# Diagnosis and Management of Major Depressive Disorder

## Scope

This guideline, adapted from recent guidelines developed by the Canadian Network for Mood and Anxiety Treatments and the Canadian Psychiatric Association,[1,2] summarizes the current recommendations for diagnosis and treatment of major depressive disorder (MDD) in primary care and provides tools to assist physicians with the management of depression.

This guideline applies only to adults between the ages of 19 and 65 and should not be extrapolated to children, adolescents or geriatric populations. Both presentation and treatment of major depressive disorder may differ in these populations.

The level of evidence for each recommendation is indicated in brackets:

Level 1 Supported by meta-analysis or replicated, large sample randomized controlled trials
Level 2 Supported by at least one randomized controlled trial
Level 3 Supported by nonrandomized studies or expert opinion

**SUMMARY RECOMMENDATION** **Care objectives**

Depending on the type of depression and treatment required, these care objectives may be more or less difficult to achieve. There may also be circumstances where the patient's condition (comorbidity, chronicity, treatment-resistance) means that more limited care objectives will take priority over the targets and goals listed here. Therefore, treatment goals must be tailored to the individual.

See Table on page 2.

| Care | Strategy | Targets and Goals |
|---|---|---|
| Identification of patients at risk | Two quick question screen for high-risk patients (during routine visits). | • Early detection of Major Depressive Disorder (MDD) |
| Diagnosis and assessment of severity | Use SIGECAPS mnemonic for symptom criteria, differential diagnosis.<br><br>Use symptom-based rating scale (PHQ-9) to establish baseline. | • Chart record of SIGECAPS responses and PHQ-9 scores for patients positive on two quick question screen.<br>• Review of medications, medical conditions that may cause depression. |
| Self-management | Assess and discuss self-management goals, challenges and progress.<br><br>Provide patient education and self-management materials plus community resources list. | • Informed patient who is actively involved in care decisions. Mutually acceptable management plans.<br>• Chart record of self-management goals. |
| Suicide risk assessment | Assess suicide risk at each visit. | • Identification of patients at high-risk of suicide and documentation of management plan. |
| Post discharge care | See patients discharged from hospital with diagnosis of MDD. | • Chart record of follow-up visit within 7 days of discharge. |
| Acute treatment: Selection | Consider patient preferences and availability of resources when selecting treatment.<br><br>Provide adequate dose/duration of first-line antidepressants.<br><br>Provide or refer to first-line psychotherapies. | • Treatment without delay.<br>• Evidence-based treatment of appropriate intensity and duration.<br>• Treatment matched to patient's preferences. |
| Acute treatment: Monitoring | Plan follow-up visits.<br><br>Monitor response, side effects and adherence to treatment.<br><br>Assess symptoms using PHQ-9 at each visit. | • At least three follow-up visits in first 12 weeks of antidepressant treatment.<br>• At least one follow-up visit in first 12 weeks of psychotherapy<br><br>Goal: Full remission of symptoms (PHQ-9 < 5). |
| Managing poor/incomplete response | Review treatment plan and modify if no response to antidepressants after 3-4 weeks. | • Treatment plan reviewed and modified as needed. Psychiatric referral if warranted.<br>• Patients identified for long-term follow-up. |
| Maintenance treatment | Encourage adherence to continued treatment even after remission.<br><br>Discuss relapse risk factors, symptoms and prevention.<br><br>Discuss and plan gradual discontinuation of antidepressants. | • Continued antidepressant treatment for 6 months after remission, at least 2 years for those with risk factors.<br>• Follow-up visits during maintenance. PHQ-9 at least once a year.<br><br>Goal: Prevention of relapse and recurrence. |
| Social network | Discuss need for social network of friends and family. | • Recognition of early warning signs and impending crisis. Ongoing support. |

## Recommendation 1 Detection

a) For patients at high-risk of MDD, use the 'two quick question' screening method:

In the past month:
Have you lost interest or pleasure in things you usually like to do?
Have you felt sad, low, down, depressed or hopeless?

An answer of Yes to **either** question should trigger a more detailed assessment. [Level 2]

**Individuals at High-Risk for MDD [Level 1]**

- chronic insomnia or fatigue
- chronic pain
- multiple or unexplained somatic complaints, "thick charts"
- chronic medical illnesses (e.g., diabetes, arthritis)
- acute cardiovascular events (myocardial infarction, stroke)
- recent psychological or physical trauma
- other psychiatric disorders
- family history of mood disorder

b) Depression may present differently in special populations. For example, some cultural groups may focus primarily on physical symptoms. [Level 3]

## Recommendation 2 Diagnosis

a) The diagnosis of MDD is based on criteria from the DSM-IV-TR. The symptom criteria can be recalled using the SIGECAPS mnemonic (see below). A diagnostic questionnaire such as the PHQ-9 (Appendix 1) can also be helpful to identify key symptoms. [Level 2]

b) In the differential diagnosis, look for symptoms of an anxiety disorder, bipolar disorder (hypomania/mania), psychosis, alcohol and substance abuse. Collateral information from family or friends is very helpful in making the diagnosis. [Level 3]

c) In the differential diagnosis, look for medical conditions that may cause or exacerbate depression by performing a history, physical exam, and selected laboratory tests as indicated. Review medications to identify any that may exacerbate depressive symptoms.

