

# BEYOND DEPRESSION for Older Iowans

## A Medical Reference Chart for Primary Care Providers



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Additional copies of this document and other materials related to treating Major Depression are found at: <http://www.higherplain.org>



The Higher Plain, Inc.

## 7 KEY CHALLENGES FOR PRIMARY CARE IN MANAGING DEPRESSION

1. Make a diagnosis.
2. Educate and recruit the patient as a partner in treatment\*.
3. Start with the best possible treatment. Avoid minor tranquilizers. Use antidepressants and/or psychotherapy.
4. Use an adequate dose.
5. Establish an adequate treatment duration. (Patients often take 6 to 10 weeks to respond.)
6. Monitor outcomes and adjust treatment as needed. Consider consultation with a mental health specialist if patient isn't improving.
7. Prevent relapse. (Relapse rate after one episode is 50%, after two episodes is 70%, and after three episodes is 90%.)

\*Companion materials at the Higher Plain, Inc. website are available for:

- Older Iowans with Major Depression and their families:
  - General information about depression in late life
  - Treatment options
  - How to cope with depression
  - Tips for those who provide care
  - What to do if worried about someone committing suicide
- Community members:
  - What is depression and what impact does it have on a community?
  - What do we know about depression in older adults?
  - What is the best treatment for depression?
  - What can a community member do to help?



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*Beyond Depression for Older Iowans* is part of a project supported by The Wellmark Foundation, developed by Higher Plain, Inc. May 2007.

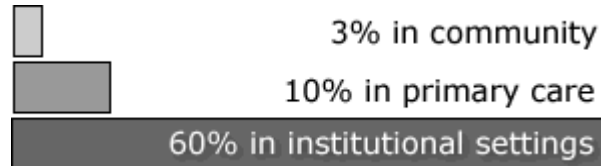
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## GERIATRIC DEPRESSION: REVALENCE AND RISK FACTORS

### Prevalence

Depression for seniors is thought to be between 17 and 25% in older primary care patients. Incidence increases as seniors move from community settings to institutional settings.

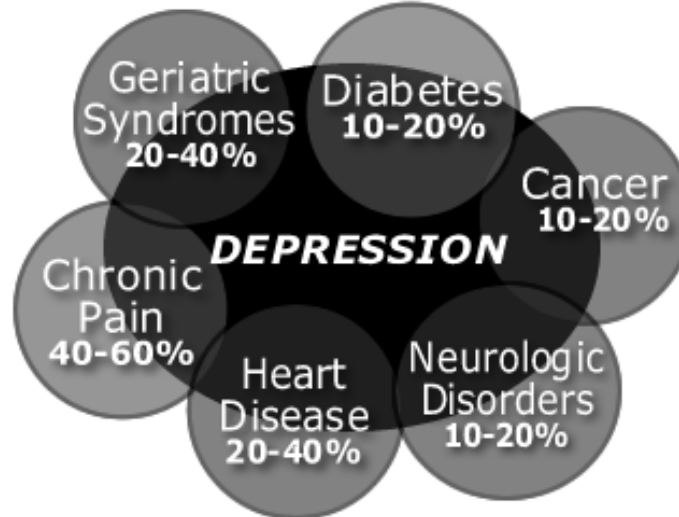


Late life depression is prevalent in Primary Care. More than 20% of those over 65 have clinical depression that needs treatment.

Only about half of depressed adults are identified and receive treatment in primary care. Of those, only 20 to 40% show substantial improvement over 12 months because of early treatment dropout.

When seniors have a chronic health condition, the likelihood of depression in-

In late life, depression is rarely the *only* health problem.

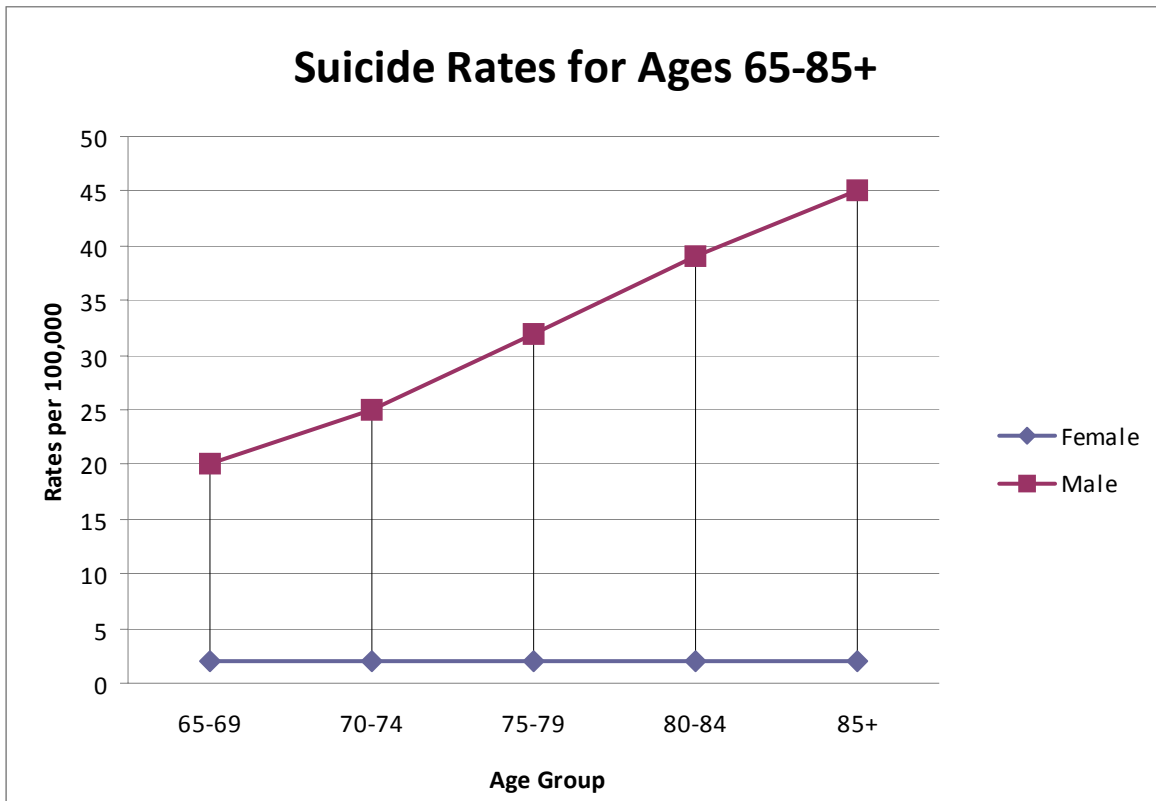


Older male adults have the highest rate of suicide. Common signs of depression in older males are the display of anger and excessive criticism.

Over 60% of suicides are attributed to major depressive disorder. Some risk factors for suicide among older adults are:

- Social isolation
- Physical illnesses
- Male gender
- Depression

## DEPRESSION IS DEADLY



Elderly (male and female combined) age 70+ had the highest rate of suicide, 2.1 times greater than the rate for 15-19 years of age.

