



City Health Information

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The New York City Department of Health and Mental Hygiene

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DETECTING AND TREATING DEPRESSION IN ADULTS

- **Depression is the second most common condition seen in primary care.**
- **Approximately 6% of all adult New Yorkers report significant emotional distress.**
- **Treatment is effective and can be managed in most cases by the non-psychiatrist.**
- **Referral resources can be obtained by calling (800) LIFENET/(800) 543-3638, or 311.**

Depression is more commonly seen in primary care than any other condition except hypertension.¹ It is estimated that 1 in 4 women and 1 in 10 men will suffer from a major depressive episode during the course of their lives.²⁻³

Primary care physicians and other non-psychiatrists can effectively screen for and manage depression. However, there are barriers to providing effective care, including lack of adequate education and training, time constraints, poor coordination with mental health programs, and inadequate reimbursement.

DIAGNOSIS OF DEPRESSION Screening for Depression

Simple observation and active listening during an office visit are powerful screening tools. Many depressed patients, especially the elderly, do not realize that they are suffering from depression. Thus, physicians should be alert to the possibility of depression in patients who present with unexplained physical symptoms. Chronic pain, anxiety, or substance abuse may be associated with underlying depression.¹ Providers should also be alert to clues indicating depression while performing the review of systems and taking a social history. Asking questions in an open-ended manner about a patient's level of functioning, energy, motivation, and any work or social problems can be revealing, while avoiding stigmatization. A physician can simply and quickly screen for depression by asking 2 questions⁴ (see Box). If the patient's

Physicians should screen for depression by asking the following 2 questions:⁴

During the past month, have you been bothered by:

- **little interest or pleasure in doing things?**
- **feeling down, depressed, or hopeless?**

A "yes" to either question requires further evaluation.

response to both questions is "no," then the screen is negative. If the patient responds "yes" to either question, or if the clinician is still concerned about the possibility of depression, then consider asking more detailed questions or using the Patient Health Questionnaire (PHQ-9).⁵ The PHQ-9, a 9-item, self-administered questionnaire (see Table 1), can be completed by the patient before, during, or after the office visit and can reliably detect and quantify the severity of depression.⁵ Criteria for the diagnosis of a major depressive episode from the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (DSM-IV) are provided in Table 2.⁶

Assessing Suicide Risk

Asking a patient about suicidal thoughts or plans does not initiate such ideas or foster action.⁷ For depressed patients, detecting suicidal risk can be life-saving. Among older patients who committed suicide, 20% visited their primary care physician on the same day as their suicide, 40% within 1 week, and 70% within 1 month.⁸

Elicit the presence or absence of suicidal ideation.

The physician should begin by asking depressed patients questions to elicit feelings about being alive, such as "Have you ever felt that life is not worth living?" or "Did you ever wish you could go to sleep and just not wake up?" Based on the response, the physician can proceed to more specific questions about suicide, such as "Are you imagining that others would be better off without you?" and "Are you having thoughts about killing yourself?"

Elicit the presence or absence of a suicide plan.

If suicidal ideation is present, the physician should ask if the patient has a suicide plan. This includes asking how, where, and when suicide would be attempted. If the

TABLE 1. PATIENT HEALTH QUESTIONNAIRE (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

add columns: + +

(Health care professional: For interpretation of TOTAL please refer to scoring card below)

TOTAL:

10. 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 _____

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. **Consider Major Depressive Disorder** if there are at least 5 ✓s in the shaded section (1 of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder if there are 2–4 ✓s in the shaded section (1 of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician. A definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of major depressive disorder or other depressive disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling

out normal bereavement, a history of a manic episode (bipolar disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (e.g., every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: "Several days" = 1 "More than half the days" = 2 "Nearly every day" = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the PHQ-9 Scoring Card (at right) to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for health professional use only

Scoring — add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1–4	Minimal depression
5–9	Mild depression
10–14	Moderate depression
15–19	Moderately severe depression
20–27	Severe depression

This PHQ-9 questionnaire is also available at www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/

*Reprinted with permission from Spitzer RL, Kroenke K, Williams JBW, and the Patient Health Questionnaire Primary Care Study Group. Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. JAMA. 1999;282:1737-1744. PRIME-MD PHQ-9. Copyright © 1999 Pfizer Inc.