**SIGECAPS Mnemonic for Symptom Criteria for Major Depressive Episode**

Must have depressed mood (or loss of interest) and at least 4 other symptoms, most of the time, most days, for at least 2 weeks.

S – sleep disturbance (insomnia, hypersomnia)
I – interest reduced (reduced pleasure or enjoyment)
G – guilt and self-blame
E – energy loss and fatigue
C – concentration problems
A – appetite changes (low appetite/weight loss or increased appetite/weight gain)
P – psychomotor changes (retardation, agitation)
S – suicidal thoughts

## RECOMMENDATION 3 Assessment of suicide risk

Assess suicide risk regularly throughout the course of treatment. Include consultation with family and friends where appropriate. Be aware that agitation and suicide risk may increase early in treatment. [Level 3]

### SUICIDE RISK ASSESSMENT

Adapted from Rubenstein, Unutzer, Miranda et al, 1996 [3] [Level 3]

- Ask all depressed patients if they have thoughts of death or suicide, or if they feel hopeless and feel that life is not worth living. Also ask if they have previously attempted suicide.
- If the answer is yes, ask about plans for suicide. How much have they thought about suicide? Have they thought about a method? Do they have access to material required for suicide? Have they said goodbyes, written a note or given away things? What specific conditions would precipitate suicide? What is stopping them from suicide?
- Assess risk factors for suicide (see below).
- Consider emergency psychiatric consultation and treatment if:
  - Suicidal thoughts are persistent
  - The patient has a prior history of a suicide attempt or a current plan, or
  - The patient has several risk factors for suicide

**RISK FACTORS FOR SUICIDE**

| Psychosocial | History | Clinical/Diagnostic |
|---|---|---|
| First Nations | Prior suicide attempt | Hopelessness |
| Male | Family history of suicide | Psychosis |
| Advanced age | Family history of substance abuse | Medical illness |
| Single or living alone | | Substance abuse |

## RECOMMENDATION 4 Disease management

For many patients, depression can be considered a recurrent and/or chronic condition. Organizational interventions within a chronic disease management (CDM) program, such as registration, recall and regular review, can improve the care of patients with depression. [Level 1]

Physicians are encouraged to:

- Identify all patients with depression in their practice
- Participate in patient registries (local or provincial) whenever possible
- Use a flow sheet* for each patient with depression
- Use recall systems to ensure that patients with depression are seen at appropriate intervals
- Review patient records to ensure that treatment objectives are met

* A flow sheet is a short form that gathers all important data regarding a patient's depression treatment. Attached to the patient's chart, the flow sheet serves as a reminder and a record of whether treatment objectives have been met. See attached flow sheet.

## Recommendation 5 Self-management

a) Involve patients in the management of their own illness by engaging them in discussion about the diagnosis and treatment options, developing a goal-oriented treatment plan, and monitoring for response and signs of relapse/recurrence (see patient information sheet). [Level 2]

b) When appropriate, use education and self-management resources, including available community resources and self-help agencies. Note: some patients, especially those with more severe symptoms, may not be able to take advantage of self-management while acutely ill. [Level 2]

### SELF-MANAGEMENT RESOURCES

- Recommend "bibliotherapy" for depression, e.g., self-help workbooks; in particular, the Self-Care Depression Patient Guide, developed at UBC, free download from www.mheccu.ubc.ca/publications
- Other self-help workbooks include *The Feeling Good Handbook* by David D. Burns, Plume Books, 1999, about $30; and *Mind Over Mood* by Dennis Greenberger and Christine A. Padesky, Zipper Books, about $40.
- BC Partners for Mental Health and Addictions Information: provides Mental Disorders, Depression and Anxiety Disorders Toolkits. www.mentalhealthaddictions.bc.ca
- Chronic Disease Self-Management Program: a patient education program offered in communities throughout British Columbia, which teaches practical skills on managing chronic health problems. www.coag.uvic.ca/cdsmp
- Recommend consumer and self-help organizations, including the Canadian Mental Health Association (Tel: 1 800 555-8222; www.cmha-bc.org) and the Mood Disorders Association of BC (Tel: 604 873-0103; www.mdabc.ca).

