Adult Depression Screening Toolkit for Clinicians

This toolkit is designed to support primary care practitioners and care managers in the implementation of Universal Screening for Depression. With guidance on using the PHQ-9 as a screening tool, evidence-based practice guidelines and medication management pearls, the toolkit helps providers better identify depression in patients and appropriately manage their care in the primary care setting.

Screening and Treatment

Screening Pearls:

What is the difference between a PHQ 2 and 9?

The PHQ 2 is a preliminary screening tool administered prior to the PHQ 9. Anyone who scores 2 or more on the PHQ 2 will need to have a PHQ 9 administered. A clinical evaluation is needed to confirm or rule out a diagnosis of depression.

Who can administer the PHQ 2 and 9 to patients?

Anyone in the office can administer and score the PHQ 2/9. Only a clinician can interpret the results after speaking with the patient.

For what ages is the PHQ 2 and 9 tools validated?

For any patient age 12 and over. The tool included with this document can be used for both adults and adolescents.

How often should the PHQ 2 depression screening tool be administered?

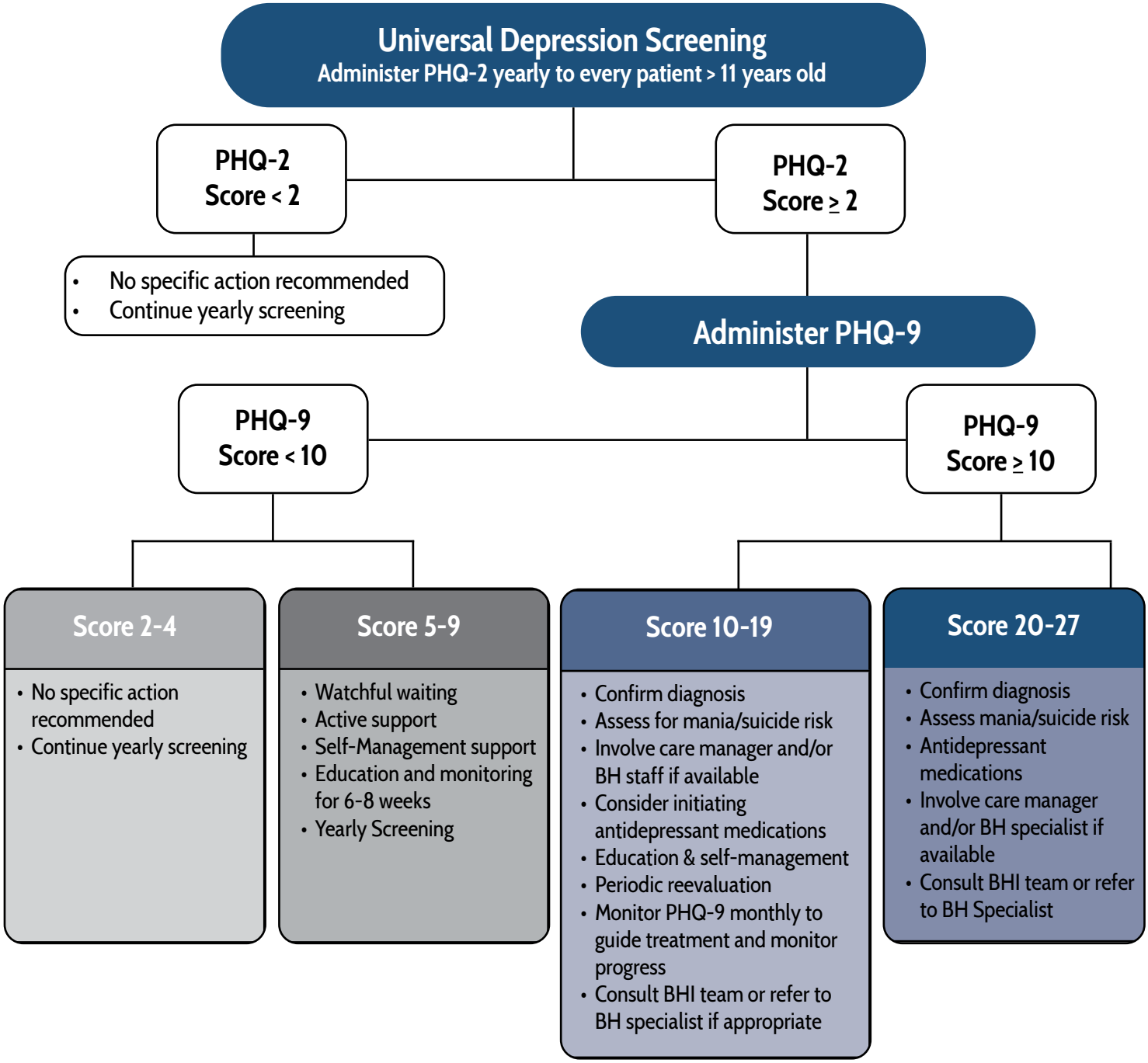
The AHP Behavioral Health Integration (BHI) team recommends screening for depression in individuals ages 12 and over **at least once yearly**. Peripartum women should be screened at least once during their pregnancy and postpartum period. Individuals who score positive on the PHQ 9 (score 10 and above) should be screened again every 4 weeks to assess their progress and guide their treatment.

