Screening for Depression

Train the Trainer Manual

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ESRD Network Strategies

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ESRD Network 10

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Resource Material Legend

This icon represents materials that may be used by a patient. Please review these materials with your patient, provide instructions and encourage discussion.

This icon represents materials that may be used by a clinician to gauge a patient's condition, level of severity and allow for patient engagement.

Depression: General Information

Depression

Depression is a common health condition that affects patients' thoughts, feelings, behavior, and physical health. However, only about half of those affected by depression receive treatment, and most of those who are treated receive treatment in primary care. Moreover, many primary care patients have untreated depression, which contributes to poorer health outcomes and inflated healthcare costs. This applies to ESRD patients as well. While many of your dialysis patients will choose to receive treatment for depression from their PCP, this manual aims to help ESRD providers understand ways to help with the treatment process, whether in the clinic or at the PCP office.

Although depression can present in many forms, the most salient symptoms are often sadness, irritability, loss of interest, changes in sleep and appetite, fatigue, social withdrawal, concentration difficulties, and feelings of hopelessness or guilt. These symptoms often occur episodically and cause functional impairment. Patients with a history of depressive episodes are at increased risk for experiencing future episodes of depression.

Best-practice treatment of depression usually involves both medication and behavioral interventions. Treatment with antidepressant medication should be considered for patients with: current moderate to severe symptoms of depression, previous episodes of moderate to severe depression, chronic experience of mild depressive symptoms, and mild symptoms of depression that persist following other interventions (NICE Clinical Guidance 90). Several behavioral interventions for depression have demonstrated efficacy in primary care: Cognitive Behavioral Therapy, Problem-Solving Therapy, and Behavioral Activation. *Cognitive Behavioral Therapy* aims to identify and correct distorted cognitions that underlie depressive symptoms. *Problem-Solving Therapy* assists patients in resolving or coping with stressful experiences through the acquisition of adaptive coping skills. *Behavioral Activation* assists patients in developing a plan to re-engage in activities they once found enjoyable and meaningful, based on the rationale that symptoms often improve following re-engagement in pleasurable activities. These behavioral interventions can be adapted for use in the dialysis clinic.

Provider Action:

The Resource Materials section of this manual includes a patient handout entitled **What is Depression?** that provides brief overview of depression as well as a description of its symptoms and common treatment recommendations. Additionally, this section contains a list of frequently asked questions regarding antidepressant medications and a behavioral activation patient handout. This latter handout, **Do What You Used to Enjoy to Help Depression**, describes the rationale for behavioral activation—that deactivation, or the absence of engagement in pleasurable and meaningful activities, maintains or exacerbates depressive symptoms. Additionally, the handout guides the provider and patient through the process of identifying enjoyable and valued activities, developing a goal to act opposite his/her emotions, and a plan to engage in the identified activity despite their enduring lack of interest.

Fast Facts: Depression

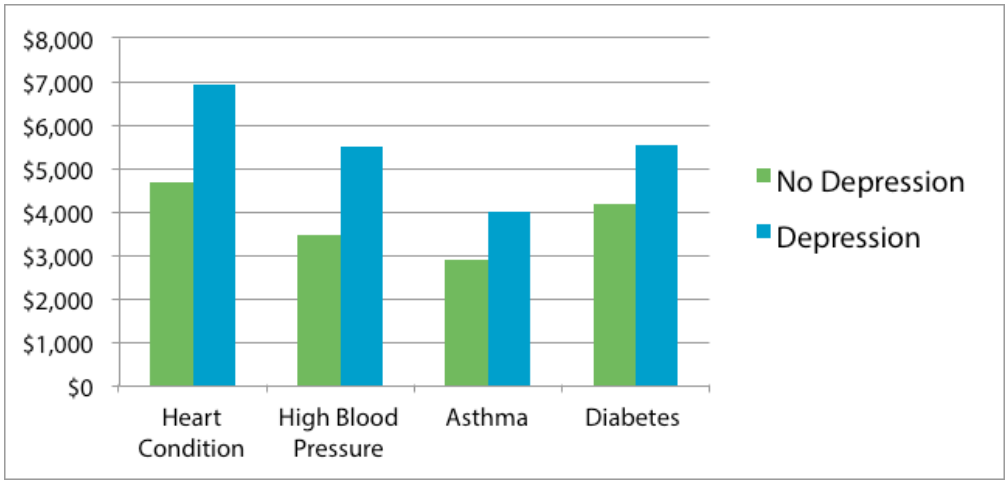
Depression is a common behavioral health concern that also impacts physical health status, yet it is often under-identified in primary care settings.

Untreated depression negatively impacts healthcare quality and cost. Additionally, challenges in effective care coordination for depression and other behavioral health conditions contribute to high hospital readmission rates and poor treatment adherence.

Most people do not go to specialty providers for treatment of behavioral health needs. In fact, of the 41 percent of people who do receive care for behavioral health needs, 56 percent of these people get this care from primary care providers. We know that dialysis patients can have very full schedules, so when dialysis professionals are able to perform similar interventions as PCP's, it can be very helpful for the patient.

Depression

- In a 12-month period, the incidence of depression in the general population is 3.2 percent. The incidence increases to 9.3 percent - 23 percent among patients with comorbid chronic medical conditions.[1]
- Patients with depression are three times as likely as patients without depression to be non-adherent with medical treatment, have more severe functional impairment, and poorer overall health outcomes.[2]
- Depression treatment in primary care for those with chronic health considerations resulted in **increased** total health care cost over 24 months.[5,6]



[1]Moussavi, S et al. *Lancet*. 2007; 370(9590) 851-858; [2]DiMatteo MR, et al. *Arch Intern Med*. 2000;160(14):2101-2107; [3]Katon et al., Diabetes Care. 2006;29:265-270;29:265-270; [4]U.S. Dept of HHS the 2002 and 2003 MEPS

Screening

Screening Recommendations

Depression

The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression in adult patients with a grade of B for the prevention and early detection of symptoms when an infrastructure is in place to address screening results. The Centers for Medicare & Medicaid Services (CMS) encourages and covers an annual screening for depression.

US Preventive Service Task Force Summary of Recommendations

Population	Recommendation	Grade
Adults age 18 and over – when staff-assisted depression care supports are in place	The USPSTF recommends screening for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up	**B** The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.
Adults age 18 and over – when staff-assisted depression care supports are not in place	The USPSTF recommends against routinely screening adults for depression when staff-assisted depression care supports are not in place. There may be considerations that support screening for depression in an individual patient.	**C** The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.

CROWNWeb Clinical Depression Screening and Follow-Up Reporting Options

In order to comply with QIP requirements, dialysis providers must submit Clinical Depression Screening and Follow-up Plan information for each eligible patient at least once during the calendar year.