## Recommendation 6 Acute treatment

a) The goal of acute treatment is full remission of symptoms (e.g., PHQ-9 < 5) and return to premorbid psychosocial function. [Level 1] Treatment selection should consider patient preferences and availability of resources.

b) In patients with mild to moderately severe MDD, evidence-based psychotherapies are as effective as antidepressant medications. For most patients, combined treatment with pharmacotherapy and psychotherapy is no more effective than either therapy alone. Combined treatment should be considered for patients with chronic or severe episodes, patients with co-morbidity, and patients not responding to monotherapy. [Level 1]

c) First-line psychotherapies include cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT) and problem-solving therapy (PST). [Level 1] See Appendix 2. For most family physicians, this will mean referral to a psychotherapist with appropriate training.

Note: If another health professional delivers psychotherapy, there must be regular communication about the patient's progress, especially if medications are also used.

d) Even if formal psychotherapy is not used, patients can benefit from supportive management by physicians, especially in conjunction with medication treatment. [Level 2]

**Supportive Interventions** [Level 2]

- Arrange regular follow-up visits.
- Use the power of the prescription pad to "prescribe" one brief walk per day, one nutritious meal per day, and one pleasurable activity per day.
- Encourage the patient to keep a simple daily mood chart.
- Encourage and promote patient self-management.

e) Antidepressant medications are also first choice treatments for MDD in primary care, especially for those with moderate to severe depressions. [Level 1]

f) Many effective first-line antidepressants are now available with different neurochemical actions and side effect profiles (Appendix 3). Most systematic reviews have not shown any clinically significant differences in efficacy among antidepressants. However, clinical factors that should be considered when choosing a medication include: [Level 1]

- previous response
- depressive subtype
- comorbid conditions
- side effects
- drug-drug interactions
- short-term remission rates
- cost

g) Give simple messages about antidepressants to every patient, to promote adherence. [Level 2]

**Simple Messages to Promote Antidepressant Adherence** [Level 2]

1. Antidepressants are not addictive.
2. Take your antidepressants daily.
3. It may take 2 to 4 weeks to start noticing improvement.
4. Do not stop antidepressants without talking to your physician, even if feeling better.
5. Mild side effects are common, but are usually temporary.
6. Call your physician with any questions.

h) Consider the subtype of depression when selecting treatment.

**Subtypes of Depression with Treatment Implications**

| Subtype | Key features | Treatment consideration |
|---|---|---|
| Psychotic depression | Presence of hallucinations or delusions (especially delusions of guilt). | Antidepressant + atypical antipsychotic agent, [Level 2] OR electroconvulsive therapy. [Level 1] |
| Winter depression (seasonal affective disorder) | Regular onset of depressive episodes during the fall/winter with summer remissions. | Bright light therapy OR antidepressant. [Level 1] |
| Postpartum depression | Onset of depressive episode within 4 weeks post-partum. May be associated with psychotic features. | Consider breastfeeding issues with pharmacotherapy. [Level 3] |
| Depression associated with Bipolar Disorder | Previous history of manic (type I) or hypomanic (type II) episodes. | Mood stabilizer ± antidepressant. [Level 2] |

## Recommendation 7 Monitoring outcomes

a) MDD is often a chronic or recurrent condition that requires close initial monitoring until symptoms are eliminated and then periodic monitoring to make sure a relapse or recurrence does not occur. [Level 3]

b) Use a validated measure of patient outcome, such as the PHQ-9 (Appendix 1), to evaluate response. [Level 2]

c) Follow up with patients at least weekly or biweekly, depending on severity, until patients show clear improvement. Visits can then be reduced to monthly or less often, depending on individual circumstances. Like other patients with chronic conditions, depressed patients can benefit from regularly scheduled visits. [Level 3]

d) For antidepressant treatment, expect the usual trajectory of response:
- initial mild symptom improvement (e.g., > 20% improvement in PHQ-9) within 2-4 weeks
- good clinical response (e.g., > 50% improvement in PHQ-9) within 4-8 weeks
- remission of symptoms (e.g., PHQ-9 < 5) by 8-12 weeks.

Remission of symptoms by 12-16 weeks is a realistic goal in about 65% of all patients with MDD. Recovery of baseline function may take longer. [Level 1]

e) Patients referred for psychotherapy or engaging in self-management programs should also be monitored for treatment response at monthly or bimonthly intervals. [Level 3] For psychotherapy treatment, expect clinical improvement within 6-8 weeks and remission of symptoms by 12-16 weeks.

## Recommendation 8 Maintenance treatment

a) The goal of maintenance treatment is to prevent relapse and recurrence. [Level 1]

b) Continue patients on antidepressants for at least 6 months after a full remission of symptoms. Use the same antidepressant dosage in the maintenance phase as in the acute phase. [Level 1]

c) Patients with high-risk factors for recurrence require longer maintenance treatment – at least 2 years, and, for some, lifetime (based on individual assessment of ongoing risk and tolerability). [Level 1]

d) When discontinuing an antidepressant, the physician should taper the medication slowly to avoid discontinuation symptoms. Education about early signs of relapse should continue (e.g. recurrence of SIGECAPS symptoms or increase in PHQ-9), and patients should have regular follow-ups every 2-3 months for the first 6 months. Psychotherapy (see Recommendation 6) is helpful and self-management programs (see Recommendation 5) may be helpful to prevent relapses. [Level 2]

