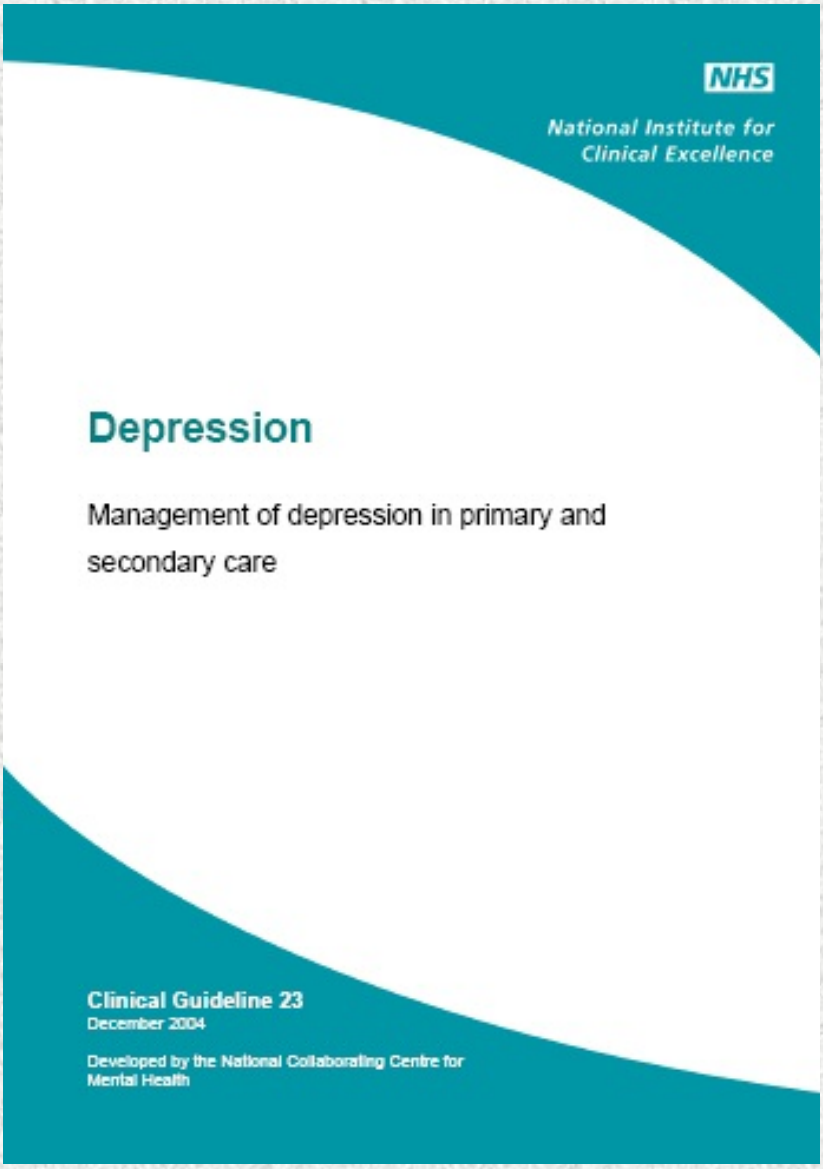
Depression: Implementing the NICE Guideline



More resources on our website:

http://nww.bradfordsouthwest-pct.nhs.uk/Our+Teams/Primary+Care+Mental+Health+Team.htm

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DEPRESSION: NICE GUIDELINE
A SUMMARY FOR PRIMARY CARE PRACTITONERS

Following are some reflections and signposts which summarise much of what is important arising from the NICE Depression Guidelines:

1. Screening

We are encouraged to screen particularly at risk groups. A suggested simple screening tool is the 2 question is

- "During the last month have you often been bothered by feeling down, depressed or hopeless?"
- "During the last month have you often been bothered by having little interest or pleasure in doing things?"

Another for use in elderly is:
4 Item GDS – that's 4 questions. (EMIS users it is in mentor article "Screening for Dementia")

These are screening not diagnostic tools – though both have reasonable specificity.
Useful diagnostic tools include
ICD-10 Primary Care Version
(see http://www.nimhe.org.uk/downloads/enhanced.pdf page 41 of this document)

PHQ-9
(see http://www.nimhe.org.uk/downloads/enhanced.pdf page 45 of this document)

2. Diagnostic Issues

NICE helpfully point out that the diagnostic label of depression is too broad. The recommended interventions drawing on the evidence base differ depending on the severity etc of depression. We are encouraged to look at Depression as Mild, Moderate and Severe.

