

BEYOND DEPRESSION: *Toolkit for Medical Providers*

Medical professionals have found a quick way of screening patients for depression by asking these two questions:

During the last month, have you often been bothered by:

- Little interest or pleasure in doing things?
- Feeling down, depressed, or hopeless?

If there is a “no” answer to both questions, the person is probably not depressed. If there is a “yes” to either or both questions, further screening should be done.

(Primary Care Evaluation of Mental Disorders
PRIME-MD, Two Question Screen)

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Companion toolkits include:

- Medical Provider Desk Reference
- Toolkit for Community Members
- Toolkit for Those Who Live With Depression

This publication is part of a project supported by The Wellmark Foundation, called *"Beyond Depression: Tools for Collaboration"*, developed by Joan Blundall, MS, HCA, and Carol Hodne, PhD, for Higher Plain Inc. June 2005.



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>

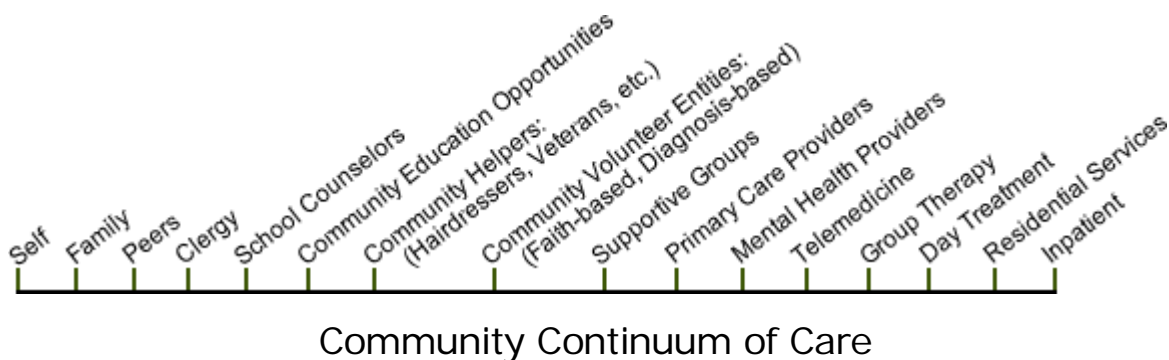
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Introduction

Best Practice Treatment of Depression

This toolkit is designed to provide science-based best practice information on treating Major Depression for use by health practitioners who work in mental health shortage areas and/or in medically underserved areas. Toolkits have been to help primary care providers more effectively recognize and manage depression. Tools include materials on rural risk factors, assessment and treatment, patient education, monitoring, and referral information to be filled in by workshop participants.

Several groups make up a community's Continuum of Care. Quality care happens when all segments of a community understand that each segment has a role in supporting the emotional well-being of individuals, families, and communities. Health care and community representatives have reviewed the toolkits in order to enhance their usability.



After review of the research regarding best practice programs available for integrating Treatment for Major Depression in Primary Care Practices, the Beyond Depression Project has identified the MacArthur Initiative on Depression & Primary Care as a key resource for medical providers. The Depression Management Toolkit has been included in the Beyond Depression Toolkit. Medical peer reviewers have found this material useful in considering how to provide quality care in both a medical and mental health shortage area. The reviewers recognize that medical providers in rural areas will find certain sections of the toolkit easy to implement in their practice, while other sections will be more difficult to implement.

The Institute of Medicine of the National Academies (2003), in *Priority Areas for National Action: Transforming Health Care Quality*, states:

- One in seven men and one in four women experience major depression at some point in their lives.
- The 2000 Global Burden of Disease Study estimates that major depression contributes to more disability than any other disorder within the United States.
- Fewer than 1/2 of the of individuals in community and primary care settings are correctly diagnosed.
- Less than one-third of those diagnosed receive care based on treatment guidelines.
- Because depression commonly occurs with other chronic disorders, outcomes are compromised when depression is not recognized and treated.
- Certain subgroups (e.g., older patients, ethnic minorities, less educated patients) are vulnerable to under-treatment and poor quality care.

Best Practice Philosophy

What Science Tells Us

The scientific literature indicates that Major Depression is one of the most costly chronic conditions facing our citizenry. When depression occurs with other disorders (e.g., congestive heart failure, diabetes, cancer, stroke, rheumatoid arthritis), patients may find it more difficult to adhere to depression treatment and engage in self-care. The literature shows that depression is under-diagnosed by primary care providers and they may not follow the recommended treatment regimens.

