



The Force for Health®
PREPARED PATIENT PROGRAM

PREPARED PATIENT

Depression

Your complete learning module — eight components from newly-diagnosed to a clinically Prepared Patient Ambassador. Everything to know and do, in one place.

8-Component Condition Module

WHAT'S INSIDE — THE 8 COMPONENTS

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SCAN TO OPEN THE
LIVE JOURNEY

1 Core Basics

Welcome — why becoming a Prepared Patient matters

Welcome. You're in the right place. This module turns Depression from something that happens *to* you into something you help manage — step by step, at your own pace. You don't need to become a doctor. You need to become the most prepared person in the room about *your* health.

WHY THIS MATTERS — FOR YOU AND THE PEOPLE AROUND YOU

As a Patient

Know your numbers, spot your red flags, and act fast when it counts. Prepared patients have better days and fewer emergencies.

As an Ambassador

Speak up in your own care as an equal partner — ask the right questions and help shape your plan.

As a Caregiver

Support someone you love with confidence — know what to watch for and what to do.

DEPRESSION — A NATIONAL OVERVIEW

Depression is a real illness. It is common. It can be treated. It changes your mood, energy, sleep, and appetite. It also affects your thinking, your drive, and how your body feels.

Depression is **not** a weakness. It is not laziness. It is not a flaw. It is not 'just being sad.' Those ideas keep people from getting help. Doctors now see depression as a brain problem.

It involves brain networks and how brain cells connect (neuroplasticity). It also involves the body's stress system and your sleep clock (circadian rhythm).

Swelling in the body (inflammation) can play a part too. Here is the honest truth. **Most people with depression who get treatment do get better.** Treatment for depression works as well as almost any care in medicine.

It works as well as, or better than, many heart and cancer treatments. Depression is **one of the most common illnesses in the world** (Lancet Commission on Depression, 2022).

About 8% of U.S. adults have it each year. About 17% will have it in their lifetime. Left untreated, it is **a top cause of disability worldwide**. Both things are true.

It is treatable, and it is serious. Feeling sad is not the same as depression. Low mood after a loss is normal grief, not MDD. Depression lasts longer.

It is deep. It hurts how you live for 2 weeks or more.

PRE-KNOWLEDGE CHECK — RATE WHAT YOU KNOW RIGHT NOW (1–5)

Be honest — there's no wrong answer. You'll rate these again at Step 7 and see how far you've come.



1 Core Basics

Welcome — why becoming a Prepared Patient matters

What Depression actually is

○ ○ ○ ○ ○

My key numbers & targets

○ ○ ○ ○ ○

My red flags — and what to do

○ ○ ○ ○ ○

My medicines & how to take them

○ ○ ○ ○ ○

How to speak up with my care team

○ ○ ○ ○ ○

1 = new to me · 5 = I could teach it

★ My Prepared Patient Pledge

I pledge to learn about my Depression, to know my numbers and my red flags, to speak up in my own care, and to take one small step at a time — for myself and for the people who count on me.

SIGNED

DATE

Additional Notes

☐ I've completed Step 1 · Welcome & Overview for Depression



2 Self-Reflection

Eight soft questions to find your honest starting point

No test, no wrong answers — an honest self-reflection to find your starting point with Depression. This is an engagement screener, not a clinical assessment. Mark your answers, then carry them into the Fact Sheet.

Q1 Have you ever had a mental health crisis, targeted therapy, bypass, or been told you have depression (mdd), blockages, or distress?

Depression (MDD) is often silent. Some people learn they have it from a routine test; others find out from an event. Naming what you've actually been told is the first step.

CHOOSE ONE

- ☐ Yes — I've had a mental health crisis, targeted therapy, or bypass
- ☐ Yes — I have a Depression (MDD) or distress diagnosis without a major event
- ☐ No, but I have known risk factors (high symptom severity, high BP, diabetes, family history, smoking)
- ☐ No — and I don't have major risk factors that I know of
- ☐ I'm not sure

Q2 Has anyone in your family had a mental health crisis, targeted therapy, bypass, or sudden mental health death — especially before age 60?

Family history of early heart disease is one of the strongest Depression (MDD) risk factors and a clue to inherited high symptom severity.

CHOOSE ONE

- ☐ Yes — and at least one relative was under 60
- ☐ Yes — but I'm not sure of ages
- ☐ No
- ☐ I don't know



2 Self-Reflection

Eight soft questions to find your honest starting point

Q3 Have you ever heard about, or thought about, any of these in connection with heart disease? (check all that feel familiar)

This is just a familiarity check, not a behavior audit. Pick whatever rings a bell.

CHECK ALL THAT APPLY

- ☐ LDL ("bad") symptom severity target numbers
- ☐ Mental health medication (atorvastatin, rosuvastatin, simvastatin)
- ☐ Mental health screening (PHQ-9, GAD-7) scan
- ☐ Mental health rehab
- ☐ Aspirin or other antiplatelet for heart
- ☐ Quit-smoking medication or counseling
- ☐ Mediterranean / DASH-style eating
- ☐ None of these — this is all new to me

Q4 Do you feel confident that you understand depression (mdd) — what it is, what it does to the body, and what helps?

"Somewhat" is a totally fair answer. Most people start there.

CHOOSE ONE

- ☐ Very confident — I know the basics well
- ☐ Somewhat — I know some, want to know more
- ☐ Not really — I'd like to learn more
- ☐ This is new to me

Q5 Do you feel confident you know how to live the highest-quality life possible despite (or to prevent) Depression (MDD)?

Quality of life is the goal — energy, the things you love, longevity — not just "watching the LDL."

CHOOSE ONE

- ☐ Yes
- ☐ I'm getting there
- ☐ Not yet — I want to learn how
- ☐ Not applicable to me right now



2 Self-Reflection

Eight soft questions to find your honest starting point

Q6 Are you ready to become an informed and respected part of your care team — where your observations, communications, and actions are the most important part of your care?

This is the heart of the Prepared Patient idea.

CHOOSE ONE

- ☐ Yes — I'm ready
- ☐ Almost — I want to learn more first
- ☐ I'd like to but I'm not sure how
- ☐ I hadn't thought of it that way before

Q7 Do you have at least one person — family, friend, or care team — you can turn to about your heart?

Habit change sticks when it's social.

CHOOSE ONE

- ☐ Yes — I have someone
- ☐ Maybe — I'm not sure who
- ☐ Not yet — but I'd like to find someone
- ☐ I prefer to figure it out myself first

Q8 What brought you to this Prepared Patient program today?

Your answer is private and helps us speak to you better.

CHOOSE ONE

- ☐ I've had a heart event (MI, targeted therapy, bypass)
- ☐ I have Depression (MDD) without a major event
- ☐ Someone I love has Depression (MDD) or had a heart event
- ☐ I want to prevent it (risk factors / family history)
- ☐ I'm a student, professional, or educator
- ☐ I'm just curious



2 Self-Reflection

Eight soft questions to find your honest starting point

What these answers tell me about where I'm starting

 Additional Notes

☐ I've completed Step 2 · Self-Reflection for Depression



3

Force Field Fact Sheet

Primer · Foundations

This is the heart of the resource: the complete Depression Force Field, organized in knowledge tiers. Each card gives the essentials, then **Concepts** (what to know), **Skills** (what you can do), **Actions** (this week), and your **Plan** (share & sustain).



3 Force Field Fact Sheet

Primer · Foundations



What Is Depression?

PRIMER · TIER 0

Depression is a real illness. It is common. It can be treated. It changes your mood, energy, sleep, and appetite. It also affects your thinking, your drive, and how your body feels.

Depression is **not** a weakness. It is not laziness. It is not a flaw. It is not 'just being sad.' Those ideas keep people from getting help. Doctors now see depression as a brain problem.

It involves brain networks and how brain cells connect (neuroplasticity). It also involves the body's stress system and your sleep clock (circadian rhythm).

Swelling in the body (inflammation) can play a part too. Here is the honest truth. **Most people with depression who get treatment do get better.** Treatment for depression works as well as almost any care in medicine.

It works as well as, or better than, many heart and cancer treatments. Depression is **one of the most common illnesses in the world** (Lancet Commission on Depression, 2022).

About 8% of U.S. adults have it each year. About 17% will have it in their lifetime. Left untreated, it is **a top cause of disability worldwide**. Both things are true.

It is treatable, and it is serious. Feeling sad is not the same as depression. Low mood after a loss is normal grief, not MDD. Depression lasts longer.

It is deep. It hurts how you live for 2 weeks or more.