White men over the age of 85 were at the greatest risk of all age-gender-race groups. In 2004, the suicide rate for these men was 2.5 times the current rate for men of all ages.

**Nearly half of suicide victims have had contact with a primary care provider within 1 month of suicide.**

*"PASSIVE or INDIRECT SUICIDE"*

The number of lives lost because depression interferes with motivation and the ability to comply with medical recommendations is much higher than those lost to suicide. Depression sets a person up for *"passive suicide."* The patient's inability to focus on being an active partner in treatment is severely limited. The Impact Collaborative Care model provides a science based best practice method that has worked in many parts of the country.

## GENERAL RISK FACTORS FOR LATE LIFE DEPRESSION

### Physical Risk Factors:

- Genetic susceptibility
- Chronic/severe medical illness
- Medication side effects
- Chronic pain conditions
- Prolonged stress, related physical problems
- Care giving for persons with chronic or severe disorders
- Substance abuse
- Neurological illness

### Psychosocial Risk Factors:

- Major losses; unresolved grief
- Serious or prolonged stressors
- Severe, prolonged, or cumulative traumas
- Divorce, separation, widowhood
- Adult abuse
- Early childhood traumas and abuse
- Low perceived control
- Social isolation
- Limited social support
- Care giving responsibilities

### Environmental Risk Factors:

- Rural health hazards
- Occupational health hazards
- Strong exposure to neurotoxins
- Serious disability of self/family member from occupational accident/illness
- Inability to work after disability

# INTRODUCTION TO DIAGNOSIS AND ASSESSMENT

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**CONDITIONS CHARACTERIZED BY DEPRESSIVE SYMPTOMS**  
**MAJOR DEPRESSION - Diagnostic Criteria for *Major Depression***  
**(DSMR-TR)**

Major depression is present when the patient has had **5 of the 9** symptoms listed below for at least two weeks.

**One of the symptoms must be either item 1 or 2.**

**1. Depressed mood**  
**OR**  
**2. Loss of interest or pleasure**

**3. Significant change in weight or appetite**  
**4. Insomnia or hypersomnia**  
**5. Psychomotor agitation or retardation**  
**6. Fatigue or loss of energy**  
**7. Feelings of worthlessness or guilt**  
**8. Impaired concentration or ability to make decisions**  
**9. Thoughts of suicide or self-harm**

**Initial Screening: TWO QUESTION SCREEN**

Anyone with a chronic health condition should be considered for the TWO QUESTION SCREEN, which may indicate the need for a full depression assessment.

TWO QUESTION SCREEN
During the last month, have you often been bothered by: 1. Little interest or pleasure in doing things? 2. Feeling down, depressed, or hopeless?

- If the patient's response to both questions is "no", the screen is negative.
- If the patient responded "yes" to either question, consider running baseline lab tests to rule out other illnesses which have symptoms similar to depression, and using the PHQ-9 Patient Health Questionnaire (described on next page)

**Baseline Lab Tests:**

**Could depression symptoms be caused by something else?**

When working up a patient who exhibits depression symptoms, baseline lab tests can be done to identify undiagnosed and untreated conditions:

- CBC: unidentified anemia leads to fatigue and may mimic other depression symptoms. Depression is more difficult to treat when the patient has untreated anemia.
- TSH: hypothyroidism can mimic depression. Once the patient is on thyroid supplementation, their depression symptoms may disappear.
- Metabolic Panel: detecting undiagnosed chronic conditions improves patient outcomes.

## SUGGESTED ASSESSMENT TOOLS

Quick to administer and score, these tools may be copied for use in your practice. They can be found in the "PRINTABLE ASSESSMENT TOOLS" section of this Reference Chart.

### PHQ-9 (Patient Health Questionnaire)\*

The PHQ-9 is the recommended depression assessment tool because it enables the Depression Care Management Team to regularly record and monitor symptoms, track progress and relapse periods. *The PHQ-9 can be self-administered or given by a nurse, medical assistant, or therapist.* It will not assess for anxiety conditions or cognitive functioning.

There may be other conditions which, if left untreated, can adversely affect patient outcomes. The following assessment tools are provided to assist in diagnosing these conditions.

### HOSPITAL ANXIETY AND DEPRESSION (HADS) – ANXIETY SUBSCALE\*

Anxiety Disorders frequently co-exist with depression. Identifying the presence of this condition and treating the disorder will increase the chances of compliance with treatment recommendations and make the patient feel comfortable more quickly. *The HADS Anxiety Subscale is a 7-question screen which can be self-administered.*

### COGNITIVE SCREENER\*

The 6-Item Cognitive Screener may be used to identify cognitive impairment. Such testing along with the PHQ-9 may be helpful in identifying situations where signs of depression are masking dementia or signs of dementia are masking depression.

\* *These assessment tools are included in the **PRINTABLE ASSESSMENT TOOLS** section, and may be copied for use in your practice.*

### HEALTH LITERACY QUESTION (full explanation in the PATIENT EDUCATION section)

This assessment tool, while not expressly designed for the depressed patient, will assist care providers in assessing a patient's ability to understand basic English and medical concepts. *(People with a score of 3 or higher should be positively identified as "at risk.")*

#### How confident are you filling out medical forms by yourself?

Answers / score:

Extremely (1); Quite a bit (2); Somewhat (3); A little bit (4); Not at all (5)

**Depressed geriatric patients often have a co-occurring anxiety disorder.**

It is generally recommended that anti-anxiety measures should be initiated as quickly as possible. Medications that show an onset of action within the first week of treatment (e.g. benzodiazepines) can help accomplish this more easily for patients with severe anxiety.

Short-term use of anti-anxiety medications within the first two weeks may encourage patients' compliance with their antidepressant regimen and reduce the likelihood of premature discontinuation from treatment. Improved compliance increases the likelihood of resolution of depressive symptoms, resulting in remission.

**CONDITIONS CHARACTERIZED BY MIXED ANXIETY-DEPRESSIVE DISORDER**

**MIXED ANXIETY-DEPRESSIVE DISORDER - Diagnostic Criteria for Mixed Anxiety-Depressive Disorder (DSMR-TR)**

Presence of persistent or recurrent dysphoric mood **lasting  $\geq$  4 weeks** and accompanied by  **$\geq$  4 of the following symptoms\***:

- Sleep disturbances
- Fatigue or low energy
- Irritability
- Worry
- Being easily moved to tears
- Hypervigilance
- Anticipating the worst
- Concentration or memory difficulties
- Hopelessness or pessimism about the future
- Low self-esteem
- Feelings of worthlessness

\*Symptoms are not due to a medication, drug /alcohol abuse, or a medical condition and cause significant distress or impairment in social, occupational, or other important areas of functioning.

\*Symptoms do not meet criteria of any other mental disorder.