Quality Care for Major Depression

Four Key Components

1. Recognizing and assessing depression.
2. Educating the patient, while including the family.
3. Treating depression, while actively involving the patient, by utilizing medication, referrals to specialty services, counseling, or any combination of these options.
4. Monitoring symptoms and signs of relapse by using support staff, self-monitoring, family assistance, and/or peer supports.

Primary care providers in Iowa are often in difficult situations because they frequently provide service in Medically Underserved Areas as well as Mental Health shortage areas. Staff support may be limited. Limited access to specialty services can result in long waiting lists which hinders successful referral processes. Stigma and belief systems place barriers to patients' adherence to treatment recommendations. Beyond Depression is designed to help health care providers deal with these barriers. In medical shortage areas the community can be encouraged to strengthen its Community Continuum of Care. This is supportive of medical providers and those who live with depression.

Beyond Depression provides three separate, yet related, toolkits for medical providers, patients and their families, and community members. Treatment is most effective when all three groups are actively involved. The management of health and disease is too difficult to be handled in isolation. Healthy communities work cooperatively to make up for resource scarcity.

Risk Factors for Depression

Incidence of Co-morbid Depression	
Congestive Heart Failure	10% - 25%
Cancer	6% - 39%
Diabetes	11% - 15%
Stroke Patients	15% - 25%

Risk Factors for Depression

Rural and urban rates of depression among adults are generally similar; rates may vary within subpopulations. For example, farmers (especially younger ones) tend to have higher rates of depression than rural residents in other occupations. Elderly residents can face increased risks of depression from health problems, institutionalization, or socioeconomic problems.

Several serious medical conditions co-occur with depression. While the incidence of depression in the general population (within a six-month period) is 6.6%, the incidence of depression increases to 10-14% among patients with medical conditions. Co-morbid depression inhibits help seeking, and is related to poor self-care and poor adherence to medical recommendations. Significant role impairments are associated with co-morbid disorders, particularly hypertension, arthritis, asthma and ulcers.

The chart on the following page shows the general physical, psychosocial, and socioeconomic risk factors for depression and the risk factors that tend to be higher among farm and rural residents than urban residents. In general, rates of depression for women are twice those for men. "(W)" denotes risk factors that are often higher among women.

Limitations regarding the treatment of physical and mental health disorders in rural areas may increase the risk factors for the onset and recurrence of depression. Shortages of health and mental health professionals create barriers to accessing care for the treatment of depression and the physical problems that can create risks for depression. Professional shortages can make it difficult to develop and maintain effective collaboration and mutual referrals with other professionals.

The proportion of mental health care, particularly for continuing treatment, provided by primary care practitioners in rural America is higher than in urban areas. Fewer specialty mental health services exist in rural areas, and rural residents may have to drive great distances to obtain care. Both rural and urban Iowans often lack adequate insurance and do not seek treatment for physical disorders or mental health problems.

Physical Risk Factors

General:

- Genetic susceptibility
- Chronic/severe medical illness
- Chronic pain conditions
- Prolonged stress, related physical problems
- Care giving with chronic/severe disorders (W)
- Substance abuse
- Neurological illness
- Strong exposure to neurotoxins
- Pregnancy, postpartum depression (W)

Farm/Rural:

- Environmental health hazards
- Occupational health hazards
- Serious disability of self/family member from occupational accident/illness

Psychosocial Risk Factors

General:

- Major losses; unresolved grief
- Serious or prolonged stressors
- Severe, prolonged, or cumulative traumas
- Divorce, separation, widowhood
- Domestic abuse (W)
- Early childhood traumas and abuse (W)
- Low perceived control
- Social isolation
- Limited social support
- Neuroticism (negative affect-based trait)

Farm/Rural:

- Decline in community cohesion and resources
- Rural social isolation
- Death of family member from occupational accident/illness
- Stigmatized attitudes about mental health care

Risk Factors for Depression

Socioeconomic Risk Factors

General:

Serious or prolonged economic stressors
Economic hardship, scarcity of necessities
Unemployment, underemployment
Job insecurity
Low socioeconomic status (income, education, occupation)
Social and economic discrimination (W)
Internalized victim blaming

