



Depression Toolkit

A Primary Care Provider Reference Guide



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Purpose of This Toolkit

This toolkit is designed to be a resource for primary care physicians and office staff, in order to identify and help treat depression in patients. The World Health Organization (WHO) recognizes depression as “the leading cause of disability worldwide,” and globally more than 280 million people suffer with depression.

The federal government has recommended depression screenings since 2002. In a study of Medicare recipients, researchers found that those with major depressive disorder had almost twice the overall medical costs as those without major depressive disorder (\$87,445 vs. \$41,583). Although 13-16% of adults experience depressive symptoms, only 5% receive depression screening in primary care.

Primary care is an ideal opportunity in which to identify depression in patients. During annual exams, a simple two or nine-item questionnaire could be the difference between providing the member with tools and resource to alleviate depression or addressing a patient’s struggle through numerous depressive symptoms, some of which may not resolve on their own. While implementation of a depression screening protocol may alter the workflow and add additional tasks and steps, these could be incorporated in a variety of ways which allow providers the ability to address the patient’s physical and mental health.

This toolkit addresses many areas related to depression including common symptoms of depression (whether or not the patient complains of being sad), depressive symptoms in different populations, chronic conditions and their relationship to depression, adverse effects of medication on depression, screening tools, referral options, suicidality, and how to implement depression screenings.

We recommend having this toolkit on hand during appointments (e.g., what to ask and what to do if a patient is suicidal). Other sections are more educational (e.g., the relationship between chronic conditions and depression). Our hope is that this toolkit supports clinic staff with information and can guide conversations about depression so that staff is more comfortable talking with patients about mental health.

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Common Signs of Depression

Depression affects people in different ways, and not everyone who is depressed experiences every symptom. It is important to recognize common signs of depression that may not relate to sadness ([NIMH](#)):

Feeling sad, irritable or anxious.	Feeling empty, hopeless, guilty or worthless.	Loss of pleasure in usually enjoyed hobbies or activities, including sex.
Fatigue and decreased energy, feeling listless.	Trouble concentrating, remembering details and making decisions.	Not being able to sleep or sleeping too much. Waking too early.
Eating too much or not wanting to eat at all, possibly with unplanned weight gain or loss.	Thoughts of death, suicide or suicide attempts.	Aches or pains, headaches, cramps or digestive problems without a clear physical cause and/or which do not ease, even with treatment.

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013) lists common presentations for patients who are not complaining of major depression or anhedonia:

Multiple medical visits (more than five per year).	Multiple unexplained symptoms.	Work or relationship dysfunction.	Dampened affect.
Changes in interpersonal relationships.	Poor behavioral follow through with activities of daily living or prior treatment recommendations.	Weight gain or loss.	Memory or other cognitive complaints, such as difficulty concentrating or making decisions.
	Irritable bowel syndrome.	Volunteered complaints of stress or mood disturbance.	

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Depression Affects People Differently

Depression often begins in the teenage years or early 20s or 30s. High levels of anxiety in children could lead to chronic mood and anxiety disorders as well as higher risk of depression in adulthood. If depression is left untreated, it will often persist and reoccur ([NIMH](#)).

Symptoms of Depression in Different Populations

Older children and teens: sulk, get into trouble at school, are negative and irritable, and feel misunderstood.

Teens with depression: may also have anxiety, eating disorders, or substance abuse, and may also be at higher risk for suicide.

Teens often do not get help because depression symptoms seem like just part of the typical stress of school or being a teen. As a result, symptoms of depression during the teenage years are disregarded.

Women: symptoms of sadness, worthlessness and guilt.

During pregnancy and postpartum: oversleeping or inability to sleep even when the baby is sleeping, anger or rage, physical aches and pains, withdrawing from or avoiding friends and family, trouble bonding or forming an emotional attachment with the baby, constantly doubting their ability to care for the baby, thoughts about self-harm or harming the baby. (For additional information related to screening for perinatal depression, please see the *Additional Resources* section).