**Risk Factors Indicating Longer-Term (at least 2 years) Antidepressant Maintenance** [Level 1]

- chronic episodes (> 2 years duration)
- severe episodes (suicidality, psychosis)
- resistant or hard-to-treat episodes
- frequent episodes (2 episodes in past 2 years)
- recurrent episodes (3 or more lifetime episodes)
- age > 65 years-of-age

## Recommendation 9 Management of poor or incomplete response

a) If treating with antidepressants, at least minimal response (greater than 20% reduction in depression scores) or partial response should occur after 3-4 weeks of treatment at a therapeutic dose. If there is no response, the antidepressant dose should be increased every 2-4 weeks until response occurs, maximum approved dose is reached, or limiting side effects are experienced.

b) If treating with psychotherapy produces poor or incomplete response, add antidepressants.

**Management Options for Inadequate or Incomplete Response to Maximized Dose of Antidepressant**

- **Re-evaluate** diagnostic issues (e.g., mania/hypomania, depressive subtypes, medical or psychiatric comorbidity, alcohol and substance abuse, personality traits/disorders).
- **Re-assess** treatment issues (e.g., compliance, side effects).
- **Add** psychotherapy. [Level 2] See Recommendation 5.
- **Switch** to another antidepressant in the same class (if on SSRI) or in a different class. [Level 2] See Appendix 4.
- **Augment** with lithium [Level 1], triiodothyronine (T3) [Level 2] or an atypical antipsychotic agent. [Level 3] Second line augmentations include buspirone, tryptophan or stimulants. [Level 3]
- **Combine** with another antidepressant in a different neurochemical class. [Level 3]
- **Refer** to a specialist or community mental health centre. Clinical situations that warrant a psychiatric referral include: severe depressive symptoms (active suicidality, psychosis); diagnostic uncertainty; significant psychiatric/medical co-morbidity; and unsatisfactory response to adequate trials of two or more antidepressants. [Level 3]

### Rationale

The health, financial and social burdens associated with depression are profound: 1.4 million people in Canada afflicted at any given time; over $3 billion in direct medical costs; 40,000 person-years lost from work and over $1 billion in associated economic costs; the second leading medical cause of long-term disability; the fourth leading cause of global burden of disease (predicted to be second leading cause by 2020).[4] Mortality rates are high: approximately 4% of people with a mood disorder die by their own hand and at least 66% of all suicides are preceded by depression.[5] Depression is also associated with increased rates of death and disability from cardiovascular disease.[5,6]

Depression is commonly encountered in primary practice, but frequently under-diagnosed. The WHO Psychological Problems in General Health Care study found that only 42% of patients with major depression were diagnosed appropriately by their primary care physician.[7] Depression is often missed in people with chronic illness, those who present with somatic symptoms, teens and the elderly.[8] Recognition is hampered by the fact that many depressed patients present with non-specific physical complaints, without spontaneously divulging the psychological nature of their problems.[9] Recognizing high-risk patients and using simple screening and diagnostic tools can improve detection of depression in primary practice.

Once diagnosed, depression may be effectively treated with antidepressants, certain forms of psychotherapy, or both.[10] Antidepressant medications are clinically effective across the full range of severity of major depressive disorders. Specific forms of time-limited psychotherapy (cognitive therapy, interpersonal therapy) are as effective as antidepressants for mildly to moderately severe major depressive disorder.[11,12] However, even when depression is recognized and treated, treatment is often provided ineffectively in a manner inconsistent with current evidence.[13]

Common problems in the management of depression include:

- Patient reluctance both to seek and comply with treatment due to the stigma associated with mental disorders
- Inadequate dosage and duration of antidepressant therapy
- Failure to educate patients about the nature of depression and support self-management
- Failure to recommend evidence-based psychotherapy
- Limited access to psychiatrists and other mental health professionals
- Lack of ongoing monitoring and maintenance treatment despite high rates of relapse and recurrence[14]

About half of people who become depressed will develop either a chronic or recurrent course. The risk of recurrence and/or chronicity increases if residual symptoms persist.[5] Each new episode tends to occur sooner, last longer and become more severe and more difficult to treat.[15] Thus, the goals of treatment should be full remission of symptoms, return to premorbid function, and prevention of recurrence. Achieving these goals, however, can be difficult in a system where patients must initiate visits. Accordingly, some researchers have suggested that a chronic disease management (CDM) model is required to reduce the burden of depression.[16,17] Experience with the CDM approach in other jurisdictions suggests that managing depression proactively and supporting self-management can improve patient outcomes.[17]

The challenges of busy primary care practices may make it difficult for primary care physicians to feel comfortable providing psychiatric services. However, the reality is that most depressed patients will be treated either by a general practitioner or not at all. Analysis of utilization data in British Columbia suggests that 82% of individuals between the ages of 16 and 65 who were diagnosed with a mental disorder received their only treatment from a general practitioner.[13] The Ministry of Health recently commissioned a 3-year Provincial Depression Strategy designed to reduce the morbidity, mortality and economic impacts associated with depression.[18] A major focus of the Provincial Depression Strategy is to enhance primary care treatment of depression.