Farm/Rural:

Loss of farm or land
Financial adjustments, poor cash flow
Debt negotiation, bankruptcy, foreclosure
Severe weather and related stressors
Limited number of good jobs
Limited context for small businesses

Cognitive Risk Factors

People who are depressed or are at risk for depression often:

- Focus upon negative, self-relevant events, expectations, and evaluations
- Make cognitive distortions or “errors”
- Ruminates (repetitively mull over negative events)
- Make negative attributions (i.e., inferences about the causes of events, the behavior of others, oneself)
- Perceive the causes of negative events as:
 1. personal (internal) more than situational (external);
 2. global (general) rather than specific; and
 3. stable over time, rather than unstable.

This summary was adapted from Hodne, Carol J. (2003). Depression among rural residents: Etiology, treatment, and prevention. Prepared for professional trainings sponsored by United Behavioral Health.

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

Organization		Waiting Period						Policies/		
		Services for Major Depression	Name/ Address/ Phone	Emergency	Med Mgmt	Evaluation	Indiv. Counseling	Group Counseling	Indigent Drug Assist Program	Sliding Fee Scale

* Inclusion on this list does not constitute an endorsement of services.
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Availability of Services to Treat Major Depression In Your Area*
 (contact providers of Mental Health Counseling Services to fill in this form)

Organization		Waiting Period						Policies/				
		Services for Major Depression	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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Depression Measures Used in Primary Care Settings

Introduction

A variety of measures for depression exist. The following measures are commonly used to screen for depression in adults, including the elderly, in primary care settings. These measures are well-established and psychometrically sound. In selecting a depression measure, you may wish to consider the: (1) population to be screened, (2) time required to complete the measure, and (3) time and effort required to score the measure. These measures (except for PRIME-MD Two Question Screen) can be used to monitor severity of symptoms and response to treatment.

PRIME-MD, Two Question Screen

Number of items and administration time: Less than 1 minute to complete. Respondents select Yes or No responses for items that are framed in terms of "during the past month."

A No response to both questions indicates that the screen is negative. If the patient responds yes to either question, ask more detailed questions or administer a more detailed measure.

Effective initial screen. As a two-item measure, it less reliably monitors severity or response than longer measures.

It has been used in primary care settings, including rural populations.

Beck Depression Inventory (BDI)

Free, initial 20-item inventory takes 5-10 minutes to administer. Other updated versions available for a fee.

Respondents choose from four statements of symptom severity per item. Items are framed in terms of the "past few days." A Spanish version exists.

Scoring is completed by totaling the numbers next to each response. Score Range is 0-63.

Scoring categories: 1–10: These ups and downs are considered normal;

11–16: Mild mood disturbance; 17–20: Borderline clinical depression;

21–30: Moderate depression; 31–40: Severe depression;

over 40: Extreme depression.

It has been used with many populations.

Depression Measures Used in Primary Care Settings

Geriatric Depression Scale (GDS), Short and Long Versions

It takes 2-5 minutes to administer in the short version (15- item) and 5-10 minutes in the longer version.

Items are framed within the past week. Responses require a "yes" or "no" which makes the items easier to understand and answer. A Spanish version exists.

For the *long version*, score one point for each of these answers: 1.no; 2. yes; 3. yes; 4. yes; 5. no; 6. yes; 7. no; 8. yes; 9. no; 10. yes; 11. yes; 12. yes; 13. yes; 14. yes; 15. no; 16. yes; 17. yes; 18. yes; 19. no; 20. yes; 21. no; 22. yes; 23. yes; 24. yes; 25. yes; 26. yes; 27. no; 28. yes; 29. no; 30. no.

For the *short version*, score one point for each of these answers: 1. no; 2. yes; 3. yes; 4. yes; 5. no; 6. yes; 7. no; 8. yes; 9. yes; 10. yes; 11. no; 12. yes; 13. no; 14. yes; 15. yes.

In the *long version*, the range is 0-30 and the cut point is ≥ 11 . The cutoff points for long version are: normal: 0-9; mild depressives: 10-19; severe depressives: 20-30. In the *short version*, a score of 0-5 indicates the normal range, scores above 5 suggest depression.

