

# Depression

Information for primary  
health practitioners



The National Depression Initiative (NDI) is a campaign to help reduce the impact of depression on the lives of New Zealanders ([www.depression.org.nz](http://www.depression.org.nz)). The focus of the NDI campaign is on depression of mild to moderate severity.

The information in this booklet is provided to help primary health practitioners support the initiative. This resource does not explicitly address depression in children, adolescents or the elderly, as presentation and management differs in these groups. Nor does it address postnatal depression, dysthymia, atypical depression or depression with other medical illnesses.

The information in this booklet has been developed through consensus by an expert panel. Reference is made to pertinent evidence relating to mild and moderate depression available at the time of publishing. A comprehensive evidence-based best practice guideline to support the assessment and management of mild to moderate depression in primary care is in development.

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# INTRODUCTION

Depression accounts for the largest burden of non-fatal disease in the world,<sup>1</sup> due to its high prevalence, high level of associated disability and young age of onset. It may be a recurrent disorder.<sup>2</sup>

Most people who present to health care services with depression present in general practice.<sup>3</sup> Other community providers, such as counselling services, employment assistance services and spiritual support services may also have a critical role in the identification and management of depression.

Depression affects about 6% of the general population,<sup>4</sup> 8–13% of women postnatally<sup>5,6</sup> and 18% of the general practice population<sup>7</sup> in New Zealand each year.<sup>4</sup>

The recent New Zealand Mental Health Survey found that the 12-month prevalence of depression was similar for Māori and non-Māori when adjusted for age, sex, education and household income.<sup>4</sup> There was criticism that the DSM-IV tool used for the survey was too blunt to accommodate Māori understandings of mental incapacity. Prevalence in Pacific Island peoples in this survey was lower than for Māori and non-Māori.

Significant barriers to recognition and disclosure of depression include people's belief that they should deal with their problems themselves and that a general practitioner is not the right person to help with mental health problems.<sup>8</sup> Also, the expectation of stigmatisation from others reduces the likelihood of seeking help for depression.<sup>9</sup>

There are significant limitations to the current evidence base about depression. As outlined in the recent UK NICE guideline,<sup>10</sup> the concept of depression itself is problematic. As practitioners are aware, it is a very broad and heterogeneous category,<sup>10</sup> which may in some cases limit validity for effective treatment planning in primary care.

# RISK FACTORS FOR DEPRESSION

- Female sex
- Age 16–24<sup>4</sup>
- Recent childbirth
- Ongoing conflict, including spiritual or cultural conflict
- A past personal history of depression
- Any lifetime anxiety disorder or other previous mental health problems
- Family history of depressive illness
- Loss or stress, including unemployment, loneliness and divorce
- History of physical or sexual abuse
- Substance abuse
- Socioeconomic deprivation
- Significant illness causing chronic pain or disability
- Some prescription medications

## ISSUES IN DIAGNOSIS

Depression is a very broad and mixed diagnostic grouping with a variety of presentations, and comorbidities with overlapping symptoms. It frequently manifests in primary care with vague physical complaints or symptoms of anxiety. In New Zealand, up to 50% of people with depression also have an anxiety disorder and about 20% of people with depression also have a substance use disorder.<sup>7</sup> A US study found that over 50% of people with depression had a concurrent medical condition.<sup>11</sup>

### Screening for depression

The cost-effectiveness of routine screening is controversial. A New Zealand study found that general practitioners recognised most cases of depression in patients with whom they had regular contact.<sup>8</sup> Therefore, it is suggested that screening is restricted to the following groups:

- where there is clinical suspicion
- those who are new to the primary health care setting or infrequent attenders<sup>8</sup>
- those with risk factors, such as a past personal history of depression, a physical illness causing significant disability or other mental health problems.<sup>10</sup>

The following three questions will detect most cases of depression in primary practice. Given a positive response to *either* questions 1 or 2 *and also* to question 3, the test has a sensitivity of 96% (95% CI 86–99%), specificity of 89% (87–91%) and positive likelihood ratio of 9.1 (7.4–11.1).<sup>12</sup>

#### Screening questions

1. During the past month have you often felt down, depressed or hopeless?
2. During the past month have you had little interest or pleasure in doing things?
3. Is this something with which you would like help?

While many patients with depression in primary care do not present in clear-cut ways, in some instances it may also be helpful to assess patients according to criteria, such as the ICD-10 classification.

## The ICD-10 criteria for major depressive episodes

### Key symptoms

- Persistent sadness or low mood
- Loss of interest or pleasure
- Fatigue or low energy

If one or more of these symptoms present most days, most of the time for >2 weeks, ask about associated symptoms.