PHQ 2/9 Screening Tool Link

Contact BHI Team for Consultation:

The simplest way to obtain a consultation from the BHIT is to send an email to AHPBHIT@urmc.rochester.edu.
It is important the care manager in the practice when available is included on this request. A response should be expected within 24 to 48 hours of the request.

PHQ 2/9 Administration and Workflow



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PHQ 9 Scores and Recommended Actions

Levels of Depressive Symptoms Severity	PHQ-9 Score	Recommended Action Plan
Community norm	0-4	• No specific action recommended • Yearly screening
Mild symptoms	5-9	• Watchful waiting • Active support • Self-management support • Education and monitoring for 6-8 weeks • Yearly screening
Major Depression, mild to moderate	10-19	• Confirm diagnosis • Assess for mania/suicide risk • Involve care manager and/or BH staff if available • Consider initiating antidepressant medications • Education and self-management support • Periodic reevaluation • Monitor PHQ 9 monthly to guide treatment and monitor progress • Consult BHI team or refer to BH specialist if appropriate
Severe Depression	20-27	• Confirm diagnosis • Assess mania/suicide risk • Antidepressant medications • Involve care manager and/or BH specialist if available • Consult BHI team or refer to BH specialist

Phases of depression and treatment goals

Treatment Phase	Acute	Continuation	Maintenance
Duration	6-12 weeks	4-12 months	>1 year
Treatment Goals	• Decrease symptoms • Improve function	• Target any residual symptoms • Optimize functioning • Prevent relapse	Prevent recurrence of another episode over time

Medication Management

When to maintain medications beyond the first year

Number of Depression Episodes	Lifetime recurrence rates	Antidepressant maintenance
1 Episode	50%	Treat only current episode. Usually **no need for maintenance beyond the first year**. Use your clinical judgment.
2 Episodes	80%	Treat for **3 years** following remission
3 Episodes	>90%	**Lifetime maintenance.** Use your clinical judgment.

Antidepressant Treatment Algorithm

Step 1: Access Depression Severity

Mild Depressive Symptoms
PHQ - 9 score of 5 - 9
Options for Treatment include:
- Psychotherapy alone
- Pharmacotherapy usually not indicated

Moderate Depressive Symptoms
PHQ - 9 score of 10 - 19
Options for Treatment include:
- Pharmacotherapy alone or
- Pharmacotherapy and Psychotherapy

Severe Depression Symptoms
PHQ - 9 score of ≥ 20
Treatment options:
- Pharmacotherapy
- If severe impairment/poor response, expedite referral to mental health

Step 2: Initiate an Antidepressant Medication

SSRIs are considered first-line treatment options.

- Choice may be based on presenting symptoms, safety and tolerability, history of response, patient preference, cost, potential drug interactions, and comorbidities
- Sertraline, citalopram and escitalopram have fewer drug-drug interactions than fluoxetine and paroxetine
- Citalopram has a higher risk of QTc prolongation than other SSRIs
- Paroxetine has a higher incidence of adverse effects compared to other SSRIs, avoid in pregnancy
- All SSRIs are available generically and many are on $4 drug lists at pharmacies
- Fluoxetine capsules are much less expensive than tablets
- Set expectations with patients about time to effect as well as side effects and that they diminish over time

Refer to medication management tables

Medication Management

Step 3: Follow-up Assessments (typically every 4 weeks)

Access response (PHQ-9), side effects, adherence, and suicide risk at each visit. Treatment goal is Remission (PHQ-9 <5).

Good Response
Reduction in PHQ-9 of ≥ 50%
Options for Treatment include:
- Continue therapy(s)
- Reassess Q4 weeks until remission

Remission and Maintenance:
- Follow every 3 months
- If first episode, taper to off after 9-12 months of remission
- If recurrent, consider long-term maintenance – especially if 3 or more lifetime episodes
- If symptoms recur, reenter treatment algorithm

Partial Response
PHQ-9 Improves, but < 50%
Options for Treatment include:
- Reassess adherence
- Consider concurrent psychotherapy
- If no significant side effects: Dose escalation by at least 50%
- If significant side effects: Switch to medication in the same or another drug class (SSRI, SNRI, or other)
- If failed 2 optimized doses and duration for antidepressant trials: Consider combination therapy
- AHP BHI consultation and/or BH speciality referral