Use with elderly populations (those older than 60 years). An advantage for elderly patients is that it contains fewer somatic items.

Hopkins Symptom Checklist

The 15-item Depression symptom inventory takes 2-5 minutes for a health care professional to administer.

Respondents use four frequency ratings from 1: "not at all" to 4: "extremely" to indicate their experience within the past week, including today. Versions exist in several languages.

The score is the average of the 15 items. An average score > 1.75 indicates the need for intervention.

The HSCL includes a category for depression (below) as well as other psychiatric categories, such as anxiety.

PRIME-MD Patient Health Questionnaire (PHQ-9)

(Actual form located on page 17 of the MacArthur Toolkit included with this manual, and on page 4 of the Beyond Depression: Toolkit for Medical Providers Desk Reference.)

The 9 items take 2-5 minutes to answer.

The four frequency ratings range from "not at all" to "nearly every day." The time frame is the last 2 weeks.

Refer to page 14 of the Mac Arthur Depression Toolkit for scoring procedures.

Use with rural or special populations. It is designed for use in primary care settings and is based on DSM-IV diagnostic criteria. It has been used in rural settings.

Depression Measures Used in Primary Care Settings

Screening Measures for Depression in Adults			
Measure	Number of Items	Time to Complete	Population/ Advantages
PRIME-MD 2-Item Screen	2	1 Minute	Initial screen
Beck Depression Inventory (BDI)	21	5 to 10 Minutes	Widely used
Geriatric Depression Scale (Long Version)	30	5 to 10 Minutes	Elderly patients
Geriatric Depression Scale (Short Version)	15	2 to 5 Minutes	Elderly patients, including those with dementia
Hopkins Symptom Checklist	15	2 to 5 Minutes	Widely used, includes other psychiatric disorders
PRIME-MD [PHQ-9] Patient Health Questionnaire 9	9	2 to 5 Minutes	Primary care settings

Primary Care Evaluation of Mental Disorders PRIME-MD, Two Question Screen

Question	Yes or No
1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?	
2. During the past month, have you often been bothered by little interest or pleasure in doing things?	

Depression Measures Used in Primary Care Settings

Mood Assessment Scale Short Form

Circle "yes" or "no" in answer to each question:

1. Are you basically satisfied with your life?	Yes	No
2. Have you dropped many of your activities and interests?	Yes	No
3. Do you feel that your life is empty?	Yes	No
4. Do you often get bored?	Yes	No
5. Are you in good spirits most of the time?	Yes	No
6. Are you afraid that something bad is going to happen to you?	Yes	No
7. Do you feel happy most of the time?	Yes	No
8. Do you often feel helpless?	Yes	No
9. Do you prefer to stay at home, rather than going out and doing new things?	Yes	No
10. Do you feel like you have more problems with memory than most?	Yes	No
11. Do you think it is wonderful to be alive now?	Yes	No
12. Do you feel pretty worthless the way you are now?	Yes	No
13. Do you feel full of energy?	Yes	No
14. Do you feel that your situation is hopeless?	Yes	No
15. Do you think that most people are better off than you are?	Yes	No

Depression Measures Used in Primary Care Settings

Mood Assessment Scale Long Form (page 1)

Circle "yes" or "no" in answer to each question:

1. Are you basically satisfied with your life?	Yes	No
2. Have you dropped many of your activities and interests?	Yes	No
3. Do you feel that your life is empty?	Yes	No
4. Do you often get bored?	Yes	No
5. Are you hopeful about the future?	Yes	No
6. Are you bothered by thoughts you can't get out of your head?	Yes	No
7. Are you in good spirits most of the time?	Yes	No
8. Are you afraid that something bad is going to happen to you?	Yes	No
9. Do you feel happy most of the time?	Yes	No
10. Do you often feel helpless?	Yes	No
11. Do you often get restless and fidgety?	Yes	No
12. Do you prefer to stay at home, rather than going out and doing new things?	Yes	No
13. Do you frequently worry about the future?	Yes	No
14. Do you feel like you have more problems with memory than most?	Yes	No
15. Do you think it is wonderful to be alive now?	Yes	No

Depression Measures Used in Primary Care Settings

Mood Assessment Scale Long Form (page 2)

Circle "yes" or "no" in answer to each question:

16. Do you often feel downhearted and blue?	Yes	No
17. Do you feel pretty worthless the way you are now?	Yes	No
18. Do you worry a lot about the past?	Yes	No
19. Do you find life very exciting?	Yes	No
20. Is it hard for you to get started on new projects?	Yes	No
21. Do you feel full of energy?	Yes	No
22. Do you feel that your situation is hopeless?	Yes	No
23. Do you think that most people are better off than you are?	Yes	No
24. Do you frequently get upset over little things?	Yes	No
25. Do you frequently feel like crying?	Yes	No
26. Do you have trouble concentrating?	Yes	No
27. Do you enjoy getting up in the morning?	Yes	No
28. Do you prefer to avoid social gatherings?	Yes	No
29. Is it easy for you to make decisions?	Yes	No
30. Is your mind as clear as it used to be?	Yes	No

Depression Measures Used in Primary Care Settings

Hopkins Symptom Checklist

Listed below are symptoms or problems that people sometimes have. Please read each one carefully and describe how much the symptoms bothered you or distressed you in the last week, including today.

In the last week, including today:	Not At All 1	A Little 2	Quite A Bit 3	Extremely 4
1. Feeling low in energy, slowed down.				
2. Blaming yourself for things.				
3. Crying easily.				
4. Loss of sexual interest or pleasure.				
5. Poor appetite.				
6. Difficulty falling asleep, staying asleep.				
7. Feeling hopeless about future.				
8. Feeling blue.				
9. Feeling lonely.				
10. Thoughts of ending your life.				
11. Feelings of being trapped or caught.				
12. Worry too much about things.				
13. Feeling no interest in things.				
14. Feeling everything is an effort.				
15. Feeling of worthlessness.				

Depression Measures Used in Primary Care Settings

Beck Depression Inventory (BDI) page 1 of 3

Item	Scale	Statements
1	0	I do not feel sad.
	1	I feel sad.
	2	I am sad all the time and I can't snap out of it.
	3	I am so sad or unhappy that I can't stand it.
2	0	I am not particularly discouraged about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel that the future is hopeless and that things cannot improve.
3	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failure.
	3	I feel I am a complete failure as a person.
4	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I used to.
	2	I don't get any real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with everything.
5	0	I don't feel particularly guilty.
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
6	0	I don't feel I am being punished.
	1	I feel I may be punished.
	2	I expect to be punished.
	3	I feel I am being punished.
7	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.
8	0	I don't feel I am any worse than anybody else.
	1	I am critical of myself for my weaknesses or mistakes.
	2	I blame myself all the time for my faults.
	3	I blame myself for everything bad that happens.
9	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry them out.
	2	I would like to kill myself.
	3	I would kill myself if I had the chance.
10	0	I don't cry any more than usual.
	1	I cry more now than I used to.
	2	I cry all the time now.
	3	I used to be able to cry, but now I can't cry even though I want to.

Depression Measures Used in Primary Care Settings

Beck Depression Inventory (BDI) page 2 of 3

Item	Scale	Statements
11	0	I am no more irritated by things than I ever am.
	1	I am slightly more irritated now than usual.
	2	I am quite annoyed or irritated a good deal of the time.
	3	I feel irritated all the time now.
12	0	I have not lost interest in other people.
	1	I am less interested in other people than I used to be.
	2	I have lost most of my interest in other people.
	3	I have lost all of my interest in other people.
13	0	I make decisions about as well as I ever could.
	1	I put off making decisions more than I used to.
	2	I have greater difficulty in making decisions than before.
	3	I can't make decisions at all anymore.
14	0	I don't feel that I look any worse than I used to.
	1	I am worried that I am looking old or unattractive.
	2	I feel that there are permanent changes in my appearance that make me look unattractive.
	3	I believe that I look ugly.
15	0	I can work about as well as before.
	1	It takes an extra effort to get started at doing something.
	2	I have to push myself very hard to do anything.
	3	I can't do any work at all.
16	0	I can sleep as well as usual.
	1	I don't sleep as well as I used to.
	2	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
	3	I wake up several hours earlier than I used to and cannot get back to sleep.
17	0	I don't get more tired than usual.
	1	I get tired more easily than I used to.
	2	I get tired from doing almost anything.
	3	I am too tired to do anything.
18	0	My appetite is no worse than usual.
	1	My appetite is not as good as it used to be.
	2	My appetite is much worse now.
	3	I have no appetite at all anymore.
19	0	I haven't lost much weight, if any, lately.
	1	I have lost more than five pounds.
	2	I have lost more than ten pounds.
	3	I have lost more than fifteen pounds. (Score 0 if you have been purposely trying to lose weight.)