The assessment periods are from Jan. 1 to Dec. 31 of each calendar year. Users can enter data during the entire assessment period and are given one month past the end of the assessment period (Jan. 31 of the next calendar year) to complete their reporting. On Feb. 1 the previous year's assessment period closes and the reported values become read-only.

- Only required to be submitted for patients age 12 or older
- Only required to be submitted for patients treated at the facility for 90 days or longer
- Only required of facilities with at least 11 eligible patients during the assessment period selected
- Only required of facilities with a CCN open date prior to July 1 of the assessment year selected

You will be asked to select one of the following options describing the clinical depression screening and (when necessary) the follow-up plan documented for the selected patient.

1. Screening for clinical depression is documented as being positive, and a follow-up plan is documented
2. Screening for clinical depression documented as positive, and a follow-up plan not documented, and the facility possess documentation stating the patient is not eligible
3. Screening for clinical depression documented as positive, the facility possesses no documentation of a follow-up plan, and no reason is given (Patients should not have a positive screen with no follow up plan documented)
4. Screening for clinical depression is documented as negative, and a follow-up plan is not required
5. Screening for clinical depression not documented, but the facility possesses documentation stating the patient is not eligible
6. Clinical depression screening not documented, and no reason is given (Patients should not have undocumented screening with no reason given)

Selecting Pre-Screening Tools

Screening begins with a brief pre-screen to determine if more comprehensive assessment is indicated. A positive pre-screen neither establishes a diagnosis nor necessarily indicates symptom severity, but it does suggest distress that should be further evaluated.

There are several evidence-based pre-screening tools that can be used to assess depression. Thus, it is possible to tailor the screening process to best meet the needs of the clinic and patient population. Below is the most commonly utilized evidenced-based pre-screening tool currently reported as being used by most dialysis providers.

Depression Prescreen

PHQ-2 (Patient Health Questionnaire-2)
The PHQ-2 assesses frequency of depressed mood and anhedonia within the past two weeks and includes the first 2 items of the more comprehensive PHQ-9. PHQ-2 scores range from 0-6. A score of 3 or higher is generally considered positive and suggests that further screening is indicated.

Languages – Wide variety, including English, Spanish, Arabic, Chinese (Cantonese, Mandarin), French, German, Greek, Hindi, Hebrew, Italian, Japanese, Russian, Swahili.
Literacy level – 8th grade reading level
Time to administer – 1 minute
Sensitivity – High
Specificity – Moderate to High
Reliability – High

Selecting Screening Tools

The majority of patients will generate negative pre-screens, indicating that no additional assessment is warranted. However, patients with a positive pre-screen need additional assessment to help guide intervention and treatment planning. There are numerous evidence-based screening tools. Included below is a non-exhaustive list of screeners commonly used in primary care. It is important to remember that a positive screen does not necessarily indicate diagnosis, but that further assessment is warranted.

Depression Screening Tools

Geriatric Depression Scale (Short Form) (GDS)

The Geriatric Depression Scale (Short Form) is a 15-question assessment of depression in patients who are elderly. The scale assesses the presence of depression-related distress in the previous week. A score greater than five is considered positive.

Languages – Available in 30 languages including English, Spanish, Chinese, Arabic, Dutch, Farsi, French, German, Greek, Hebrew, Hindi, Japanese, Italian, Korean, etc.
Literacy level – 4th grade reading level

Time to administer –5-7 minutes
Sensitivity – High
Specificity – High
Reliability – High

Hamilton Depression Rating Scale (HAM-D)

The HAM-D is a 21-item assessment of depressive symptoms. A score greater than seven is positive. HAM-D scoring also categorizes symptom severity with 10-13 indicating mild symptoms, 14-17 mild to moderate, and greater than 17 moderate to severe.

Languages – English, Spanish, Dutch, French, Chinese, Turkish, German, Thai
Literacy level – 8th grade reading level

Time to administer – 20-30 minutes
Sensitivity – Moderate to High
Specificity – High
Reliability – High

Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 is emerging as the standard measure of adult depression in primary care. It assesses the frequency of depressive symptoms in the prior two weeks. The first two questions of the PHQ-9 are the two questions which compose the PHQ-2. Four responses in the shaded section (see appendix) indicate a positive screen. Scores 5-14 indicate mild symptoms, 15-19 moderate, and 20 and above severe.

Languages – Wide variety including English, Spanish, Arabic, Mandarin, French, German, Greek, Hindi, Hebrew, Italian, Japanese, Russian, Swahili.
Literacy level – 8th grade reading level

Time to administer – <5 minutes
Sensitivity – High
Specificity – High
Reliability – High

Screening Implementation: Embedding Screening into Existing Workflow

It is essential that screening for depression use be embedded into the existing clinic workflow. Buiding screening into existing workflow improves acceptance and sustainability of the screening process, as it becomes a routine aspect of care. Many clinics find that it is helpful to view depression as "behavioral health vitals."

When developing your clinic workflow, which includes routine screening of depression, it can be helpful to consider the following:

Q: **Who will you screen and with what frequency?**

A: Most clinics that embed routine depression screenings into their clinic workflow recommend routinely screening all new patients and re-screening established patients annually. For dialysis clinics, QIP requires a depression screening *at least* once per year, but can and should be completed more often as needed.