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Guidelines and Protocols Advisory Committee
1515 Blanshard Street 2-3
Victoria BC V8W 3C8
Phone: (250) 952-1347
Fax: (250) 952-1417
E-mail: hlth.guidelines@gems6.gov.bc.ca
Web site: www.healthservices.gov.bc.ca/msp/protoguides

The principles of the Guidelines and Protocols Advisory Committee are:

- to encourage appropriate responses to common medical situations
- to recommend actions that are sufficient and efficient, neither excessive nor deficient
- to permit exceptions when justified by clinical circumstances.

## 1. Appendix 1. Patient Health Questionnaire – PHQ-9 (www.primary-care.org)

| PATIENT NAME | DATE |
|---|---|
| | |

1. Over the last 2 weeks, how often have you been bothered by any of the following problems ?

| | | Not at all (0) | Several days (1) | More than half the days (2) | Nearly every day (3) |
|---|---|---|---|---|---|
| a) | Little interest or pleasure in doing things. | ❑ | ❑ | ❑ | ❑ |
| b) | Feeling down, depressed, or hopeless. | ❑ | ❑ | ❑ | ❑ |
| c) | Trouble falling/staying asleep, sleeping too much. | ❑ | ❑ | ❑ | ❑ |
| d) | Feeling tired or having little energy. | ❑ | ❑ | ❑ | ❑ |
| e) | Poor appetite or overeating. | | | | |
| f) | Feeling bad about yourself, or that you are a failure, or have let yourself or your family down. | ❑ | ❑ | ❑ | ❑ |
| g) | Trouble concentrating on things, such as reading the newspaper or watching TV. | ❑ | ❑ | ❑ | ❑ |
| h) | 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 more than usual. | ❑ | ❑ | ❑ | ❑ |
| i) | Thoughts that you would be better off dead or of hurting yourself in some way. | ❑ | ❑ | ❑ | ❑ |

2. If you checked off any problem on this questionnaire so far, 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?

a) ❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult

TOTAL SCORE: ____

## Instructions – How To Score The PHQ-9

**Major depressive disorder is suggested if:**
- Of the 9 items, 5 or more are checked as at least 'more than half the days'
- Either item a. or b. is positive, that is, at least 'more than half the days'

**Other depressive syndrome is suggested if:**
- Of the 9 items, a., b. or c. is checked as at least 'more than half the days'
- Either item a. or b. is positive, that is, at least 'more than half the days'

Also, PHQ-9 scores can be used to plan and monitor treatment. To score the instrument, tally each response by the number value under the answer headings, (not at all=0, several days=1, more than half the days=2, and nearly every day=3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide listed below.

**Guide for Interpreting PHQ-9 Scores**

| Score | Action |
|---|---|
| 0-4 | The score suggests the patient may not need depression treatment |
| 5-14 | Mild major depressive disorder. Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment. |
| 15-19 | Moderate major depressive disorder. Warrants treatment for depression, using antidepressant, psychotherapy or a combination of treatment. |
| 20 or higher | Severe major depressive disorder. Warrants treatment with antidepressant, with or without psychotherapy; follow frequently. |

### Functional Health Assessment

The instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, things at home, or relationships with other people. Patient responses can be one of four: Not difficult at all, Somewhat difficult, Very difficult, Extremely difficult. The last two responses suggest that the patient's functionality is impaired. After treatment begins, functional status and number score can be measured to assess patient improvement.

**For further information on the PHQ-9:**
Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. *J Gen Intern Med* 2001;16: 606-613.

## Appendix 2. First-line psychotherapies for treatment of depression [Level 1]

| Psychotherapy | General Principles | Length of Therapy |
|---|---|---|
| Cognitive Behavioral Therapy (CBT) | • Identify automatic, maladaptive thoughts and distorted beliefs that lead to depressive moods.<br>• Learn strategies to modify these beliefs and practice adaptive thinking patterns.<br>• Use a systematic approach to reinforce positive coping behaviours. | 8 to 12 sessions |
| Interpersonal Therapy (IPT) | • Identify significant interpersonal/relationship issues that led to, or arose from, depression (unresolved grief, role disputes, role transitions, social isolation).<br>• Focus on 1 or 2 of these issues, using problem-solving, dispute resolution, and social skills training. | 12 to 16 sessions |
| Problem-Solving Therapy (PST) | • Use a structured approach to identify and actively solve problems that contribute to depression. | 6 to 8 sessions |

### Resources for Psychological Treatment in BC

1. Private psychiatrists by referral.

2. Private psychologists, particularly those with CBT training; the BC Psychological Association (604 730-0522) operates a referral service.