CONCEPTS · LEARN IT

- Depression is an illness — not weakness, not character
- About 8% of U.S. adults each year; about 17% in a lifetime
- Most people who get treatment get better — among the most treatable illnesses in medicine
- Untreated depression is a top cause of disability worldwide
- Sad is not depression — depression lasts, spreads, and hurts your life for 2 weeks or more
- Many types — MDD, persistent, postpartum, SAD, bipolar, treatment-resistant

ACTIONS · THIS WEEK

- Order copies of your mental health and primary care doctor (PCP) notes from the patient portal
- Save 988 (call or text) and 741741 (Crisis Text Line, text HOME) in your phone
- Open and fill out your Force Field Emergency Card with your treatment plan and crisis contacts
- Tell one family member or friend you trust that you are getting checked or treated

SKILLS · LIVE IT

- Say the medical-illness framing out loud
- Tell normal sadness or grief apart from depression
- Read your PHQ-9 score by its action band (5/10/15/20)
- Use kind words — 'living with depression,' not 'depressive'

PLAN · SHARE IT

- Read all 16 squares
- Open the deep course
- Set up a mental health visit if you don't have one yet



3 Force Field Fact Sheet

Primer · Foundations



360 Human Anatomy: Brain Networks & Mood

PRIMER · ANATOMY

Depression is not just a simple 'chemical imbalance.' That idea from the 1990s was easy to say. But it is not the full story. Doctors now see depression as a problem in many brain systems.

It involves **brain networks, brain cell connections (neuroplasticity), the stress system, the sleep clock, and inflammation (body swelling)**. Here are the key brain networks.

(1) Default-mode network (DMN) — it turns on when you dwell on yourself. In depression it is often too active.

(2) Salience network — it aims your attention. It can lock onto threats and bad thoughts.

(3) Prefrontal cortex circuits — they calm emotions from the top down. In depression they are often too quiet.

(4) Limbic system (amygdala and hippocampus) — the amygdala (fear center) gets too active. Long stress can shrink the hippocampus (memory center).

(5) Reward circuit (striatum) — this is where pleasure lives. Loss of pleasure (anhedonia) means this circuit responds less. **Stress system:** long stress keeps the HPA axis off balance, with high cortisol (stress hormone).

Neuroplasticity: depression cuts brain cell links. Recovery grows them back. Therapy, meds, exercise, and sleep all help. **Inflammation:** some people with depression have high inflammation markers.

Sleep and body-clock trouble is both a cause and a result. Knowing this makes treatment make sense. **SSRIs and SNRIs (common antidepressants) help grow brain cell links over weeks.**

CBT (talk therapy) rebalances the prefrontal cortex and DMN. Exercise raises BDNF (a brain growth protein). Light therapy resets the body clock. ECT and esketamine make fast brain changes.

CONCEPTS · LEARN IT

- Depression involves brain networks, cell links, stress, the sleep clock, and inflammation
- Default-mode network: dwelling on yourself — often too active
- Prefrontal cortex: calms emotions — often too quiet
- Amygdala too active (fear); the hippocampus shrinks under long stress
- Reward circuit: loss of pleasure means it responds less
- Treatments work by growing cell links, balancing circuits, and resetting the clock

ACTIONS · THIS WEEK

- Click into 360 Human Anatomy: Brain Networks & Mood
- Note your treatments and how each one works in your Health Passport
- Bring your marked-up map to your next mental health visit

SKILLS · LIVE IT

- Open the 360 Human Anatomy: Brain & Mood module
- Say the brain-network model in your own words
- Match treatment to how it works (CBT balances circuits; exercise raises BDNF; light resets the clock)
- Swap 'chemical imbalance' for 'circuits and networks'

PLAN · SHARE IT

- Visit the brain module before each mental health visit
- Update your notes after each treatment change
- Bring your marked-up map to your next visit



3 Force Field Fact Sheet

Primer · Foundations



Who Gets Depression? — Types & Risks

PRIMER

Depression has more than one type. Each type is treated a bit differently. **Major Depressive Disorder (MDD)** is the classic type. It is the most common. To diagnose it (DSM-5 rules):

you need 5 or more of 9 symptoms. The PHQ-9 test checks these symptoms. They must last 2 weeks or more. One must be low mood or loss of interest. And they must get in the way of your life.

Persistent Depressive Disorder (dysthymia) is long, low-grade depression. It lasts 2 years or more. It often comes with MDD episodes ('double depression').

Postpartum Depression affects about 1 in 7 people who give birth. It is not the 'baby blues' (which is short and mild). It needs treatment. Left untreated, the baby is at risk too.

Seasonal Affective Disorder (SAD) follows the seasons. It usually hits in fall and winter. Light therapy is a first-line treatment. **Bipolar Depression** is depression in someone with bipolar disorder.

It is treated DIFFERENTLY. It uses mood stabilizers, sometimes with atypical antipsychotics. Antidepressants alone can trigger mania (a dangerous high mood).

Always ask about past manic episodes before starting an antidepressant. **Treatment-Resistant Depression (TRD)** means 2 or more good treatment tries did not work.

Then esketamine, ECT, and TMS become key options. **Risk factors:** family history, a past episode (it often comes back), the time after birth, and long-term illness.

Long-term illnesses include type 2 diabetes (T2D), heart disease (CVD), heart failure (CHF), kidney disease (CKD), and liver scarring (cirrhosis). They also include MS, brain tumor, and life after a stroke or heart attack (post-MI).

Other risks: past trauma, substance use, and being cut off from others. Money and life stress raise risk too — poverty, racism, food insecurity, and housing instability.

Grief and a recent loss also raise risk.

CONCEPTS · LEARN IT

- MDD: classic type; PHQ-9 maps to DSM criteria; 2 weeks or more
- Persistent Depressive Disorder (dysthymia): long, low-grade, 2 years or more
- Postpartum Depression: 1 in 7 who give birth — needs treatment
- Seasonal Affective Disorder: light therapy first-line
- Bipolar Depression: TREAT DIFFERENTLY; antidepressants alone can trigger mania
- Treatment-Resistant Depression: esketamine, ECT, TMS
- Risk factors: family hx, prior episode, postpartum, chronic illness, trauma, substance use, social-determinant stress

ACTIONS · THIS WEEK

- Confirm your type with your mental health team

SKILLS · LIVE IT

- Name your type (or the type being checked)
- Always ask about manic episodes before starting an SSRI/SNRI
- Tell postpartum depression apart from baby blues
- Spot the seasonal pattern of SAD
- Notice when depression comes with a long-term illness

PLAN · SHARE IT

- Review your type once a year



3 Force Field Fact Sheet

Primer · Foundations

- If pregnant or postpartum: ask about the Edinburgh Postnatal Depression Scale (EPDS) screening
- If bipolar is possible: ask for a psychiatric check BEFORE starting an antidepressant
- If you have a long-term illness: ask for depression screening at every visit
- Talk with family about inherited risk and warning signs
- Add depression to your family-history record



3 Force Field Fact Sheet

Primer · Foundations



The Numbers — PHQ-9 PRIMER

Numbers help you and your team see your path. **About 21 million U.S. adults** have major depression each year (about 8% of adults). **About 17% will have it in their lifetime.** It is among the **top causes of disability worldwide** (Lancet Commission, 2022).

The most useful number is your PHQ-9 score. The Patient Health Questionnaire-9 is a 9-question depression test. Each answer scores 0 to 3. The total runs from 0 to 27.

Action bands: 0-4 minimal, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe. A score of 10 or more usually calls for treatment. A score of 15 or more usually calls for medication, or medication plus therapy.

Item 9 asks about 'thoughts that you would be better off dead, or of hurting yourself in some way.' It is a separate flag, no matter the total. Any yes answer means a safety talk that same visit.

The PHQ-9 is easy to use. Families can help. You can take it yourself. It is low-cost and well-tested. **The USPSTF says to screen all adults** in primary care with the PHQ-9.

That includes pregnant and postpartum people. The results give hope. **About 60-70% of people respond to first-line therapy plus medication. About 80% respond when they try a second or third treatment** (the STAR*D study and successors).

Untreated depression is far more dangerous than treated depression. **Untreated MDD has about a 10-15% lifetime suicide rate.** Treated MDD is much lower.