TABLE 2. SUMMARY OF DSM-IV CRITERIA FOR MAJOR DEPRESSIVE EPISODE

- Five (or more) of the following symptoms have been present during the same 2-week period, nearly every day, and represent a change from previous functioning; at least 1 of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure:
 - depressed mood most of the day
 - markedly diminished interest or pleasure in all, or almost all, activities most of the day
 - significant weight loss when not dieting, or weight gain, or decrease or increase in appetite
 - insomnia or hypersomnia
 - psychomotor agitation or retardation
 - fatigue or loss of energy
 - feelings of worthlessness or excessive or inappropriate guilt
 - diminished ability to think or concentrate, or indecisiveness
 - recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The symptoms do not meet criteria for a mixed episode (both depression and mania during the same episode), are not due to the direct physiological effects of a substance or a general medical condition, or are not better accounted for by bereavement.

Adapted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. text rev. Washington, DC: American Psychiatric Association; 2000.

patient is actively thinking of suicide or has made attempts in the past — and particularly if he or she has a plan for committing suicide — the primary care physician should arrange a mental health consultation with a psychiatrist or other qualified mental health professional *as soon as possible*. This constitutes a medical emergency that may necessitate calling 911. The primary care physician and psychiatrist can decide which safety measures and treatments, including hospitalization, are needed. (See Table 3 for further information on management of the suicidal patient.)

Referral

Referral should be considered for depressed patients who have a history of any of the following:

- Psychotic or manic symptoms
- Suicidal ideation or attempts
- Substance abuse or dependence
- Severe psychosocial problems
- Severe personality disorder
- Poor response to antidepressant medication.

MANAGEMENT OF DEPRESSION BY THE NON-PSYCHIATRIST

Treatment Approaches

Once a diagnosis has been made, effective management includes patient education, treatment, and ongoing monitoring. Depression may be treated with pharmacotherapy,

psychotherapy, or both (see Algorithm, page 5). Either modality alone appears to be equally effective in the treatment of mild depression, but there is less evidence that psychotherapy alone is effective for the more severely depressed patient.⁹ Some patients may prefer not to take medication or may be reluctant to see a specialist for psychotherapy. It is important for the primary care physician to remain engaged with these patients, to approach them in a supportive manner, and to offer additional treatment or referral as the opportunity arises. When psychosis, suicidal ideation, or severe dysfunction is present, medication will be needed and hospitalization may be necessary. Electroconvulsive therapy may be useful for some of these patients, especially those with psychosis or failure to respond to treatment.

Educating the Patient

Patients often experience confusion and shame when given a diagnosis of depression. Therefore, it is essential to try to dispel negative perceptions of the disorder with an explanation of the causes, mechanisms, and impact of the illness. Comparing depression to other treatable medical illnesses will help patients feel less stigmatized. For example, the physician can explain that depression is a physical illness just as hypertension is, but the brain, rather than the heart and blood vessels, is affected. Inform patients that antidepressant medication helps correct imbalances in brain chemicals.

The physician should provide information about available medications, including effectiveness, onset of action, and potential adverse effects. Inform patients that it might be necessary to take antidepressants for as long as 6 weeks before benefits are evident, and that maximum benefit may not be evident until weeks later. Although some patients may respond more quickly, all patients should be cautioned not to expect immediate symptom relief, especially of depressed mood. (Sleep and appetite may improve before mood.) If patients know what to expect concerning the usual pharmacologic responses, they will be less likely to become frustrated and discontinue treatment before the medication has had sufficient time to take effect.

Adverse Effects

Adverse effects are common with most, if not all, antidepressant medications, and patients should be aware of which symptoms to expect and how to cope with them. Early adverse effects may cause patients to question the appropriateness of the agent chosen for treatment or to discontinue it before a therapeutic effect can be achieved. To avoid this, physicians should caution patients about early adverse effects and reassure them that these will usually diminish within a short time, usually less than 2 weeks. If patients have questions about their medications or adverse effects, they should be encouraged to discuss these issues with their physician or pharmacist. Finally, patients should be counseled to avoid alcohol while taking an antidepressant, since alcohol may reduce the medication's therapeutic effects, and antidepressants may potentiate the effects of alcohol.

Antidepressants can sometimes increase a patient's level of energy and activity before improving mood, and can thus enable a person to act on suicidal ideas. However, this risk is far lower than the risk of untreated depression. Patients with suicidal thoughts should be counseled to call the physician immediately if such thoughts become more specific, frequent, or intense after initiation of an antidepressant.

