

# BEYOND DEPRESSION: *Toolkit for Medical Providers*

## ■ DESK REFERENCE

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The full Tool Kit and additional materials can be found on the Internet at:

[www.depression-primarycare.org](http://www.depression-primarycare.org)

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The project focuses on increasing science-based knowledge and skills in identifying and treating Major Depression, and promoting self-care for urban and rural residents in Iowa.

The goals of the project are:

- Create and disseminate toolkits on Major Depression for 1) medical providers, 2) community members, and 3) those who live with Major Depression.
- Offer consultation and technical assistance.
- Provide community and professional trainings.

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Please help us improve future editions of this toolkit by giving us your feedback. The feedback form for this toolkit is found on the web at:

**<http://www.beyonddepression.info/pdf/provider1.pdf>**

This publication is designed by Linden Tree Web Works.

## MacArthur Toolkit Excerpts

A quick way of screening patients you think may be depressed requires asking patients these two questions:

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 asking more detailed questions or using PHQ-9 patient questionnaire. (See following page.)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

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

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

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use “✓” to indicate your answer)	Not at all	Sev-eral days	More than ½ the days	Nearl-y every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling/staying asleep, sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
<b>add columns:</b>			+	+
<b>TOTAL:</b>				

If you checked off <i>any</i> problem on this questionnaire so far, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

## MacArthur Toolkit Excerpts

### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Diagnostic Categories for Depression

PHQ-9 Symptoms & Impairment	PHQ-9 Severity	Provisional Diagnosis	Treatment Recommendations**
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 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.

AHCPR (AHRQ) Treatment Guidelines

ANTIDEPRESSANT TREATMENTS:  
ACUTE PHASE TREATMENT - AIM: REMOVING ALL SYMPTOMS

<i>Acute Phase - Expected Response</i>	<i>Continue Treatment</i>	<i>Modify Treatment</i>
<p><b>Every 1 - 2 weeks:</b> monitor patient compliance /symptoms;</p> <p><b>4 - 6 weeks:</b> <math>\geq</math> 5 point reduction in PHQ-9 score</p> <p><b>8 - 10 weeks:</b> 50% reduction in PHQ-9 score</p> <p><b>10 - 12 weeks:</b> near 100% reduction in symptoms, score &lt; 5 points on PHQ-9</p>	<p>If <b>partial response by 5 - 6 weeks</b>, continue with same antidepressant for another 5 - 6 weeks</p>	<p>* If <b>no response by 6 weeks</b>-increase dose or switch drugs</p> <p>* If <b>partial response by 12 weeks</b> - increase dose or switch drugs</p>

CONTINUATION/MAINTENANCE PHASE TREATMENT-  
PREVENTING RELAPSE/RECURRENCE

<i>Type of Patient</i>	<i>Continuation Treatment</i>	<i>Maintenance Treatment</i>
<b>Initial Episode</b>	<b>4 to 9 months</b> after return to well state	Discuss with patient the Pros/ Cons of continuing antidepressant therapy based on severity of episode
<b>Recurrent Episode</b> (2 or more episodes of depression in a 5 year period)	At least <b>9 months</b>	Continue long-term maintenance therapy. Consult AHCPR (AHRQ) guidelines for details about maintenance treatment

PSYCHOLOGICAL COUNSELING TREATMENTS  
ACUTE PHASE TREATMENT - AIM REMOVING ALL SYMPTOMS  
CONTINUATION/MAINTENANCE PHASE TREATMENT-  
PREVENTING RELAPSE/RECURRENCE

<i>Severity of MDD</i>	<i>Initial Psychological counseling</i>	<i>Continue Psychological counseling</i>	<i>Modify Treatment Plan</i>
<b>Mild or Moderate</b>	<b>6 - 8 week trial</b> - partial remission of symptoms	If psychosocial function has not been fully restored	No improvement after <b>6 - 8 weeks</b> Only partial improvement <b>after 12 weeks</b>
<b>Severe</b>	Psychological counseling should be used <b>only in conjunction with antidepressants</b>	Prevents subsequent relapses and recurrences once treatment with antidepressants ends	Prevents subsequent relapses and recurrences once treatment with antidepressants ends

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

<b>Initial response after Four weeks of an Adequate Dose of an Antidepressant</b>		
<i>PHQ-9</i>	<i>Treatment Response</i>	<i>Treatment Plan</i>
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>		
<i>PHQ-9</i>	<i>Treatment Response</i>	<i>Treatment Plan</i>
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

See top of page 8 for further information on this diagram.