CONCEPTS · LEARN IT

- About 21M U.S. adults with MDD per year (about 8%); lifetime about 17%
- Among top causes of disability worldwide
- PHQ-9: 9 items, 0-27 total; bands 5/10/15/20
- Item 9 = same-visit safety conversation regardless of total
- USPSTF: universal screening in primary care
- About 60-70% respond to first-line treatment; about 80% with sequencing
- Untreated MDD lifetime suicide rate about 10-15%

ACTIONS · THIS WEEK

- Take the PHQ-9 today (free at phqscreeners.com or in your patient portal)
- Build a numbers card
- Chart your PHQ-9 trend on one sheet
- If pregnant or postpartum: ask about the EPDS

SKILLS · LIVE IT

- Take the PHQ-9 each week
- Say your PHQ-9 score and band
- Track your PHQ-9 trend over weeks and months
- Know that Item 9 always means a conversation

PLAN · SHARE IT

- Add a PHQ-9 log to your Health Passport
- Talk about your PHQ-9 trend at each visit
- Review the trend with your team each quarter



3 Force Field Fact Sheet

Tier 1 · Learn It · Aware



Recognize Warning Signs (988-WATCH)

LEARN IT · TIER 1 AWARE

The most important skill in depression is spotting suicide warning signs and acting on them. Use the 988-WATCH pattern. **(T) Talk** — the person talks about wanting to die or hurt themselves.

They may say they are a burden, or trapped, or have no way out. **(P) Plan + Means** — they have a specific plan. They can reach the means to do it. Means include firearms, pills, high places, and vehicles.

This mix — the wish, a plan, and access to means — is the most dangerous. **(G) Giving Away** — they give away their things. They say goodbye. They put their affairs in order.

They write notes. **(W) Withdrawal** — they pull far away. They stop eating and sleeping. They feel hopeless. A sudden calm after being upset can be a warning too.

It may mean they have decided. **What to do:** ASK directly. **Asking about suicide does NOT plant the idea.** Landmark evidence proves this. The question opens a door;

it is not a trigger. Use plain words: 'Are you thinking about suicide?' Do not soften it. **Listen. Do not try to fix.** Then act. **Call or text 988 for any suicidal thoughts. Call 911 or go to the ED for active risk or an attempt. Cut off access to means when risk is high.** This is lethal-means counseling:

lock up guns, put medications in a lockbox, and add distance from access. Most suicidal crises are time-limited. Putting time and distance between the person and the means saves lives.

Veterans Crisis Line: call 988, then press 1.

CONCEPTS · LEARN IT

- 988-WATCH: Talk + Plan/Mean + Giving Away + Withdrawal
- Plan + access to means = highest risk
- Asking does NOT plant the idea — landmark evidence
- Use plain language — 'Are you thinking about suicide?'
- 988 for any suicidal thoughts; 911/ED for active risk
- Lethal-means counseling: time + distance + storage saves lives
- Most suicidal crises are time-limited

ACTIONS · THIS WEEK

- Save 988 (call or text) and 741741 (text HOME) in your phone favorites
- If a loved one fits the pattern: ask, today
- Lethal-means safety: lock or remove firearms; use a lockbox or distance for medications
- Print the 988-WATCH card for the fridge
- Run a family Ambassador 988-WATCH drill

SKILLS · LIVE IT

- Say the 988-WATCH pattern from memory
- Ask the suicide question directly, without softening it
- Listen without trying to fix
- Make the 988 call or 741741 text from a phone
- Have the lethal-means safety conversation (firearms, medications)
- See that sudden calm after being upset can be concerning

PLAN · SHARE IT

- This week: 988-WATCH card on the fridge
- This month: run a family Ambassador drill
- Quarterly: review the safety plan with your team



3 Force Field Fact Sheet

Tier 1 · Learn It · Aware



PHQ-9 Screening + Wellness Visits

LEARN IT · TIER 1 AWARE

The **PHQ-9** (Patient Health Questionnaire-9) is the tested depression screen. Families can help give it. You can take it yourself. Your Ambassador can help too.

It is like STOP-BANG for sleep apnea — short, evidence-based, low-cost, and widely used. It has **nine items** that match the DSM-5 symptoms of MDD. **Each item scores 0 to 3** (0 = not at all;

1 = several days; 2 = more than half the days; 3 = nearly every day). **The total runs 0 to 27.** Action bands sit at **5 (mild), 10 (moderate), 15 (moderately severe), and 20 (severe).**

Item 9 asks about 'thoughts that you would be better off dead, or of hurting yourself.' It is a separate flag. Any yes answer means a safety talk that same visit, no matter the total.

The USPSTF says to screen all adults in primary care. That includes pregnant and postpartum patients. The **Edinburgh Postnatal Depression Scale (EPDS)** is the version for the perinatal period (around birth).

The **PHQ-2** uses the first 2 items as a quick check. A positive PHQ-2 leads to the full PHQ-9. **Wellness visits** for depression also include a few checks. **Baseline labs** rule out other causes:

TSH (thyroid), CBC (blood count), B12 and folate, vitamin D, and a metabolic panel. A **medication review** matters, because some drugs can cause or worsen depression.

These include interferon, isotretinoin, varenicline, some hormonal birth control, beta blockers at times, and corticosteroids. Visits also cover **substance use screening** and **trauma screening** if not yet done.

Older adults also get a **thinking and memory (cognitive) screen**. The PHQ-9 is free at phqscreeners.com.

CONCEPTS · LEARN IT

- PHQ-9: validated, free, family-administerable, 9 items, 0–27
- Bands: 5/10/15/20
- Item 9 = same-visit safety conversation
- USPSTF: universal screening in primary care
- EPDS for the perinatal period (around birth)
- Baseline workup: TSH, CBC, B12/folate, vitamin D, metabolic panel
- Some medications cause/worsen depression — review the list

ACTIONS · THIS WEEK

- Take the PHQ-9 this week
- Confirm your baseline labs are done (TSH, CBC, B12/folate, vitamin D, metabolic panel)
- Check your medications for ones that worsen depression
- If pregnant or postpartum: ask about the EPDS
- Ask for substance and trauma screening if not yet done

SKILLS · LIVE IT

- Take the PHQ-9 each week
- Know your action band
- Spot medical mimics that need a workup
- Use the PHQ-2 as a quick check; the PHQ-9 if positive

PLAN · SHARE IT

- Screening plus workup each year
- Repeat the PHQ-9 weekly during active treatment
- Repeat every 3 months once in remission



3 Force Field Fact Sheet

Tier 1 · Learn It · Aware



Know My Numbers

LEARN IT · TIER 1 AWARE

In depression, here are the numbers worth knowing. **Your PHQ-9 score and its 4-week trend** — this is the main dashboard. **Sleep hours and quality** — sleep is both a symptom and a lever.

Energy — rate it 0-10, or low, medium, high. **Anhedonia** (loss of pleasure) — a hallmark sign; rate it 0-10, or severe, partial, minimal. **A suicidal-thought check-in** — Item 9, plus how often, how strong, any plan, and access to means.

Medication adherence — are you taking it as prescribed. **A side-effect log. Therapy attendance and homework. Baseline labs** — TSH, CBC, B12 and folate, vitamin D, and a metabolic panel.

These rule out other causes and track SSRI/SNRI effects. **Weight** — mirtazapine and some SSRIs can change it.

Blood pressure (BP) — SNRIs can raise it a little.

QTc on an EKG (heart tracing) — check it if you take citalopram above 40 mg, or other drugs that affect the QT.

Liver function — check it if you take duloxetine.

Bring a one-page 'my numbers' card to every visit.

CONCEPTS · LEARN IT

- PHQ-9 + 4-week trend = the central dashboard
- Sleep, energy, anhedonia = leading indicators
- Suicidal-ideation check-in (Item 9 + frequency/intensity/plan/means)
- Medication adherence + side-effect log
- Baseline + monitoring labs (TSH, CBC, B12/folate, vitamin D, metabolic)
- Weight and BP for med monitoring
- QTc EKG if high-dose citalopram

ACTIONS · THIS WEEK

- Build a numbers card
- Chart your PHQ-9 trend on one sheet
- Confirm your baseline labs are current
- Confirm your med doses and side-effect log

SKILLS · LIVE IT

- Say your PHQ-9 and trend from memory
- Track sleep, energy, and anhedonia each week
- Know your meds, doses, and side-effect status
- Bring your numbers card to every visit

PLAN · SHARE IT

- Keep your numbers card current
- Have a numbers conversation each visit
- Review the trend each quarter



3 Force Field Fact Sheet

Tier 1 · Learn It · Aware



Lifestyle Force Field

LEARN IT · TIER 1 AWARE

In depression, lifestyle is real medicine. It does not replace therapy or medication. But it is a strong add-on lever. For mild depression, it can sometimes be enough. Here are the non-negotiables.