Depression Measures Used in Primary Care Settings

Beck Depression Inventory (BDI) page 3 of 3

Item	Scale	Statements
20	0	I am no more worried about my health than usual.
	1	I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
	2	I am very worried about physical problems, and it's hard to think of much else.
	3	I am so worried about my physical problems that I cannot think about anything else.
21	0	I have not noticed any recent change in my interest in sex.
	1	I am less interested in sex than I used to be.
	2	I am much less interested in sex now.
	3	I have lost interested in sex completely.

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- Yeesavage, J. A., Brink, T. L., Rose, T. L., Lum, O., Huang, V., Adey, M., et al. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research*, 17, 37-49.

Annotated Reference List

The following articles describe issues and resources regarding best-practice treatment of depression in primary care settings, particularly in rural settings. Recent studies, particularly randomized trials, are emphasized. Related review articles are included.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, fourth edition revised*. Washington, DC: American Psychiatric Association.

This comprehensive manual describes symptoms, diagnostic and differentiating criteria, and co-morbid conditions for a wide variety of mental disorders, including various types of depression. It serves as the "gold star" encyclopedic standard for describing mental disorders for a variety of disciplines.

Casacalenda, N., Perry, J. C., & Looper, K. (2002). Remission in major depressive disorder: A comparison of pharmacotherapy, psychotherapy, and control conditions. *American Journal of Psychiatry*, 159(8), 1354-1360.

This recent article reviewed six randomized, controlled, double-blind studies (total n = 883 outpatients) that compared rates of remission of depression among three conditions: (1) medication treatment (with tricyclic antidepressants and phenelzine), (2) psychotherapy (especially cognitive behavioral and interpersonal therapies), and (3) control conditions. The median length of treatment was 16 weeks (with the range from 10 to 34 weeks). The control conditions were less effective than the medication and psychotherapy treatments, which did not vary in their effectiveness in producing remission. The remission rates were 24.4%, 46.4%, and 46.4%, respectively. Fewer (22.2%) patients discontinued psychotherapy, than discontinued medications (37.1%). The authors conclude that both psychotherapy and medications may be first-line treatments for mild to moderately depressed outpatients.

Geddes, J. R., Carney, S. M., Davies, C., Furukawa, T. A., Kupfer, D. J., Frank, E., & Goodwin, G. M. (2003). Relapse prevention with antidepressant drug treatment in depressive disorders: a systematic review. *The Lancet*, 361(9358), 653-661.

This recent, systematic study pooled data from 31 randomized trials (n = 4410) in order to assess how long antidepressant medications should be continued in order to promote remission and prevent relapse. Continuing treatment with various antidepressants reduced the odds of relapse by 70%, compared with discontinuing medication treatment. In average, the rate of relapse on active treatment was 18%, compared to 41% for placebo conditions. Results suggest that continued treatment with antidepressants would benefit people with recurrent depression. Greater benefits would accrue to those at higher risk of relapse. More research is needed to assess the optimum length of antidepressant treatments, including comparisons of individuals with varying risks of relapse.

Gilbody, S., Whitty, P., Grimshaw, J., & Thomas, R. (2003). Educational and organizational interventions to improve the management of depression in primary care: A systematic review. *JAMA*, 289(23), 3145-3151

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This thorough review of 36 studies regarding educational and organizational interventions to improve primary care-based depression management compared clinical effectiveness and cost-effectiveness of various types of interventions. Of the 36 studies, 21 had generally positive results and usually involved more complex, integrative interventions that were more involved than education or simple guideline implementation. Such successful interventions integrated: clinician education, nurse care management, and integration between primary and secondary care (consultation-liaison). This recent review provides an important summary for primary care practitioners seeking to efficiently improve their treatment of depression.