3. Ambulatory Psychiatric Clinics or Day Programs at hospitals, or community Mental Health Centres.

4. *Changeways* – a best-practice, group-based psychoeducational program for depression, offered in a number of hospitals and Community Health Centres throughout the province. www.changeways.com

## Appendix 3. Therapeutic doses & costs of commonly prescribed antidepressants [Level 1]

| Antidepressant | Usual Daily Dose (mg) | Cost Per Day ($) |
|---|---|---|
| **First Line Antidepressants** | | |
| **Novel action** | | |
| bupropion-SR | 150-300 | 0.88-1.54 |
| mirtazapine | 30-60 | 1.33-2.66 |
| trazodone | 200-400 | 0.84-1.68 |
| **RIMA** | | |
| moclobemide | 450-600 | 1.17-1.53 |
| **SNRI** | | |
| venlafaxine-XR | 75-225 | 1.73-5.19 |
| **SSRI** | | |
| citalopram | 20-40 | 0.94-1.88 |
| fluoxetine | 20-40 | 1.08-2.16 |
| fluvoxamine | 100-200 | 0.95-1.90 |
| paroxetine | 20-40 | 1.18-2.36 |
| sertraline | 50-150 | 1.07-3.21 |
| **Second Line Antidepressants** | | |
| **TCA** | | |
| amitriptyline | 100-250 | 0.32-0.80 |
| clomipramine | 100-250 | 0.86-2.15 |
| desipramine | 100-250 | 0.92-2.28 |
| imipramine | 100-250 | 0.66-1.65 |
| nortriptyline | 75-150 | 0.77-1.63 |
| **Third Line Antidepressants** | | |
| **MAOI*** | | |
| phenelzine | 30-75 | 0.74-1.86 |
| tranlycypromine | 20-60 | 0.73-2.20 |

* Use with caution because of dietary restrictions and drug-drug interactions

Data adapted from the BC Drug Formulary and the Manufacturers' list (2001)

RIMA = Reversible monoamine oxidase inhibitor
SNRI = Serotonin and norepinephrine reuptake inhibitor
SSRI = Selective serotonin reuptake inhibitor
TCA = Tricyclic antidepressant
MAOI = Monoamine oxidase inhibitor

### Appendix 4. Washout recommendations for switching antidepressants

Adapted from Guidelines for the Diagnosis and Pharmacological Treatment of Depression. Toronto, ON, Canadian Network for Mood and Anxiety Treatments, 1998.

| SWITCH TO ➡ | SSRI | Novel | TCA | RIMA | MAOI |
|---|---|---|---|---|---|
| **SWITCH FROM ⬇** | | | | | |
| **SSRI**<br>citalopram<br>fluoxetine<br>fluvoxamine<br>paroxetine<br>sertraline | No washout<br><br>May have additive serotonergic side effects for 1 week (5 wks for fluoxetine) | No washout<br><br>May have additive serotonergic side effects for 1 week (5 wks for fluoxetine) | No washout<br><br>Start TCA at a lower dose<br><br>Some SSRIs can increase serum TCA levels for 1 week (5 wks for fluoxetine) | 1 week<br><br>(5 wks for fluoxetine) | 1 week<br><br>5 wks for fluoxetine) |
| **NOVEL**<br>bupropion-SR<br>mirtazapine<br>venlafaxine-XR | No washout<br><br>May have additive serotonergic side effects for 1 week | No washout<br><br>May have additive serotonergic side effects for 1 week | No washout | 1 week | 1 week |
| **TCA**<br>desipramine<br>nortriptyline<br>amitriptyline<br>imipramine<br>others | No washout<br><br>Serum TCA levels may be increased by some SSRIs for 1 week | No washout | No washout | 1 week | 1 week |
| **RIMA**<br>moclobemide | 3 days | 3 days | 3 days | N/A | 3 days |
| **MAOI***<br>phenelzine<br>tranylcypromine | 2 weeks | 2 weeks | 2 weeks | 2 weeks | 2 weeks |

* Use with caution because of dietary restrictions and drug-drug interactions

RIMA = Reversible monoamine oxidase inhibitor
SNRI = Serotonin and norepinephrine reuptake inhibitor
SSRI = Selective serotonin reuptake inhibitor
TCA = Tricyclic antidepressant
MAOI = Monoamine oxidase inhibitor

BRITISH COLUMBIA MEDICAL ASSOCIATION

BCHealthServices

# DEPRESSION
# PATIENT CARE FLOW SHEET

NAME OF PATIENT

BIRTHDATE

DIAGNOSIS

❑ Single episode ❑ Recurrent episode ❑ Chronic episode

TELEPHONE NUMBER

COMORBID CONDITIONS

PHN

PSYCHIATRIC: ❑ Alcohol/drugs ❑ Mania/Hypomania ❑ Past suicide attempt ❑ Anxiety disorder