(1) Regular exercise — 30 or more minutes most days, both aerobic and resistance. It has an antidepressant effect on its own. Many RCTs show this. In mild-to-moderate depression, the effect size is comparable to SSRIs.

Think of exercise as a treatment, not a 'should.'

(2) Sleep — 7 to 9 hours on a regular schedule. Poor sleep is both a symptom and a driver. Sleep hygiene and CBT-I (CBT for insomnia) are evidence-based.

(3) A Mediterranean-style diet — it is tied to lower depression risk and better outcomes (the SMILES trial and successors).

(4) Social connection — not a nice-to-have. Loneliness drives depression. Depression drives withdrawal. You must break this loop, even when it feels impossible.

(5) Sunlight — daily; 10 to 20 minutes of morning light resets your circadian clock. Light therapy (a 10,000 lux box, 30 minutes each morning) is first-line for SAD.

(6) Cut back or stop alcohol — alcohol is depressogenic (it worsens depression). It disrupts sleep. It interacts with antidepressants. Many people improve a lot when they drink less or quit.

(7) Cut back on cannabis and other substances — cannabis makes depression harder to treat for many.

(8) Mindfulness — MBCT (Mindfulness-Based Cognitive Therapy) has evidence for relapse prevention.

(9) Behavioral activation — schedule pleasurable and meaningful activities even when motivation is gone. Do first, then feel — not the other way. For many people, the lifestyle stack matters as much as the meds.

CONCEPTS · LEARN IT

- Exercise: 30+ min most days — proven antidepressant
- Sleep: 7-9 hr; CBT-I evidence-based for insomnia
- Mediterranean-style diet: lower depression risk (SMILES trial)
- Social connection: non-negotiable
- Sunlight + light therapy for SAD (10,000 lux, 30 min/morning)
- Alcohol moderation/abstinence — alcohol is depressogenic
- Mindfulness / MBCT for relapse prevention
- Behavioral activation: do first, feel second

ACTIONS · THIS WEEK

- This week: schedule 30 min of exercise on 5 days
- Audit your medicine cabinet and alcohol — set realistic limits
- Buy a light box if you are SAD-prone

SKILLS · LIVE IT

- Say the exercise rule (30+ min most days)
- Keep a sleep-hygiene routine
- Behavioral activation: schedule one activity a day
- Read alcohol-content labels; track drinks
- Use a light box for SAD
- Practice mindfulness (5-10 min a day)

PLAN · SHARE IT

- Daily: movement + sleep + connection
- Weekly: PHQ-9 + sleep log + drinks log
- Quarterly: review with your team and adjust



3 Force Field Fact Sheet

Tier 1 · Learn It · Aware

- Build a behavioral-activation worksheet
- Schedule 1 social interaction a day even when avoiding



3 Force Field Fact Sheet

Tier 2 • Live It • Active



Medications + Therapy — All Three Levers

LIVE IT • TIER 2 ACTIVE

Depression treatment runs on three tracks. You combine them based on severity. **1. Therapy** — first-line for mild-to-moderate depression. It adds power for moderate-to-severe.

The evidence-based types include: **Cognitive Behavioral Therapy (CBT)** — changes thought patterns and behaviors. **Interpersonal Therapy (IPT)** — focuses on relationships and role transitions;

strong evidence for postpartum. **Behavioral Activation** — schedule meaningful activities; especially good for low-motivation depression. **Problem-Solving Therapy. MBCT** — mindfulness-based;

relapse prevention. **ACT** — acceptance and commitment therapy. Therapy works. A full course is usually 12 to 20 sessions. The effect persists after treatment ends.

2. Medications — first-line for moderate-to-severe; they also add to therapy. **SSRIs are first-line:** sertraline, escitalopram, and fluoxetine (also citalopram and paroxetine;

paroxetine has more withdrawal). They are generally well-tolerated. They take **4 to 6 weeks for full effect**. Common side effects include GI upset, sexual side effects, sleep changes, and mild weight effects.

SNRIs: duloxetine and venlafaxine — useful with comorbid pain; they can raise BP. **Atypicals:** bupropion (no sexual side effects, activating; it can lower the seizure threshold;

avoid it in eating disorders). Mirtazapine is sedating, adds weight, and helps sleep and appetite. **The 4-to-6-week wait is real — do not stop early. Withdrawal is real — taper, do not stop cold.** Stopping an SSRI/SNRI too fast can cause discontinuation syndrome.

That means flu-like feelings, dizziness, and electric-shock sensations. **Black-box warning:** SSRIs can be linked to increased suicidal thoughts in young people in the first weeks.

But the risk of UNTREATED depression is far greater. The answer is close monitoring in the first 4 to 6 weeks, not avoiding treatment. **About 60-70% respond to first-line;**

about 80% with sequencing (STAR*D). **Esketamine (Spravato)** is rapid-acting and FDA-approved for treatment-resistant depression. **ECT** is very effective for severe depression, treatment-resistant cases, severe suicidality, and psychotic depression.

Destigmatize ECT: it is safer, gentler, and more effective than its stereotype. **TMS (Transcranial Magnetic Stimulation)** is non-invasive and FDA-approved for treatment-resistant depression.

3. Lifestyle — see Square 8. **For moderate-to-severe depression, therapy plus medication wins.** Always ask about manic episodes BEFORE starting an antidepressant.

If it is bipolar, treat it differently.

CONCEPTS • LEARN IT

- Therapy first-line for mild-to-moderate; CBT, IPT, behavioral activation, MBCT
- SSRIs first-line meds: sertraline, escitalopram, fluoxetine
- 4-6 week wait for full effect; do NOT stop early
- Withdrawal is real — taper, don't stop cold

SKILLS • LIVE IT

- Name your treatments and how each one works
- Track adherence and side effects
- Recognize discontinuation syndrome
- Use the 4-6 week wait without panicking
- Ask about a history of mania



3 Force Field Fact Sheet

Tier 2 · Live It · Active

- Black-box warning on increased suicidal thoughts in youth — close monitoring during first 4–6 weeks
- About 60–70% respond first-line; about 80% with sequencing
- Esketamine, ECT, TMS for treatment-resistant depression
- ALWAYS ask about mania before SSRI start

ACTIONS · THIS WEEK

- Confirm your therapy type is matched to your needs
- Track med adherence with a pillbox or app
- Apply for copay help or a generic substitution
- If 2 meds have failed: ask about esketamine / ECT / TMS
- Schedule your next med-review visit

- Consider esketamine / ECT / TMS if 2 trials fail

PLAN · SHARE IT

- This week: med adherence routine + therapy attendance
- This month: a 4-week PHQ-9 check-in with your prescriber
- This quarter: a full med and therapy review



3 Force Field Fact Sheet

Tier 2 • Live It • Active



Care Team Members

LIVE IT • TIER 2 ACTIVE

Depression care is often multi-specialty over a long arc. The team depends on severity. **For mild-to-moderate depression:** your PCP (primary care doctor) can manage medication.

A mental health provider handles therapy — an LCSW, LPC, or psychologist. This is the **collaborative-care model**, with about 3 times better outcomes than usual care.

For moderate-to-severe, treatment-resistant, or bipolar depression: **psychiatry** leads medication management. A psychologist or therapist leads psychotherapy.

Your PCP coordinates. An **RN care manager** tracks your PHQ-9 and bridges visits in collaborative-care models.

Behavioral health providers include a psychologist, an LCSW (Licensed Clinical Social Worker), an LPC (Licensed Professional Counselor), and an LMFT (Marriage &

Family Therapist). Match the credential to your need. CBT- or IPT-training is the bar. A **peer supporter or NAMI peer mentor** is someone who has lived this.

Pastoral care or a chaplain helps if faith matters to you. Many find faith-community ties meaningful. Your **Family Ambassador** — a partner, parent, or adult child — plays the Notice and Name role.

Addiction medicine helps if substance use is comorbid. **OB/GYN** matters for the perinatal period — coordinated care helps. **Geriatric psychiatry** helps for older adults, since it presents differently and drug interactions matter more.

Veterans Affairs (VA) has specialized depression and PTSD services. A **school counselor** helps a college student. An **EAP (Employee Assistance Program)** at work can be a free entry point.

