difficult for patients to fully understand the diagnosis and treatment plan. For these reasons, it is very helpful to provide information in the form of an education brochure which the patient can take home, read over as many times as necessary and share with family members. *(Please see attachment B.)*

**C. Pharmacologic Treatment**

Medication usually begins with serotonin-specific reuptake inhibitors (SSRI’s), which are generally better tolerated and safer than other antidepressants. Major reasons not to use SSRI’s include prior good response to another agent, or known hypersensitivity. Consult with a psychiatrist before prescribing an antidepressant if the patient has suicidal ideation (PHQ#9), anxiety, mania, psychosis, pregnancy or substance abuse. *(Please see attachment C & D for patient education and side effects.)*

Patients should be evaluated in a face-to face meeting at least 3 times during the first 12 weeks following the initial diagnosis of depression to address:

- medication compliance
- treatment response and symptom remission
- side effect tolerance
- possible comorbid substance abuse or anxiety disorder

Patients should continue treatment for 6-12 months following symptom remission.

If an SSRI is tried for 6 weeks and the PHQ-9 has not improved by at least 5 points, double the dose unless side effects necessitate transition to another medicine.

Treatment goals to consider:

- 5 point reduction in PHQ score
- 50% reduction in PHQ score
- PHQ-9 score less than 10

1. SSRI choices include citalopram, fluoxetine, and sertraline. All SSRI’s have been found to be equally effective. Cost has become a deciding variable. If a first choice SSRI is not effective, another is as likely to be effective as switching out of class.

   a. Citalopram (Celexa) – begin with ½ of a 20mg tab and increase to one whole tab daily with food after one week. Max is 40mg.
b. Fluoxetine (Prozac) – begin with 10mg daily for one week then increase to 20mg daily with food. Max is 80mg.

d. Sertraline (Zoloft) – begin with ½ of a 50mg tablet and increase to one whole tab daily with food after one week. Max is 200mg daily.

2. Alternatives to SSRI antidepressants

a. Buproprion (Wellbutrin) in SR (twice daily) or XL (once daily) form. - Begin with 150mg daily and increase after one week to 150mg twice daily (SR) or 300mg in a.m.(XL). Maximum is 450mg daily. **Contraindicated in patients with pre-existing seizures or active bulimia.** Advantages include lack of sexual side effects or sedation.

b. Mirtazapine (Remeron) – Begin with 15 – 30mg nightly. Max 45mg. Advantages are improving appetite and sleep.

c. Duloxetine (Cymbalta) – Begin with 30mg daily. Max of 60mg daily.

d. Venlafaxine (Effexor XL) – Begin with 37.5mg. Increase weekly by this amount until 4 caps daily or 150mg. Max of 300mg. **May cause hypertension.**

V. Maintenance Treatment of Depression

A. Continuation Therapy aims to keep the patient symptom free for the duration of the current episode. The evidence supports a 6-12 month duration.

Maintenance Therapy is designed to prevent future episodes of depression. A second episode of depression should be treated for 3 years. A second episode with complications: (pre-existing dysthymia, inability to achieve remission, suicide risk, co morbid anxiety or substance misuse, or return of symptoms when trying to lower or discontinue treatment) or a third episode should lead to consideration of lifetime treatment. The risk of relapse is high, please see below.

VI. Remission of Depression

A. The evidence is strong that at least 50% of patients successfully treated for an episode of major depression will experience a recurrence at some point in their life. Therefore, an essential part of treatment once remission is achieved is education of the patient about depression and which symptoms to look for should they experience a recurrence. Often a patient will have a similar symptom cluster in a recurrent depressive episode, so a review with the patient of the presenting symptoms can be helpful in recognizing a recurrence at an early stage.

B. Continuing medication and cognitive-behavioral therapy beyond the point of initial response to treatment can reduce the risk of relapse and possible recurrence. Those patients who have responded to cognitive therapy are less likely to relapse compared to patients treated with medication alone. Prior treatment with cognitive therapy appears to cut the relapse rate by one half. In addition, inclusion of cognitive therapy as part of ongoing treatment can help reduce the risk of both relapse and/or recurrence after medications are discontinued.
Management of Depression

Value of Care

References:

1. Brody, David S, MD; Hahn, Steven R., MD; Spitzer, Robert L., MD; Kroenke, Kurt, MD; Linzer, Mark, MD; DeGry, Frank V., MD, Williams, Janet B.W. DSW. “Identifying Patients with depression in the primary care setting: A more efficient method.” Archives of Int Med, 158(22), pp. 2469-2475.


9. Kroenke, Kurt MD; Spitzer, Robert L. MD and Williams, Janet B.W., DSW. “The Patient Health Questionnaire-2: Validity of a two-item depression screener.” Med Care, 41(11), pp. 1284-1292.


11. Lowe, Bernd; Spitzer, Robert L; Grafe, Kerstin; Kroenke, Kurt; Quenter, Andrew; Zipfel, Stephan; Buchholz, Christine; Witte, Steffan; Herzog, Wolfgang. “Comparative Validity of three screening questionnaires for DSM-IV depressive disorders and physicians’ diagnoses.” Journal of Affective Disorders, 78, pp. 131-140.


17. Thibault, Jane M, MSSW, PhD and Steinder, Robert William Prasaad, MD, PhD. “Efficient Identification of Adults with Depression and Dementia.” American Family Physician, Week 70, No. 6, pp. 1101-1110.