Treatment protocols differ somewhat depending on the severity. The diagnostic tools above (ICD-10 and PHQ-9) will aid practitioners in this assessment

Mild Depression

a) Watchful waiting with reassessment (make contact if follow up doesn't happen).
b) Exercise Programme (BEEP may be a useful service in this respect).
c) Guided Self Help (see Bradfordised Northumberland Leaflet).
d) CBT / Counselling / Problem Solving depending on presentation.
e) Develop and maintain good therapeutic alliance with patients.
f) Antidepressant Drugs – shown to have similar efficacy to placebo but with significantly more side effects. The NICE message is largely to avoid prescribing in this group; however antidepressant medication could be considered for those not improving with other interventions or those with history of more severe depression.

Moderate/Severe Depression

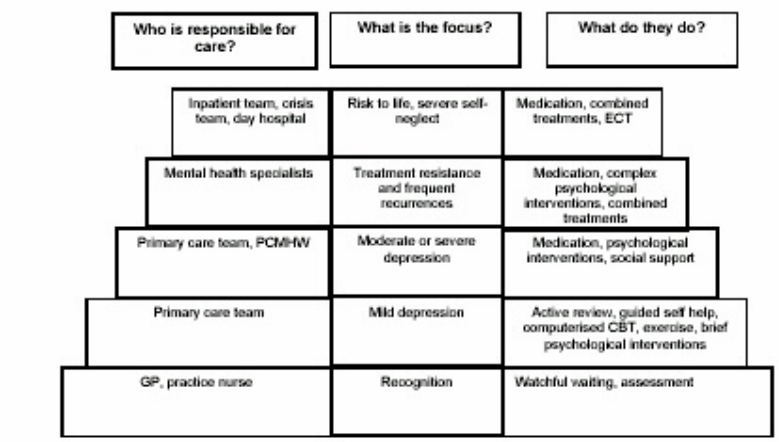
a) **Risk** – if significant risk to self or others this may require urgent secondary care referral and support.
b) Antidepressants shown to be as effective as psychological interventions in this group. Patient **preference and past experience** should guide decision re antidepressant use.
c) Patients considered at **high risk** who start on antidepressant, or less than 30 years old should be **reviewed within 1 week** to monitor side effects and risk profile. Consider planned **telephone contact** for some of your additional support.

d) Lower risk patients prescribed antidepressants ought to be reviewed initially at 2 weeks then 2-4 weekly as required.
e) Consider a change in antidepressant if no response at 4 weeks or partial response at 6 weeks.
f) Psychological interventions. The NICE Guidelines put **CBT** as the psychological treatment of choice, and also acknowledge the utility of **interpersonal therapy** for some patients. This should be offered to those patients who make this choice in preference to pharmacotherapy and in those who have not responded to medication. Within the PCT we have 3 strands of response to this given the skills shortage both locally and nationally around CBT. These include, recruitment of additional CBT therapists to work within the Primary Care Mental Health Team, up-skilling existing members of the PCMHT both with brief training for all the team, and supporting members of this team in gaining formalised training and qualifications, finally a supported training programme for traditional primary care health professional has started its first cohort with future opportunities planned over the next 2-3 years (watch for flyers).

3. Planned Care / Stepped Care

The concept of Stepped Care is hinted at in the previous item on Diagnostic Issues and is helpfully summarised in the diagram below. The notion of planned care is one which we are all familiar with for chronic disease groups such as diabetes, asthma, COPD, and CHD. Primary Care has delivered significant improvements in service delivery to these groups of patients within South and West more latterly supported through PMS and QoF. The paper "Enhanced Services Specification for depression Under the New GP Contract" (http://www.nimhe.org.uk/downloads/enhanced.pdf) helpfully acknowledges this and challenges primary care to transfer some of these principles to treatment and care of patients with depression.

Stepped Care



4. Self Help

Guided Self Help is developing a good evidence base and has a place both in mild depression and for some patients with moderate to severe depression. It is suited to integrated use primary care as a new option or alongside "usual" treatment.
(http://nww.bradfordsouthwest-pct.nhs.uk/Our+Teams/Primary+Care+Mental+Health+Team.htm)

5. CBT

See above

6. Antidepressant Choice Issues

Three specific points are worth noting
SSRIs are the antidepressant medications of choice (which concurs with PCT prescribing guidelines)
Dosulepin (dothiepin) – recommends that we stop using because the risk benefit assessment no longer supports its routine use. (There is acknowledgement that this might conflict with patient choice and this can be taken into account)
Venlafaxine – risk issues such as raising blood pressure, apparent increase in cardiovascular events in this group of patients and significant risk in overdose meant that NICE recommend that Venlafaxine

- should only be initiated by specialist mental health medical practitioners including General Practitioners with a Special Interest in Mental Health
- should only be managed under the supervision of specialist mental health medical practitioners including General Practitioners with a Special Interest in Mental Health