Q: **What screeners will you use?**

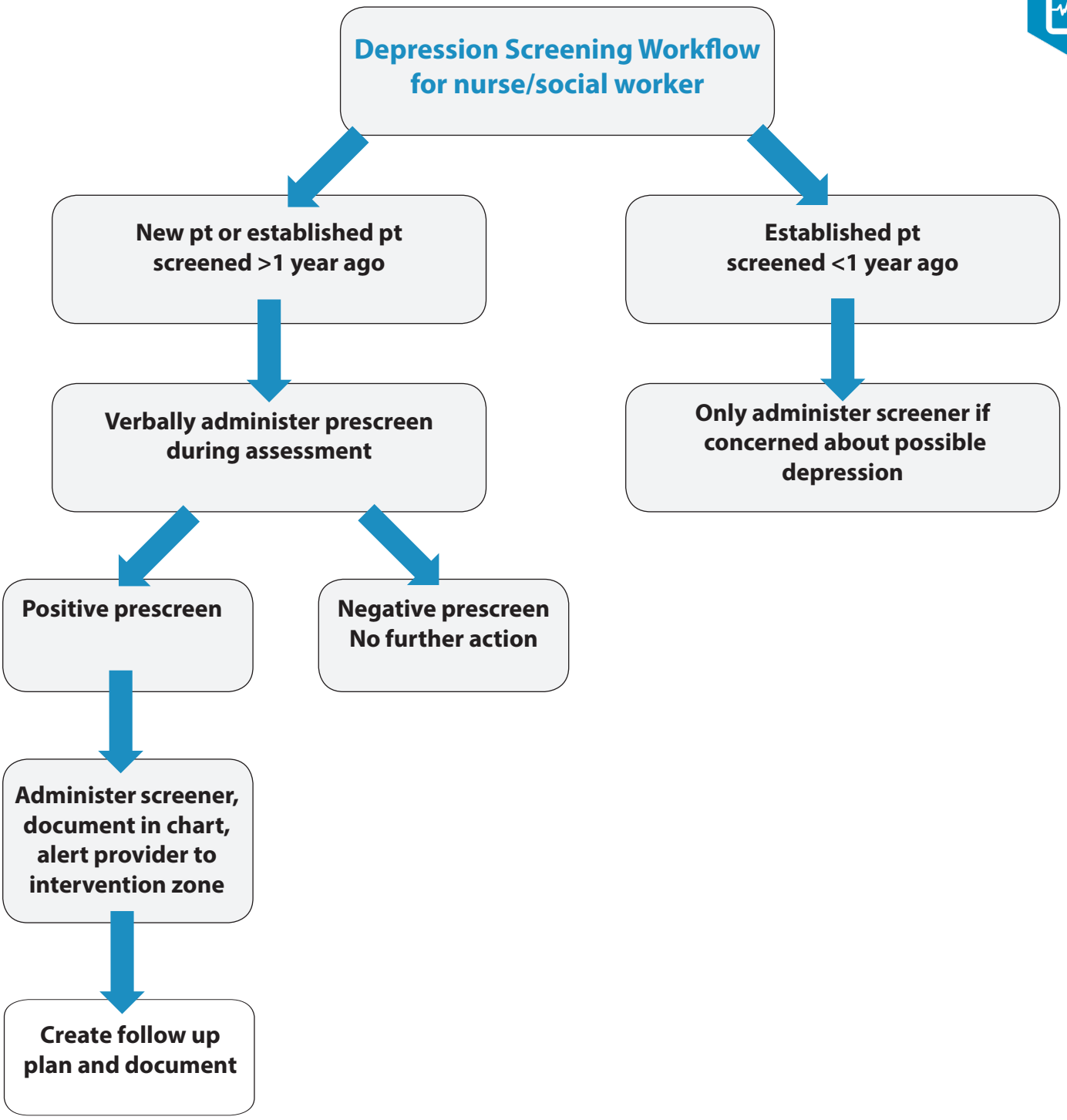
A: Consistent with the information presented above, most clinics choose to utlize psychometrically-sound, easy-to-admininster, and quick screeners that are easily understandable by patients with a wide range of literacy levels.

Q: **Who will administer the screeners?**

A: If screeners are embedded into the clinic workflow, it may be helpful to consider having nurses or social workers incorprate them into their vitals and assessment so that it becomes a regular component of patients' plan of care.

Tips from CHS: Our nurses administer our behavioral health vitals in conjunction with physical health vitals. As a result, our patients have grown accustomed to having their behavioral health needs addressed as a routine component of their care. This reduces stigma and helps with early identification and prevention efforts.

Tips from CHS: We use the PHQ-2 and the PHQ-9 to screen for depressive symptoms because of its psychometric properties, ease of administration, and short administration time. Our medical assistants and/or nurses administer these as a component of patients' behavioral health vitals


Depression Screening Workflow for nurse/social worker
New pt or established pt screened >1 year ago
Established pt screened <1 year ago
Verbally administer prescreen during assessment
Only administer screener if concerned about possible depression
Positive prescreen
Negative prescreen No further action
Administer screener, document in chart, alert provider to intervention zone
Create follow up plan and document

Screening Administration

Screening Administration Guidance

Step 1: Introduce and Administer Prescreens

Say: "May I ask you a few questions to help us care for you better? We routinely ask these questions to all patients seen in our clinic."

Screen: Administer depression & substance misuse prescreen

Triage: Was either prescreen positive?

Yes → Continue to Step 2

No → Screening complete. STOP
Inform provider of negative prescreening results

Step 2: Introduce and Administer Screeners

Say: "Thank you for your honesty. May I ask you a few more questions to help us help you?"

Screen: Administer screener for each positive prescreen.

Triage: Was either screener positive?

Yes → **Depression Screen Positive:**

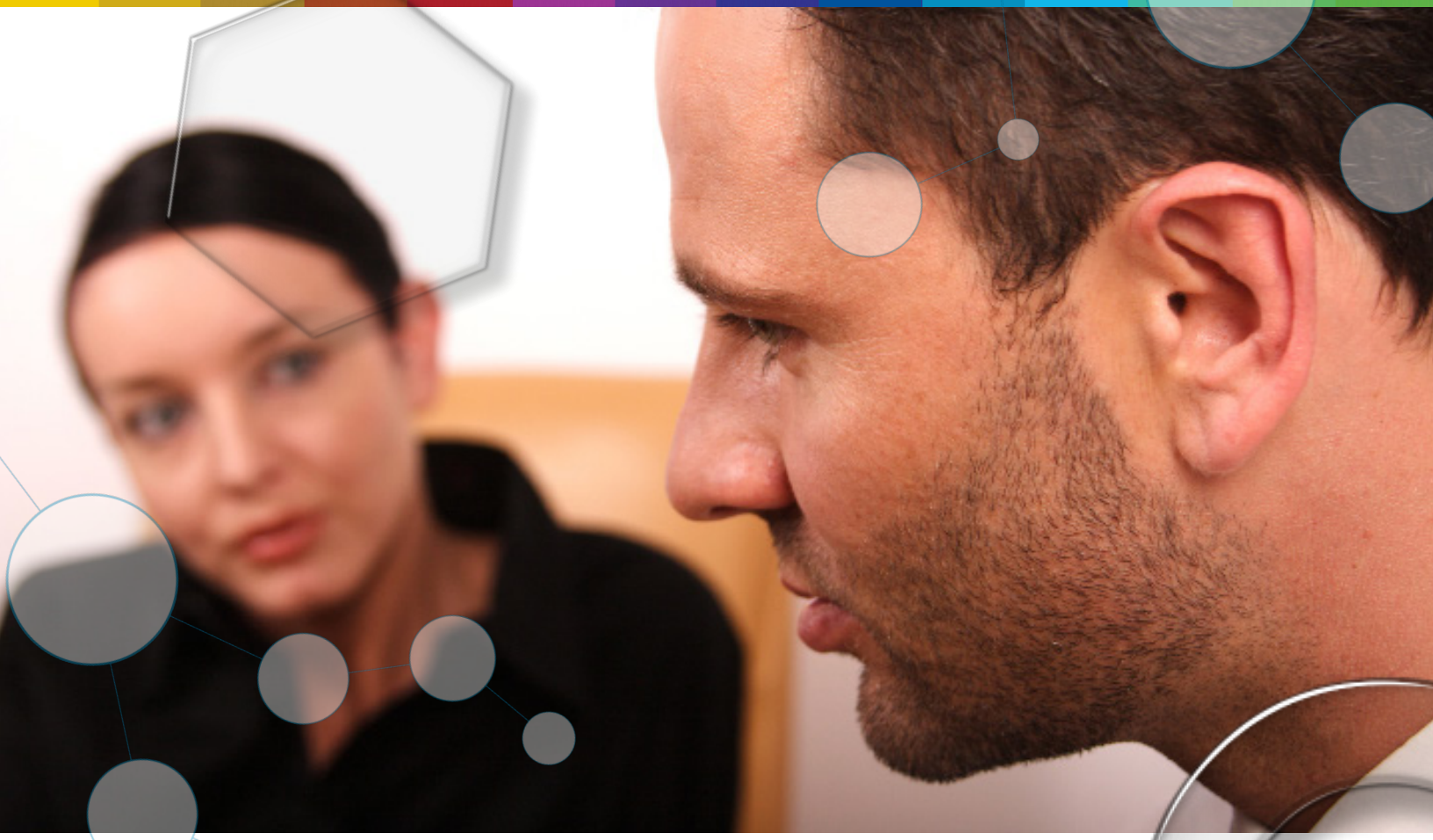
Ask: "Are you currently having thoughts about ending your own life or suicide?"