Men: more likely to become frustrated, discouraged, very tired, irritable, angry, sometimes abusive, lose interest in once-pleasurable activities, difficulty sleeping, may throw themselves into their work to avoid talking about depression or may behave recklessly.

Older adults:

- May appear to feel tired, have trouble sleeping, or seem grumpy and irritable.
- Depression can cause confusion or attention problems, which mimic symptoms of Alzheimer's disease and other brain disorders.
- Chronic conditions and medications with side effects may cause depressive symptoms or depression.
- Vascular depression (arteriosclerotic depression or subcortical ischemic depression): blood vessels become less flexible and harden, becoming constricted and preventing normal blood flow to the body's organs, including the brain. This also increases the risk for heart disease or stroke.

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[National Institute of Mental Health \(NIMH\) Brochures and Fact Sheets for depression in different populations](#)

What to Do When a Patient Becomes Tearful or Emotional

Patients can feel overwhelmed when talking about their emotions or difficult life circumstances, or they may also become emotional unexpectedly. There are many positive ways to communicate with patients so that they feel understood, heard and cared for. The reason for their visit may not have been related to depression or sadness, but if the patient becomes emotional or tearful, it is now an immediate concern for them, even if unexpected.

[Ranjan, Kumar, and Chakrawarty \(2015\)](#)

Discuss good communication strategies, as well as the benefits:

See the *Additional Resources* section to find *Resources for Improving Physician Communication*.

- Listen to the patient, express compassion and show empathy. This is an active process which requires the nurse, MA and physician to be attentive to not only the patient's words, but also to their nonverbal (body language, posture, facial expressions, etc.) and preverbal expressions (voice tone, pitch, volume).
- Help the patient be comfortable. Staff need to avoid discussions about the patient's health outside of the exam room (such as in a hallway).
- Listen actively to the patient and show interest with your own body language. Expressing empathy nonverbally is as simple as leaning in, nodding at what the patient says and making eye contact at appropriate intervals (do not stare down your patient while they are feeling vulnerable).
- Avoid interrupting the patient when they are expressing their concerns.
- Ask the patient if there is anything else they would like to add.

After attending to the patient one-on-one:

- Schedule a warm hand-off with a mental health specialist within your clinic if the patient needs immediate attention.
- Refer the patient to Caredon Behavioral Health who will conduct a Behavioral Health Assessment and refer the patient to mental health services. See the section on *Caredon Behavioral Health* for more information.

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Chronic Conditions and Risk Factors

Depression can be affected by chronic medical conditions, sometimes directly resulting from a new diagnosis, and other times resulting from physiological changes. Chronic conditions are just one of the many risk factors for depression. Depression may persist, even as physical health improves. Research suggests that those with depression and another medical condition have more severe symptoms of both ([NIMH – Chronic Conditions](#)).