Clearly referral of all patients currently on venlafaxine would overwhelm CMHTs.
Dr Andrew Venables and Dr Angela Moulson have put together some useful recommendations re its continuation and discontinuation.
(http://nww.bradfordsouthwest-pct.nhs.uk/Our+Teams/Primary+Care+Mental+Health+Team.htm)

7. Antidepressant Discontinuation Syndrome

- Flu like symptoms
- Insomnia
- Excessive dreaming
- Irritability
- "shock like" sensation
- Dizziness exacerbated by movement
- Crying spells
- Movement disorders

Maudsley Guidelines suggest this is more common in shorter acting antidepressant drugs and mentions paroxetine and venlafaxine specifically as being likely to be associated with this condition along with amitriptilene and imipramine amongst the TCAs.

NICE says that this phenomenon should be discussed and that discussion documented **before** starting antidepressants. For antidepressants with shorter half life or when a troublesome discontinuation reaction is experienced then slow titration down can help.

8. Exercise

NICE guidelines promote the use of exercise in helping patients with depression; much has subsequently been in the general press regarding this. If you feel this is appropriate then using BEEP would be an appropriate support to treatment.

Dr's Angela Moulson, Matt Walsh & Andrew Wilson
November 2005

Guidance on patients currently taking Venlafaxine for depression in Primary Care

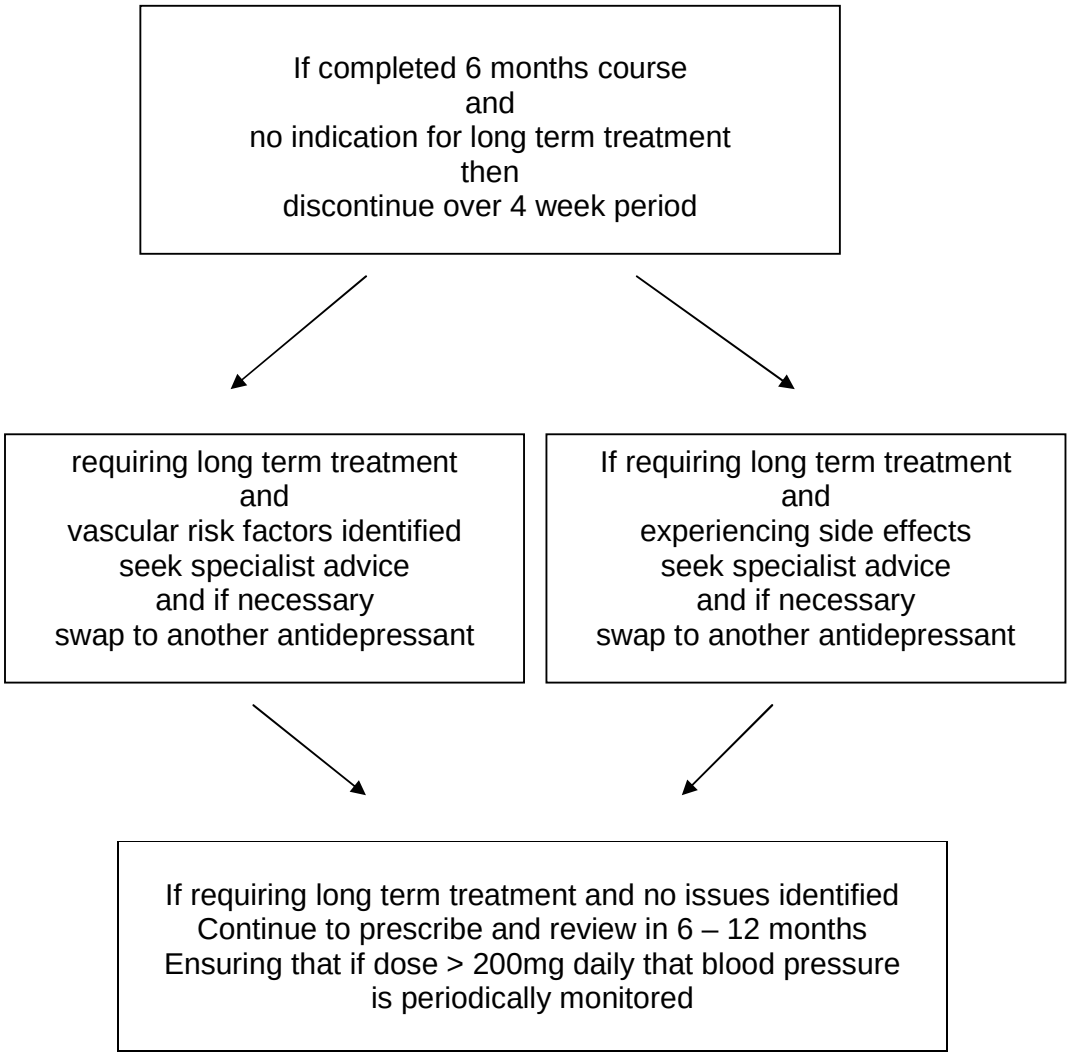
1. Identify all patients on venlafaxine

2. Review

   i. indication for treatment
   ii. length of treatment
   iii. cardiovascular risk factors
   iv. side effects

3. If patient is to remain on treatment and does not have a recent ECG consider doing one.

4.