- **Yes** → Screening complete. STOP
  Inform provider of intervention **Zone Red** result.
- **No** → Go to Step 3.

Step 3: Triage & Care Coordination

1. Determine the intervention zone corresponding with patient's screening results: **Green (at-risk)** or **Yellow (positive)**.

→ Inform provider of zone. STOP



Intervention

Clinical Decision Making Considerations

Once a patient has completed screeners and scores have been triaged into intervention zones, the provider can plan clinically indicated intervention and follow up care using the following clinical decision making tool. These "TERMS" can be applied to most/all clinical scenarios, including dialysis clinics, to provide guidance for triage and intervention based on screening outcomes, patient need, and patient engagement.

Task demand (clinic flow, available clinic resources, type of visit, etc.)
Engaging the patient
Referral Resources
Moving patient towards motivation for change
Severity of symptoms

Provider Guide to Brief Intervention Following Positive Screening: Zones Green and Yellow

Step 1: Offer Feedback

Provide Feedback: Ask the patient's permission to talk about his or her screening results. If possible, connect the results to patient's current health problem(s) or risk posed to future health status.

Ask: "Have you ever thought about getting treatment for depression?"

Yes → Continue to Step 2

No → Proceed to Step 3

Step 2: Assess Motivation

Ask: "On a scale of 1-10, with 10 being the most, how interested are you in working with me to improve your depression today?"

Score of:

7-10 → Proceed to Brief Interventions for Depression Guidance.

1-6 → Continue to Step 3.

Step 3: Enhance Motivation

Ask: "If, hypothetically, you decided to partner with me to improve your depression, what might be the potential benefits."

Listen for statements about motivation to change.

Ask: "Would you like to talk about some treatment options today?"

Yes → Proceed to Brief Interventions for Depression and Guidance.

No → Express willingness to help in the future, offer a handout, and reassess patient's symptoms and motivation at next appointment.

Brief Interventions for Depression

Zone Green Intervention: Ask-Risk For Depression

- **Educate** patient about the benefits of healthy lifestyle choices, including exercise.
- **Monitor**.

Suggested patient handouts:

Did You Know? Fast Facts about Depression

Zone Yellow Intervention: Positive Screen

- **Educate** patient about best-practice treatment for depression (i.e., medication and behavior change).
- **Engage in collaborative** treatment planning.
  - **Consider** antidepressant medication.
  - **Consider** encouraging behavioral activation using *Managing Depression by Engaging in Activities You Enjoy* handout.
- **Offer referral** for behavioral health treatment if symptoms and functional impairment are severe or treatment refractory.
- **Monitor closely**.

Suggested patient handouts:

Did You Know? Fast Facts about Depression
Managing Depression by Engaging in Activities You Enjoy

Zone Red Intervention: Crisis Due to Acute Suicidal Ideation (see pg 25 & 26)

- **Remain calm**. Reinforce patient's honesty and indicate willingness to help.
- **Offer referral** for continued risk assessment and behavioral health treatment. See *Crisis Management in Primary Care* for assistance determining level of risk and appropriate level of crisis response (i.e., outpatient clinic, Mobile Crisis, or ER, etc.).
- **Engage another supportive adult**, with patient's permission, in the implementation of a safety and monitoring plan. Educate him/her about the need to monitor patient closely, engage in means restriction, and call crisis numbers/proceed to ER if symptoms intensify.
- **Monitor closely**.

Suicide Risk Assessment & Intervention Plan

(Screening):

1. "Do things ever get so bad you think about ending your own life or suicide?"

Yes → Go to Question 2.

No → Discontinue suicide risk assessment.

(Previous Suicide Attempt(s)):

2. "Have you ever tried to kill yourself before?"

Yes → Ask, "When did this happen" and "How did you try to kill yourself?" Go to Question 3.

No → Go to Question 3.

(Current Suicidal Episode):

3. "Are you currently having thoughts about ending your own life or suicide?"

Yes → Go to Question 4.

No → "When is the last time you had those thoughts?" and "Tell me more specifically about what you were thinking at that time." Go to Questions 6 and 7, and refer to decision tree.

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4. "Have you thought about how you might kill yourself?"

Yes → Go to Question 5.

No → Go to Question 6.

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5. "Do you have access to [*method*]?"

Yes → Go to Question 6.

No → Go to Question 6.

(Protective Factors):

6. "What is keeping you alive right now?"

Listen for reasons to live such as religious beliefs and social supports.

Then, go to Question 7.

(Substance Use):

7. "Are you currently using any substances such as alcohol, marijuana, cocaine, or pain or nerve pills?"

Yes → Ask, "How much and how often do you use [*substance(s)*]?" Then, refer to decision tree.