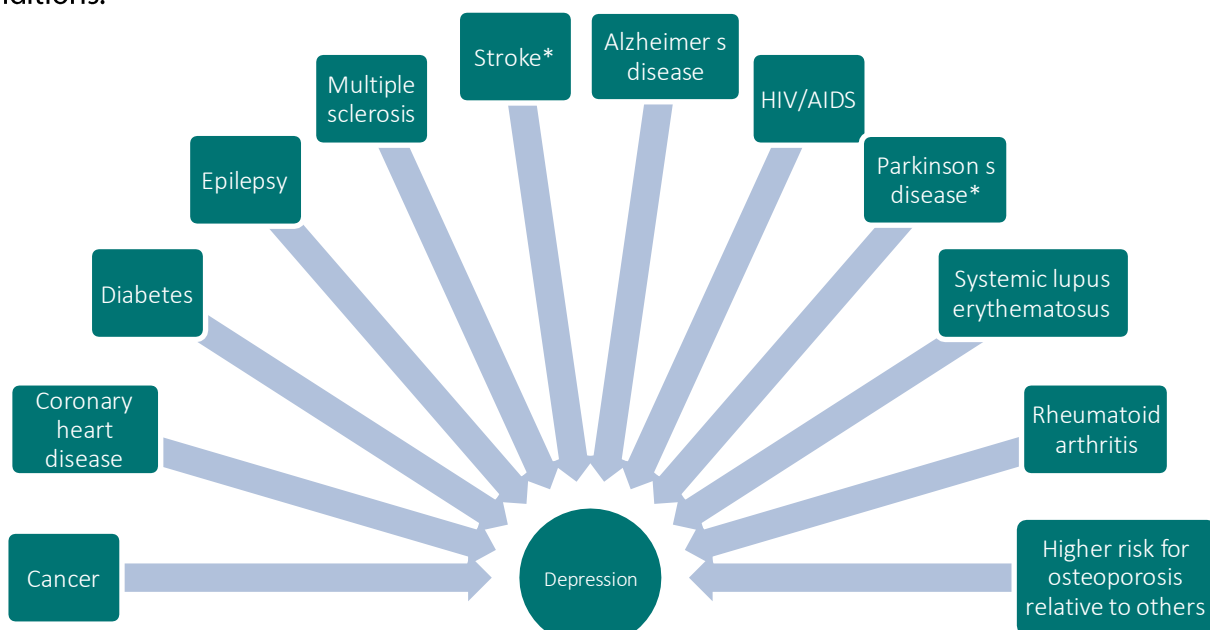
Triggers for Depression

Depression can result from various social or physiological triggers; see some example triggers below:

- A recent medical diagnosis, which can be a new diagnosis of any type and initially be devastating or discouraging, may cause symptoms of depression. Symptoms may lift as the patient adjusts to the new diagnosis or as the other condition is treated.
- Certain medications prompt depression.
- Depression, in addition to another medical illness, leads to more severe symptoms of both illnesses.
- Medical complications can trigger depression.
- During pregnancy and postpartum:
 - Having had depression during a previous pregnancy.
 - Complications during childbirth, including premature delivery.
 - Having a baby with medical problems.
 - Having mixed feelings about the pregnancy.

Chronic Conditions

Having a chronic condition can result in anxiety and stress and can lead to a higher risk of depression and depressive symptoms. Depression is common in those with the following conditions:



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* Parkinson's disease and stroke specifically cause changes in the brain – which may have a direct role in depression.

Factors that may exacerbate the relationship between depression and an increased risk for other medical conditions:

- Less access to good medical care.
- When a patient has a harder time caring for their own health (e.g., not knowing how to seek care, take prescribed medication, eat well and exercise).
- Scientists have found that physiological changes related to depression can increase physical illness, such as:
 - Increased inflammation.
 - Changes in the control of heart rate and blood circulation.
 - Abnormalities in stress hormones.
 - Metabolic changes (similar to those with diabetes).

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Medications Can Have an Adverse Effect on Depression

Research by [Qato, Ozenberger, and Olfson \(2018\)](#) indicates that certain medications have an adverse effect on depression.

CAUTION

Carefully monitor patients who are on multiple medications, as their depression may become worse.
The top 5 medication combinations associated with an adverse effect on depression are:

Gabapentin & Cyclobenzaprine
Alprazolam & Gabapentin
Metoprolol & Alprazolam
Hydrocodone & Clonazepam
Hydrocodone & Alprazolam

The researchers further list medications that could cause suicidal symptoms and depressive (non-suicidal) symptoms:

Medication Classes	Suicidal Symptoms	Non-Suicidal Symptoms	Examples
Analgesics	X	X	Acetaminophen/Tramadol, Fentanyl, Morphine, Oxycodone
Anticonvulsants	X		Carbamazepine, Diazepam, Gabapentin, Lorazepam
Antidepressants	X		Amitriptyline, Bupropion, Citalopram
Anxiolytics, hypnotics and sedatives	X		Alprazolam, Clonazepam, Diazepam
Antihypertensives		X	Atenolol, Timolol, Enalapril
Corticosteroids		X	Cortisone, Dexamethasone, Prednisolone, Prednisone
Gastrointestinal agents	X	X	Atropine, Metoclopramide, Atropine, Famotidine
Hormones/hormone modifiers	X	X	Levonorgestrel, Progesterone, Conjugated estrogens, Estradiol, Hydroxyprogesterone, Testosterone
Respiratory agents	X	X	Montelukast, Ribavarin, Cetirizine
Other therapeutic classes	X	X	Ciprofloxacin, Interferon Beta-1a, Memantine, Naltrexone, Risperidone, Haloperidol, Propranolol

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Refer to [JAMA's article](#) with the full list of 30 medication combinations and specific medications that have an adverse effect (suicidal or non-suicidal).