### Associated symptoms

- Disturbed sleep
- Poor concentration, indecisiveness, reduced concentration and attention
- Low self-confidence
- Poor or increased appetite
- Agitation or slowing of movements
- Guilt or self-blame
- Suicidal thoughts or acts

### Suggested guide to assessment of severity

**Mild:** 4 symptoms (including  $\geq 1$  key symptom)

**Moderate:** 5 or 6 symptoms (including  $\geq 1$  key symptom)

**Severe:**  $\geq 7$  symptoms (including  $\geq 1$  key symptom)

**Adapted from:** World Health Organization. The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva: WHO; 1992.

## Key points in assessment

- Risk of suicide or risk to others
- Subtype, severity and duration of depression
- Comorbidity (with medical and/or psychiatric illness or alcohol and substance abuse)
- Current stressors, strengths and supports
- Relevant personal and family history (including past abuse, trauma or mental illness)

**Adapted from:** Ellis P et. al. Aust N Z J Psychiatry 2004;38(6):389–407.

# TREATMENT OPTIONS

The following guidance needs to be viewed in the light of local service constraints. However, there are an increasing range of options available for treating depression, both publicly and privately, in the primary care setting including counselling networks, psychotherapists and psychologists.

The table below can be used in association with the ICD-10 classification, to help guide treatment planning.<sup>10</sup>

## Guide to treatment planning for depression

Treatment plan	Factors in the history and presentation
<b>General advice and watchful waiting</b>	<ul style="list-style-type: none"> <li>• ≤4 ICD-10 symptoms</li> <li>• no past personal or family history of depression</li> <li>• social support available</li> <li>• symptoms intermittent, or &lt;2 weeks duration</li> <li>• no suicidal thoughts</li> <li>• little associated disability</li> </ul>
<b>More active treatment* in primary care</b>	<ul style="list-style-type: none"> <li>• ≥5 ICD-10 symptoms</li> <li>• past personal or family history of depression</li> <li>• low social support</li> <li>• suicidal thoughts</li> <li>• associated social disability</li> </ul>
<b>Referral to a secondary mental health care team</b>	<ul style="list-style-type: none"> <li>• poor or incomplete response to two interventions</li> <li>• recurrent episode within 1 year of last one</li> <li>• person or relatives request referral</li> <li>• self-neglect</li> </ul>
<b>Urgent referral to a secondary mental health care team</b>	<ul style="list-style-type: none"> <li>• actively suicidal</li> <li>• psychotic symptoms</li> <li>• severe agitation accompanying severe (≥10 ICD-10) symptoms</li> <li>• severe self-neglect</li> </ul>

\* This may involve consulting with a specialist mental health team by phone if there are any questions about the person's safety and/or management.

**Adapted from:** National Institute for Clinical Evidence. Depression: Management of Depression in Primary and Secondary Care. Clinical Guideline 23. London: 2004. Appendix E.

# MANAGEMENT OF DEPRESSION

## General points

- The therapeutic relationship will assist in securing compliance with an effective treatment for a sufficient time.
- Take into account response to any past treatment.
- Encourage self-help strategies (see below).
- Ask about alcohol or substance use or gambling problems.
- Check available level of social and economic support.
- Ask about socioeconomic or interpersonal stressors that may have precipitated the episode, and assist in providing appropriate help. This may include referral to relationship counselling, housing assistance, budgeting advice or financial assistance services.
- Assess suicide risk. There is no evidence to suggest that asking directly about this increases the risk.<sup>13</sup>
- Assess potential risk to others (eg, dependent children).
- Consider providing routine telephone support<sup>3</sup> (eg, practice nurse phones weekly to encourage treatment compliance).
- Involve family/whānau/friends and other health care practitioners in treatment planning, as far as possible.

## Self-help strategies for depression

**Physical activity:** Encourage daily physical activity – ideally a structured and supervised exercise programme, but a daily walk may also help.

**Sleep:** Encourage behavioural methods to improve sleep.

**Daily planning:** Recommend ways to structure the day.

*For more information on self-help strategies see the companion resource for members of the public.*

## Mild depression

- Advise on self-help strategies
- Consider:
  - watchful waiting (supportive monitoring and reassessment at 2 weeks)
  - problem-solving therapy (see psychological interventions, page 11)
  - contacting someone who does not attend the follow-up appointment
  - brief psychological therapy or an antidepressant if symptoms persist beyond about 8 weeks<sup>3</sup> or if the person has a history of more severe depression.<sup>10</sup>

## Moderate depression

- Advise on self-help strategies
- Consider:
  - either an antidepressant or brief psychological therapy.<sup>2,10</sup>  
Monitor at least weekly, by phone or face-to-face
  - revising treatment if symptoms persist beyond 8 weeks<sup>2</sup>
  - involving a member of the Community Mental Health team, if available.