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

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.

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

<b>ACUTE PHASE: PATIENT RESPONSE TO TREATMENT</b>	
<i>Antidepressants</i>	
<p><b>4 - 6 weeks:</b> ≥ 5 point reduction in PHQ-9 score</p> <p><b>8 - 10 weeks:</b> 50% reduction in PHQ-9 score</p> <p><b>10 - 12 weeks:</b> near full response, remission of symptoms, score of &lt;5 on PHQ-9</p>	Continue with same treatment
<b>5 - 6 weeks:</b> partial response to treatment	Continue with treatment another 5 - 6 weeks
No response by 6 weeks or partial response by 12 weeks	Use alternative drug and/or combined treatment
<i>Psychological counseling</i>	
<b>6 - 8 week:</b> partial remission of symptoms	Continue with psychological counseling
No improvement at 6 - 8 weeks or only partial improvement at 12 weeks	Add antidepressants

## MacArthur Toolkit Excerpts

### SCHEDULING FOLLOW-UP APPOINTMENTS AFTER INITIAL MANAGEMENT (DEPRESSION SYMPTOMS PRESENT)

<b>Minor</b>	Watchful waiting, with a re-evaluation in 4 to 8 weeks
<b>Mild</b> - Major Depressive Disorder (PHQ-9 score of 5-14 and less than 5 symptoms endorsed as present "more than half the days")	Visit or phone contact <u>every month</u> .
<b>Moderate</b> - Major Depressive Disorder (PHQ-9 score of 15-19 or 5 or 6 symptoms endorsed as present at least "more than half the days")	Visit or phone contact <u>every 2 weeks</u>
<b>Severe</b> - Major Depressive Disorder (PHQ-9 score of $\geq 20$ or 7 to 9 symptoms endorsed as present at least "more than half the days")	Visit or phone contact <u>at least every week</u> .

At follow up visits, typical functions the clinician and/or support staff will perform include:

- Re-assessing the diagnosis of depression;
- Measuring changes in symptom severity (depression scores) and patient function;
- Making changes in treatment recommendations if improvements are not noted.

#### **Scheduling Follow-Up Appointments (After Symptom Resolution)**

Patients need regular contact with their primary care clinician after their symptoms have remitted to assure that they complete the course of recommended treatment and that there is no relapse of symptoms:

For all patients-those, with no active treatment, those on antidepressant medications and/or psychological counseling, a visit or phone contact should occur every 2-3 months following remission.

#### **Periodic Monitoring**

Major depression is often a chronic disease. Continuation of antidepressants for 4 to 9 months after achieving remission considerably reduces relapse<sup>2,9</sup>. As many as 40 - 50% of depressed patients may experience a new episode of depression within two years of a first episode of major depression. Once depression has recurred, the subsequent recurrence rate approaches 75%. Long-term maintenance for patients with recurrent episodes significantly reduces recurrence<sup>9</sup>. Many patients with recurrent depression do not seek help from their primary care clinician as soon as symptoms reappear. This makes it important for the primary care clinician or office to actively monitor the status of patients with a history of depression, for example in periodic check-ups once a year. It is also useful to have an increased level of suspicion regarding depression when these patients are seen in the interim for other problems.