Pharmacotherapy

Selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants, and other agents, such as bupropion (Wellbutrin[®]), mirtazapine (Remeron[®]), nefazodone (Serzone[®]), and venlafaxine (Effexor[®]), are all effective in treating depression. Most antidepressants are equally effective; therefore, a physician should consider the adverse effect profile of the medication and the patient's specific complaints. For example, a patient who complains of insomnia might benefit most by taking a sedating antidepressant, such as paroxetine, nefazodone, or mirtazapine. Duration and dosage of an antidepressant are critical in determining the effectiveness of a therapeutic trial. The patient must take an adequate dosage of the medication for a sufficient period of time; if not, it cannot be determined that the trial of medication has failed. Table 4 lists some individual agents with dosage ranges and information on cost. Monoamine oxidase inhibitors are not listed; they are now rarely used for depression because of potentially serious side effects and should be prescribed only by physicians experienced in their use.

TABLE 3. MANAGEMENT OF THE SUICIDAL PATIENT*

Investigators have developed the following recommendations to aid physicians in assisting potentially suicidal patients:¹⁰

Be attentive. The patient needs to believe that someone understands his or her distress and takes it seriously. It is essential that patients not feel ignored or feel that their concerns are being dismissed or minimized. Listen carefully and offer empathic statements.

Remain calm and do not appear threatened. This helps the patient to feel secure and facilitates a productive doctor-patient conversation.

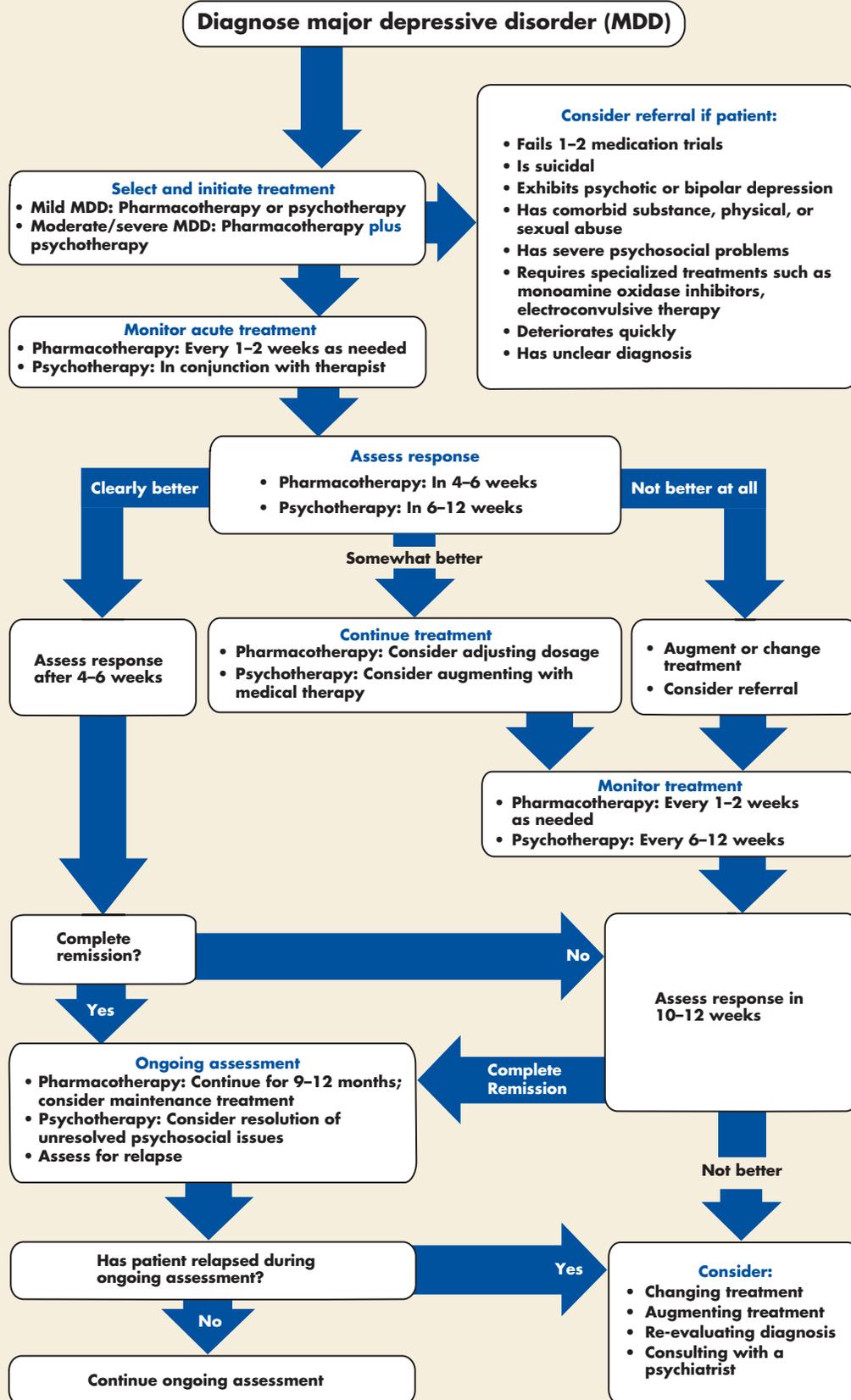
Stress a partnership approach. Let the patient know that he or she shares responsibility for choosing the treatment approach. Explain that the acute mental distress and hopelessness will subside with appropriate treatment.