Attachment A

Quick Facts about Psychological Counseling

- In psychological counseling, patients with depression work with a qualified health care professional who listens to them, talks and helps them correct overly negative thinking (which reinforces depressed mood) and improve their relationships with others.

- Psychological counseling for depression is not talking about your childhood, but rather focused on current concerns and ways to address them.

Treating Depression with Psychological Counseling

Psychological counseling has been shown to be as effective as antidepressants in treating many people with depression. Psychological counseling can be done individually (only you and a mental health professional), in a group (a mental health professional, you and other people with similar problems) or can it can be family or marriage counseling where a mental health professional, you and your spouse or family members participate. More than half of the people with mild to moderate depression will respond to psychological counseling.

While the length of time that persons are involved in counseling differs, people with depression can typically expect to attend counseling for 6 – 12 sessions. If your depression is not noticeably improved after 6 to 12 sessions of counseling, this usually means that you need to try different treatment for your depression. Psychological counseling by itself is not recommended as the only treatment for persons whose depression is recurrent, more chronic or severe. Medication is needed for those types of depression and it can be taken in combination with psychological counseling.

What Can You Do?

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

English

Spanish
Attachment B

What is Depression?

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

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

Symptoms Include:

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

If I'm Depressed, What Can Be Done About It?
The good news is that depression is treatable. Your primary care doctor can effectively treat depression by supportive counseling, prescribing an antidepressant medication and/or referring depressed persons to a mental health professional for counseling. Talking with your doctor about how you are feeling is a very important first step. You can further help you doctor treat you most effectively by participating actively in treatment by (a) asking questions and (b) following through with the treatment that both you and your doctor decide is best for you.

English
http://www.depression-primarycare.org/images/pdf/what_is_depression.pdf

Spanish
**Attachment C**

**Instructions for Antidepressants:** SSRI’s

fluoxetine, citalopram (Celexa), sertraline (Zoloft), escitalopram (Lexapro), fluvoxamine (Luvox), paroxetine (Paxil)

**Take Every Day.** Missing doses may cause your medicine to work less well.

**Take With Food.** This will reduce the chance of upset stomach.

**It May Take Several Weeks to Work.** Some people feel better in 1-2 weeks while in others it may take more than a month. Usual length of treatment is 6-12 months.

**If You Feel Worse or Suicidal, Call Your Doctor.** Sometimes people feel worse before their medicine can work. It is important to let your doctor know.

**Antidepressants Are Not Addicting.** Please talk with your doctor before changing the dose or stopping any medicine. Sometimes stopping suddenly can cause side effects or return of symptoms.

**Possible Side Effects:** Starting with the low dose your doctor has recommended lessens side effects. Some are still possible but not dangerous.

**Most side effects are temporary and last less than a week!**

- Nausea, or loose stools (helps to take with food)
- Jittery or shakiness (limit or stop caffeine)
- Mild headaches
- Trouble sleeping or sleepiness
- Sexual dysfunction (less interest or longer to finish)
- Weight loss or gain (can be a symptom of depression, too!)
Attachment D

Instructions for Antidepressants: non-SSRI

Bupropion or Wellbutrin XL

Take Every Day. Missing doses may cause your medicine to work less well.

It May Take Several Weeks to Work. Some people feel better in 1-2 weeks while in others it may take more than a month. Usual length of treatment is 6-12 months.

If You Feel Worse or Suicidal, Call Your Doctor. Sometimes people feel worse before their medicine can work. It is important to let your doctor know.

Antidepressants Are Not Addicting. Please talk with your doctor before changing the dose or stopping any medicine. Sometimes stopping suddenly can cause side effects or return of symptoms.

Possible Side Effects: Starting with the low dose your doctor has recommended lessens side effects. Some are still possible but not dangerous.

Most side effects are temporary and last less than a week!

Jittery or shakiness (reduce or stop caffeine)

Trouble sleeping (if this happens, do not take in the evening)

Headache

Less appetite or mild weight loss

Constipation (a higher fiber diet will help)

Helps smokers to stop smoking!
Attachment E
Self Administered Patient Health Questionnaire (PHQ-9)

Name: _______________________________      Date: ______________________

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

Please check ☐ your answer.

1. Little interest or pleasure in doing things.
2. Feeling down, depressed, or hopeless.
3. Trouble falling/staying asleep, sleeping too much.
4. Feeling tired or having little energy.
5. Poor appetite or overeating.
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.
7. Trouble concentrating on things, such as reading the newspaper or watching television
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.
9. Thoughts that you would be better off dead or of hurting yourself in some way.

Score 0  Score 1  Score 2  Score 3
Not at all  Several days  More than half the days  Nearly every day

Total Score:______
Durante las últimas 2 semanas, ¿qué tan frecuentemente le han molestado cualquiera de los siguientes problemas?

Por favor marque su respuesta [ ]

1. Poco interés o placer en hacer cosas.
2. Sentirse decaído, deprimido, o sin esperanza.
3. Dificultad para dormir/ quedarse dormido, dormir mucho.
4. Sentirse cansado o tener poca energía.
5. Poco apetito o comer demasiado.
6. Sentirse mal con usted mismo – o que es un fracaso o que le ha fallado a su familia y a usted mismo.
7. Dificultad para concentrarse en cosas tales como, leer el periódico o ver la televisión.
8. Moverse o hablar tan despacio que otras personas lo han notado. O lo opuesto – estar tan nervioso e inquieto que ha hecho más cosas de lo normal.
9. Pensar que estaría mejor muerto o lastimarse de alguna forma.

Puntuación Total: ___