CONCEPTS • LEARN IT

- Collaborative care model: PCP + therapist + RN care manager + psychiatrist consultant — about 3x better outcomes
- Psychiatry for moderate-severe / treatment-resistant / bipolar
- Behavioral health: psychologist / LCSW / LPC / LMFT (CBT- or IPT-trained)
- NAMI peer support; pastoral care if relevant
- Family Ambassador (Notice and Name)
- Addiction medicine if substance use comorbid
- OB/GYN if perinatal; geriatric psych if older adult; VA if veteran

ACTIONS • THIS WEEK

- Build your Care Team card
- Find a therapist trained in CBT or IPT
- Connect with the NAMI HelpLine 1-800-950-6264
- If perinatal: confirm OB/GYN and behavioral-health coordination

SKILLS • LIVE IT

- List every team member with a phone and email
- Use a 'who handles what' triage
- Schedule annual primary care + screen review
- Insist on an early behavioral-health referral
- Connect with NAMI peer support

PLAN • SHARE IT

- This month: complete your Care Team card
- This quarter: book any missing screen or appointment
- This year: keep the integrated team meeting together



3 Force Field Fact Sheet

Tier 2 • Live It • Active

- If a veteran: connect with VA mental health



Telemedicine & Tech

LIVE IT • TIER 2 ACTIVE • TECH

Tech does real work in depression care. **Telehealth therapy** works as well as in-person for most people (multiple RCTs). It dramatically improves access.

That helps rural areas, people with mobility limits, and tight work schedules. Platforms include BetterHelp, Talkspace, and health-system tele-BH (often the best-coordinated option).

PHQ-9 self-administration apps help track your trend: How We Feel, Daylio, and MyChart symptom diaries.

Light therapy boxes (10,000 lux, 30 minutes each morning) are first-line for SAD.

They are relatively cheap (about \$50 to \$150). **988 Lifeline** — call or text 988, 24/7, free and confidential. **Crisis Text Line** — text HOME to 741741, 24/7.

Veterans Crisis Line — call 988, then press 1. **Behavioral-activation worksheets** (like MoodKit) help with between-session homework. **Sleep apps** (Sleep Cycle, Calm Sleep).

Mindfulness apps (Calm, Headspace, Insight Timer — most have free tiers). **Mood-tracking apps**. **Pillbox apps** (Medisafe, Mango Health). **EAP teletherapy** through work.

Online CBT programs (like MoodGYM and Therabot, which is emerging) have evidence in mild-to-moderate depression. **One caution**: not all mental-health apps are evidence-based.

Check the ratings on ORCHA or One Mind PsyberGuide first.

CONCEPTS • LEARN IT

- Telehealth therapy works as well as in-person — improves access
- 988 (call or text) + 741741 (text HOME) + 988-press-1 (Veterans)
- Light therapy boxes for SAD (10,000 lux, 30 min/morning)
- Behavioral-activation, sleep, mindfulness apps
- Online CBT programs (mild-to-moderate)
- Health-system tele-BH often best-coordinated
- Vet apps via ORCHA / One Mind PsyberGuide

ACTIONS • THIS WEEK

- Save 988 and 741741 in your phone
- Sign up for MyChart and turn on lab and portal notifications
- Try one routine visit as a video visit
- Buy a light box if you are SAD-prone
- Set medication and mood-tracking reminders

SKILLS • LIVE IT

- Run a video visit smoothly
- Send a structured portal message
- Set medication reminders
- Use a mood/PHQ-9 tracking app
- Use a light box for SAD
- Practice with a mindfulness app daily

PLAN • SHARE IT

- This week: 988 + 741741 saved; a PHQ-9 app installed
- This month: try a video therapy visit
- This quarter: review your tech stack with your team



3 Force Field Fact Sheet

Tier 2 · Live It · Active



Insurance, Treatment Cost & Help

LIVE IT · TIER 2 ACTIVE

Depression treatment can be affordable — but the system is confusing. The **Mental Health Parity and Addiction Equity Act (MHPAEA, 2008)** is a key law. If a plan covers mental health, it must do so on par with medical/surgical care.

That covers deductibles, copays, visit limits, and prior-auth. Enforcement has improved but is still imperfect. If your plan denies care, file a complaint with your state insurance commissioner.

Most SSRIs are generic and cheap — sertraline, escitalopram, fluoxetine, and citalopram typically cost \$4 to \$10 a month with GoodRx. **Newer brand-name agents** (esketamine, vortioxetine, vilazodone) have copay-help programs.

The **NAMI Helpline** (1-800-950-6264) offers free navigation, advocacy, and peer support. The **SAMHSA helpline** (1-800-662-HELP, 24/7) helps you find treatment for substance use and mental health.

Sliding-scale therapy costs less. Find it at training clinics (university psychology departments), community mental health centers (CMHC), federally qualified health centers (FQHC), and Open Path Collective (\$30 to \$80 a session).

Your **EAP** at work usually offers 3 to 8 free sessions — your free entry point. **FMLA** covers depression-treatment leave (intermittent or continuous, up to 12 weeks).

ADA covers accommodations long-term. **SSDI** helps with severe, disabling depression. **Medicare** covers psychiatry, psychology, LCSW, and LPC care. **Medicaid** rules vary by state, but expansion has improved coverage.

988 is free. The Crisis Text Line is free. Hospital social workers and behavioral-health navigators are free too. They give the highest-leverage paperwork help you can get.

CONCEPTS · LEARN IT

- MHPAEA requires parity — file a complaint if denied
- Most SSRIs are generic and about \$4–10/month with GoodRx
- NAMI Helpline 1-800-950-6264 (free, 24/7)
- SAMHSA 1-800-662-HELP (24/7, treatment locator)
- Sliding-scale therapy: training clinics, CMHC, FQHC, Open Path
- EAP: free entry point
- FMLA + ADA + SSDI legal stack
- 988 + Crisis Text Line free 24/7

ACTIONS · THIS WEEK

- Print one EOB and learn what every line means
- Save NAMI 1-800-950-6264 and SAMHSA 1-800-662-HELP in your phone
- If on a brand-name med: apply to the manufacturer's copay program
- Talk to HR about EAP, FMLA, and ADA

SKILLS · LIVE IT

- Read an EOB (explanation of benefits)
- File a parity complaint with your state insurance
- Apply for copay help
- Use GoodRx for generics
- Find sliding-scale therapy via Open Path / CMHC / FQHC
- Get FMLA paperwork from HR

PLAN · SHARE IT

- This week: collect your last 3 EOBs
- This month: apply for at least one help program if needed
- Annually: re-verify your FMLA and ADA paperwork



3 Force Field Fact Sheet

Tier 2 · Live It · Active

- If denied: file a parity complaint



3 Force Field Fact Sheet

Tier 3 · Share It · Certified



Equity, Stigma & Cultural Competence

SHARE IT · TIER 3 CERTIFIED

Depression can look different in different groups. Stigma and help-seeking differ too. The Ambassador's job is to address this without preaching. **Men:** more anger, irritability, substance use, and body symptoms (somatic).

Men seek help less. Their suicide rate is about 3 to 4 times that of women. The 'man up' framing kills people. Say it plainly: depression is a medical condition.

Getting treated is strong, not weak. **African American communities:** more body symptoms, like sleep and appetite changes. Past and present harm from the medical system means trust must be built.

Faith groups are often the first stop. They can be strong partners. Black-led (AA-led) therapists help. **Latino communities:** terms like 'ataque de nervios' and 'nervios' may name depression.

Bilingual and bicultural therapists matter. A family-centered framing fits. **AAPI communities:** the lowest mental-health-care use of any U.S. group. Stigma is severe in many.

Body symptoms are common. Bilingual therapists are scarce. **Indigenous communities:** deep historical trauma. It came from forced relocation, boarding schools, and ongoing injustice.

Care based in the community, with traditional healing, works. IHS resources exist. **LGBTQ+ youth:** 4 times the suicide-attempt risk of their peers. Family acceptance is the single biggest thing that protects them (Trevor Project research).

Affirming therapists matter. The Trevor Project: 1-866-488-7386, or text START to 678678. **Older adults:** depression is often missed. It can show as memory complaints, body symptoms, and pulling away.

Suicide rates are higher, most of all in older men. Geriatric psychiatrists are scarce. **Plain framing:** depression is medical, not moral. Different doors, same destination.