## **TEAM - BASED DEPRESSION CARE**

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## Team-Based Depression Care in Primary Care Settings

This treatment care model is based on the IMPACT Model for Collaborative Care, which has been used successfully in the primary care setting for over ten years. The IMPACT model utilizes “stepped care” as a part of treatment.

Stepped Care goes beyond prescribing and medication checks. It includes:

- *Systematic Outcomes Tracking* by monitoring symptoms utilizing the PHQ-9. Scores are tracked to show status of outcomes and communicated to the provider.
- *Treatment Adjustment* as needed based on: clinical outcomes, according to evidence-based algorithm, and when needed in accordance with a specialist
- *Relapse Prevention*

### Preferred Approach

The preferred approach utilizes the services of a Depression Care Manager and “stepped care” to meet the challenges of managing depression. The Depression Care Manager (DCM) educates the patient on depression, monitors the patient’s symptoms and medication adherence, and communicates with the primary care provider. Problem solving treatment can be a part of the role of the DCM. This Preferred Approach uses both pharmacological and non-pharmacological treatment to manage depression.

**Both patient and medical provider benefit from collaborative depression care:**

<b>Benefits to Medical Provider</b> <ul style="list-style-type: none"><li>• DCM handles time-consuming tasks</li><li>• Provider’s time and energy are freed up to care for more patients</li><li>• Depressed patients are monitored without overburdening provider</li><li>• Monitoring, educating and assessing difficult patients is shared</li><li>• Increased accuracy in diagnosis</li><li>• Provides a system of measurement to identify progress over time</li></ul>	<b>Benefits to Patient</b> <ul style="list-style-type: none"><li>• Fewer health resources are needed</li><li>• Patient actively participates in managing their multiple health concerns</li><li>• Increases patients’ motivation to follow medical recommendations</li><li>• Less frequent medical visits</li><li>• Improved health outcomes</li><li>• Problem Solving Treatment helps patients understand symptoms and care for self</li></ul>
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**How a Depression Care Manager (DCM) or staff member trained to provide Problem Solving Treatment (PST) can positively affect the profitability of your practice**

Depending on the credentialing of staff, PST may be a billable reimbursable service.

When non-credentialed staff are utilized to perform DCM services or PST, Primary Care Providers are freed to work with other patients. In capitated systems, depression care management historically reduces total healthcare cost per

### **Where to get a Depression Care Manager**

You may already have a potential Depression Care Manager on your staff, one who just needs a little more support and training. Staff working with chronic care patients are good candidates for the position. Consultation on integrating this service into practice can be provided by contacting: Higher Plain, Inc. (see next paragraph for contact info.)

### **How to integrate Problem Solving Treatment within a Practice Setting**

Training for Problem Solving Treatment can be obtained through a 3-hour internet course. Consultation on integrating this service into practice can be provided by contacting:

Higher Plain, Inc.  
680 Garfield Road  
West Branch, IA 52358  
319-643-5628  
joan-blundall@higherplain.org

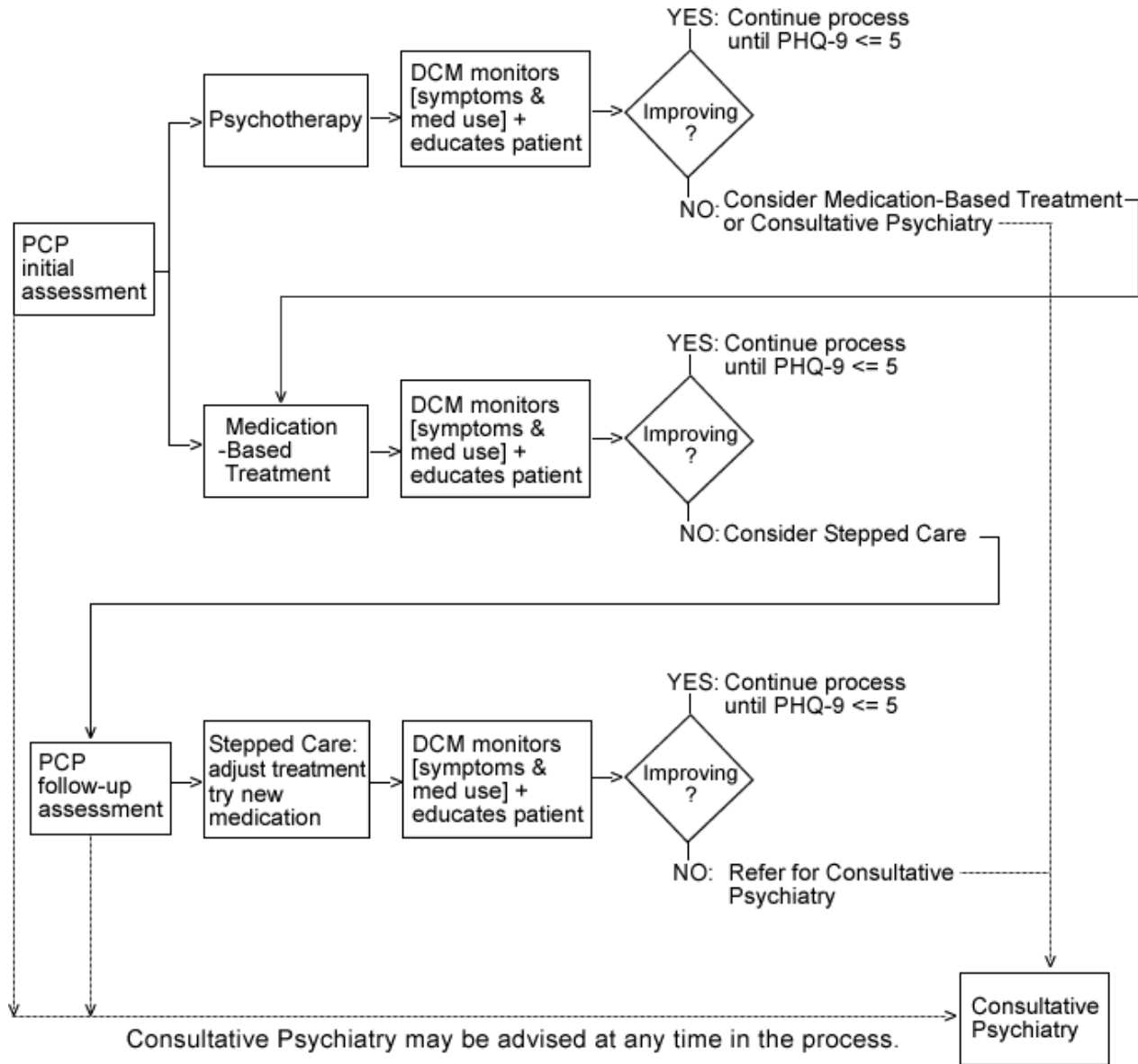
The Depression Care Manager works with the patient on 3 goals:

1. Help the patient understand their current depression symptoms and current problems.
2. Assist the patient in developing problem solving skills and strategies.
3. Help the patient remember and engage in pleasant events and activities again.