**INFORMATION GUIDE TO ANTIDEPRESSANTS**  
*Revised June 2004*

Antidepressant *	Therapeutic Dose Range (mg/day)	Initial Suggested Dose	Titration Schedule**
<b>Serotonin Reuptake Inhibitors (SSRIs)</b>			
Citalopram (Celexa)	20 - 40	20 mg in morning with food (10 mg in elderly or those with panic disorder).	Maintain 20 mg for 4 weeks before dose increase. If no response, increase in 10 mg increments every 7 days as tolerated.
Escitalopram (Lexapro)	10 - 20	10 mg for escitalopram	Increase to 20mg if partial response after 4 weeks
Fluoxetine (Prozac)	10 - 80	20 mg in morning with food (10 mg in elderly and those with comorbid panic disorder)	Maintain 20 mg for 4-6 weeks and 30 mg for 2-4 weeks before dose increases. Increase in 10 mg increments at intervals of 7 days. If significant side effects occur within 7 days, lower dose or change medication.
Paroxetine (Paxil)	10 - 50 (40 in elderly)	20 mg once daily, usually in morning with food (10mg in elderly and those with comorbid panic disorder)	Maintain 20 mg for 4 weeks before dose increase. Increase in 10 mg increments at intervals of approximately 7 days up to a maximum of 50 mg/day.
(Paxil CR)	25 - 62.5 (50 in elderly)	25 mg daily (12.5mg in elderly and those with panic disorder)	Increase by 12.5 mg at weekly intervals, maintain 25 mg for 4 weeks before dose increase
Sertraline (Zoloft)	25 - 200	50 mg once daily, usually in morning with food (25mg for elderly)	Maintain 50 mg for 4 weeks. Increase in 25-50 mg increments at intervals of 7 days as tolerated. Maintain 100 mg for 4 weeks before next dose increase.
<b>Serotonin and Norepinephrine antagonist</b>			
Mirtazapine (Remeron)	15 - 45	15 mg at bedtime (7.5 mg for those in need of sedation / hypnotic)	Increase in 15 mg increments (7.5 mg in elderly) as tolerated. Maintain 30 mg for 4 weeks before further dose increase

## MacArthur Toolkit Excerpts

*Please see following page for further information on these antidepressants.*

\* \*\* † ‡

Advantages	Disadvantages
Probably helpful for anxiety disorders. Possibly fewer cytochrome P450 interactions. Generic soon.  s-enantiomer more potent than racemic, 10mg dose usually effective for most	
Helpful for anxiety disorders. Long half-life good for poor adherence, missed doses. Generic available. Less frequent discontinuation symptoms.	Slower to reach steady state. Sometimes too stimulating. Possibly more cytochrome P450 interactions.
FDA approved for most anxiety disorders. Generic soon.  May cause less nausea and GI distress	Sometimes sedating. Occasionally more anticholinergic-like effects. Possibly more cytochrome P450 interactions. May have more frequent discontinuation symptoms.
FDA approved for anxiety disorders. Safety shown post MI.	
<b>t</b>	
Few drug interactions. Less or no sexual dysfunction <u>Less</u> sedation as dose increased. May stimulate appetite.	Sedation at low dose only. May initially stimulate appetite.

**INFORMATION GUIDE TO ANTIDEPRESSANTS**  
*Revised June 2004*

Antidepressant*	Therapeutic Dose Range (mg/day)	Initial Suggested Dose	Titration Schedule**
<b>Norepinephrine- and dopamine-reuptake inhibitor</b>			
Bupropion† (Wellbutrin SR, Wellbutrin XL)	300 - 400	150 mg in morning	Increase to 150 mg b.i.d. after 7 days. Increase to 200mg bid if insufficient response after 4 weeks. 8 hours between doses and initially not at bedtime. With hepatic disease only 100 mg total per day.
<b>Serotonin and Norepinephrine reuptake inhibitor</b>			
Venlafaxine (Effexor, Effexor XR)	75 - 375	75 mg with food; if anxious or debilitated, 37.5 mg	Dose should be divided b.i.d. or t.i.d. unless XR. For extended release (XR) give 37.5 in a.m. then increase to 75 mg in a.m. after 1 week, 150 mg in the a.m. after 2 weeks. If partial response after four weeks increase to 225 mg in the morning. Norepinephrine effect only occurs above 150mg.
<b>Primarily Norepinephrine reuptake inhibitor</b>			
Desipramine‡ (Norpramin, Pertofrane)	100-300 (25-100 in elderly)	50 mg in the morning	Increase by 25 to 50 mg every 3 to 7 days to initially target of 150mg for 4 weeks.
Nortriptyline‡ (Aventyl, Pamelor)	25-150	25 mg (10mg in frail elderly) in the evening	Increase in 10-25 mg increments every 5 days as tolerated to 75mg. Dosing too high may be ineffective. Obtain serum drug levels after 4 weeks if not effective.