Keller, M. B., McCullough, J. P., Klein, D. N., Arnow, B., Dunner, D. L., Gelenberg, A. J., Markowitz, J. C., Nemeroff, C. B., Russell, J. M., Thase, M. E., Trivedi, M. H., & Zajecka, J. 2000. A comparison of Nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. *The New England Journal of Medicine*, 342(20), 1462-1470.

Major depression is increasingly viewed as a chronic condition for some people and may be associated with serious impairments. A few studies have been conducted to compare the relative efficacy of medications, psychotherapies, or their combination in treating major depression. This study had three 12-week conditions for treating 681 adults with major depression: (1) outpatient treatment with nefazodone, (2) cognitive behavioral psychotherapy, and (3) a combination of these treatments. Among the 519 participants who completed the study, the overall rates of response (remission and satisfactory response) were 55%, 52%, and 85%, for the above conditions, respectively, by week 12. Nefzodone was more effective earlier during the treatment, while psychotherapy was more effective during the second part of the treatment. By week 12, their efficacy was similar. These results support previous recommendations for using medication and psychotherapy for treating chronic depression.

Ludman, E., Katon, W., Bush, T., Rutter, C., Lin, E., Simon, G., Von Korff, M., & Walker, E. (2003). Behavioral factors associated with symptom outcomes in a primary care-based depression prevention intervention trial. *Psychological Medicine*, 33, 1061-1070.

Patients at high risk for depression recurrence or relapse who received a 12-month primary care-based intervention, compared to similar patients who received usual care for depression, reported greater improvement of depression management, monitoring (of depression symptoms and early warning signs), and planning for coping with high risk situations. Each group of patients (approximately ¾'s of which were women) had received "new" prescriptions for depression. The low-intensity intervention included education regarding depression, shared decision-making regarding maintenance medications, and cognitive-behavioral self-management strategies. This study among 386 Washington state participants also showed that improvements in depression symptom scores (measured by the Hopkins Symptoms Checklist) were linked to self-efficacy for depression management, monitoring symptoms and early warning signs, and engaging in pleasant activities and social activities.

Annotated Reference List

Rost, K., Nutting, P. A., Smith, J. L., Elliot, C. E., & Dickinson, M. (2002). Managing depression as a chronic disease: a randomized trial of ongoing treatment in primary care. *British Medical Journal*, *325*(7370), 934-940.

A randomized control trial (n = 211; 84% female) among twelve primary care practices across the U.S. (including four non-metropolitan practices) assessed the long-term benefits of a 24-month intervention to improve the treatment of depression in primary care settings by matching the duration of the intervention to the chronicity of depression. Depression care management was enhanced through routine depression screening by office staff and patient education and follow-up phone calls to depressed patients by trained practice nurses. The ongoing intervention improved symptoms of patients at 24 months, increasing their remission rates and improving their emotional and physical functioning. Length of antidepressant usage increased among the enhanced care patients during the 24 months. The greater utilization of counseling among the intervention patients occurred at six months and 12 months.

Schoenbaum, M., Unutzer, J., Sherbourne, C., Duan, N., Rubenstein, L. V., Miranda, J., Meredith, L. S., Carney, M. F., & Wells, K. (2001). Cost-effectiveness of practice-initiated quality improvement for depression: Results of a randomized controlled trial. *JAMA*, *286*(11), 1325-1330.

This 3-year randomized control trial regarding improvements in depression treatment among 46 primary care clinics involved 181 primary care clinicians and 1356 patients who screened positive for current depression. Outcomes from usual care were compared to outcomes from two interventions involving training to practice leaders and nurses, enhanced educational and assessment resources and either (1) nurses for medication follow-up or (2) treatment by trained local psychotherapists. Average health care costs, compared to costs for usual care, increased \$419 for the medication follow-up conditions and \$485 for the psychotherapy condition. Estimated costs per quality-adjusted-life-years (QALY) gained were \$15,331 to \$36,467 for the medication treatment, while estimated costs per QALY gained were \$9,478 to \$21,478 for psychotherapy. These results suggest the value and cost-effectiveness of improving access to psychotherapy for depression.

Schulberg, H. C., Katon, W., Simon, G. E., & Rush, J. (1998). Treating major depression in primary care practice: an update of the Agency for Health Care Policy and Research Practice Guidelines. *Archives of General Psychiatry*, *55*(12), 1121-1127.