Depression Screening Tools

Patient Health Questionnaire (PHQ): The family of PHQ screening tools are some of the most commonly recommended by organizations such as the American Psychological Association (APA) and United States Preventive Services Task Force (USPSTF). The PHQs have high reliability and are clinically validated instruments. They can be self-administered and are used to screen for, and sometimes to monitor, depression.

In addition to the PHQ tools, many other screening tools are available to assess for depression:

Instruments for Adolescents (12–17 years)	Results Considered as Positive Finding
Patient Health Questionnaire (PHQ-9)® Available in over 75 languages.	Total Score ≥5
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	Total Score ≥5
PRIME MD-PHQ2® Available in 24 languages	Total Score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®*(order from Pearson Assessments)	Total Score ≥4
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥10
PROMIS Depression (pediatric)	Total Score (T Score) ≥52.5

Instruments for Adults (18+ years)	Results Considered as Positive Finding
Patient Health Questionnaire (PHQ-9)® Available in over 75 languages.	Total Score ≥5
PRIME MD-PHQ2® Available in 24 languages	Total Score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®*(Order from Pearson Assessments)	Total Score ≥4
Beck Depression Inventory (BDI-II)	Total Score ≥14
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥10
Geriatric Depression Scale Short Form (GDS) (available in over 30 languages)	Total Score ≥5
Geriatric Depression Scale Long Form (GDS) (available in over 30 languages)	Total Score ≥10
Edinburgh Postnatal Depression Scale (EPDS) (can be used anytime during pregnancy or postpartum)	Total Score ≥9
My Mood Monitor (M-3)® (computer-based only)	Total Score ≥5
PROMIS Depression	Total Score (T Score) ≥52.5
Clinically Useful Depression Outcome Scale (CUDOS)	Total Score ≥11

*Proprietary; may have cost or licensing requirement associated with use.

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Carelon Behavioral Health

Central California Alliance for Health contracts with Carelon Behavioral Health in order to link members to behavioral health services. Anyone can make a referral to Carelon – the provider, the Alliance’s Care Management team, member self-referral, etc.

Carelon has a team of Board-Certified Behavior Analysts (BCBAs) on staff. From the time the member is referred, BCBAs coordinate the member’s care and provide linkages to behavioral health providers.

Carelon Authorization Forms: [Release of Confidential Information](#)

Carelon can only provide limited information related to the referral outcome if the patient completes this form.

- Carelon’s role is to assess the patient and provide mental health service options, but they do not necessarily have information related to whom the patient chose to see or their mental health records.
- The behavioral health provider is a separate entity from Carelon. The provider has information related to treatment.
- The PCP may need to ask the patient for the behavioral health provider’s name in order to request records and be involved in treatment. The patient however, is not obligated to provide this information.

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Assessing Suicidality

Suicide was the leading cause of death in 2022, and specifically the second leading cause of death for those ages 10-14 and 25-34 ([cdc.gov](https://www.cdc.gov)). Suicide rates increased 36% between 2000-2022. Research has indicated that the majority of those who died by suicide *did not* have a known diagnosed mental health condition at the time of death. This is one of the reasons it is imperative to screen for depression and assess for suicidality.