Management of Depression in Primary Care
Summary of the use of antidepressants
(Clinical Guideline 23 NICE Dec 2004) Issued May 2005

Primary Care

Recognition of depression – screening questions
(MeRec Extra No 16 March 2005 see over)

Treatment of mild depression

Watchful waiting, sleep and anxiety management, guided self help, CCBT, psychological interventions

Antidepressants not recommended for initial treatment as the risk-benefit ratio is poor

Only consider an antidepressant : if mild depression persists despite other interventions **or** previous history of moderate/severe depression **or** significant psychosocial or other stressors

Treatment of moderate to severe depression

Offer antidepressant medication to all patients routinely, before psychological interventions

- If suicide risk initially limit quantities and make frequent contacts
- Monitor under 30s weekly after starting treatment Watch for akathasia, anxiety, agitation, suicidal ideas
- If no suicide risk see patient at 2-4 weekly intervals for the first 3 months

1st line SSRI fluoxetine or citalopram in adults, citalopram in the elderly

- Caution: fluoxetine, the cheapest SSRI, has significant drug interactions and may cause hypomania in bipolar patients
- Allow 4 weeks treatment in adults (6 weeks in the elderly) before considering drug ineffective.
- If partial response and side effects tolerated increase dose as suggested by SPC
- If initial choice ineffective despite being taken regularly and at the correct dose or is not tolerated then switch to another single antidepressant When switching use gradual and modest incremental changes (washout period with moclobemide/MAOIs)

2nd line Tricyclic e.g. imipramine (or lofepramine if risk from cardiovascular disease or overdose) or another SSRI

- Once medication taken for 6 months after remission review the need for continued treatment
- Consider previous episodes, presence of residual symptoms, concurrent psychosocial difficulties
- Discontinuation –reduce doses gradually over 4 week period, advise patient on potential symptoms of stopping
- Chronic depression – combination of CBT and antidepressants, maintain regular review
- Maintenance treatment for 2 years for those more than with 2 episodes of depression or significant functional problems

Practice points

- *Dosulepin is no longer recommended due to its high risk of toxicity*
- *Consider sertraline if risk of cardiovascular disease*
- *Consider the propensity for sedation and weight gain with mirtazapine*
- *Caution with risk of upper GI bleeds with SSRIs*
- *To minimise side effects tricyclics should be started at low dose and titrated upwards*
- *Side effects of tricyclics tolerated reasonably well in men*

Specialist Mental Health Services

Referral for severe depression OR after adequate trial of 2 different antidepressants

Treatment by Mental Health Specialists (inc. primary care mental health teams)

Treatment resistant depression consider :
Mirtazapine, venlafaxine, escitalopram, phenelzine, lithium augmentation , combination CBT

Venlafaxine should only be initiated and managed after appropriate ECG and blood pressure monitoring and under the supervision of a specialist mental health practitioners, Designated Primary Care Mental Health Lead (inc GPSI in Mental Health) or shared care arrangements

Inpatient treatment for depression

MeRec Extra Issue No 16 March 2005
Assessing the severity of depression in primary care

For a diagnosis of depression, at least one of the key symptoms should be present for at least 2 weeks

- Persistent sadness or low mood
- Loss of interest or pleasure
- Fatigue or low energy
- Disturbed sleep
- Poor concentration or indecisiveness
- Low self confidence
- Poor or increased appetite
- Suicidal thoughts or acts
- Agitation or slowing of movements
- Guilt or self blame

Mild depression ≤ 4 symptoms
Moderate depression 5-6 symptoms
Severe depression ≥7 with or without psychotic symptoms

Antidpressant switching

The speed of cross-tapering is best judged by monitoring patient tolerability. There are no clear guidelines, so caution is required, and the patient should be monitored carefully.