The **Depression Care Manager** regularly administers and tracks PHQ-9 scores, educates the patient on symptoms and behavioral activation, monitors symptoms and medication adherence, provides patient education, provides information to members of the team regarding outcomes, and develops a relapse prevention plan with patient. One-on-one treatment and education provided by the Depression Care Manager increase the elder's ability to monitor their own symptoms and assume the responsibilities for self-care.

As the **informed and motivated patient** becomes an active member of the treatment team, outcomes for both psychotherapy and medication improve.

## Critical Pathways in Team-Based Depression Care



### **Alternate Approach in Primary Care Settings**

When the Team-based IMPACT Model for Collaborative Care is not possible in your practice setting due to limited staff and resources, it is recommended that your practice still utilize stepped care and the assessment tools provided.

The Prevention of Suicide in Primary Collaborative Trial (PROSPECT) Algorithm is designed to reduce suicide rates among older adults by identifying and treating

#### **PROSPECT Algorithm**

##### **Initial Therapy for Depression**

Citalopram 10 mg, increasing up to 30 mg for 12 weeks

(may use other SSRI if patient has a prior history of response)

If unable to tolerate citalopram, switch to bupropion up to 300 mg/day for 12 weeks

Use interpersonal therapy for:

1. Patients unable to tolerate medications
2. Those who refuse antidepressant therapy

##### **Patients Who Fail to Respond to Initial Therapy\***

Step 1 - Check compliance, maximize dosage and duration of therapy with initial agent

Step 2 - Switch to citalopram if another agent was used

Step 3 - Switch to bupropion up to 200 - 400 mg/day in divided doses

Step 4 - Switch to venlafaxine up to 150 - 300 mg q AM

Step 5 - Switch to nortriptyline *with monitoring of serum levels*

Step 6 - Switch to mirtazapine 30 - 45 mg q hs

##### **Partial Responders\***

Step 1 - Check compliance, maximize dose and duration of therapy with initial agent

Step 2 - Augment with bupropion up to 200 - 400 mg/day in divided doses

Step 3 - Augment with nortriptyline *with monitoring of serum levels*

Step 4 - Augment with lithium *with monitoring of serum levels*

Step 5 - Use steps 2, 4, and 6 above for nonresponders

As determined by assessment tools, such as PHQ-9. (PHQ-9 with scoring and interpretation is in the "PRINTABLE ASSESSMENT TOOLS & REFERENCES" section of this document.

## PHARMACOLOGICAL & NON-PHARMALOGICAL TREATMENT

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## **PHARMACOLOGICAL & NON-PHARMACOLOGICAL TREATMENT**

Depressed older adults are often unwilling to seek treatment from psychiatrists or mental health specialists. The burden of care often rests on the primary care provider. Preferred treatment options include medication, psychotherapy, and a combination of both psychotherapy and medication.

Finding the treatment that is available, affordable, and preferred by the patient are key to increasing the likelihood of compliance. The major focus of this section is on pharmacological treatments for older adults with depression. Information on anxiety disorders is provided because it may occur with depression.

Topics covered are:

- Antidepressant Medications
- Managing Side-effects of Medication
- Anxiety Disorder Medications

### **Effective Non-Pharmacological Treatments for Late Life Depression**

- Exercise
- Light Therapy
- Grief Therapy
- Problem Solving Treatment
- Cognitive Behavioral Therapy
- Interpersonal therapy
- ECT

### **Problem Solving Treatment**

Problem Solving Treatment may be provided by a Primary Care Provider, a Depression Care Manager, or other qualified medical staff. The patient may regain a sense of control after four (or up to eight) half-hour Problem Solving Treatment sessions.

Problem Solving Treatment focuses on the present, and develops practical steps that can be taken to improve the areas of one's life that have produced pain. Plans are also made to increase pleasurable activities.

Patients who have experienced Problem Solving Treatment as part of the IMPACT program have described these benefits:

- taking charge of my life
- staying in the present
- dealing w/ problems
- taking care of myself
- able to take care of the things my husband used to handle
- it makes me face up to things, puts problems in perspective

## Pharmacological Treatments

**Start antidepressant medications at a low dose and titrate upwards to a therapeutic dose as tolerated over a 4-6 week period.**

- It is recommended that patients be started on a first line antidepressant SSRI (Selective Serotonin Reuptake Inhibitor) initially.
- Patients who fail an adequate trial of a first line antidepressant should then be considered for a trial from a different class.
- Patients who have previously failed or not tolerated a first line antidepressant should be started on an alternative antidepressant medication.
- Patients previously responding to an antidepressant that is not first line should be re-started on the same antidepressant.

**Exceptions include:**

- If the patient has a new medical condition for which the previous antidepressant medication is contraindicated.
- If the patient was previously on a TCA (tricyclic antidepressant) such as Imipramine, Amitriptyline, or Doxepin. These TCA's have severe side effects in older adults. Patients who have previously responded to these medications should be started on a secondary tricyclic or alternate antidepressant.

## Guidelines for Using Antidepressant Medications

### 1. Selective Serotonin Reuptake Inhibitors (SSRIs)

Common side effects to *all SSRIs*: insomnia, restlessness, agitation, fine tremor, GI distress, headache, nausea, dizziness, dry mouth, sedation, and sexual dysfunction.

<b>Drug Name</b>	<b>Unit doses available (in mg)</b>	<b>Therapeutic usual dosage range (mg)</b>	<b>Maximum dose (mg)</b>	<b>Starting dose in elderly pts (mg)</b>	<b>Comments/common side effects specific to this drug in addition to common side effects described above</b>
1. Fluoxetine* (Prozac)	10, 20	10-40 /day	60 /day	10 qam	Fluoxetine has a very long half life <i>Many drug interactions.</i> It is less sedating than other
2. Paroxetine* (Paxil)	10, 20, 30, 40	10-40 /day	50 /day	10 qhs	Dry mouth, constipation, weakness/fatigue. Mild anticholinergic properties. More likely to be sedating, administer at bedtime. Withdrawal symptoms may occur with discontinuation and missed
Paroxetine CR (Paxil CR)	12.5, 25, 50	25-37.5 /day	62.5 /day	12.5 qhs	Dry mouth, constipation, weakness/fatigue. Mild anticholinergic properties. More likely to be sedating, administer at bedtime. Withdrawal symptoms may occur with discontinuation and missed
3. Citalopram* (Celexa)	20, 40	20-40 /day	80 /day	10 qam	<i>It has few drug interactions.</i>
4. Sertraline* (Zoloft)	50, 100	50-200 /day	200 /day	25 qam	<i>It has few drug interactions.</i>
5. Escitalopram (Lexapro)	10, 20	10-20 /day	20 /day	10 qam	<i>It has few drug interactions.</i>

\* generics available

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## Guidelines for Using Antidepressant Medications

