Appendix 1 Management of depression in adults in primary care[1]

Immediate referral* !

Refer at any stage if:

- serious suicidal intent
- psychotic symptoms
- severe self-neglect.

* **Immediate referral:** referral is to be made by the primary care practitioner that day with the expectation of a same-day response to the referral

Urgent referral†

Refer at any stage if:

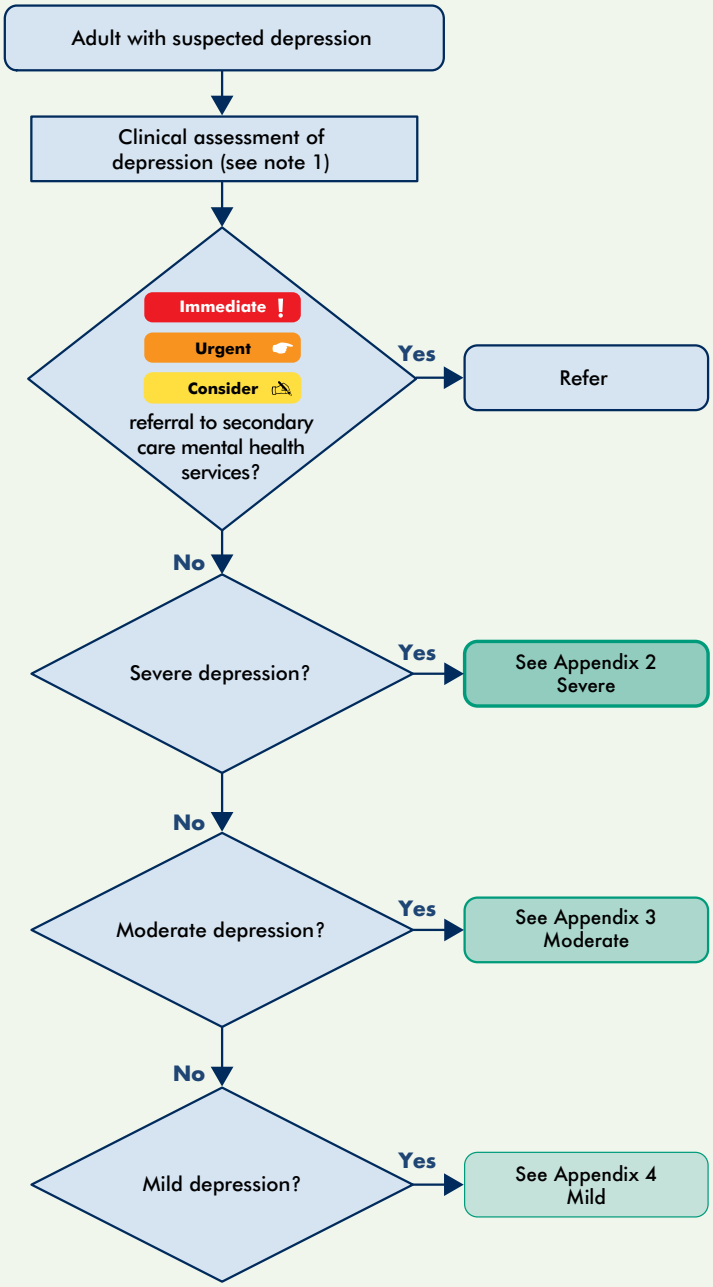
- significant but not immediate risk of harm to self/others
- suspected new-onset bipolar disorder
- treatment resistant.

† **Urgent referral:** referral is to be made by the primary care practitioner within 24 hours, with the expectation that the person referred will be seen within 7–10 days, or sooner depending on secondary care service availability

Consider referral

Refer at any stage if:

- comorbid medical condition that impacts on antidepressant use
- recurrent depression
- atypical depression resistant to initial treatment
- diagnostic uncertainty.



Note 1

Accurate assessment of acuity and severity is important for appropriate management and referral. In addition to the practitioner's clinical assessment, consideration should be given to the use of assessment tools. Tools such as the Patient Health Questionnaire for Depression (PHQ-9) will enable the practitioner to appropriately attribute the degree of severity.