To / From	Tricyclic (including Trazodone)	SSRIs Citalopram/Escitalopram Fluoxetine Paroxetine Sertraline Fluvoxamine	Mirtazapine	Reboxetine	Venlafaxine	Moclobemide
Tricyclics	Cross taper cautiously	Halve dose TCA, add SSRI at half the lowest strength oral formulation and cross taper cautiously	Cross taper cautiously	Cross taper cautiously	Cross taper cautiously, starting with venlafaxine at 37.5mg od	Withdraw and wait at least one week
SSRIs (except fluoxetine)	Cross taper cautiously and start tricyclc at very low dose.	Withdraw and start alternative SSRI	Cross taper cautiously	Withdraw and start reboxetine cautiously	Withdraw and start venlafaxine at 37.5mg od	Withdraw and wait at least 2 week
Fluoxetine	Stop, start tricyclic at very low dose ad increase slowly	Withdraw and wait 4-7 days then start SSRI at half its lowest strength oral fonrulation and increase slowly	Withdraw and start mirtazpine cautiously	Withdraw and start at 2mg bd , increasing cautiously	Withdraw and wait 4-7 days and start venlafaxine at 37.5mg od, increase very slowly	Withdraw and wait at least 5 weeks
Mirtazapine	Withdraw then start tricyclic at low dose	Withdraw then start SSRI	_____	Withdraw and start reboxetine	Withdraw and start mirtazapine	Withdraw and wait 1 week
Reboxetine	Cross taper cautiously	Cross taper Cautiously	Cross taper cautiously	_____	Cross taper cautiously	Withdraw and wait at least 1 week
Venlafaxine	Cross taper cautiously with very low dose tricyclic	Cross taper cautiously, adding SSRI at half its lowest strength oral formulation	Cross taper cautiously	Cross taper cautiously	_____	Withdraw and wait at least 1 week
Trazodone	Cross taper cautiously and start tricyclc at very low dose.	Withdraw and start SSRI	Cross taper cautiously	Withdraw and start at 2mg bd , increasing cautiously	Withdraw and start venlafaxine at 37.5mg od	Withdraw and wait at least 1 week

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RISK FACTORS

Things to consider if someone has suicidal ideation:

Age

- is more prevalent in males and since the 1970's the largest increase in suicides has been in males between the ages of 15-24yrs. (1)

Gender

- Men more commonly abuse alcohol and drugs which subsequently increases their risk. (2)
- There is evidence to suggest that men find it more difficult to cope during times of change e.g relationship breakdown or change in employment status.

- Men are less likely to seek out support.

- Deliberate self harm is three to four times more common in women. (2)

Social Class

- Over the past 30yrs there has been a general increase in suicides as you move down the social groups. Relevant issues being depravation/ financial hardship. (3)

Unemployment

- Loss of role within the family. (4)

Occupation

- e.g. farmers during the BSE crisis. (4)

Bereavement or divorce. (4)

Mental Illness

- People suffering from affective disorders (which include depression) are higher risk.
- Feelings of hopelessness, feelings of being a burden, can't see a future. (4)

Previous self harm or suicide attempts

- Always ask if they have ever acted on similar thoughts before.
- Ask specific questions about what they did e.g how many times, how many tablets, how they felt when unsuccessful.

SELF HARM / SUICIDAL INTENT

I I P P (a useful tool)

I Ideas
What have the thoughts been around self harm or suicide?
Are they fleeting thoughts, constant thoughts?
Have the thoughts been present over a prolonged period of time?

I Intentions
Are the ideas specific such as wanting to crash car or take tablets or more vague such as wanting to go to sleep and not wake up or needing respite from how they are feeling?

P Plans
Ideas of method, when, where?
Have they got the means to do this?

P Previous attempts
Previous actions, what was done?
Were they feeling similar then as they are now?
If just previous thoughts what stopped them acting?
How they felt when unsuccessful? (5)

REMEMBER THE MAJORITY OF PEOPLE WITH DEPRESSION ARE NOT SUICIDAL

If you're practice or place of work is interested in a further training session on Risk Assessment and Management then please contact:

Amanda Dutton
Primary Care Liaison Nurse
The Elms, Odsal Clinic
55 Odsal Road
Bradford
BD6 1PR
Tel: 01274 693161

Email: amanda.dutton@bdct.nhs.uk or amanda.dutton@bradford.nhs.uk

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Mental health – Depression

Target	Description	Read Codes	Comments
1	The number of patients with an active diagnosis of depressive illness.	Eu320, Eu321, Eu322 **only and** 9HA0 without a corresponding 9HA1	Patients will be included if they have one of the read codes for depression and the read code for "On depression register". See note 1 below.
2	Practice protocol for identifying and screening high risk patients.	Protocol linked to ZV790	See note below about how patients at risk are identified.
3	PCT audit	N/A	For patients identified in 1 above see note below.
4	The number of patients from 1 who have had a risk assessment in the last 12 months.	1BD* or U2*	See note below.
5	The number of patients from 1 who have had a review within 4 weeks of initiation of treatment.	6891	Read code 6891 will be linked to the depression template. See note below.
6	The number of patients on lithium therapy with a record of lithium levels in the therapeutic range (0.4 – 0.8) within the previous 6 months.	6657 and 44W80	