No Response
No or minimal improvement in PHQ-9
Options for Treatment include:
- Reassess adherence and diagnosis (e.g. bereavement, bipolar)
- Engage behavioral health resources
- If no significant side effects and dose is not optimized: increase dose by at least 50%
- If significant side effects or dose is adequate: Switch to medication in the same or another drug class.
- If failed 2 optimized doses and duration for antidepressant trials: Consider combination therapy.
- AHP BHI consultation and/or BH specialty referral

Antidepressant Doses and Side Effect Comparison

	Starting Dose (mg)	Therapeutic dose range (mg)	Adverse Effect Potential							
			Sedation	Anti-cholinergic	Insomnia/ Agitation	Orthostatic Hypotension	Sexual dysfunction	Wt. gain	GI	QTc
SSRIs										
Citalopram	20	20-40	0	0	1+	1+	3+	1+	1+	2+
Escitalopram	10	10-20	0	0	1+	1+	3+	1+	1+	1+
Fluoxetine	20[1]	20-80	0	0	2+	1+	3+	1+	1+	1+
Paroxetine	20[1]	20-50	1+	1+	1+	2+	4+	2+	1+	1+
Sertraline	50	25-200	0	0	2+	1+	3+	1+	2+	1+
SNRIs										
Duloxetine	20 BID[2]	40-60	0	0	2+	0	3+	0		0
Venlafaxine ER	75	75-225	0	0	2+	0	3+	0	2+	1+
MISC.										
Bupropion XL[3]	150[1]	300-450	0	0	2+	0	0	0	2+	1+
Mirtazapine	15 **QHS**	15-45	4+	1+	0	0	1+	4+		1+

[1]use lower doses in elderly and preferably dose in the morning;
[2]dose BID initially, then can change to daily;
[3]**contraindicated if significant anxiety, seizure disorder, active alcohol use or history of an eating disorder**

Combination Therapy

This refers to the addition of a second medication when the response to two antidepressants is deemed inadequate. The choice of the second medication is often guided by target symptoms as outlined below.

Note: Always consider a consultation with the AHP BHI team and/or a referral to BH specialty when available for your patients who require combination treatment or whose depression is not responding adequately to usual treatment.

Combination Medication	Typical Dose*	Target Symptoms:
Buproprion XL (Wellbutrin®)	150-300 mg daily	Reduced motivation or lack of energy
Mirtazepine (Remeron®)	7.5-30 mg QHS	Weight loss, nausea, or anxiety
Buspirone (Buspar®)	10-30 mg BID	Anxiety
Aripiprazole (Abilify®)	5-15 mg QAM	Irritability or obsessive thinking
Quetiapine (Seroquel®)	50-200 mg QHS	Anxiety, insomnia, or agitation

*Medications should be dosed at a scheduled frequency, not dosed prn

Antidepressant Switch Strategies

Switching a patient from one antidepressant medication to another is a clinical decision made when one or several of the following occur:

- Complete lack of response to one antidepressant medication
- Increasing the dose is expected to cause intolerable side effects
- Patient preference

	Direct Switch	Cross Taper
When to Consider	Agents in same drug class	Agents in a different drug class, high dose
Benefits	Simple for the patient	Minimizes discontinuation syndrome*, and symptom relapse
Risks	Discontinuation syndrome*, drug interactions	Drug interactions, adverse effects
Notes	• If concerned about emergence of new side effects, start new agent at slightly lower dose • **Fluoxetine** has a long half-life – start new agent 4-7 days after last fluoxetine dose	Typically accomplished over 1-4 weeks. Longer durations may be warranted if doses are high, return of depressive symptoms, symptoms of withdrawal, or side effects

*Discontinuation syndrome is of more concern with **paroxetine, duloxetine and venlafaxine**. Other factors that increase risk: shorter drug elimination half-life (<24 hours), higher antidepressant doses, prior history of discontinuation syndrome, etc.

Approximate dose conversions for select antidepressants:

	Approximate Equivalent Dose* (mg)
SSRIs	
Citalopram	20
Escitalopram	10
Fluoxetine	20
Paroxetine	20
Sertraline	100
SNRIs	
Duloxetine	30-60
Venlafaxine	75-150
MISC	
Bupropion XL	150
Mirtazapine	30

*Equivalent doses are approximated and may vary based on patient-specific factors

A Brief Screener for Suicide in Primary Care – P4 Screener

Have you had thoughts of actually hurting yourself?