\* There are more antidepressants than those listed in this table; however, this list provides a reasonable variety of drugs that have different side effects and act by different neurotransmitter mechanisms. Treatment of Parkinson's disease may include selegiline (Eldepryl), which is a selective monoamine oxidase inhibitor at low doses only. Because the use of many antidepressants is contraindicated in conjunction with a nonselective MAOI, caution with or discontinuation of Eldepryl may be in order. For pregnancy, TCAs and SSRIs (particularly fluoxetine, because of more data collected) are not associated with congenital malformations or developmental delay. SSRIs in the third-trimester are associated with a slight decrease in gestational age and correspondingly lower weight, and occasionally with neonatal withdrawal symptoms. Diarrhea, drowsiness, and irritability are occasionally seen in breast fed infants of mothers taking antidepressants. The risks of maternal depression on child development should be balanced against the effects of antidepressants on an individual basis.

## MacArthur Toolkit Excerpts

Advantages	Disadvantages
Stimulating. Less or no sexual dysfunction.	At higher dose, may induce seizures in persons with seizure disorder. Stimulating. Usually b.i.d. dosing, unless more expensive XL
XR version can be taken qd Helpful for anxiety disorders. Possibly fewer cytochrome P450 interactions.	May increase blood pressure at higher doses. Bid dosing unless use XR. Expensive.
More effect on norepinephrine than serotonin, less sedating. Generic available.	Like all TCAs, anticholinergic. Caution with BPH. <u>Can exacerbate cardiac conduction problems or CHF.</u>
Availability of reliable, valid blood levels. Lower orthostatic hypotension than other tricyclics. Generic available.	Like all TCAs, anticholinergic. Caution with BPH. <u>Can exacerbate cardiac conduction problems or CHF.</u>

\*\* For SSRIs, generally start at beginning of therapeutic range. If side effects are bothersome, reduce doses and increase slower. In debilitated or those sensitive to medications, start lower. For all antidepressants, allow four weeks at a therapeutic dose, assess for a response. If a partial or slight response then increase the dose. If no response or worse symptoms then consider switching drugs.

† Generally avoid bupropion in patients with a history of seizures, significant central nervous system lesions, or recent head trauma.

‡ Tricyclic antidepressants (TCAs) have lower costs but somewhat higher discontinuation rates compared to SSRIs due to side effects and are more lethal in overdose. TCAs may be contraindicated in patients with certain physical comorbidities such as recent myocardial infarction, cardiac conduction defects, urinary retention, narrow angle glaucoma, orthostatic hypotension, and cognitive impairment.

**ANTIDEPRESSANT FACT SHEET page 1****Anxiolytics**

Anxiolytic medications (benzodiazepines and barbiturates) have not been shown to be effective in treating depression. Anxiolytics may be useful as an adjunctive, short-term medication (e.g. 12 weeks) for patients with pronounced anxiety. Benzodiazepines may be useful for short-term treatment (e.g., 2-6 weeks) for pronounced insomnia.

**Treating Elderly Patients With Antidepressants:**

- More sensitive to side effects, particularly to those of tricyclics; start with SSRIs.
- Are often on multiple other medications (beware of drug interactions).
- Metabolism is slower; may need lower doses, increase doses slowly.

**Discontinuing Antidepressant Therapy**

While antidepressant medications are generally considered safe, they should be discontinued if they are not required. For first episodes of depression, it is appropriate to discontinue medication after 4-9 months of continuation phase treatment. Tricyclic antidepressants and other drugs listed on page 3 of the administration schedule should be tapered if the patient has had exposure at therapeutic dosages for 3 months or more. A tapering schedule of over 2 to 4 weeks is recommended.

**Managing Side Effects**

Clinicians may elect to refer to the table on page 36, which lists strategies for managing antidepressant side effects. This tool provides information about types of side effect, suggestions to minimize or eliminate the side effect and alternative drugs to consider if the patient cannot tolerate the side effect.

**Antidepressant Side Effects**

Side effects account for as many as two-thirds of all pre-mature discontinuations of antidepressants. Most side effects are early onset and time limited (e.g. SSRI decreased appetite, nausea, diarrhea, agitation, anxiety, headache). These can be managed by temporary aids to tolerance. Some side effects are early-onset and persistent or late onset (e.g. SSRI apathy, fatigue, weight gain, sexual dysfunction) and may require additional medications or a switch in antidepressant.