Notes to Mental Health PMS targets

1. Patients diagnosed with depression should be added to the depression register using read code 9HA0. When they have recovered they should be removed from the register using read code 9HA1.Thus the constitution of the register will change depending on the date when a search or audit is carried out. If the patient has some other problem or complication or further description of depression, for example anxiety with depression, post-natal depression or manic-depressive psychosis, this should be coded separately.

2. All patients on any chronic disease "register", this includes all patients with cardiovascular diseases (CHD, hear failure, PVD, stroke etc.), diabetes, COPD and any other long term conditions, should be considered as at risk and have an initial short screen during their normal disease review. Any patients considered at risk after the short screen should be screened using the protocol based on PHQ-9 or ICD-10 questions. This protocol should be linked to read code ZV790 (screening for depression).

3. Audit:
   - The number of patients at the time of audit who are on the depression register (read codes as target 1)
   - The number of patients who have been prescribed antidepressants (BNF category 4.3, read code d7*, d8*, d9*, da*)
   - The number of patients who have been prescribed antidepressants who have been given advice about antidepressant discontinuation syndrome (read code 8B35 – Drug rx stopped – medication advice. Not strictly correct but the best available)
   - The number of patients on "watchful waiting" - 8H8D Follow up (wait and see)

4. Any code starting 1BD (Harmful thoughts) or U2 (Intentional self-harm) will count. The 12 month period will be taken from date of audit.

5. The date of initiation of treatment will be the date of the latest occurrence of any of Eu320, Eu321 or Eu322. A review will be deemed to have taken place if the patient has an entry with read code 6891 (Depression screen) in their medical record. This read code will be linked to a template for completion.

6. The base date for measuring the 6 month time period will be the date of the latest occurrence of any of Eu320, Eu321 or Eu322.

Depression read codes

Code	Description	Use
Core diagnoses		
Eu320	**Mild depressive episode**	All episodes of depression must have one of these codes
Eu321	**Moderate depressive episode**	
Eu322	**Severe depressive episode**	
9HA0	On depression register	Add when one of the codes above is added (for active depression only, not historical episodes)
9HA1	Removed from depression register	Add when the episode of depression has been resolved
ZV790	Screening for depression	When protocol is used
Other diagnoses		
Eu33%	Recurrent depressive disorder	
Eu341	Dysthymia	
Eu31%	Bipolar affective disorder	Also use for manic depression
Eu412%	Mixed anxiety and depression	Also use for reactive depression
Eu530	Postnatal depression	

Notes

When summarising patient notes if there have been episodes of depression in the past add them to the medical record but **DO NOT** add 9HA0 on depression register **UNLESS** the episode is current and on-going. Seek advice if necessary.

Wherever possible use a code from the Eu3 series – Mood affective disorders

Do **NOT** use the E11 series of codes unless there is absolutely nothing else and you have sought advice from a clinician.

E204 (neurotic (reactive) depression) has been used indiscriminately in the past. Do **NOT** use it, find something more appropriate.

Template dataset for information:

Template For Depression screen (6891) (read code for template)

Prompt	Age & Sex	Coded Subsets
On depression register **(9HA0)**	0-140	
Removed from depression register **(9HA1)**	0-140	
Depression interim review **(9H92)**	0-140	
Depression screen **(6891)**	0-140	
		[X]Mild depressive episode **(Eu320)**
		[X]Moderate depressive episode **(Eu321)**
		[X]Severe depressiv no psychot **(Eu322)**
Ethnic groups (census) **(9S)**	0-140	
		White)**(9S1)**
		Black Caribbean)**(9S2)**
		Black African)**(9S3)**
		Black, other, non-mixed origin) **(9S4)**
		Black - other, mixed)**(9S5)**
		Indian)**(9S6)**
		Pakistani)**(9S7)**
		Bangladeshi)**(9S8)**
		Chinese)**(9S9)**
		Other ethnic non-mixed (NMO)) **(9SA)**
		Other ethnic, mixed origin) **(9SB)**
		Vietnamese)**(9SC)**
		Ethnic group - patient refused) **(9SD)**
		Ethnic group not recorded) **(9SE)**
		Other black ethnic group) **(9SG)**
		Other Asian ethnic group) **(9SH)**
		Irish traveller)**(9SI)**
		Other ethnic group)**(9SJ)**
		Ethnic groups (census) NOS) **(9SZ)**
O/E - weight **(22A)**	0-140	
O/E - height **(229)**	0-140	
Body Mass Index **(22K)**	0-140	
Systolic blood pressure **(2469)**	0-140	
Diastolic blood pressure		
Tobacco consumption **(137)**	0-140	
		Never smoked tobacco**(1371)**
		Current non-smoker**(137L)**
		Current smoker**(137R)**
		Ex smoker**(137S)**
Smoking cessation advice **(8CAL)**	0-140	
Alcohol consumption **(136)**	0-140	
Occupations **(0)**	0-140	
		Top managers)**(01)**
		Management support professions) **(02)**
		Education/welfare/health prof.) **(03)**
		Literary/artistic/sports occ.) **(04)**
		Prof. scientists/engin/technol) **(05)**
		Managerial occupations)**(06)**
		Clerical occupations)**(07)**