### 2. Other Newer Antidepressants

<i>Drug Name</i>	<i>Unit doses available (in mg)</i>	<i>Therapeutic usual dosage range (mg)</i>	<i>Max dose (mg)</i>	<i>Starting dose in elderly pts (mg)</i>	<i>Comments and common side effects specific to this drug</i>
1. <b>Bupropion*</b> (Wellbutrin)	75, 100	75-300 /day	150 /dose 450 /day, divided tid	75 qam	Insomnia/agitation, risk of seizures greater at maximum doses**
<b>Bupropion SR*</b> , *** (Wellbutrin SR)	SR100, SR150	100-400 /day	200/dose 400/day	100 qam	Insomnia/agitation, risk of seizures at high doses** <b>Allow 8 hrs between doses.</b>
<b>Bupropion XL</b> (Wellbutrin XL)	150, 300	150-300 mg/day	450/day	150mg qam	<b>Must have 24hr interval between doses.</b> Insomnia/ agitation, risk of sei- zures at high doses**
2. <b>Venlafaxine XR</b> allows once daily dosing. (Effexor XR)	XR37.5, XR75, XR150	75-225 /day	225 /day	37.5 qam	Nausea, agitation/ insomnia. Elevations in BP at higher doses (>150 mg/day). Withdrawal symptoms may occur with discontinuation and missed dose.
4. <b>Mirtazapine *</b> (Remeron)	15, 30	15-45 /day	45 /day	7.5 or 15 qhs If 15mg oversedates, start at 30mg	Increased sedation at lower doses. Sedation decreases as dose increases. Weight gain.

\* generics available

\*\* **Bupropion** should be avoided in patients with a history of seizures or with significant head trauma or CNS lesions that put the patient at higher risk for seizures. Most patients will respond to lower doses of **Bupropion** and will not require such high doses, but patients with partial responses to lower doses should be titrated up to the maximum doses as tolerated.

\*\*\* **Bupropion SR**: administer 2nd daily dose before 3 pm. Dosing is once or twice daily.

3. Secondary Amine Tricyclics (TCAs)

**Common side effects:** arrhythmia, dry mouth, constipation, blurry vision, orthostatic hypertension, confusion, tachycardia and weight gain.

All TCAs are available in generic preparations.

<i>Drug Name</i>	<i>Unit doses available (in mg)</i>	<i>Therapeutic usual dosage range (mg)</i>	<i>Maximum dose (mg)</i>	<i>Starting dose in elderly pts (mg)</i>	<i>Comments/common side effects specific to this drug in addition to common side effects described above</i>
<b>1. Nortriptyline# (Aventyl) (Pamelor)</b>	10, 25, 50, 75	50-150 /day	150 /day	10 qhs	Weakness, fatigue  Check blood levels, especially if not effective at 75 mg - aim for a level of 50 - 150 ng/ml.
<b>2. Desipramine# (Norpramin)</b>	10, 25, 50, 75, 100, 150	25-100 /day	150 /day	25 qhs	Tachycardia, insomnia, agitation.  Check blood level if not effective at 150 mg - aim for a level of 115-180 ng/ml.

# generics available

- Tertiary amine tricyclic medications such as amitriptyline, doxepin, or imipramine are to be avoided in older adults because of high rates of potentially harmful side effects.
- These medications are to be avoided in patients with a recent history of myocardial infarction or with preexisting cardiac conduction defects (1<sup>st</sup> or 2<sup>nd</sup> degree heart block), urinary retention, or narrow angle glaucoma.
- Serum levels are useful IF patients don't have a response at a 'therapeutic' dose or if patients have significant side effects at very low doses.

## Guidelines for Switching Antidepressants

Abrupt discontinuation of short acting antidepressants can lead to an uncomfortable antidepressant withdrawal syndrome. The following is a strategy for switching antidepressants.

Definitions:

**TCA** (tricyclic antidepressant) – An antidepressant drug that works by blocking the reabsorption of both serotonin and norepinephrine.

**SSRI** (selective serotonin reuptake inhibitor) - An antidepressant drug that works by blocking the reabsorption of serotonin.

**SNRI** (serotonin-noradrenaline reuptake inhibitor) - An antidepressant drug that works by blocking the reabsorption of serotonin and norepinephrine. SNRIs include Duloxetine (Cymbalta) and Venlafaxine (Effexor).

<b>Switching from SSRI to SSRI:</b>	<ul style="list-style-type: none"> <li>• One can usually switch from one SSRI to another without much difficulty. Discontinue first SSRI Day 1 and start next SSRI on Day 2.</li> </ul>
<b>Switching from SSRI or SNRI to TCA:</b>	<ul style="list-style-type: none"> <li>• Fluoxetine may be abruptly discontinued. TCAs should be increased slowly as the remaining flextime may increase TCA levels.</li> <li>• Other SSRIs or SNRIs should be tapered over 1-2 weeks in small increments. A TCA may be started and increased slowly as the SSRI or SNRI is discontinued.</li> </ul>
<b>Switching from TCA to SSRI</b>	<ul style="list-style-type: none"> <li>• SSRIs can significantly increase the blood levels of TCAs. Therefore, one should taper a TCA over 1-2 weeks by increments of 25-50mg q 2-3 days. An SSRI can be started when the dose of a TCA has been significantly reduced or after the TCA is tapered off completely.</li> </ul>

## Treatment Strategies for Antidepressant Side Effects

Sedation	<ul style="list-style-type: none"> <li>• Give medication at bedtime</li> <li>• Try caffeine</li> </ul>
Orthostatic hypotension/dizziness	<ul style="list-style-type: none"> <li>• Consider switching to a different antidepressant</li> <li>• Give at bedtime</li> <li>• Sit-stand-get up slowly</li> <li>• Adequate hydration</li> <li>• Support hose</li> </ul>
Anticholinergic (dry mouth/eyes, constipation, urinary retention, tachycardia)	<ul style="list-style-type: none"> <li>• Consider switching to a different antidepressant</li> <li>• Hydration</li> <li>• Sugarless gum or sour candy</li> <li>• Dietary fiber</li> <li>• Artificial tears</li> <li>• For confusion – stop medication and rule out other causes</li> </ul>
GI distress/nausea	<ul style="list-style-type: none"> <li>• This often improves or resolves during first week</li> <li>• Take with meals</li> <li>• <i>Short-term use (&lt; 10 days)</i> antacids or H2 blockers</li> </ul>
Activation/jitters/tremors	<ul style="list-style-type: none"> <li>• Start with small doses (especially with underlying anxiety disorder)</li> <li>• Reduce dose</li> <li>• Refer to specialist if side effect persists</li> </ul>
Headache	<ul style="list-style-type: none"> <li>• Lower dose</li> <li>• Try acetaminophen</li> </ul>
Insomnia	<ul style="list-style-type: none"> <li>• Trazodone 25-100 mg po qhs (can cause orthostatic hypotension and priapism)</li> <li>• Make sure stimulating antidepressants are taken in a.m.</li> </ul>
Sexual dysfunction	<ul style="list-style-type: none"> <li>• May be part of depression or medical disorders</li> <li>• Decrease dose</li> <li>• Try adding buspirone 15-30 mg bid</li> <li>• Try adding cyproheptadine 4 mg 1-2 hrs before intercourse</li> <li>• Consider a trial of sildenafil, tadalafil, or vardenafil in consultation with PCP or urologist</li> </ul>

### Antidepressant Drug Interactions

All antidepressants are metabolized by the P450 enzyme system. Some antidepressants may inhibit specific subtypes of P450 enzymes which can increase blood serum levels in patients who are taking other medications metabolized by the same isoenzyme systems.