Discuss suicide in a calm, reasoned manner. Emphasize that suicidal feelings are symptoms of a treatable condition, worsen when patients are under stress, and are often temporary. Avoid judgmental statements.

Emphasize that suicide causes a great deal of pain to family members. Explain that this pain may last for many years.

*This approach may be utilized when evaluating a patient for active suicidal intent or managing a patient with a history of suicidal ideation who is also under the care of a mental health professional.

DEPRESSION TREATMENT ALGORITHM



Adapted with permission from Schwenk TL, Terrell LB, Harrison RV, Shadigian EM, Valenstein MA. Depression (Update): UMHS Guidelines for Clinical Care. Ann Arbor, Mich: GUIDES, Office of the Executive Vice President for Medical Affairs, University of Michigan Health System; 2004.

TABLE 4. DRUGS FOR DEPRESSION

Drug	Usual Daily Dosage	Cost¹
SSRIs		
Escitalopram – <i>Lexapro</i> ^{®*}	10–20 mg once/day	\$ 63.00
Citalopram – <i>Celexa</i> ^{®*}	40 mg once/day	73.50
Fluoxetine – average generic price	20 mg once/day	67.20
<i>Prozac</i> ^{®*}		93.30
<i>Prozac Weekly</i> ^{®*}	90 mg once/week	82.64
Paroxetine – <i>Paxil</i> ^{®*}	20 mg once/day	83.10
<i>Paxil CR</i> ^{®*}	25 mg once/day	83.10
Sertraline – <i>Zoloft</i> ^{®*}	100–150 mg once/day	74.10
Tricyclic Antidepressants		
Amitriptyline – average generic price	150 mg once/day	26.40
Desipramine – average generic price	150 mg once/day	49.80
<i>Norpramin</i> ^{®*}		109.80
Imipramine – average generic price	150 mg once/day	79.20
<i>Tofranil</i> ^{®*}		226.80
<i>Tofranil PM</i> ^{®*}		122.10
Nortriptyline – average generic price	75–125 mg once/day	60.00
<i>Pamelor</i> ^{®*}		269.70
Other Antidepressants		
Bupropion – average generic price	100 mg t.i.d.	65.70
<i>Wellbutrin</i> ^{®*}		121.50
<i>Wellbutrin SR</i> ^{®*}	150 mg b.i.d.	112.80
Mirtazapine – average generic price	45–60 mg once/day	149.70
<i>Remeron</i> ^{®*}		88.20
<i>Remeron SolTab</i> ^{®*2}		76.80
Nefazodone – <i>Serzone</i> ^{®*}	200 mg b.i.d.	94.20
Trazodone – average generic price	300 mg in divided doses	65.40
<i>Desyrel</i> ^{®*}		183.00
<i>Desyrel Dividose</i> ^{®*}		173.95 ³
Venlafaxine – <i>Effexor</i> ^{®*}	75 mg b.i.d.	93.60
<i>Effexor XR</i> ^{®*}	150 mg once/day	86.70

¹ Cost for 30 days' treatment with the lowest usual dosage, according to data from retail pharmacies nationwide provided by NDCHealth, a health care information services company, April 2003.

² Disintegrating tablets.

³ Cost for 30 days' treatment based on AWP listings in *Drug Topics Red Book* 2002.

Adapted with special permission from The Medical Letter, Inc. Treatment guidelines from The Medical Letter: drugs for psychiatric disorders. *The Medical Letter*. 2003;1:69-76.