		Selling occupations)**(08)** Security/protective services)**(09)** Catering/personal services)**(0A)** Farming/fishing occupations)**(0B)** Materials processors exc metal)**(0C)** Making/repairing ex metal/elec)**(0D)** Metal/electrical workers)**(0E)** Painters/product assemblers)**(0F)** Product inspectors/packagers)**(0G)** Construction/mining workers)**(0H)** Transporting/moving/storing)**(0I)** Other occupations)**(0Z)**
Loss of interest **(1BP)**	0-140	Loss of interest**(1BP)** Loss of capacity for enjoyment**(1BQ)** Normal interest**(1BS1)** Loss of hope for the future**(1BU)**
Sleeping pattern **(1BX2)**	0-140	Poor sleep pattern**(1B1Q)** Good sleep pattern**(1B1R)** Delayed onset of sleep**(1BX0)** Excessive sleep**(1BX1)** Early morning waking**(1BX3)**
Fatigue **(1682)**	0-140	Not tired**(1681)** Fatigue**(1682)**
Appetite symptom **(161)**	0-140	Appetite normal**(1611)** Appetite loss - anorexia**(1612)** Appetite increased**(1613)** Excessive eating - polyphagia**(1614)** Reduced appetite**(1615)**
Reduced concentration **(1BR)**	0-140	Reduced concentration**(1BR)** Normal concentration**(1BS2)** Poor concentration**(1BW)**
General nervous symptoms **(1B1)**	0-140	Anxiousness**(1B13)** Agitated**(1B16)** Blunted affect**(1BI)** Feeling calm**(1BS6)** No psychomotor agitation**(1BS9)** No psychomotor retardation**(1BSA)**
Guilty ideas **(1BF)**	0-140	Guilty ideas**(1BF)** Lack of guilt feelings**(1BS3)**
Poor self esteem **(1B1N)**	0-140	Poor self esteem**(1B1N)** Loss of confidence**(1BJ)** High self-esteem**(1BS7)** Confident**(1BS8)**
[X]Lack or loss of sexual desire **(Eu520)**	0-140	Normal libido**(1BS5)** Inhibited sexual desire**(E2271)**

		[X]Lack or loss of sexual desire **(Eu520)**
Suicidal ideation **(1BD1)**	0-140	
		Suicidal**(1B19)** Suicidal ideation**(1BD1)** Suicidal plans**(1BD3)** High suicide risk**(1BD5)** Moderate suicide risk**(1BD6)** Low suicide risk**(1BD7)** No suicidal thoughts**(1BS4)**
[X]Intentional self-harm **(U2)**	0-140	
		[X]Intentional self poisoning) **(U20)** [X]Int self hang/strang/suffoc) **(U21)** [X]Inten self drown/submersion) **(U22)** [X]Intention self harm handgun) **(U23)** [X]Intent self harm larger gun) **(U24)** [X]Int self harm ot/un firearm) **(U25)** [X]Intent self harm explosion) **(U26)** [X]Intent self harm smoke/fire) **(U27)** [X]Int self harm hot vapor/obj) **(U28)** [X]Inten cut self sharp object) **(U29)** [X]Intention blunt self injury) **(U2A)** [X]Intentional jump from high) **(U2B)** [X]Inten lie bef moving object) **(U2C)** [X]Intent crash motor vehicle) **(U2D)** [X]Self mutilation)**(U2E)** [X]Int self harm oth spec mean) **(U2y)** [X]Intent self harm unsp means) **(U2z)**
On lithium **(6657)**	0-140	
MED3 issued to patient **(9D11)**	0-140	
Depression medication review **(9H91)**	0-140	
Drug Rx stopped-medical advice **(8B35)**	0-140	
Follow up (wait and see) **(8H8D)**	0-140	
Depression interim review **(9H92)**	0-140	
Refer to counsellor **(8H78)**	0-140	
Psychiatric referral **(8H49)**	0-140	

PHQ-9 Monitoring tool

This tool is available as an excel worksheet which can be placed on your PC desktop.