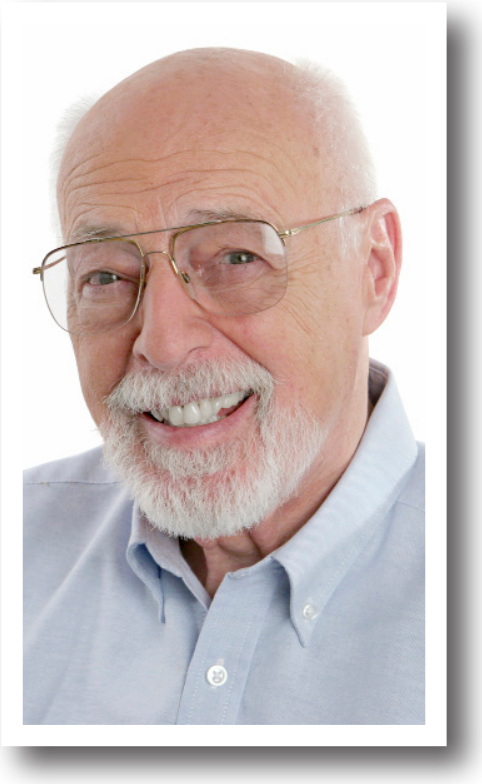
No → Refer to decision tree.

Decision Tree

Risk	Summary of Symptoms	Action
Low	• May feel depressed and have periodic thoughts of death, but no active suicidal ideation • No current plan or intent to harm self • No previous suicide attempts • Feels cared for by family/ friends • Wants things to change, some hope for the future • No or minimal substance use	• Reinforce healthy coping mechanisms and utilizing social support • Provide crisis numbers for the patient to use if active suicidal ideation were to develop
Moderate	• Regularly occurring thoughts of death or wanting to die that are difficult to get rid of • May be ambivalent about suicide plan and dying, not sure when but soon • May have access to means to carry out plan (e.g., has a friend who owns a gun) • Limited social support • Negative about future plans, may feel hopeless • May have had a previous suicide attempt • May be using substances to cope	• Develop safety plan with patient (i.e. restricting means, including family/friend for monitoring, crisis numbers) if suicidal ideation worsens or they have concerns about ability to keep themselves safe • Consider medication therapy for depression if clinically appropriate and close follow-up • If you are concerned about patient's safety or have doubts they will access crisis resources if suicidal ideation worsens, help them access care for voluntary admission via local resources or facilitate crisis assessment for involuntary admission
High	• Thoughts of death or wanting to die are intense and feel impossible to get rid of • Has plan for suicide with date and time in mind, access to lethal means to carry out plan, clear threats • Does not give reasons for living, wants to die • Limited or no social support, feels rejected and hopeless • Previous suicide attempts or severe self-mutilation • Current substance use	• Make sure the patient is in a safe location. If the patient is a flight risk notify designated staff member to keep an eye on the patient • See if patient would be willing to consider a voluntary hospitalization and help them access care via local resources • If unwilling to consider involuntary hospitalization facilitate crisis assessment for involuntary admission via local resources

* **Yes** responses to suicide risk assessment questions indicate patient is at an increased risk.

Patient Example #1



Patient:	Clyde Myers, 66 years old
Reason for Visit:	Chronic disease management: Diabetes & Hypertension End Stage Renal Disease
Medical Vitals:	Height: 5'11" Weight : 244 lbs. BP: 158/96 Pulse: 82 and regular
Behavioral Vitals:	PHQ-2—Positive PHQ-9—Score of 11

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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	Several days	More than half 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 or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching 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 CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult 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
☐	☐	☐	☐

Mr. Myers denies current suicidal ideation. Intervention zone = yellow

Patient Example #2

Patient:	Jane Doe, 71 years old
Reason for Visit:	ER follow up and discussion of recent aggressive behavior
Medical Vitals:	Height: 5'10" Weight : 168 lbs. BP: 132/80 Pulse: 82 and regular
Behavioral Vitals:	PHQ-2—Positive PHQ-9—Score of 4

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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	Several days	More than half 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 or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching 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 CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult 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
☐	☐	☐	☐

Significant symptoms were denied and patient denied ongoing impact of recent aggressive behavior. Intervention zone = green and will continue to monitor symptoms

Resources

Overcoming Common Challenges When Implementing Screening for Depression

Challenges	Potential Solutions
There isn't enough time for screening.	Make screening a routine component of existing workflow by implementing behavioral health vitals.
The visit is complicated enough without identifying additional problems requiring treatment.	The problem is present even if it is not identified through screening. Identification and treatment of depression will likely improve management of comorbid conditions.
Worry about offending the patient.	Introduce screening as means of offering comprehensive healthcare and describe depression as a treatable health condition.
Limited confidence and competence to treat the problems identified by screenings.	Dialysis providers spend a lot of time with patients. They may be able to offer first-line interventions (i.e., education, advice, medication, etc.). As with other health conditions, a specialty referral may be needed to provide a more intensive level of care.
Not sure how to refer.	Identify a referral issue the patient is concerned about. Ask the patient to meet with the referral source so that he/she "can help me, help you" address the patient's primary area of concern.
Concern that the patient won't follow through with the referral.	Patients may need assistance recognizing a problem and building motivation to engage in treatment. Education and motivational interviewing can assist patients in following through with referrals.

Stage-Matched Brief Interventions

Readiness to Change Stages	Brief Interventions
"I resent your assertion that I have a problem."	Stop, don't push. Convey readiness to help in the future. *"I respect that you don't want to talk about __ today. I'd like to partner with you to improve all aspects of your health. Maybe we could talk about __ at another time."*
"I don't have a problem."	Don't push. Ask permission and build awareness by providing personalized information. *"Would it be okay if I told you why I am concerned about your __?"* *"I worry that your ___ is…"*
"I know I have a problem, but I have no interest in changing at this time."	Don't push too hard. Encourage the patient to talk about his/her perception of the problem and discuss the potential benefits of changing. *"Would you tell me why you think your __ is a problem?"* *"If you decided you wanted to, can you think of potential benefits of changing?"*
"I'd like to change soon, but need some help determining how to begin."	Reinforce desire to change. "Excellent, we'd like to partner with you to make changes in your __." Problem-solve barriers and identify small action steps. *"Are there things that are getting in the way of you starting to make changes?"* *"Patients often find that __, __, or __ are helpful first steps. Would you like to try one of these options?"*
"I'm starting to make changes, but need help to continue to make progress."	Reinforce any progress thus far. Problem-solve barriers and refine action plan. *"Are there things that are getting in the way of you making more progress?"* *"What have you already tried (or considered trying)?"* *"What has been most helpful so far?"*
"I've made changes and am stable, but need help to stay that way."	Reinforce maintenance of progress. Identify successful strategies and problem-solve ways to continue to employ these. *"Can you identify strategies that have helped you manage your __ successfully?"* *"Can you identify any barriers to continuing these strategies to manage your __?"*

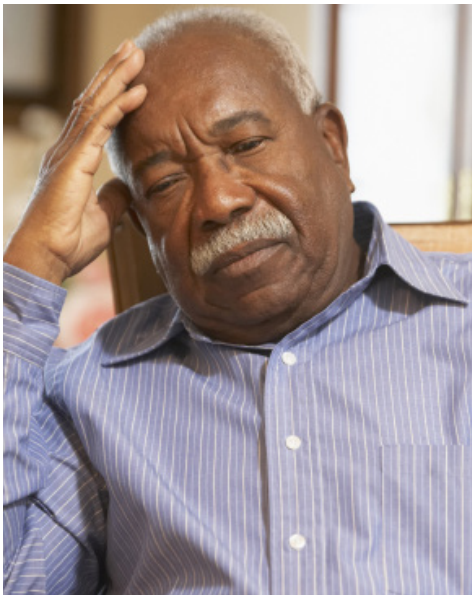
What is Depression?