NO YES

4 Screening Questions

1. Have you ever attempted to harm yourself in the past?

NO YES

2. Have you thought about how you might actually hurt yourself?

NO YES → [How?_____]

3. There's a big difference between having a thought and acting on a thought. How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life some time over the next month?

a. Not at all likely _____
b. Somewhat likely _____
c. Very likely _____

4. Is there anything that would prevent or keep you from harming yourself?

NO YES → [What?_____]

Shaded ("Risk") Response		
Risk Category	**Items 1 and 2**	**Items 3 and 4**
Minimal	Neither is shaded	Neither is shaded
Lower	At least 1 item is shaded	Neither is shaded
Higher		At least 1 item is shaded

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Screening for Mania: The Mood Disorder Questionnaire (MDQ)

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. This instrument is designed for screening purposes only and is not to be used as a diagnostic tool.
The questionnaire takes less than 5 minutes to complete. Patients simply check the yes or no boxes in response to the questions. The last question pertains to the patient's level of functional impairment.

Instructions: Check the answer that best applies.

1. Has there ever been a period of time when you were not your usual self and...

...you were so irritable that you shouted at people or started fights or arguments?	☐ Y	☐ N
...you felt much more self-confident than usual?	☐ Y	☐ N
...you got much less sleep than usual and found you didn't really miss it?	☐ Y	☐ N
...you were much more talkative or spoke faster than usual?	☐ Y	☐ N
...thoughts raced through your head or you couldn't slow your mind down?	☐ Y	☐ N
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐ Y	☐ N
...you had much more energy than usual?	☐ Y	☐ N
...you were much more active or did many more things than usual?	☐ Y	☐ N
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐ Y	☐ N
...you were much more interested in sex than usual?	☐ Y	☐ N
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐ Y	☐ N
...spending money got you or your family in trouble?	☐ Y	☐ N

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ Y ☐ N

3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights?
Please check 1 response only

☐ No problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious problem

4. Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? ☐ Y ☐ N

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? ☐ Y ☐ N

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How to Score

Further medical assessment for bipolar disorder is clearly warranted if patient:

- Answers Yes to seven or more of the events in question #1

AND

- Answers Yes to question #2

AND

- Answers Moderate problem or Serious problem to question #3

Patient Safety Plan Template

Step 1: Warning signs: (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity, individual distraction, mindfulness):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____ 4. Place _____

Step 4: People whom I can ask help:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name _____ Phone _____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name _____ Phone _____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services _____
   Urgent Care Services Address _____
   Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Template (Stanley & Brown, 2008)

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Brief Instructions for use of Safety Template:

Step 1: Recognizing Warning Signs

- Ask, "How will you know when the safety plan should be used?"
- Ask, "What do you experience when you start to think about suicide or feel extremely distressed?"
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patients' own words.

Step 2: Using Internal Coping Strategies

- Ask, "What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"
- Ask, "How likely do you think you would be able to do this step during a time of crisis?"
- If doubt about using coping strategies is expressed, ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"
- Use a collaborative, problem solving approach to ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

Step 3: Social Contacts Who May Distract from the Crisis

- Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Ask, "Who or what social settings help you take your mind off your problems at least for a little while? "Who helps you feel better when you socialize with them?"
- Ask patients to list several people and social settings, in case the first option is unavailable.
- Ask for safe places they can go to do be around people, e.g. coffee shop.
- Remember, in this step, suicidal thoughts and feelings are not revealed.

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

- Instruct patients to use Step 4 if Step 3 does not resolve the crisis or lower risk.
- Ask, "Among your family or friends, who do you think you could contact for help during a crisis?" or "Who is supportive of you and who do you feel that you can talk with when you're under stress?"
- Ask patients to list several people, in case they cannot reach the first person on the list. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis.
- Ask, "How likely would you be willing to contact these individuals?"
- If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 5: Contacting Professionals and Agencies

- Instruct patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask, "Who are the mental health professionals that we should identify to be on your safety plan?" and "Are there other health care providers?"
- List names, numbers and/or locations of clinicians, local urgent care services, Suicide Prevention Hotline: (1-800-273-TALK (8255))
- If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 6: Reducing the Potential for Use of Lethal Means

- The clinician should ask patients which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means.
- For methods with low lethality, clinicians may ask patient to remove or restrict their access to these methods themselves.
- Restricting the patient's access to a highly lethal method should be done by a designated, responsible person — usually a family member or close friend, or the police.

Community Referral Resources

Call 911 for any mental health emergency
For more information about area services call 211

Monroe County

Mobile Crisis Team services **(585) 529-3721**

Lifeline **(585) 275-5151**

Emergency Resources Link

Regional Resources

Livingston County Mobile Integration Team Link

URMC Behavioral Health Crisis Call Line **(585) 275-8686**

Hillside Service Integration **(585) 256-7500**

Tompkins County Behavioral Health Mobile Crisis Team **(607) 272-1616**

Suicide Prevention National Line **1-800-273-TALK**