Patients who are taking medications with a narrow therapeutic index, such as TCA's, are to be observed clinically for side effects, and blood serum levels checked as the dose is titrated upwards.

<b>MAOI's</b>	<i>Do not co-administer with other antidepressants, lithium, hesperidins, stimulants, pseudo ephedrine, phenylphrine, reserpine, sumatriptan, l-dopa, tyramine, or morphine.</i>
ALWAYS consult a psychiatrist before prescribing MAOI's, as these medications have a narrow therapeutic window and can result in serotonin syndrome or hypertensive crisis if used incorrectly.	

### IMPORTANT:

Information regarding drug safety and new drug treatments may change quickly.

In order to have the most up to date information on these changes, visit these websites:

- U.S. Food and Drug Administration:  
<http://www.fda.gov>
- American Association for Geriatric Psychiatry:  
<http://www.aagppa.org>
- IMPACT Evidence-based depression care:  
<http://www.impact-uw.org>

## Secondary Anxiety in the Later Life

Primary anxiety disorders are less prevalent in elderly cohorts than in younger cohorts. When encountered, they usually represent conditions that began earlier in life and persisted into old age. Secondary anxiety disorders, in contrast, are more prevalent in the elderly population because conditions associated with these disorders (e.g. angina, emphysema) and the use of anxiogenic medications are more common in this population. Additionally, other clinical indications for anxiolytic and sedative-hypnotic medications, including insomnia, periodic limb movements of sleep, agitation or aggression in the context of dementia, and sedations for brief diagnostic or surgical procedures-occur

<b>Benzodiazepines for Anxiety Recommended for Older Adults</b>					
<b><i>Drug Name</i></b>	<b><i>Unit doses available (in mg)</i></b>	<b><i>Therapeutic usual dosage range (mg)</i></b>	<b><i>Maximum dose (mg)</i></b>	<b><i>Starting dose in elderly pts (mg)</i></b>	<b><i>Comments/common side effects specific to this drug</i></b>
<b>Lorazepam</b>	Tablets: • 0.5 mg • 1 mg • 2 mg	2-6 mg /day	6 mg /day	1 to 2 mg /day in divided doses; increase gradually.	<ul style="list-style-type: none"> <li>• drowsiness /sedation</li> <li>• dizziness</li> <li>• tiredness</li> <li>• weakness</li> <li>• dry mouth</li> <li>• diarrhea</li> <li>• upset stomach</li> <li>• changes in appetite</li> <li>• psychomotor slowing</li> </ul>
<b>Oxazepam</b> Contraindicated with: • Digoxin • Oxazepam  Increases serum digoxin concentrations.	Tablets: • 15 mg  Capsules: • 10 mg • 15 mg • 30 mg	30-120 mg /day	120 mg /day	10 mg, 3 times /day; increase cautiously up to 15 mg, 3 to 4 times /day.	<ul style="list-style-type: none"> <li>• drowsiness</li> <li>• dizziness</li> <li>• vertigo</li> <li>• headache</li> <li>• syncope</li> <li>• excitement</li> <li>• stimulation of affect</li> <li>• nausea</li> <li>• lethargy</li> </ul>
<b><i>Nonbenzodiazepine Hypnotics: Zolpidem (Ambien), Zaleplon (Sonata), and Eszopiclone (Lunesta) should not be used for treatment of anxiety disorders.</i></b>					

## PATIENT EDUCATION

Topic	page
<i>Health Literacy 1 Question Screen</i>	26
<i>Patient Handout: Plain Talk About Depression for Seniors</i> (Low Literacy Patient Handout)	27
<i>Patient Handout: Medication Questions for the Patient to Ask Their Doctor</i>	28
<i>Patient Handout: Frequently Asked Questions About Antidepressant Medication</i>	29
<i>Friends/Family Handout: What Friends and Family Should Know About Depression</i>	31
<i>Friends/Family Handout: How Can I Help?</i>	32

ALL of the handouts listed above are available in Spanish on the Higher Plain, Inc. website, where they can be downloaded and printed for free:

<http://www.higherplain.org>

## Patient Education

An informed and motivated patient is an integral part of the Depression Care Management Team. Providing patients with appropriate information will enable them to understand their disease and participate in their own recovery. Older adults may require more education than some other patient populations.

- *Many older adults know little or nothing about depression.*
- *Few older adults think of depression as a medical/health problem.*
- *Older adults may feel like they should “handle it themselves.”*
- *About 60% of people aged 65 and over believe it is “normal” for people to get depressed as they age.*

Although other members of the patient’s Depression Care Management Team may have the primary role in patient education, this section of the Medical Provider Reference Chart includes patient education materials which may help you anticipate and alleviate the depressed patient’s concerns regarding their treatment.

### **When communicating with a patient, literacy is an important consideration.**

Most of those affected by low literacy include:

- Older patients
- Recent immigrants and those for whom English is a second language
- People with chronic diseases
- Those with low socioeconomic status

It is helpful to ask all patients this question to screen for limited health literacy skills:

**How confident are you filling out medical forms by yourself?**

Answers/ score:

Extremely (1); Quite a bit (2); Somewhat (3); A little bit (4); Not at all (5)

People with a score of 3 or higher should be identified as “at risk.” These patients need extra support for to understand and interpret health information. Support may be provided by medical staff or with permission of the patient, family or friends. Patients’ capacity to understand is also hindered by the shock of hearing a diagnosis, stress, fear, and dealing with multiple health problems.

This section contains 4 educational handouts\* for patients and their friends and family. You are encouraged to print off these handouts for use in your practice.

- Patient Handout: Medication Questions for the Patient to Ask Their Doctor\*
- Patient Handout: Frequently Asked Questions about Antidepressant Medication\*
- Friends/Family Handout: What Friends and Family Should Know About Depression
- Friends/Family Handout: How Can I Help?\*

\* Available in **Spanish** on the Higher Plain website.

## PLAIN TALK ABOUT DEPRESSION FOR SENIORS

### WHAT IS DEPRESSION?

- Depression affects all kinds of people.
- Depression is a disease that affects a person's brain.
- The brain helps us think and have feelings.
- People who have depression feel sad and feel bad about themselves.
- They may have trouble thinking and getting things done.
- This is because depression is causing problems in their brain.
- Depression often happens when a person has other health problems.