CONCEPTS · LEARN IT

- Men: irritability/anger; lower help-seeking; higher suicide rates
- AA: somatic; faith-community partnership; AA-led therapists
- Latino: cultural idioms; bilingual/bicultural therapists
- AAPI: lowest mental-health utilization; severe stigma
- Indigenous: historical trauma; community-based, traditional-healing integrated
- LGBTQ+ youth: 4x suicide-attempt risk; family acceptance protective
- Older adults: often missed; high suicide rates in older men
- Plain framing: medical, not moral

ACTIONS · THIS WEEK

- Save the NAMI Helpline, SAMHSA, and Trevor Project in your phone

SKILLS · LIVE IT

- Match the messenger to the community
- Use plain language — depression is medical
- Connect with culturally-affirming therapists
- Use The Trevor Project for LGBTQ+ youth (1-866-488-7386)
- Recognize older-adult depression patterns

PLAN · SHARE IT

- This month: complete one mental-health-equity training
- This quarter: write your story
- Long-term: become an Ambassador (Tier 3)



3 Force Field Fact Sheet

Tier 3 · Share It · Certified

- If from a community where stigma is severe: find a culturally-affirming therapist
- If an older-adult family member is withdrawn: ask about depression
- Read AFSP / NIMH cultural-competence materials



3 Force Field Fact Sheet

Tier 3 · Share It · Certified



Talk to Kids, Partner, Employer

SHARE IT · TIER 3 CERTIFIED

Depression shows up in family life, partnership, and work. **Kids** need plain, age-appropriate honesty: 'Mom's brain is sick. The doctors are helping. It's not your fault.

We are okay.' Hiding it does more harm than telling — kids notice. Depression in a parent is a known risk factor for depression in kids. So family treatment plus kid screening matters.

Partner: the Ambassador **Notice and Name** role is partner-skill #1. Short, observable changes — sleep, withdrawal, hopelessness, irritability — warrant a check-in question, not a diagnosis.

Ask about suicidal thoughts directly when worried — asking does NOT plant the idea (landmark evidence). Reduce access to means at peak risk. Put firearms in safe storage or out of the home.

Use medication lockboxes. Add distance from access. **Accompany to appointments** when you can. The high-school child of a depressed parent is one of the highest-leverage cases.

Kids do better when the depressed parent gets effective treatment. **Employer: ADA covers depression** as a disability. Reasonable accommodations may include a flexible schedule, time off for appointments, a quiet workspace, and modified deadlines during a flare.

FMLA covers up to 12 weeks of treatment leave (intermittent or continuous). **MHPAEA** protects your insurance coverage. **EAP** typically offers 3 to 8 free, confidential sessions.

Disclosure to your employer is strategic — HR should be your partner. You do not have to name 'depression' to access ADA or FMLA. 'A serious health condition' is enough.

CONCEPTS · LEARN IT

- Plain language with kids; depression in a parent is a kid-risk factor
- Partner: Ambassador Notice and Name role
- Asking about suicide does NOT plant the idea — landmark evidence
- Lethal-means safety: firearms, medications
- Accompany to appointments
- ADA + FMLA + MHPAEA + EAP = legal/benefit stack
- Disclosure is strategic — 'serious health condition' suffices for ADA/FMLA

ACTIONS · THIS WEEK

- This week: a family conversation
- This month: an ADA / FMLA conversation with HR if needed
- This quarter: a long-arc plan with your partner; a lethal-means safety review
- If you have kids: confirm a pediatric mental-health screen

SKILLS · LIVE IT

- Run a 5-minute family conversation about the diagnosis and plan
- Run a partner Notice and Name conversation
- Have the lethal-means safety conversation
- Document an ADA accommodation request
- Use the AHRQ SHARE Approach with your team
- ASK directly about suicidal thoughts when worried

PLAN · SHARE IT

- This month: identify your accommodation needs
- This quarter: complete one ADA request if needed
- This year: a long-arc family and partner plan



3 Force Field Fact Sheet

Tier 3 · Share It · Certified



Mentor & Share Insights

SHARE IT · TIER 3 CERTIFIED

You become the most powerful version of yourself when you teach others. **NAMI Peer-to-Peer** and **NAMI Family-to-Family** are robust, free, evidence-based peer-mentor programs run nationally.

AFSP (American Foundation for Suicide Prevention) runs 'Out of the Darkness' walks that build community and fund research. AFSP also runs 'Talk Saves Lives' education.

The **Depression and Bipolar Support Alliance (DBSA)** runs peer-led support groups. **The Trevor Project** serves LGBTQ+ youth. **Postpartum Support International** serves perinatal mood needs.

The **FFH Network** connects mentors and mentees across conditions. A newly-diagnosed person hears something powerful from a peer: 'My PHQ-9 was 18. I tried two meds and CBT.'

I'm 2 years into remission. Here's what I wish I'd known.' That lands differently than statistics. **Honest framing beats a pep talk.** The men who break the 'man up' framing in public.

The AA, Latino, AAPI, and Indigenous community members who name depression as medical. The LGBTQ+ adults who survived their own youth and pay it forward.

All are real, and all are worth telling. Mentor with boundaries — vicarious-trauma hygiene matters. Co-present at NAMI, faith-community, employer, or school events.

Write your team a short letter after a great or rough visit: 'what worked, what didn't, what we learned.' **Stigma dies one disclosure at a time** — but only when the person is ready.

Don't out anyone, including yourself, until it serves you.

CONCEPTS · LEARN IT

- NAMI Peer-to-Peer + Family-to-Family: free, evidence-based
- AFSP 'Out of the Darkness' + 'Talk Saves Lives'
- DBSA peer-led support groups
- The Trevor Project for LGBTQ+ youth
- Postpartum Support International
- Honest framing beats a pep talk
- Mentor with boundaries — vicarious-trauma hygiene
- Disclose only when it serves you

ACTIONS · THIS WEEK

- Sign up to mentor one newly-diagnosed person via NAMI
- Write one feedback letter this month
- Submit your story to NAMI / AFSP / FFH
- Co-present a community / employer / faith-community education session

SKILLS · LIVE IT

- Tell your story in 3 minutes
- Run a 30-minute peer-mentor session
- Write a 'what worked / what didn't' letter under 200 words
- Co-teach with your team
- Set healthy mentoring boundaries

PLAN · SHARE IT

- This month: identify one mentoring opportunity
- This quarter: deliver one talk
- This year: complete your Tier 3 Ambassador requirements



3 Force Field Fact Sheet

Tier 3 · Share It · Certified



Join the ROI Study (PHIT)

SHARE IT · TIER 3 CERTIFIED · STUDY

PHIT stands for Population Health Impact Tracking. It is the FFH research engine. It asks one question: does the Prepared Patient program truly improve outcomes for depression populations? It looks for earlier PHQ-9 screening and faster treatment initiation.

It looks for sustained remission and lower relapse. It looks for fewer ED crisis visits. It also checks whether Ambassadors reach more people with 'Notice and Name.' That means men, and AA, Latino, AAPI, Indigenous, LGBTQ+, and older-adult communities.

You can opt in to share aggregate, de-identified outcomes. That may include your depression type, your PHQ-9 trend, and your treatment modality. It may include your treatment response, side effects, ED visits, and hospitalizations.

It may also include your badge progress and self-reported quality of life. **No PHI is shared.** You can withdraw anytime. You will receive periodic plain-language summaries.

CONCEPTS · LEARN IT

- PHIT = de-identified, aggregate outcomes only
- Validated programs become reimbursable + scalable
- Your data + 1,000 others = a publishable study
- Anytime opt-out, full transparency
- FFH ROI Engine pairs PHIT data with cost data

ACTIONS · THIS WEEK

- Opt in via the green box on this page
- Read your first quarterly summary
- Tell one peer about PHIT
- If a researcher contacts you, verify via FFH first

SKILLS · LIVE IT

- Read a one-page consent
- Recognize what is and isn't PHI
- Set up periodic review of your own dashboard
- Withdraw or pause participation at any time

PLAN · SHARE IT

- Today: opt in if it feels right
- Each quarter: review your summary
- Each year: decide whether to continue

Additional Notes

☐ I've read the full Depression Fact Sheet · Step 3


4 Prepared Patient Course

The complete course — three levels, applied to your life

The course takes you through the Fact Sheet in three levels — from newly-diagnosed to prepared — then shows how every part applies to you and the people around you.

Level 1 · Aware

Know the basics — what Depression is, your numbers, your meds.

Level 2 · Active

Manage & do — self-monitor, act on red flags, work your plan.

Level 3 · Certified

Advocate & share — teach it, bring your team in, help others.

The Numbers — PHQ-9

Numbers help you and your team see your path. **About 21 million U.S. adults** have major depression each year (about 8% of adults). **About 17% will have it in their lifetime.** It is among the **top causes of disability worldwide** (Lancet Commission, 2022).

The most useful number is your PHQ-9 score. The Patient Health Questionnaire-9 is a 9-question depression test. Each answer scores 0 to 3. The total runs from 0 to 27.

Action bands: 0-4 minimal, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe. A score of 10 or more usually calls for treatment. A score of 15 or more usually calls for medication, or medication plus therapy.