APPENDIX 9
PHQ-9 MONITORING TOOL

The Patient Health Questionnaire (PHQ) is a brief 9-item patient self-report questionnaire specifically developed for use in primary care and used extensively in the United States. The PHQ-9 has acceptable reliability, validity, sensitivity and specificity as an assessment tool for the diagnosis of depression in primary care. The questionnaire can also be used to monitor progress with possible scores ranging from 0 to 27 with higher scores indicative of increasing severity.

PATIENT NAME	DATE

1 Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

A Little interest or pleasure in doing things

Not at all **Several days** **More than half the days** **Nearly every day**

B Feeling down, depressed, or hopeless

Not at all **Several days** **More than half the days** **Nearly every day**

C Trouble falling asleep, staying asleep, or sleeping too much

Not at all **Several days** **More than half the days** **Nearly every day**

D Feeling tired or having little energy

Not at all **Several days** **More than half the days** **Nearly every day**

E Poor appetite or overeating

Not at all **Several days** **More than half the days** **Nearly every day**

F Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down

Not at all **Several days** **More than half the days** **Nearly every day**

G Trouble concentrating on things such as reading the newspaper or watching television

Not at all **Several days** **More than half the days** **Nearly every day**

H Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual

Not at all **Several days** **More than half the days** **Nearly every day**

I Thinking that you would be better off dead or that you want to hurt yourself in some way

Not at all **Several days** **More than half the days** **Nearly every day**

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?

Not Difficult at All **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

SCORING THE PHQ-9 WHEN USED TO MEASURE SEVERITY

Of the 9 items in question1 count one point for each item ticked 'several days', two points for each ticked 'half the days' and three points for those ticked 'nearly every day'. Sum the total for a severity score.

APPENDIX 10
RECOMMENDED CATEGORIES FOR RESPONSE AND MONITORING WITH THE PHQ-9

SCORE	SEVERITY	CLINICAL PATHWAY
<10	Mild depression	Step 1 or 2
10-14	Moderate depression	Step 2 or 3
15-19	Moderate to severe depression	Step 3 or 4
>20	Severe depression	Step 4 or 5

Definition of improvement

Improved A reduction of 2 or more points on the baseline score

Not improved Drop of 1 point or no change or increased score

Definition of remission

A PHQ-9 score of less than 5 is the eventual goal of acute phase treatment. When this goal is achieved, patients enter the continuation phase of treatment. Changes of treatments within steps and stepping up are considered for patients who do not meet this goal.

ICD-10 Monitoring tool

This tool is available in Emis LV as a protocol. I hope to make this available to other clinical systems in the future.

APPENDIX 3
ASSESSING THE SEVERITY OF DEPRESSION (ICD-10 PRIMARY CARE VERSION)

KEY SYMPTOMS		
HAVE ANY OF THE FOLLOWING OCCURRED MOST OF THE TIME FOR TWO WEEKS OR MORE?	YES	NO
A Persistent sadness or low mood		
B Loss of interest or pleasure		
C Fatigue or low energy		
IF YES TO ANY OF THE ABOVE, CONTINUE BELOW		
ASSOCIATED SYMPTOMS		
1 Sleep disturbance • difficulty falling asleep • early morning wakening		
2 Appetite disturbance • Appetite loss • Appetite increase		
3 Poor concentration or indecisiveness		
4 Agitation or slowing of movement		
5 Decreased libido		
6 Low self-confidence		
7 Suicidal thoughts or acts		
8 Guilt or self-blame		
CONCLUSION		
POSITIVE TO A, B OR C AND: • 4 OF THE ASSOCIATED SYMPTOMS ABOVE = MILD • 5-6 OF THE ASSOCIATED SYMPTOMS ABOVE = MODERATE • 7 OR MORE OF THE ASSOCIATED SYMPTOMS = SEVERE		

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Depression Screen PHQ-9

Questions	Answers			
Over the last two weeks, how often have you been bothered by any of the following problems? Read each item carefully, and tick your response.	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
How often have you had little interest of pleasure in doing things				
How often have you felt down, depressed or hopeless				
How often have you had trouble falling asleep, staying asleep, or sleeping too much				
How often have you been feeling tired or having little energy				
How often have you had a poor appetite or been overeating				
How often have you felt bad about yourself, felt that you are a failure, or felt that you have let yourself or your family down				
How often have you had trouble concentrating on things such as reading the newspaper or watching television				
How often have you been moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
How often have you thought that you would be better off dead or that you want to hurt yourself in some way				