❑ Other: _____

EMPLOYMENT STATUS

❑ Employed ❑ Unemployed
❑ Student ❑ Retired
❑ Homemaker

MEDICAL: ❑ Respiratory ❑ Neurological disorder ❑ Cancer ❑ Hypertension ❑ Other endocrine
❑ Diabetes ❑ Kidney disease ❑ Arthritis ❑ Heart disease ❑ Liver disease

❑ Other: _____

| | | | DATE (YY/MM/DD) | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| ACUTE TREATMENT (8-16 WEEKS) | PSYCHOTHERAPY (CBT/IPT/PST | Referral made ✔ | | | | | | |
| | | Ongoing ✔ | | | | | | |
| | ANTIDEPRESSANTS | Medication/Dose ➔ | | | | | | |
| | | Side effects monitored ➔ | | | | | | |
| | PSYCHIATRY | Referral made ✔ | | | | | | |
| | | Ongoing ✔ | | | | | | |
| | SUICIDE RISK | Assessed ✔ | | | | | | |
| | | Management plan documented ✔ | | | | | | |
| | PHQ-9 (Remission: <5) | Q1 Score ➔ | | | | | | |
| | | Q2 Result ➔ | | | | | | |
| | SELF-MANAGEMENT (education/community, resources, social supports) | Goals set and/or reviewed ✔ | | | | | | |
| | ER VISIT OR HOSPITALIZATION | Follow-up visit (within 7 days) ✔ | | | | | | |
| | PLANNED FOLLOW-UP | **W** (weekly) **B** (Bi-weekly) **O** (other) ➔ | | | | | | |
| MAINTENANCE TREATMENT (6 MOS - 2 YRS OR LONGER) | RISK FACTORS FOR RELAPSE | **Y** (cont. meds 2 yrs) **N** (cont. meds 6 mos) ➔ | | | | | | |
| | ANTIDEPRESSANTS | Medication/Dose ➔ | | | | | | |
| | | Side effects monitored ➔ | | | | | | |
| | | Tapering Plan (discont symp discussed) ✔ | | | | | | |
| | PSYCHIATRY | Referral made ✔ | | | | | | |
| | | Ongoing ✔ | | | | | | |
| | PHQ-9 (Remission: <5) | Q1 Score ➔ | | | | | | |
| | | Q2 Result ➔ | | | | | | |
| | SELF-MANAGEMENT (incl discussion of relapse prevention) | Goals set and/or reviewed ✔ | | | | | | |
| | PLANNED FOLLOW-UP | **M** (monthly) **6** (6 mos) **O** (other) ➔ | | | | | | |

# Depression

A Guide for Patients

If you have been diagnosed with depression, this handout will provide you with information to help you understand and manage your illness. It is designed to help you take an active role, as a partner with your physician, in treating your depression.

## What is depression?

First of all, you need to know that depression can affect anyone. Up to 15% of adults will, at some time during their life, suffer from depression. You may be depressed if you have any of the following symptoms nearly every day, all day, for two weeks or longer:

- No interest or pleasure in things you used to enjoy
- A low mood that lasts longer than is normal for you
- Feeling anxious, worthless or guilty
- Feeling numb or empty emotionally, perhaps even to the point of not being able to cry
- Feeling slowed down, tired all the time, or, conversely, feeling restless and unable to sit still
- Change in appetite, leading to weight gain or loss
- Problems sleeping, especially in the early morning, or wanting to sleep all of the time
- Trouble thinking, remembering, focusing on what you're doing, or making everyday decisions
- Thinking about death or suicide

## What causes depression?

The cause of depression is not fully known. A number of factors may be involved, such as chemical imbalances in the brain or family history. Sometimes depression can be linked to stressful events, such as the death of a loved one, a divorce or job loss. Certain medicines, overuse of drugs and alcohol, and chronic diseases can also lead to depression. Depression isn't caused by personal weakness, lack of willpower, or a 'bad attitude'.

Whatever the cause, it is important to know that depression can be successfully treated. There is hope for recovery. However, many depressed people find it difficult both to seek help and to take care of themselves. Finding a family physician you can confide in is a critical first step to recovery. Taking an active role in dealing with your depression is also essential. Learning self-management skills that will help you cope with depression can lead to faster recovery and reduce the chances of it reoccurring.

## How is depression treated?

Once your physician has assessed the severity of your illness, treatment may involve medicine, psychotherapy and self-management. Any one of these treatments, used alone or in combination, may give you the best results.

### Antidepressant Medication

Medications for depression are called antidepressants. Antidepressants are an effective and widely used treatment. It may take some time to find the medication that works best for you. You may notice some effects of antidepressants within the first week, but you probably won't see the full effects for six to eight weeks.

Some people experience mild side effects at the start of treatment, but these may go away over time or with adjustments to your medication. Like all medications, however, there may be uncommon, but more serious side effects. Talk to your physician if you find side effects hard to cope with or experience any agitation, worsening of depression, or increase in suicidal thoughts.