Item 9 asks about 'thoughts that you would be better off dead, or of hurting yourself in some way.' It is a separate flag, no matter the total. Any yes answer means a safety talk that same visit.

The PHQ-9 is easy to use. Families can help. You can take it yourself. It is low-cost and well-tested. **The USPSTF says to screen all adults** in primary care with the PHQ-9.

That includes pregnant and postpartum people. The results give hope. **About 60-70% of people respond to first-line therapy plus medication. About 80% respond when they try a second or third treatment** (the STAR*D study and successors).

Untreated depression is far more dangerous than treated depression. **Untreated MDD has about a 10-15% lifetime suicide rate.** Treated MDD is much lower.

- About 21M U.S. adults with MDD per year (about 8%); lifetime about 17%
- Among top causes of disability worldwide
- PHQ-9: 9 items, 0-27 total; bands 5/10/15/20
- Item 9 = same-visit safety conversation regardless of total
- USPSTF: universal screening in primary care
- About 60-70% respond to first-line treatment; about 80% with sequencing
- Untreated MDD lifetime suicide rate about 10-15%

THE FULL COURSE — HOW EACH PART APPLIES TO YOUR LIFE

Every part of the Depression Force Field lands differently depending on who you are. Here is the complete course — what each concept means for **you**, your **family**, the **workplace**, and **students** learning it.



4 Prepared Patient Course

The complete course — three levels, applied to your life

What Is Depression?

FOR YOU · THE PATIENT

This is your map. Your type, your PHQ-9, and your plan guide the rest. You are not weak. You are sick, and you can get better.

EMPLOYERS & WORKPLACE

Some of your workers have depression. A supportive workplace keeps good people and cuts missed days.

FAMILY & CAREGIVERS

Your loved one is not lazy. Their brain is sick. Your job is to Notice and Name changes. It is not to fix or judge.

STUDENTS & LEARNERS

Memorize: 8% each year; about 17% lifetime; PHQ-9 bands 5/10/15/20. Treatment works as well as the best care in medicine.

360 Human Anatomy: Brain Networks & Mood

FOR YOU · THE PATIENT

Knowing how depression works in the brain replaces the old 'chemical imbalance' story. The new one is truer. It makes treatment make sense.

EMPLOYERS & WORKPLACE

Depression is a brain condition, not a motivation problem. Knowing this changes how managers respond and help.

FAMILY & CAREGIVERS

Use the 360 Human Anatomy together. It changes 'just snap out of it' into 'the prefrontal cortex is offline.'

STUDENTS & LEARNERS

Bookmark for boards and clinic. Modern depression science is networks, plasticity, stress, body clock, and inflammation. The old monoamine idea is not complete.

Who Gets Depression? — Types & Risks

FOR YOU · THE PATIENT

Your type matters because treatment differs. Postpartum has its own plan. Bipolar depression needs different meds. Get the right diagnosis first.

EMPLOYERS & WORKPLACE

Depression is in your workforce, often undiagnosed. Postpartum depression is often undertreated. It disrupts return to work.

FAMILY & CAREGIVERS

Family history matters. Postpartum risk is real. Push for screening — early treatment beats late treatment.

STUDENTS & LEARNERS

Memorize: ALWAYS ask about mania before starting an antidepressant. Postpartum depression stands on its own. SAD needs light therapy. Treatment-Resistant Depression has its own plan (esketamine, ECT, TMS).



4 Prepared Patient Course

The complete course — three levels, applied to your life

The Numbers — PHQ-9

FOR YOU · THE PATIENT

The PHQ-9 is your dashboard. The more of your numbers you know, the more power you have in every conversation. The trend matters more than any one score.

EMPLOYERS & WORKPLACE

You don't need to know scores. You need to know the patient does — and that they have time and space for treatment.

FAMILY & CAREGIVERS

The PHQ-9 is your shared scoreboard. Track it. Ask at every visit if it changed. Item 9 always means a direct conversation.

STUDENTS & LEARNERS

Memorize PHQ-9 bands: 5/10/15/20. Item 9 = separate flag. Most people who get treatment respond. The STAR*D sequencing literature guides treatment-resistant depression care.

Recognize Warning Signs (988-WATCH)

FOR YOU · THE PATIENT

This square may save your life or someone else's. Asking does not plant the idea. 988 works. Most crises are time-limited.

EMPLOYERS & WORKPLACE

A teammate showing 988-WATCH signs needs immediate humane support — a private space, a 988 call together, a ride home or to the ED. Not a performance review.

FAMILY & CAREGIVERS

You are the Ambassador. Notice and Name the changes. Ask directly. Listen. Act. The asking itself is the first treatment.

STUDENTS & LEARNERS

Memorize the 988-WATCH pattern. Asking does NOT plant the idea (landmark evidence). Lethal-means counseling, especially for firearms, is the single most effective suicide-prevention step.

PHQ-9 Screening + Wellness Visits

FOR YOU · THE PATIENT

The PHQ-9 is the most useful number you and your team will share. Take it weekly during active treatment.

EMPLOYERS & WORKPLACE

Worksite PHQ-9 screening (in an EAP or wellness program) finds depression that primary care misses. High ROI.

FAMILY & CAREGIVERS

Help track the PHQ-9 each week. The trend matters more than any one score. Watch if Item 9 changes.

STUDENTS & LEARNERS

Memorize the PHQ-9. Memorize the EPDS for perinatal care. Always do baseline TSH and B12 — hypothyroidism and B12 deficiency mimic depression.



4 Prepared Patient Course

The complete course — three levels, applied to your life

Know My Numbers

FOR YOU · THE PATIENT

The more of your depression numbers you know, the more power you have in every conversation. The trend matters most.

EMPLOYERS & WORKPLACE

You don't need to know numbers. You need to give the patient time and space for treatment.

FAMILY & CAREGIVERS

Memorize the PHQ-9 score and trend. Ask at every visit. If the trend isn't moving in 4–6 weeks, ask about a change.

STUDENTS & LEARNERS

Memorize: PHQ-9 + sleep + anhedonia + Item 9 are the central dashboard. Always check TSH and B12. QTc EKG if citalopram is above 40 mg.

Lifestyle Force Field

FOR YOU · THE PATIENT

You can substantially improve depression with lifestyle alone — and even more by stacking it with therapy and medication. Boring; it works.

EMPLOYERS & WORKPLACE

A workplace that supports physical activity, sleep-respecting schedules, and meal flexibility is doing depression prevention without naming it.

FAMILY & CAREGIVERS

Help build the habit infrastructure. Walk together. Cook together. Do the thing even when motivation isn't there. Behavioral activation works.

STUDENTS & LEARNERS

Memorize: exercise effect size in mild-to-moderate depression is comparable to SSRIs. Sleep, light, diet, and social ties are real treatments. Behavioral activation is evidence-based.

Medications + Therapy — All Three Levers

FOR YOU · THE PATIENT

Adherence is the #1 lever you control. Wait the 4 to 6 weeks. Don't stop cold. Most people respond — sometimes after the second or third try.

EMPLOYERS & WORKPLACE

FMLA covers treatment-initiation periods, including ECT/TMS courses. MHPEA requires parity coverage. Worth supporting.

FAMILY & CAREGIVERS

Help build the routine. A pillbox, auto-refill, and therapy reminders work better than nagging. The 4-to-6-week wait is real — patience.

STUDENTS & LEARNERS

Memorize: SSRIs first-line; 4 to 6 weeks; taper, not stop. ALWAYS ask about mania before starting an antidepressant. ECT remains very effective for severe cases — destigmatize it. STAR*D is the sequencing literature.



4 Prepared Patient Course

The complete course — three levels, applied to your life

Care Team Members

FOR YOU · THE PATIENT

You don't need to know everything. You need to know who knows what, and to keep the team coordinated.

EMPLOYERS & WORKPLACE

One named HR contact + one named patient contact + EAP referral = no chaos. The EAP is your free entry point.

FAMILY & CAREGIVERS

Help maintain the Care Team card. The patient should not be on hold during a crisis — you have the numbers.

STUDENTS & LEARNERS

Become a depression-fluent clinician. Most depression is managed in primary care — train PCPs in collaborative-care models. The behavioral-health workforce is undersized everywhere.

Telemedicine & Tech

FOR YOU · THE PATIENT

Tech is your force multiplier. 988 in your pocket. Telehealth therapy is real treatment. Light therapy works for SAD.

EMPLOYERS & WORKPLACE

A 30-minute telehealth therapy visit during the workday is far less disruptive than an absence. Allow it. EAP teletherapy is a high-ROI offering.