*Use of brand names is for informational purposes only and does not imply endorsement by the New York City Department of Health and Mental Hygiene.

Selective Serotonin Reuptake Inhibitors

An SSRI is generally considered to be the treatment of choice for depressed patients with or without anxiety symptoms. SSRIs help normalize serotonergic imbalances, which may contribute to both depression and anxiety. All SSRIs have similar effectiveness. Their efficacy is comparable to that of tricyclic antidepressants,⁹ but without the latter's cholinergic and sedative effects. SSRIs are easier to administer, better tolerated, and less likely to result in fatality from an overdose.

Physicians who prescribe SSRIs for treatment of depression should be aware of the possible adverse effects. Patients should be informed that although the antidepressant effect is delayed, transient adverse effects can occur immediately. During the first few days of treatment with an SSRI, patients may complain of feeling jittery or may

experience an increase in anxiety. Other adverse effects include nausea, headache, insomnia, or sedation, delayed ejaculation in men, and anorgasmia in women.

Nonpharmacologic Options

The appropriate selection of nonpharmacologic treatment is influenced by the severity of depression, the preferences of the patient, and the skills and interests of the physician. Conveying an attitude of caring and acceptance of the patient as a person in need of professional services is in itself therapeutic, as depressed individuals often have negative feelings about themselves that can interfere with treatment. Listen for and explore beliefs about the illness or methods of treatment that could interfere with recovery. The BATHE mnemonic (see Box, page 7) summarizes a

Continuing Medical Education

Detecting and Treating Depression in Adults

SPONSORED BY THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CITY HEALTH INFORMATION
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Objectives:

At the conclusion of this CME, participants should be able to:

1. Screen for major depressive disorder;
2. Diagnose major depressive disorder;
3. Assess suicidal ideation;
4. Treat major depressive disorder.

Accreditation:

The continuing medical education (CME) activity is open to physicians (MDs, DOs) and physician assistants. The New York City Department of Health and Mental Hygiene is accredited by the Medical Society of the State of New York to sponsor continuing medical education for physicians. The New York City Department of Health and Mental Hygiene designates this continuing medical education activity for a maximum of 1.5 hours in Category One credit toward the AMA/PRA (Physician's Recognition Award). Each physician should claim only those hours of credit that he/she actually spent on the educational activity.

Participants in CME activities sponsored by the NYC DOHMH are required to submit their name, address, and professional degree. Such information will be maintained in the Department's CME program database. If participants in CME activities so request, the information will be used by the CME Program to verify whether a professional participated in an activity and, if the activity was associated with an exam, passed the exam.

The Department will not share information in the CME database with other organizations without permission from persons included in the database, except in certain emergencies or disasters where

public health agencies deem communication with all health care providers to be essential or where required by law.

Participants who provide e-mail addresses upon registration for an activity may receive electronic announcements from the Department about future CME activities as well as other public health information.

Participants must submit the accompanying exam by August 31, 2004.

CME Activity Faculty: LI Sederer, MD, Executive Deputy Commissioner; AJ Kolodny, MD, Special Projects Coordinator; Division of Mental Hygiene, NYC DOHMH.

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THE BATHE MNEMONIC

This technique is often useful in eliciting information from patients and addressing it adequately in a busy practice and is known by the mnemonic **BATHE**.¹¹ The technique allows the physician to reinforce effective coping strategies and provide general support and ideas for the patient to use. The sequence is as follows:

- **Background** Ask open-ended questions such as "What is going on in your life?" to encourage open dialogue about issues that may be troubling the patient.
- **Affect** Questions such as "How do you feel about that?" or "What is your mood like lately?" make it possible for the patient to talk about the state of his or her feelings.
- **Trouble** Asking "What about the situation troubles you the most?" helps the physician elicit the meaning to the patient of a specific situation.
- **Handling** Asking "How are you handling that?" will help the physician assess the patient's coping skills and level of functioning.
- **Empathy** Comments such as "That must be very difficult for you" or "I understand that is a difficult situation" legitimize the patient's reaction to a situation.

brief technique that is often useful to both elicit and address mental health concerns adequately in a busy practice.¹¹ The technique can be employed in initial assessment and subsequent visits.

PROGNOSIS

Untreated major depressive episodes typically last about 6 months and are a frequent cause of suicide. However, improvement is seen in approximately 70%–80% of properly treated patients. To avoid relapse, patients should continue medication at the same dosage for 9–12 months. Lifelong maintenance therapy should be considered for patients who have a history of psychotic depression or who have experienced 3 or more depressive episodes.