### WHAT SHOULD I DO ABOUT MY DEPRESSION?

- Talk to your doctor about your symptoms (how you are feeling).
- Depression is not a normal part of aging.
- Your doctor will find treatments to help you get better.
- You may need to take medicine.
- You may need to have counseling (talking to someone about your problems).
- You may need medicine and counseling.

### WHY IS IT IMPORTANT FOR ME TO GET HELP FOR MY DEPRESSION?

- It will make your life better.
- It may make your other health problems get better.
- You can get your energy back.
- You can enjoy doing the things you used to like doing.
- You can take care of yourself better.
- You can get along better with friends and loved ones.

This patient handout is available in **Spanish** on the Higher Plain website:  
<http://www.higherplain.org>

Booklets called "Depression Toolkits" are also found on the Higher Plain website. These booklets are written for depressed people and their families.

**MEDICATION QUESTIONS FOR THE PATIENT TO ASK THEIR DOCTOR**  
ENGLISH VERSION

How long will I need to be on this medication?

When will I begin to feel better?

What should I do if I don't feel better?

What if I can't afford the drugs?

Will these drugs change a health problem I have, or make it worse?

Can I take herbal or "natural" remedies, drugs, alcohol, and other medications with these drugs?

What are the side effects?

Who do I call if I am having a bad side effect from my medication?

**When taking medications, remember to:**

- Go to all of your medical appointments.
- Talk to your care givers about any concerns you have about the drugs you take.
- Take medication exactly as prescribed – follow directions.
- Tell your doctor when you are doing better and if you're doing worse.
- Give your pharmacist a list of ALL the meds you are taking so they can make sure you won't get sick from a negative drug interaction.

Space for more questions

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<http://www.higherplain.org>

Booklets called "Depression Toolkits" are also found on the Higher Plain website and can be downloaded and printed for free. These booklets are written for depressed people and their families. Booklets are also available for community members

**PATIENT HANDOUT: FREQUENTLY ASKED QUESTIONS ABOUT ANTIDEPRESSANT  
MEDICATION** Page 1 — ENGLISH VERSION

**How do antidepressants work?**

They help correct the balance of important chemicals in the brain that affect a person's mood.

**Are antidepressants addictive (Will I get hooked on these drugs)?**

No, absolutely not. They are not addictive or habit-forming, and they do not make you feel "high".

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

Between 50% and 80% of people with depression get well after taking their medications as directed. If you do not feel better after about 6 weeks of taking the first type of medicine, your doctor will have you try a different antidepressant.

**How long will my medication take to work?**

People with depression often start to feel better after taking an antidepressant medication for two to six weeks. In many cases, sleep and appetite improve first before your mood and energy do. If you are still feeling depressed after about six weeks, your doctor may want to increase the dose of the medication you are taking or switch you to another antidepressant.

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

Once you have completely recovered from your depression episode, you should stay on the medication for four to nine months longer to keep your depression from coming back. Some people who have had episodes of depression before should stay on antidepressant medication for a longer time to prevent new episodes of depression.

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

Do **not** take two doses to make up for the dose you forgot without asking your doctor. Take your next dose at the regular time.

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

Alcoholic drinks can produce side effects in some people taking antidepressants. Therefore, if you plan to have any liquor while taking medication, you must talk to your doctor about it.

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

In general, antidepressants can be taken safely with other medications. But you must tell your doctor about ALL of the other medications you are taking. Tell them about over-the-counter medications so she or he can make sure that you won't get a negative drug interaction.

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

This patient handout is available in **Spanish** on the Higher Plain website: <http://www.higherplain.org>. Additional information for depressed people and their families is available in English on the Higher Plain website.

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

No. Do not stop taking the medication unless your doctor tells you to. If you stop taking the medicine too soon, your depression could come right back. When the time is right to stop your medication, your doctor will have you stop taking it bit by bit to give your body time to adjust. In most cases, you should expect to keep taking the medication for four to nine months after all the signs of your depression have gone away.

**My problem is I can't sleep. How can an antidepressant help with this?**

For many people, trouble sleeping is their main symptom (sign) of depression. Once the depression lifts, sleep improves too.

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

Some antidepressants can help relieve (take away) pain. This can help people with health problems like diabetic neuropathy, postherpetic neuralgia, and phantom limb pain.

**I have low energy and feel tired a lot of the time. Can an antidepressant help?**

Low energy and feeling tired are common in people with depression. Once the depression improves, their energy starts to return too. Antidepressants can help people who are depressed get their energy back. Then they can start to enjoy life again.

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

Stress may lead to anxiety, insomnia (not being able to sleep), and depression. Use of an antidepressant may help relieve (take away) those symptoms.

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

In many cases, anxiety can be caused by depression. When treatment makes the depression go away, the anxiety may go away too. Some antidepressant medications are also good for treating anxiety disorders.

**Are there any dangerous side effects?**

Side effects from antidepressants are usually mild. Ask your doctor what to expect and what to do if you have a problem.

In many cases, your body will get used to the medication and you won't be bothered with the side effect for long. In other cases, your doctor may tell you to lower the dose, or add another medication, or change to another antidepressant.

If you take your antidepressant medication by following directions from your doctor and pharmacist, dangerous or life-threatening side effects are very unlikely to happen.

**FRIENDS/FAMILY HANDOUT: WHAT FRIENDS AND FAMILY SHOULD KNOW ABOUT DEPRESSION — ENGLISH VERSION**

Family and friends can be helpful to a depressed person during an episode of depression.

**I am a family member or friend. I worry ...**

- Is this my fault?
  - ◆ It is easy to feel guilty about a loved one's illness. The truth is, the cause of depression is unclear. Instead of worrying about the past, think of things you can do from now on to help. When someone is depressed, they will be more crabby, and less interested in other people. Don't take it personally.
- What if I just make things worse?
  - ◆ Self-blame is a big part of depression. Try not to fall into that trap yourself. You won't always know the right thing to say, but don't let that stop you from talking. It's good to let your loved one know you care and that you are there to help. Don't give up on them.
- What should I avoid doing or saying?
  - ◆ Don't say, "Can't you just get a grip on yourself?"
  - ◆ Don't use words such as lazy, oversensitive, weak, wimpy, grumpy, self-absorbed, hopeless, confused, moody, etc.
  - ◆ Depression is not the same as being lazy. If your friend or loved one can't do the things they used to, this may put some strain on you. Try to recall times when you were feeling down, or needed the help of others.
  - ◆ Don't use the silent treatment.
  - ◆ You may want to say nothing for fear of saying something wrong. Silence leaves lots of room for a depressed person's negative or self-critical ideas. If you don't know what to say or do, try asking them. Keep trying to connect with them.
  - ◆ Don't say, "You're acting like you didn't take your pill today."
  - ◆ Try not to link taking antidepressant medication with negative events. This may give a reason to your loved one to stop taking medicine. Encourage them to talk with their doctor if you think they may have

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## FRIENDS/FAMILY HANDOUT: HOW CAN I HELP? — ENGLISH VERSION

### How can I help?

- **Encourage activities they enjoy.**

Physical and social activities work as natural antidepressants. They help people with depression get back their energy and motivation, helping depression drain away. Invite your depressed friend or loved one on a walk, or to a movie. Join them for a physical, social, or fun activity every day. You may be met with some resistance. Start slowly, offer lots of encouragement, and keep at it.