Here are a few things to know about depression and ways that we can help you manage your symptoms and do the things in life that you enjoy again.

Depression is very common.

Depression is not just feeling down or sad. Some people say they also:

- Feel restless or really slowed down
- Have trouble enjoying things that used to be fun
- Have trouble getting stuff done
- Have trouble sleeping
- Feel tired all the time
- Have a poor appetite OR eat more than they usually do
- Lose weight OR gain weight
- Feel guilty
- Feel pain in their bodies
- Feel worthless, hopeless, or helpless
- Feel like they would be better off dead



Depression is treatable just like many other medical illnesses.

Treatment Options for Depression

Your doctor may recommend one or more of the following things to help you feel better and start doing the things that matter to you again:

1. **Medicine.** The most common medicine is called an antidepressant. Your doctor can talk to you more about that and if this type of medicine is best for you.

2. **Behavior change.** Your doctor may help you find a list of things that are fun to do and help you start planning ways to make time for those things again.

3. **Counseling/therapy.** Your doctor may be able to give you a list of therapists in your community who can help treat your symptoms and improve your functioning.

4. **Regular check-ins.** Even if you do not start medicine or therapy, your doctor will want to check in with you often to be sure your symptoms do not get worse and to help you if they do.

Antidepressant FAQ

If you are talking with your doctor about starting an anti-depressant, it is important to understand what to expect from the medications. It is also very important that you speak with your provider and the nursing staff before stopping medications, changing the dose, or if you have concerns about medications. Make sure to notify your dialysis care team of any medication changes.

What are antidepressants?

Antidepressants are medications designed to help the symptoms of clinical depression and other conditions like anxiety and sleep difficulty.

How do antidepressants work?

Antidepressants work by adjusting certain chemicals (neurotransmitters) in the brain.

Are antidepressants addictive?

No, antidepressants are not addictive.

How might antidepressants help me?

Scientific research has shown that people who take antidepressants and make changes in their daily habits experience more relief from their depression and/or anxiety sooner than people who do not.

Who can prescribe me antidepressants?

Your primary care provider, psychiatric provider, or other specialists may prescribe antidepressant medication for you.

Why has my primary care provider tried me on one antidepressant when I heard from a friend that they started taking another?

Different antidepressants will affect different people in different ways. Your provider may have to try several medications before they find one that works well for you.

When can I expect my antidepressants to work?

It may take 10-21 days before you notice any reduction in symptoms; this will depend on the specific medication prescribed and your response to the medication. It may take up to three months for symptoms to significantly decrease.

What kind of symptoms may be improved if I start taking antidepressants?

Sleep	Sex Drive	Feeling physically slowed down
Appetite	Restlessness	Feeling worse in the morning
Fatigue	Agitation	Poor Concentration

Can I drink alcohol while taking antidepressants?

Do not drink alcohol if you are taking antidepressant medication. Alcohol can block the effects of the medication. If you desire to drink occasionally, discuss this with your provider.

Antidepressant FAQ (cont...)

What kind of symptoms may not be improved if I start taking antidepressants?

Some symptoms like depressed mood and low self-esteem may respond only partially to medication. The medication you'll be taking is not a "happy pill;" it is unlikely to totally erase feelings of sadness or emptiness.

How long will it take before I begin to feel better?

Typically, it may take up to three months for the major depressive symptoms to significantly decrease. In general, medication treatment goes at least six months beyond the point of symptom improvement. Occasionally, a person may need to be on long-term medication management.

Will I experience any side effects?

There is the possibility of side effects and some people may experience one or two of the following. However, these side effects usually go away in 7-10 days and can often be managed by changing the dose or by changing medication. *Please call your provider if you have concerns about side effects.*

Dry Mouth - Chew sugarless gum, eat sugarless candy, take sips of water or eat ice, but watch out for too much fluid intake.

Constipation - Eat more fiber rich foods, take a stool softener.

Drowsiness - Take frequent walks, take medication earlier in the evening, or, if taking medication during the day, ask your doctor if you can take it at night.

Wakefulness - Take medications early in the day.

Blurred Vision - Remind yourself that this is a temporary difficulty; talk with provider if it continues.

Headache - Usually temporary and can often be managed by aspirin or acetaminophen, if needed and as directed by your doctor.

Feeling Antsy - Tell yourself this will go away in 3-5 days. If not, call your provider.

Sexual Problems - Talk with your provider; a change in medications may help.

Nausea or Appetite Loss - Take medication with food.

Adapted from the "Antidepressant Medications" Handout from the Center for Integrated Healthcare, Department of Veterans Affairs

Do What You Used to Enjoy to Help Depression

When people feel depressed, they stop doing things they once found enjoyable or meaningful. The less active they are, the worse they feel. And, the worse they feel the less active they become. This is the cycle of depression.

To break this cycle, it is helpful to identify the things you once enjoyed and plan to do them again, even though you don't feel like it. Enjoyable activities don't have to cost money or be special. Calling a friend, talking a short walk, or reading a good book are examples of enjoyable activities. Repeatedly doing things you used to enjoy, even when you don't feel like it, will help your depression.

Setting a Goal:

I used to enjoy: _____

Something important to me is: _____

Even though I won't feel like it I will: _____

When? _____

Where? _____

How? _____

For How Long? _____

When to Refer to Specialty Mental Health

It is a routine practice to refer patients to specialty providers when additional assistance with diagnostic clarification, treatment planning, and interventions is needed. Unfortunately, there is a mismatch between the rate of referrals (e.g., referrals increased from 41 million to 105 million annually between 1999 and 2009) and patients' likelihood to attend the specialty provider appointments (e.g., there is a 50 percent no-show rate for most new referrals).

Before referring a patient to a specialty mental health provider and to increase your ability to provide the best care for your patients, consider the following:

Is there a safety risk involved?

- Has the patient expressed suicidal intent with plan, means, or access to a way to harm his or herself?
- Is your patient demonstrating symptoms of active withdrawal from a substance?
- This patient should be given immediate access to a higher level of care including but not limited to an inpatient psychiatric facility (or an evaluation for appropriateness) and/or a local ER for immediate stabilization of symptoms and functioning.