Suicide Assessment Tools

[The Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#)

- An evidence-supported, low-burden screening tool.
- It has demonstrated ability to predict suicide attempts in suicidal and non-suicidal individuals.
- Field-use ready; mental health training not required to administer.
- [Available in 103+ languages.](#)
- [Clinical triage guidelines using the C-SSRS also contains a suicidality screening flow on page 4, which aids the clinician in assessing for risk factors, protective factors and provides a decision tree with questions and instructions.](#)

[Ask Suicide-Screening Questions \(ASQ\) Toolkit](#)

- [This is a toolkit designed for nurses and physicians to identify youth who are at risk for suicide.](#)
- [It is a four-item questionnaire that takes 20 seconds to complete.](#)
- [If the patient screens positive for suicide risk, administer the Brief Suicide Safety Assessment \(BSSA\).](#)

American Psychiatric Association: [Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors](#)

[This quick reference guide addresses the following topics: assessment of patients with suicidal behaviors, factors associated with increased risk for suicide, psychiatric management, specific treatment modalities, and documentation and risk management.](#)

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Implementing Depression Screening and Follow-Up

[Masshealth Toolkit](#)

This guide is based on the *Plan, Do, Study, Act* model of process improvement from the *Institute for Healthcare Improvement: Quality Resources*. Highlights of the steps are below. For complete implementation guidelines, refer to MassHealth's [Primary Care Behavioral Health Screening Toolkit](#).

Step 1: Identify two office "screening champions."

- Clinician (e.g., physician, NP, PA, MA, nurse) clinical side of the practice
- Administrator (e.g., office manager, receptionist) business side of the practice

Step 2: Meet as an entire office group to plan implementation.

Step 3: Prepare for implementation.

- e.g., from assessing current screening practices to setting a date for reviewing progress

Step 4: Launch screening.

- e.g., from informing patients to addressing obstacles

Step 5: Review progress periodically as a group.

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EXAMPLE OF IMPLEMENTED SCREENING

Four Plan-Do-Study-Act rapid-cycle improvements were conducted at a Federally Qualified Health Center (FQHC) in order to increase efficacy of depression screening and follow-up (Schaeffer and Jolles, 2019).

- 237 total participants.
- Administered PHQ-2 on paper.
 - Paper-based because this improves screening rates compared to verbal screening.
 - Anything above a score of zero qualified for follow-up. Sometimes low PHQ-2 scores are associated with suicidality (Pratt and Brody, 2014).
- If PHQ-2 was positive, followed up with PHQ-9 on paper.
- Utilized an Option Grid™ to decide on treatment.
 - An Option Grid is a standardized tool that aids in shared decision-making so that the patient shares what matters most to them in their treatment process.
- “Right Care” tracking log.
 - This is a tracking log that aids clinic staff in the follow-up process for patients with positive depression scores. Some of the follow-up items: weekly follow-up phone calls, completed behavioral health appointments and warm hand off visits to a Licensed Clinical Social Worker.
- 10 Measures throughout the intervention period.
 - Measures related to PHQ Screening, Option Grid, Right Care Treatment Long, Team Engagement.
 - Four process measures.
 - Four outcome measures.
 - Composite measure.
 - Balancing measure.
- Results:
 - Over the 90-day intervention period, 123 PHQs were administered, which increased depression screening rates.
 - Rate of screening for depression: 32.5% to 85.2%.
 - Adherence to follow up: 33.3% to 60.0%.
 - Identified positive PHQs in 45.5%.

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World Health Organization (WHO). Depression. Retrieved 2018 and 2024, from: <https://www.who.int/news-room/fact-sheets/detail/depression>

Additional Resources

The American College of Obstetricians and Gynecologists (ACOG). (2015). [ACOG Committee Opinion: Screening for Perinatal Depression](#).

Institute for Healthcare Improvement (IHI) provides [resources and tools](#) using evidence-based techniques to improve health and health care.

[Better Communication, Better Care: Provider Tools to Care for Diverse Populations](#)

- This is a comprehensive toolkit that discusses essential topics in communicating with a diverse patient population such as: nonverbal communication, identifying and addressing health literacy, communicating across language barriers, the ways in which culture impacts health care delivery, guiding patient conversations, cultural variation of surrounding health literacy and how to address some of these, and many other helpful topics.

Resources for Improving Physician Communication

- [Institute for Healthcare Communication](#)
- [American Academy on Communication in Healthcare](#)
- [The Foundation for Medical Excellence](#)
- [Motivational Interviewing Network of Trainers](#)

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