Most depressed patients will respond well to pharmacotherapy and a supportive approach in the primary care setting. Referral resources for formal psychotherapy or management of severe or complicated cases can be obtained by calling (800) LIFENET/(800) 543-3638, or 311. Managing depression can be rewarding because treatments are available that can save lives and significantly improve daily functioning and quality of life. With screening, patient education, treatment, and careful monitoring, physicians can provide effective care for their depressed patients.

*Use of brand names is for informational purposes only and does not imply endorsement by the New York City Department of Health and Mental Hygiene.

CME Activity Detecting and Treating Depression in Adults

1. All of the following statements about suicidal ideation are correct EXCEPT:

- A. Asking about suicidal ideation does NOT plant the idea in a patient's mind.
- B. If suicidal ideation is present, a patient should be asked if they have a plan.
- C. It is important to emphasize that suicide causes a great deal of pain to family members.
- D. It is not necessary to ask every depressed patient about suicidal ideation.

2. All of the following statements about diagnosing major depressive disorder are correct EXCEPT:

- A. It is possible to simply and quickly screen for depression by asking 2 questions.
- B. The PHQ-9 is a 9-item, self-administered questionnaire that can reliably detect and quantify the severity of depression.
- C. DSM-IV criteria require that depressive symptoms be present for at least 2 months.
- D. At least 1 of the DSM-IV symptoms must be either depressed mood or loss of interest or pleasure.

3. All of the following are reasons for referring a depressed patient to a psychiatrist EXCEPT:

- A. Poor response to antidepressant medication
- B. Suicidal ideation
- C. Somatic complaints
- D. Psychotic symptoms

4. All of the following statements about treating depression are true EXCEPT:

- A. Electroconvulsive therapy is a useful treatment for some severely depressed patients.

- B. Some patients may experience a transient increase in anxiety when they start taking an antidepressant medication.
- C. It may take 4–6 weeks before a patient begins to experience an adequate response to an antidepressant medication.
- D. SSRIs are not an effective treatment for severely depressed patients.

5. All of the following statements about the prognosis of major depressive disorder are true EXCEPT:

- A. Untreated major depressive episodes typically last about 6 months and are a frequent cause of suicide.
- B. To avoid relapse, patients should be continued on medication at the same dosage for a total of 9–12 months.
- C. Lifelong maintenance therapy should be considered for patients who have experienced 3 or more depressive episodes.
- D. Major depressive episodes rarely respond to treatment

6. How well did this continuing education activity achieve its educational objectives?

- A. Very well
- B. Adequately
- C. Poorly

Name _____ Degree _____

Address _____

Date _____ Telephone _____

E-mail address _____

CME Activity

This issue of *City Health Information*, including the continuing education activity, can be downloaded from the publications section at nyc.gov/health. To access *City Health Information* and Continuing Medical Education online, visit www.nyc.gov/html/doh/html/chi/chi.html

Instructions

Read this issue of *City Health Information* for the correct answers to questions.

To receive continuing education credit, you must answer 4 of the first 5 questions correctly.

If you would like to participate in this activity by submitting the response card:

1. Complete all information on the response card, including your name, degree, mailing address, telephone number, and e-mail address. PLEASE WRITE CLEARLY.
2. Select your answers to the questions and check the corresponding boxes on the response card.
3. Return the response card or a photocopy of the card postmarked no later than August 31, 2004. Mail to CME Administrator; NYC Department of Health and Mental Hygiene; 125 Worth Street, CN-29C; New York, NY, 10013.

RESOURCES

LIFENET TELEPHONE NUMBERS AND WEB SITE
24 Hours a Day, 7 Days a Week

In English: (800) LIFENET (800-543-3638) or 311

In Spanish: (800) AYUDESE (877-298-3373)

In Chinese: (800) ASIAN LIFENET (877-990-8585)

For other languages, call (800) LIFENET or 311 and ask for an interpreter.

TTY hard of hearing, call (212) 982-5284

Web site: www.800lifenet.com

Agency for Healthcare Research and Quality
www.ahrq.gov/chip

American Medical Association
www.ama-assn.org

Depression and Bipolar Support Alliance
www.dbsalliance.org

National Institute of Mental Health
www.nimh.nih.gov

National Mental Health Association
www.nmha.org/ccd

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