What is your patient's preference?

- Remember, just because you make the referral, it does not mean your patient will go
- Does your patient believe the referral is necessary? At this time? For this problem?
- To increase the likelihood that your patient will attend a specialist referral appointment and to increase the likelihood that your patient will remain engaged in care, it is important to ensure that the patient believes the referral is appropriate and/or necessary. Motivational interviewing can be employed to encourage your patient to keep their appointments.

What is the patient's level of engagement?

- Has he or she consistently missed appointments in your clinic?
- Consider using a change ruler; if the patient rates his/her likelihood of attending this appointment as an seven or higher (and/or has consistently attended all of your appointments), your patient may be more likely to attend a referral appointment to a specialty provider

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Building Community Resources and Referral Protocols

For patients whose level of engagement is high and whose symptoms require additional intervention above and beyond what can be effectively implemented in the dialysis setting, appropriate referrals are necessary. When working to build collaborative relationships with community partners to facilitate these referrals, several general guidelines may be worth considering.

1. Reach out to community partners (e.g., psychologists, licensed clinical social workers, licensed counselors, university counseling centers, community mental health centers, substance abuse treatment centers, crisis units, etc.) to establish protocols for referrals.

2. When developing protocols, consider:
    - When and how to refer (e.g., for crisis only? Once patient engagement and motivation has increased? See *"When to Refer to Specialty Mental Health Providers"* for additional recommendations)
    - The type and amount of information that is needed to complete the referral
    - What forms are needed?
    - What information will be shared and how that information will be transmitted securely?
    - How will each organization obtain consent?

3. Create a list of local organizations that patients may access for additional assistance or education including but not limited to: local emergency services including crisis and detox centers; community service agencies; community mental health centers; and the local branches of the Department of Public Health, the Bureau of Substance Abuse Service, and the Department of Mental Health.

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Link to PHQ Screeners in multiple languages: http://www.phqscreeners.com/select-screener

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Websites for Integrated Care

Academy for Integrating Behavioral Health and Primary Care: www.integrationacademy.ahrq.gov

Agency for Healthcare Research and Quality: www.ahrq.gov

Collaborative Family Healthcare Association: www.cfha.net

Institute for Clinical Systems Improvement: www.icsi.org

SAMHSA-HRSA Center for Integrated Health Solutions: www.integration.samhsa.gov

Websites with Useful Clinical Tools

Addressing Suicide in Primary Care: www.sprc.org/for-providers/primary-care

Agency for Healthcare Research and Quality – Spanish Evidence-Based Practice Resource: www.ahrq.gov/patients-consumers/treatmentoptions/esp/

AIMS Center at the University of Washington: uwaims.org

American Diabetes Association: www.diabetes.org

Anxiety – CBT resources: www.anxietybc.com

Behavior Management – printable child-friendly charts: www.freeprintablebehaviorcharts.com

Center for Clinical Interventions – Consumer & Provider Resoures: www.cci.health.wa.gov.au/resources/index.cfm

Center for Integrated Healthcare: www.mentalhealth.va.gov/coe/cih-visn2/Clinical/Clinical_Resources.asp

Center on Aging Studies Without Walls: cas.umkc.edu/casww/caregivg.htm

Cornell Self-Injury and Recovery Program: http://selfinjury.bctr.cornell.edu/resources.html

Diabetes Self-Management: www.diabetesselfmanagement.com/

The Disparities Solutions Center at Massachusetts General Hospital: www.massgeneral.org/disparitiessolutions

Gero Central: gerocentral.org/

Health & Wellness – includes healthy eating & physical activity, free to register for account: www.sparkpeople.com

Health & Wellness – University of Tennessee Wellness Website: ewellness.tennessee.edu/Resources.aspx

Health Psychology Website by Dan Bruin: www.healthpsych.com/

Help with Aging: helpwithaging.com

Integrated Behavioral Health Project Screening Tools: http://www.ibhp.org/uploads/file/IBHScreeningToolsRevFinal100313.pdf

Johns Hopkins Center for Mental Health Services in Pediatric Primary Care: web.jhu.edu/pedmentalhealth/index.html

National Center for Cultural Competence: nccc.georgetown.edu

National Heart Lung and Blood Institute: www.nhlbi.nih.gov/health/

National Institute for Health and Clinical Excellence: www.nice.org.uk/cg90

National Institute on Aging at the NIH: https://go4life.nia.nih.gov

National Network to Eliminate Disparities in Behavioral Health: www.nned.net

Palliative Care Institute Comfort Curriculum: http://pccinstitute.com/comfort-curriculum/

Parenting resources – Love & Logic: www.loveandlogic.com

Patient-Centered Primary Care Collaborative: www.pcpcc.net

SAMHSA's Evidence-based Practice Website: www.samhsa.gov/ebpwebguide/appendixB.asp#Health_Treatment

Appendix

Geriatric Depression Scale

Short Form (GDS)

Geriatric Depression Scale: Short Form

Choose the best answer for how you have felt over the past week:

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 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

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

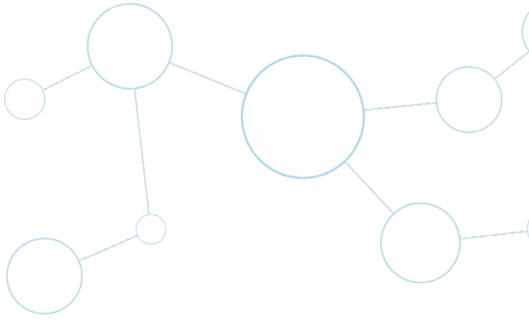
A score > 5 points is suggestive of depression.
A score ≥ 10 points is almost always indicative of depression.
A score > 5 points should warrant a follow-up comprehensive assessment.

Source: http://www.stanford.edu/~yesavage/GDS.html
This scale is in the public domain.

The Hartford Institute for Geriatric Nursing would like to acknowledge the original author of this Try This, Lenore Kurlowicz, PhD, RN, CS, FAAN, who made significant contributions to the field of geropsychiatric nursing and passed away in 2007.

Depression Screening Tool

Hamilton Depression Rating Scale (HAM-D)



The Hamilton Rating Scale for Depression

(to be administered by a healthcare professional)

Patient's Name _____

Date of Assessment _____

To rate the severity of depression in patients who are already diagnosed as depressed, administer this questionnaire. The higher the score, the more severe the depression.