## MacArthur Toolkit Excerpts

### ANTIDEPRESSANT FACT SHEET page 2

#### Strategies for Managing Antidepressant Side Effects:

1. Allow patient to verbalize his/her complaint about side effects.
2. Wait and support. Some side effects (i.e. GI distress) will subside over 1-2 weeks.
3. Lower the dose temporarily.
4. Treat the side effects (see table).  
Change to a different antidepressant.  
Discontinue medications and start psychological counseling.

SIDE EFFECT	SSRIs & EFF-EXOR	TRICYCLICs (nortriptyline, amitriptyline, imipramine)	BUPRO-PION	MIRTA-ZAPINE	MANAGEMENT STRATEGY
Sedation	+/-	++	-	+	*Give medication at bedtime. <u>Increase</u> Remeron dose. *Try caffeine.
Anticholinergic -like symptoms: Dry mouth/eyes, Constipation, Urinary retention, Tachycardia	+/-	+++	-	+/-	*Increase hydration. *Sugarless gum/candy *Dietary fiber. *Artificial tears. *Consider switching medication.
GI distress Nausea	++	-	+	+/-	*Often improves in 1-2 weeks. *Take with meals. *Consider antacids or H2 blockers.
Restlessness Jitters/Tremors	+	+/-	++	-	*Start with small doses, especially with anxiety disorder. *Reduce dose temporarily. *Add beta-blocker (propranolol 10-20 mg bid/tid). *Consider short trial of benzodiazepine.
Headache	+	-	+	-	*Lower dose. *Acetaminophen.
Insomnia	+	-	+	-	*Trazodone 25-100 mg po qhs (can cause orthostatic hypotension and priapism). *Take medication in A.M.
Sexual Dysfunction	++	-	-	-	*May be part of depression or medical disorders. *Decrease dose. *Consider a trial of Viagra. *Try adding bupropion 100 mg qhs or bid. *Try adding buspirone 10-20 mg bid/tid. *Try adding cyproheptadine 4 mg 1-2 hrs. before sex.
Seizures	-	-	+	+/-	*Discontinue antidepressant.
Weight gain	+/-	+/-	+/-	++	*Exercise *Diet *Consider changing medications
Agranulocytosis	-	-	-	+/-	*Monitor for signs of infection, flu-like symptoms *Stop drug, check WBC

**DEPRESSION MONITORING FACT SHEET**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Symptoms	<i>DATE</i>	<i>DATE</i>	<i>DATE</i>	<i>DATE</i>	<i>DATE</i>
	<i>Week</i>	<i>Week</i>	<i>Week</i>	<i>Week</i>	<i>Week</i>
Mood					
Interest					
Appetite/weight					
Sleep					
Psychomotor					
Fatigue					
Self-Esteem					
Concentration					
Death/Suicide					
PHQ-9 Score (# Symptoms/Score)					
Suicidality (Question "i" score)					
Functioning (PHQ-9 #2 Question)					
Patient Impression					
Contact With Patient/ Phone = P Visit = V					
MH Referral					
Medications/ Dosage					
Patient Compliant With Recommendations					

We encourage you to contact providers of Mental Health Counseling Services in your area to determine the availability and waiting periods associated with a variety of services to treat Major Depression. We have included a form which you can use to record this information on the next 2 pages (18 and 19).

After filling in the survey form on the following pages, you will probably notice that there is a wide range of services, access, and information-sharing, as reported by those organizations which responded.

**Availability of Services to Treat Major Depression In Your Area\***  
 (contact providers of Mental Health Counseling Services to fill in this form)

Organization	Services for Major Depression	Waiting Period				Policies/Procedures						
		Emergency	Med Mgmt	Evaluation	Indiv. Counseling	Group Counseling	Indigent Drug Assist Program	Sliding Fee Scale	Procedure to Share Reports w/PCP			

\*Inclusion on this list does not constitute an endorsement of services.  
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Organization	Services for Major Depression	Waiting Period					Policies/Procedures					
		Emer-gency	Med Mgmt	Evalu-ation	Indiv. Coun-seling	Group Coun-seling	Indigent Drug Assist Program	Sliding Fee Scale	Procdure to Share Reports w/PCP			

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Please help us improve future editions of this toolkit by giving us your feedback. The feedback form for this toolkit is found on the web at:

**<http://www.beyonddepression.info/pdf/provider1.pdf>**