Antidepressants are not addictive; however, you should never stop taking antidepressants suddenly without consulting your physician. Doing so may cause a variety of unpleasant symptoms such as flu-like sensations, insomnia, nausea, balance problems and agitation.

### Psychotherapy

Certain types of psychotherapy such as Cognitive Behavioral Therapy (CBT), Interpersonal Therapy (IPT) and Problem-Solving Therapy (PST) can be as effective as antidepressants. Many psychologists and some other mental health professionals provide these types of therapy. The focus of psychotherapy may be on your thoughts and beliefs or on your relationships. It may also help you look at your behaviour, how it's affecting you, and what you can do differently. Sessions are usually taken individually or in a group about once or twice a week for 8 to 12 weeks.

Ask your physician to recommend a therapist or a program for you.

Note: Psychotherapy services provided by a psychologist are not an insured benefit under MSP, but may be covered by some extended benefit plans. They may also be available at no charge at mental health centres run by your local health authority (see blue pages in your phone book).

For help locating a psychotherapist, contact:

- BC Psychological Association Referral Service: 1 800 730-0522
- BC Association of Clinical Counsellors: www.bc-counsellors.org/
- Employee Assistance Programs offered by your employer.

**Self-Management: Taking An Active Role in Your Treatment**

There are many things that you can do to help yourself get through your depression and reduce the risk of a relapse. Self-management does not mean dealing with your illness alone. It means being an active partner with your physician or other health care provider, communicating honestly and effectively, and being well-informed on treatment options. Most importantly, it means following through on the treatment or action plan that you and your physician decide upon – and that usually includes behavioural and lifestyle changes.

## Resources for People with Depression

### Self-Management

- *Self-Care Depression Program Patient Guide* – This booklet, published by the University of British Columbia, can help you manage depression by reactivating your life, challenging negative thinking habits, and solving problems effectively. Available at: www.mheccu.ubc.ca/publications/
- *BC Partners for Mental Health and Addictions Information* – provides both a Mental Disorders Toolkit and a Depression Toolkit designed to develop core self-management skills. Both can be found at: www.mentalhealthaddictions.bc.ca/content/products/products.php#deptoolkit
- *Changeways* – Group workshops teach a variety of problem-solving and lifestyle management skills. Offered by most Mental Health Centres in BC. Contact your local health authority (listed in the blue pages of your phone book).
- Chronic Disease Self-Management Program is a patient education program offered in communities throughout British Columbia that teaches practical skills in managing chronic health problems. See: www.coag.uvic.ca/cdsmp/ or call toll free: 1 866 902-3767.

### General Information and Support

- BC Mental Health Information Line – provides free information 24 hours a day about symptoms, causes, treatments, support groups and publications. 1 800 661-2121 or 604 669-7600 in the Lower Mainland.
- Mental Health Centres. Contact your local health authority (see blue pages in your phone book) to find out what services are available.
- BC HealthGuide Program – this program includes handbooks, on-line and phone components. *The BC HealthGuide Handbook* provides medically approved information on depression and resources available to BC residents. *BC HealthGuide OnLine* provides on-line information on treatment, assessment and support groups. See: www.bchealthguide.org/kbaltindex.asp
- The BC NurseLine – provides 24/7 access to registered nurses and seven days-a-week access to pharmacists between 5 pm and 9 am.
  1 866 215-4700 toll-free; 604 215-4700 within Greater Vancouver; 1 866 889-4700 hearing-impaired toll free.
- Mood Disorders Association of BC – provides support groups and information. 604 873-0103. See: www.mdabc.ca.
- Canadian Mental Health Association (BC) – resources and local branch information 1 800 555-8222 or 604 688-3234 See: www.cmha-bc.org.

### Depression Web Sites

The following sites offer valuable information on depression and self-care:

- PsychDirect (Cdn) is a public education & information program at McMaster University, Hamilton, Ontario. Site includes a self-test quiz for depression. See: www.psychdirect.com/index.htm
- National Institute of Mental Health (US) Web site to learn more about the symptoms of depression and depression with other illnesses: See: www.nimh.nih.gov/publicat/cooccurmenu.cfm
- NHS National Electronic Library for Health (UK) web site on mood disorders answers your questions about depression and other mood disorders. See: www.nelmh.org/home_affective_disorders.asp?c=3

### Crisis Support

- Emergency section of your local phone book provides phone numbers for local crisis lines.
- The Suicide Information & Education Centre (Cdn) provides information on suicide and suicidal behaviour. It has a list of phone numbers for crisis centres/lines throughout BC. See: www.suicideinfo.ca/support/canada/bc.htm or call 604-872-1811 for the number of the nearest centre to you.
- Crisis Intervention and Suicide Prevention Centre of British Columbia provides local crisis centre phone numbers See: www.crisiscentrebc.bc.ca

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