This article reviewed randomized controlled interventions for treating major depression in primary care settings. Agency for Health Care Policy and Research treatment guidelines were emphasized. Primary care-based depression treatment should emphasize well-organized treatment programs, regular follow-up with patients, monitoring of their adherence to treatment, and specific roles for mental health specialists. The reviewed studies generally provided evidence of the efficacy of both antidepressants and time-limited depression-specific psychotherapies as first-line treatments for depression, particularly if it is mild or moderate. Results regarding cost-effectiveness of treatments were presented. The clinical and functional outcomes of depression patients can be improved at costs ranging from \$750-\$1500 per enhanced treatment episode.

Annotated Reference List

Simon, G. E., Von Korff, M., Rutter, C., & Wagner, E. (2000). Randomised trial of monitoring, feedback, and management of care by telephone to improve treatment of depression in primary care. *BMJ*, 320, 550-554.

Primary care patients (n = 613) in the Seattle area who had received new (within the last 120 days) prescriptions for antidepressants were assigned to one of three conditions for treating depression: (1) usual treatment; (2) patient monitoring and feedback to physicians and computerized algorithm-based recommendations; and (3) feedback plus care management (telephone follow-up 8 and 16 weeks following the initial prescription, treatment recommendations, and practice support by a care manager). Feedback only (condition 2) did not improve the treatment received or patient outcomes, compared with usual care. However, feedback plus care management (at an incremental cost of \$80) increased the use of at least moderate doses of antidepressants, improved symptoms at follow-up, and lowered the probability of major depression. Secondary benefits of phone call follow-up included: cost effectiveness, reduction in travel time and waiting time, and improved access for people in rural areas and with limited mobility.

Smith, J. L., Rost, K. M., Nutting, P. A., Elliott, C. E., & Duan, N. (2000). A primary care intervention for depression. *Journal of Rural Health*, 16(4), 313-323.

This study explored differences in the effects of best practice interventions on depression treatment in rural (n = 4) and urban (n = 8) primary care settings. A total of 432 patients (from the original total of 479) completed the 6-month study. Physicians and nurses were intensively trained in the AHCPR depression treatment guidelines so they could provide "enhanced care" to their depressed patients. Compared to rural usual care patients, the rural enhanced care patients had 2.70 times the odds of taking a 3-month course of antidepressants at recommended dosages (during the six months following baseline). This 2.70 odds ratio was significantly greater than the 2.43 odds ratio of the urban patients. Rural enhanced care patients had 3.00 times the odds of rural usual care patients of attending eight or more mental health counseling visits (during the six months following baseline). Rural patients in enhanced care practices had 2.00 times the likelihood of urban enhanced care patients of making at least one visit to a mental health counselor during this time. Enhanced care rural and urban patients didn't vary in the likelihood of making eight or more visits to such counselors. Estimated costs for enhanced care were provided.

Trustees of Dartmouth College. (2003). Depression management tool kit. V 1.2, December 23, 2003. *The John D. & Catherine T. MacArthur Foundation's Initiative on Depression & Primary Care*.

This science-based toolkit was developed to assist primary care practitioners in effectively treating patients with depression, according to best practices. Depression care management guidelines from the Agency for Healthcare Research and Quality are integrated throughout the toolkit. Practical and accessible clinical guidelines, education tools, and other resources help clinicians: (1) recognize and diagnose depression, (2) educate and engage patients in the treatment process, (3) treat depression using science-based best practices, and (4) monitor patient adherence to treatment.

About the MacArthur Depression Management Toolkit

Upon agreement with the MacArthur Foundation, The Higher Plain, Inc. Beyond Depression Project is providing a full copy of the MacArthur Foundation Initiative on Depression & Primary Care Management Toolkit. (The cover of the MacArthur document displays the graphic pictured on the next page.)

After review of the research regarding best practice programs available for integrating Treatment for Major Depression in Primary Care Practices, the Beyond Depression Project has identified the MacArthur Initiative on Depression & Primary Care as a key resource for medical providers. The Depression Management Toolkit has been included in the Beyond Depression Toolkit.

Medical peer reviewers in Cedar County have found this material useful in considering how to provide quality care in both a medical and mental health shortage area. Cedar County reviewers recognize that medical providers in rural areas will find certain sections of the toolkit easy to implement in their practice, while other sections will be more difficult to implement.

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>

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