## Severe depression

- Consider:
  - referral to secondary care, based on suicide risk, functional impairment and comorbidities
  - an antidepressant and a psychological therapy together, as this is more effective than antidepressants alone.<sup>10</sup>

## Continuing treatment

- Encourage compliance with an effective treatment until full remission, in order to reduce the risk of relapse.
- If relapse occurs, reinstate an effective therapy and continue for at least 2 years.<sup>3</sup>
- Monitor suicide risk. Discuss when and how to seek urgent help with the person.

## Comorbidity with anxiety and/or substance abuse

When depressive symptoms are accompanied by anxiety, the first priority is usually to treat the depression. Often, this also alleviates the anxiety.<sup>10</sup>

When depression is accompanied by substance abuse, concurrent treatment directly targeting the substance abuse is advisable.<sup>14</sup>

# SPECIFIC INTERVENTIONS

## Physical activity

Structured and supervised physical activity has a clinically significant benefit for depressive symptoms, especially in mild depression.<sup>10</sup> There is a dose-response relationship between the intensity of the physical activity and reduction in depressive symptoms.<sup>15,16</sup> Consider issuing a Green Prescription to help support an increase in physical activity.

## Antidepressants

SSRIs are generally preferred as a first option, as they are better tolerated.<sup>10</sup> There may still be a place for tricyclic antidepressants.<sup>17</sup> The optimum length of antidepressant therapy is unclear. Guidelines suggest that they are continued for 6–12 months after remission, and for longer in the case of recurrent depression.<sup>3,10</sup>

It is helpful to provide written information to people on antidepressants and to advise them that antidepressants are not associated with tolerance or addiction.<sup>3,10</sup>

## Guided self-help manuals and websites

Guided self-help is an acceptable intervention for mild to moderate depression and has been shown to be cost-effective, at least in the short term.<sup>10</sup> It generally consists of supplying or recommending appropriate written materials or websites, with follow-up from a health professional who reviews progress and outcome over a period of weeks.

Examples include:

- Moodgym – <http://moodgym.anu.edu.au>
- BluePages – <http://bluepages.anu.edu.au>

## Psychological interventions

Evidence on psychological therapies is currently limited to the small range of interventions described below, and derives from studies of their purest forms as described in treatment manuals. However, clinical psychologists, counsellors and psychotherapists are also trained in a wide range of other modalities. In practice, most therapists treating depression in primary care use a combination of approaches. Brief psychological interventions usually comprise 6–12 treatments.

Problem solving therapy (PST) is effective for mild depression. Both interpersonal psychotherapy (IPT) and cognitive behavioural therapy (CBT) are effective for mild and moderate depression, with less side effects than antidepressants.<sup>10</sup>

- PST teaches how to identify key problem areas and break them down into achievable tasks.
- IPT seeks to reduce symptoms by identifying and addressing underlying problems related to interpersonal conflict, role transition, grief, loss or poor social skills.
- CBT teaches how to challenge and change negative thoughts and unhelpful behaviours.

Computerised programmes based on CBT are emerging as a promising resource for the management of depression in primary care.<sup>18</sup> While there are no locally developed New Zealand programmes, the following are overseas examples:

- **Beating the Blues** – [www.ultrasis.com](http://www.ultrasis.com) go to ‘products’
- **Climate** – [www.climate.tv](http://www.climate.tv)

It is important that all psychological therapies are provided by competent trained practitioners. Membership lists can be obtained from the relevant professional associations.

## Complementary and alternative medicine

There are various complementary and alternative medicines that people use for depression. Some examples are massage, acupuncture and food supplements.

St John’s wort is a herbal therapy that some people use. However, there is uncertainty about the appropriate dose and there can be serious interactions with other drugs, including oral contraceptives, anticoagulants and anticonvulsants.<sup>19</sup>

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## FURTHER INFORMATION

### General information about depression

[www.depression.org.nz](http://www.depression.org.nz)

### Guidelines for depression and suicide prevention

[www.nzgg.org.nz](http://www.nzgg.org.nz) – click on ‘Publications’ then ‘Mental Health’

### Crisis phone services

**Mental Health Services Crisis Response Team** – your local team is listed under ‘Hospitals and other Health Service Providers’ in the green section of your local phone book.

Copies of this resource and the companion resource on depression for the general public are available free from:

- Freephone 0800 111 757
- Wickliffe 04 496 2277 Order Nos. HP: 4308 (practitioner) and HP: 4309 (public)
- [www.nzgg.org.nz](http://www.nzgg.org.nz) (online)
- [info@nzgg.org.nz](mailto:info@nzgg.org.nz) (to request a copy)