For each item, write the correct number next to the item. (Only one response per item)

☐ **1. DEPRESSED MOOD** (Sadness, hopeless, helpless, worthless)
- **0**= Absent
- **1**= These feeling states indicated only on questioning
- **2**= These feeling states spontaneously reported verbally
- **3**= Communicates feeling states non-verbally—i.e., through facial expression, posture, voice, and tendency to weep
- **4**= Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and nonverbal communication

☐ **2. FEELINGS OF GUILT**
- **0**= Absent
- **1**= Self reproach, feels he has let people down
- **2**= Ideas of guilt or rumination over past errors or sinful deeds
- **3**= Present illness is a punishment. Delusions of guilt
- **4**= Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

☐ **3. SUICIDE**
- **0**= Absent
- **1**= Feels life is not worth living
- **2**= Wishes he were dead or any thoughts of possible death to self
- **3**= Suicidal ideas or gesture
- **4**= Attempts at suicide (any serious attempt rates 4)

☐ **4. INSOMNIA EARLY**
- **0**= No difficulty falling asleep
- **1**= Complains of occasional difficulty falling asleep—i.e., more than 1/2 hour
- **2**= Complains of nightly difficulty falling asleep

☐ **5. INSOMNIA MIDDLE**
- **0**= No difficulty
- **1**= Patient complains of being restless and disturbed during the night
- **2**= Waking during the night—any getting out of bed rates 2 (except for purposes of voiding)

☐ **6. INSOMNIA LATE**

0= No difficulty
1= Waking in early hours of the morning but goes back to sleep
2= Unable to fall asleep again if he gets out of bed

☐ **7. WORK AND ACTIVITIES**

0= No difficulty
1= Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbies
2= Loss of interest in activity; hobbies or work—either directly reported by patient, or indirect in listlessness, indecision and vacillation (feels he has to push self to work or activities)
3= Decrease in actual time spent in activities or decrease in productivity
4= Stopped working because of present illness

☐ **8. RETARDATION: PSYCHOMOTOR** (Slowness of thought and speech; impaired ability to concentrate; decreased motor activity)

0= Normal speech and thought
1= Slight retardation at interview
2= Obvious retardation at interview
3= Interview difficult
4= Complete stupor

☐ **9. AGITATION**

0= None
1= Fidgetiness
2= Playing with hands, hair, etc.
3= Moving about, can't sit still
4= Hand wringing, nail biting, hair-pulling, biting of lips

☐ **10. ANXIETY (PSYCHOLOGICAL)**

0= No difficulty
1= Subjective tension and irritability
2= Worrying about minor matters
3= Apprehensive attitude apparent in face or speech
4= Fears expressed without questioning

☐ **11. ANXIETY SOMATIC:** Physiological concomitants of anxiety, (i.e., effects of autonomic overactivity, "butterflies," indigestion, stomach cramps, belching, diarrhea, palpitations, hyperventilation, paresthesia, sweating, flushing, tremor, headache, urinary frequency). Avoid asking about possible medication side effects (i.e., dry mouth, constipation)

0= Absent
1= Mild
2= Moderate
3= Severe
4= Incapacitating

☐ **12. SOMATIC SYMPTOMS (GASTROINTESTINAL)**

0= None
1= Loss of appetite but eating without encouragement from others. Food intake about normal
2= Difficulty eating without urging from others. Marked reduction of appetite and food intake

☐ **13. SOMATIC SYMPTOMS GENERAL**

0= None
1= Heaviness in limbs, back or head. Backaches, headache, muscle aches. Loss of energy and fatigability
2= Any clear-cut symptom rates 2

☐ **14. GENITAL SYMPTOMS** (Symptoms such as: loss of libido; impaired sexual performance; menstrual disturbances)

0= Absent
1= Mild
2= Severe

☐ **15. HYPOCHONDRIASIS**

0= Not present
1= Self-absorption (bodily)
2= Preoccupation with health
3= Frequent complaints, requests for help, etc.
4= Hypochondriacal delusions

☐ **16. LOSS OF WEIGHT**

A. When rating by history:
0= No weight loss
1= Probably weight loss associated with present illness
2= Definite (according to patient) weight loss
3= Not assessed

☐ **17. INSIGHT**

0= Acknowledges being depressed and ill
1= Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2= Denies being ill at all

☐ **18. DIURNAL VARIATION**

A. Note whether symptoms are worse in morning or evening. If NO diurnal variation, mark none
0= No variation
1= Worse in A.M.
2= Worse in P.M.

☐ **B.** When present, mark the severity of the variation. Mark "None" if NO variation
0= None
1= Mild
2= Severe

19. DEPERSONALIZATION AND DEREALIZATION (Such as: Feelings of unreality; Nihilistic ideas)

0= Absent
1= Mild
2= Moderate
3= Severe
4= Incapacitating

20. PARANOID SYMPTOMS

0= None
1= Suspicious
2= Ideas of reference
3= Delusions of reference and persecution

21. OBSESSIONAL AND COMPULSIVE SYMPTOMS

0= Absent
1= Mild
2= Severe

Total Score

Adapted from Hedlung and Vieweg, The Hamilton rating scale for depression, *Journal of Operational Psychiatry*, 1979;10(2):149-165.

Depression Screening Tool

Patient Health Questionaire-9 (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems?
(Write number according to your answer the in the corner. Tally all answers for your final score.)

1. Little interest or pleasure in doing things

(0) Not at All
(1) Several Days
(2) More than Half the Days
(3) Nearly Every Day

2. Feeling down, depressed or hopeless

(0) Not at All
(1) Several Days
(2) More than Half the Days
(3) Nearly Every Day

3. Trouble falling or staying asleep, or sleeping too much

(0) Not at All
(1) Several Days
(2) More than Half the Days
(3) Nearly Every Day

4. Feeling tired or having little energy

(0) Not at All
(1) Several Days
(2) More than Half the Days
(3) Nearly Every Day

5. Poor appetite or over eating

(0) Not at All
(1) Several Days
(2) More than Half the Days
(3) Nearly Every Day

6. Feeling bad about yourself or that you are a failure or have let yourself or your family down

(0) Not at All
(1) Several Days
(2) More than Half the Days
(3) Nearly Every Day

7. Trouble concentrating on things, such as reading the newspaper or watching TV

(0) Not at All
(1) Several Days
(2) More than Half the Days
(3) Nearly Every Day

8. Moving or speaking so slowly that other people could have noticed. Or the opposite of being so fidgety or restless that you have been moving around a lot more than usual

(0) Not at All
(1) Several Days
(2) More than Half the Days
(3) Nearly Every Day

9. Thoughts that you would be better off dead or of hurting yourself

(0) Not at All
(1) Several Days
(2) More than Half the Days
(3) Nearly Every Day

Score

PHQ-9 Results

1-4: Minimal Depression
5-9: Mild Depression
10-14: Moderate Depression
15-19: Moderately Severe Depression
20-21: Severe Depression

Qsource
ESRD Network Strategies

The Renal Network
ESRD Network 10

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