- **Encourage hope.**

Believe that your depressed friend or loved one will get better. Remind them of a past success, and good times they've had. Encourage them to be hopeful and believe they will get better. It is hard for depressed people when friends and loved ones treat them differently. Non-judgmental love from family and friends is very helpful.

- **Help turn mountains back into molehills.**

Simple daily problems can be scary to someone who feels depressed. You can help make problems easier to handle by helping your loved one to:

- 1) Break the problem into small pieces.
- 2) Decide what to take on first.
- 3) Pick out one or two small steps to start with.
- 4) Set a specific time and place to get started.
- 5) Notice and praise their success.

- **Get involved in the depression treatment.**

Depressed people feel very much alone. Offer to help in a way that works for you. The two of you can read about depression and talk about what you have learned together. You might go along on health care visits.

- **Point out improvements.**

Tell your loved one when you see improvements. Point out attitude and behavior changes when treatments seem to be working. This is very helpful because you may notice positive changes before the depressed person does.

- **How can I keep depression from coming back?**

Once things are better, you can help by watching out for early warning signs. If signs of depression begin to appear again, you may be the first to notice. Sleep problems, crabbiness, and pulling away from social situations are signs that the depression is coming back.

This patient handout is available in **Spanish** on the Higher Plain website: <http://www.higherplain.org> . Additional information for depressed people and their families is available in English on the Higher Plain website.

## PRINTABLE ASSESSMENT TOOLS & REFERENCES

<b>Topic</b>	<b>page</b>
<b><i>PHQ-9 (Patient Health Questionnaire)</i></b> <i>with Scoring and Interpretation</i>	<b>34</b>
<b><i>HADS (Hospital Anxiety and Depression Scale)</i></b> <b><i>Anxiety Subscale</i></b> <i>with Scoring and Interpretation</i>	<b>37</b>
<b><i>Cognitive 6-Item Screener</i></b> <i>with Scoring and Interpretation</i>	<b>39</b>
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## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Over the <b>last 2 weeks</b> , how often have you been bothered by any of the following problems? (use "b" to indicate your answer)	Not at all	Several days	More than ½ 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/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
(for office) <b>Total Score =</b>			+	+
<p>If you checked off <b>any</b> problems on this questionnaire, how <b>difficult</b> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p> <p> <input type="checkbox"/> Not difficult at all              <input type="checkbox"/> Somewhat difficult              <input type="checkbox"/> Very difficult              <input type="checkbox"/> Extremely difficult         </p>				

Adapted from Kroenke K, Spitzer RL, Williams JB: The PHQ-9: validity of a brief depression severity measure. Journal of General Internal Medicine 16:606-13, 2001.

## The Patient Health Questionnaire (PHQ-9)

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

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

### Using PHQ-9 for Diagnostic Assessment

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

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

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

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

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

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

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

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

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

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

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

Patient Name	Date	Score

### Hospital Anxiety and Depression Scale (HADS) – Anxiety Subscale

Emotions play an important part in most illnesses. This activity is done so we can learn about how you feel. Read each item and check the reply that comes closest to how you have been feeling in the past week. Don't take too long over your replies. Your first reaction to each item will probably be more accurate than a long thought-out response.

Statement	Response
I feel tense or "wound up"	<input type="checkbox"/> most of the time <input type="checkbox"/> a lot of the time <input type="checkbox"/> from time to time occasionally <input type="checkbox"/> not at all
I get a sort of frightened feeling as if something awful is about to happen	<input type="checkbox"/> very definitely and quite badly <input type="checkbox"/> yes but not too badly <input type="checkbox"/> a little but it doesn't worry me <input type="checkbox"/> not at all
Worrying thoughts go through my head	<input type="checkbox"/> a great deal of the time <input type="checkbox"/> a lot of the time <input type="checkbox"/> from time to time but not too often <input type="checkbox"/> only occasionally
I can sit at ease and feel relaxed	<input type="checkbox"/> definitely <input type="checkbox"/> usually <input type="checkbox"/> not often <input type="checkbox"/> not at all
I get a sort of frightened feeling like "butterflies" in the stomach	<input type="checkbox"/> not at all <input type="checkbox"/> occasionally <input type="checkbox"/> quite often <input type="checkbox"/> very often
I feel restless as if I have to be on the move	<input type="checkbox"/> very much indeed <input type="checkbox"/> quite a lot <input type="checkbox"/> not very much <input type="checkbox"/> not at all
I get sudden feelings of panic	<input type="checkbox"/> very often indeed <input type="checkbox"/> quite often <input type="checkbox"/> not very often <input type="checkbox"/> not at all

Bjelland I., Dahl A.A., Haug, T.T., & Neckelmann, D. (2002). The validity of the Hospital Anxiety and Depression Scale; an updated review. *J Psychiat Res*, 52, 69-77.

## Hospital Anxiety and Depression Scale (HADS) - Anxiety Subscale SCORING SHEET

Total the amount of points on the HADS TEST. Higher numbers indicate the presence of anxiety.

Question #	
1	3 2 1 0
2	3 2 1 0
3	3 2 1 0
4	0 1 2 3
5	0 1 2 3
6	3 2 1 0
7	3 2 1 0

<b>Interpretation:</b>	
Minimum score: 0	
Maximum score: 21	
<b>Subscore</b>	<b>Anxiety:</b>
<=7	not present
8-10	doubtful
>=11	definite

## Cognitive 6-Item Screener with scoring and interpretation

(This screener is given verbally. Speak loudly and clearly. Read the text in **bold** print aloud to the patient.)

### Part A

**I would like to ask you some questions that ask you to use your memory. I am going to name three objects. Please wait until I say all three words, then repeat them. Remember what they are because I am going to ask you to name them again in a few minutes. Please repeat these words for me:**

**APPLE – TABLE – PENNY.**

(Interviewer may repeat words 3 times if necessary, but repetition is not scored.)

### Part B

Ask the patient:

1. **What year is this?**
2. **What month is this?**
3. **What is the day of the week?**

### Part C

**What were the three objects I asked you to remember?**

Scoring:

<i>Part A</i>		
Did the patient correctly repeat all three words?	Yes	No
<i>Part B</i>	Correct	Incorrect
1. What year is this?	1	0
2. What month is this?	1	0
3. What is the day of the week?	1	0
<i>Part C</i>		
4. Apple=	1	0
5. Table=	1	0
6. Penny=	1	0
Total		

Interpretation:

Score of 4 or less indicates that a referral to a specialist is recommended.

Older depressed adults experiencing ongoing cognitive decline may be at higher risk for poor depression outcomes and may require more careful clinical monitoring and management of both cognitive and affective symptoms.

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