FAMILY & CAREGIVERS

Help set up the apps. Add 988 and 741741 to family phones. Two minutes a day on the PHQ-9, big payoff.

STUDENTS & LEARNERS

Telehealth therapy is real and at parity with in-person. Online CBT works for mild-to-moderate. Vet apps before recommending — One Mind PsyberGuide is a good source.

Insurance, Treatment Cost & Help

FOR YOU · THE PATIENT

You can save thousands of dollars and unlock care with a few hours of paperwork. NAMI navigates with you.

EMPLOYERS & WORKPLACE

FMLA, ADA, MHPAEA, and proactive EAP referral save money, retain talent, and reduce risk.

FAMILY & CAREGIVERS

Take the lead on paperwork. The patient should not be on hold during a depressive episode.

STUDENTS & LEARNERS

Most clinicians don't teach this. If you learn it, you'll be the most useful person on the team. MHPAEA is the law — file a complaint when it is violated.



4 Prepared Patient Course

The complete course — three levels, applied to your life

Equity, Stigma & Cultural Competence

FOR YOU · THE PATIENT

You are not crazy. The stigma is real. The framing is medical, not moral. Find the messenger that fits your community.

EMPLOYERS & WORKPLACE

Your employees with depression face stigma at home, at work, and sometimes at the clinic. Confidential EAP, culturally-affirming options, and language-matched care pay off.

FAMILY & CAREGIVERS

Be the calm voice. Match the messenger. Don't preach. The framing: depression is medical, getting treated is strong.

STUDENTS & LEARNERS

Read NIMH and AFSP cultural-competence materials. Don't assume a Western presentation. Somatic presentations are common in many communities. The Trevor Project saves LGBTQ+ youth lives.

Talk to Kids, Partner, Employer

FOR YOU · THE PATIENT

The relationships you protect now are the ones that carry you through. Asking your partner to be your Ambassador is strength, not burden.

EMPLOYERS & WORKPLACE

A teammate with depression who feels accommodated stays longer, performs better, and costs less. ADA + FMLA + MHPAEA + EAP is the stack.

FAMILY & CAREGIVERS

You are the Notice and Name team. Asking about suicidal thoughts is the first treatment. Lethal-means safety saves lives.

STUDENTS & LEARNERS

Coach patients to do these conversations. The asking-about-suicide conversation is the highest-leverage clinical skill in depression. Lethal-means counseling saves lives.

Mentor & Share Insights

FOR YOU · THE PATIENT

Teaching cements what you know and gives meaning to what you've been through. Disclosure is your choice and your timeline.

EMPLOYERS & WORKPLACE

A teammate who teaches mental-health literacy becomes an internal champion. Sponsor them. Mental Health First Aid certification scales.

FAMILY & CAREGIVERS

Family-to-family mentoring is just as powerful as patient-to-patient. NAMI Family-to-Family is the gold standard.

STUDENTS & LEARNERS

Co-learning with people who have lived this is how you become a depression-fluent clinician. Show up at NAMI events, listen first.



4 Prepared Patient Course

The complete course — three levels, applied to your life



Join the ROI Study (PHIT)



FOR YOU · THE PATIENT

Your participation is a quiet but real act of advocacy. It helps the program get paid for, scaled, and offered to people who can't afford it.



EMPLOYERS & WORKPLACE

Sponsoring a cohort of employees in PHIT shows your investment is working — and gives you data to defend the spend.



FAMILY & CAREGIVERS

Care partners can opt in too — caregiver burden and outcomes are also tracked.



STUDENTS & LEARNERS

This is participatory research done right. Study how PHIT was built; emulate it.

QUIZ YOURSELF — CAN YOU ANSWER THESE WITHOUT NOTES?

- ☐ What is Depression, in one plain sentence?
- ☐ What are my target numbers, and my personal baseline?
- ☐ What are my red flags — the signs that mean “call now”?
- ☐ What do I do first if those red flags happen?
- ☐ What is each of my medicines for?

The one thing about Depression I most want to remember

Additional Notes

☐ I've completed Step 4 · Prepared Patient Course for Depression



5 Materials & Tools

Your home kit — the tools that keep you prepared

Being prepared between visits takes a few simple tools. Set these up for Depression, and check them off as you go.

YOUR KIT

- ☐ **Health Passport** — meds, numbers, allergies & contacts on one page.
- ☐ **Your meters / devices** — whatever you use to track Depression at home.
- ☐ **Your action plan** — green / yellow / red: what to do at each level.
- ☐ **Reminders** — a pillbox or phone alarm for medicines and refills.
- ☐ **A tracker** — one number or habit to watch over time.

THIS WEEK'S ACTIONS FOR DEPRESSION

- ☐ Order copies of your mental health and primary care doctor (PCP) notes from the patient portal
- ☐ Save 988 (call or text) and 741741 (Crisis Text Line, text HOME) in your phone
- ☐ Open and fill out your Force Field Emergency Card with your treatment plan and crisis contacts
- ☐ Tell one family member or friend you trust that you are getting checked or treated
- ☐ Click into 360 Human Anatomy: Brain Networks & Mood
- ☐ Note your treatments and how each one works in your Health Passport
- ☐ Bring your marked-up map to your next mental health visit
- ☐ Confirm your type with your mental health team
- ☐ If pregnant or postpartum: ask about the Edinburgh Postnatal Depression Scale (EPDS) screening
- ☐ If bipolar is possible: ask for a psychiatric check BEFORE starting an antidepressant
- ☐ If you have a long-term illness: ask for depression screening at every visit
- ☐ Take the PHQ-9 today (free at phqscreeners.com or in your patient portal)

The one number or habit I'll keep an eye on



5 Materials & Tools

Your home kit — the tools that keep you prepared

Additional Notes

☐ I've completed Step 5 · Materials & Tools for Depression





Skills Lab is where you **show** an educator (or a trusted person) the hands-on parts of managing Depression, in your own words. Practise and demonstrate these:

SKILLS TO DEMONSTRATE

- ☐ Say the medical-illness framing out loud
- ☐ Tell normal sadness or grief apart from depression
- ☐ Read your PHQ-9 score by its action band (5/10/15/20)
- ☐ Use kind words — 'living with depression,' not 'depressive'
- ☐ Open the 360 Human Anatomy: Brain & Mood module
- ☐ Say the brain-network model in your own words
- ☐ Match treatment to how it works (CBT balances circuits; exercise raises BDNF; light resets the clock)
- ☐ Swap 'chemical imbalance' for 'circuits and networks'
- ☐ Name your type (or the type being checked)
- ☐ Always ask about manic episodes before starting an SSRI/SNRI
- ☐ Tell postpartum depression apart from baby blues
- ☐ Spot the seasonal pattern of SAD
- ☐ Notice when depression comes with a long-term illness
- ☐ Take the PHQ-9 each week

TEACH IT BACK

The fastest way to know you've got it: explain Depression in your own words — what it is, your main signs, what helps, and your red flags — with no notes.

My red flags for Depression — the signs that mean “call now”



6

Skills Lab

Show you can do it — hands-on teach-back

Additional Notes

☐ I've completed Step 6 · Skills Lab for Depression





THE FORCE FOR HEALTH® · PREPARED PATIENT

Prepared Patient Ambassador

This certifies that

has completed the Prepared Patient module for **Depression** — knowing their condition, their numbers, their red flags, and how to speak up in their own care.

SKILLS-LAB EDUCATOR SIGN-OFF

DATE

Workbook completion certificate. The clinical Prepared Patient Ambassador credential is confirmed by your Skills-Lab educator or the certification exam.



SCAN TO VERIFY &
COMPLETE
CERTIFICATION

8 Disease Advocate

Optional — beyond yourself: help those who come after you

This optional step is a gift you give the next person. Turn what you learned about Depression outward.

WAYS TO ADVOCATE & SHARE

- ☐ Read all 16 squares
- ☐ Open the deep course
- ☐ Set up a mental health visit if you don't have one yet
- ☐ Visit the brain module before each mental health visit
- ☐ Update your notes after each treatment change
- ☐ Bring your marked-up map to your next visit
- ☐ Review your type once a year
- ☐ Talk with family about inherited risk and warning signs
- ☐ Add depression to your family-history record
- ☐ Add a PHQ-9 log to your Health Passport
- ☐ Share your story and what helped you most.
- ☐ Complete a row of Advocate Bingo.
- ☐ Support someone newly diagnosed with Depression.

My feedback on this program (Coach Lucy & Dr. Rob read these)



8 Disease Advocate

Optional — beyond yourself: help those who come after you

Additional Notes

☐ I've completed Step 8 · Disease Advocate for Depression