PHQ-9 score for Major Depression

PHQ-9 score	Provisional diagnosis
10–14*	Mild depression
15–19*	Moderate depression
≥20*	Severe depression

Management of severe depression in adults in primary care[1]

Appendix 2

Immediate referral*

Refer at any stage if:

- serious suicidal intent
- psychotic symptoms
- severe self-neglect.

* **Immediate referral:** referral is to be made by the primary care practitioner that day with the expectation of a same-day response to the referral

Urgent referral†

Refer at any stage if:

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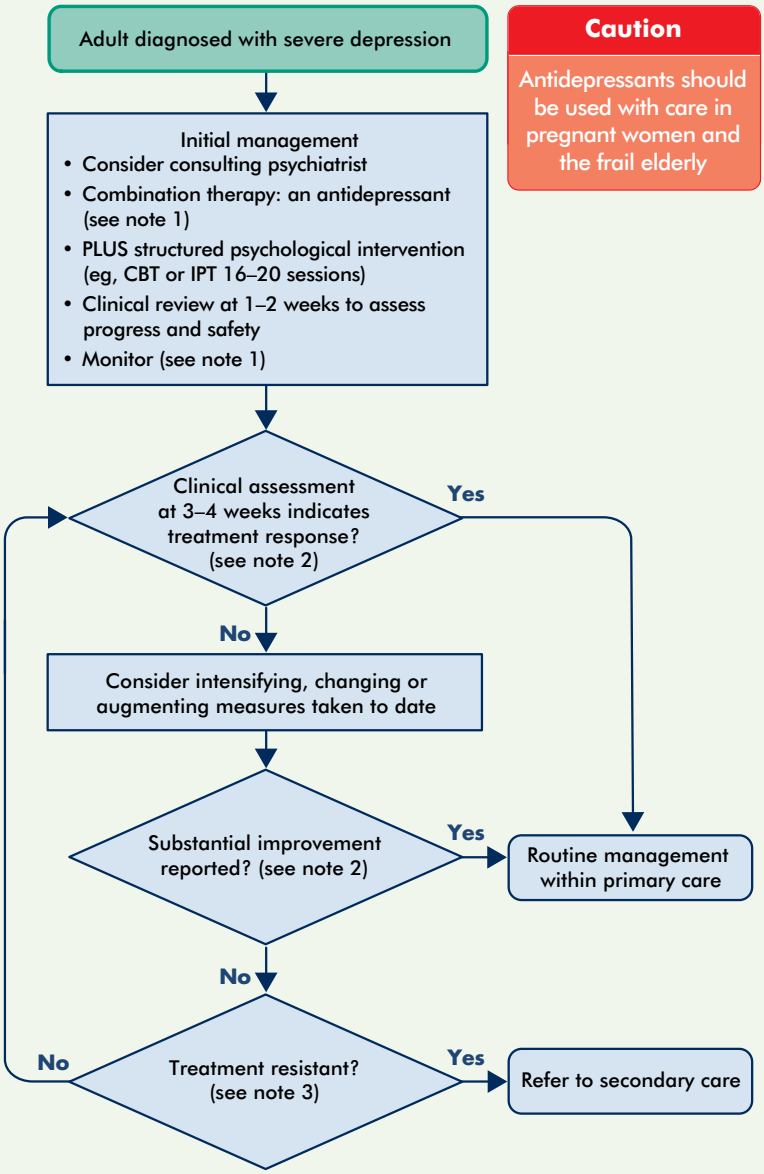


Caution

Antidepressants should be used with care in pregnant women and the frail elderly

Note 1: Monitoring after initiation of an antidepressant

If at increased risk of suicide:

see at 1 week, monitor 1–2 weekly, preferably face-to-face, until the risk is not significant, then at least 2-weekly until clear improvement.

If not at increased risk of suicide:

review within 1–2 weeks, then monitor at least 2-weekly until clear improvement.

Note 2: Antidepressants

At 3–4 weeks

If only a partial response, consider increasing the dose.

If no response or minimal response, or unacceptable side effects, consider changing antidepressant, or changing to or adding a psychological therapy.

At 4–6 weeks

If the person has not responded to treatment, consider increasing the dose, changing antidepressant, or changing to or adding a psychological therapy.

Antidepressants should normally be continued for at least 6 months after remission, to reduce the risk of relapse.

Note 3: Treatment resistance

Treatment resistance is defined as lack of a satisfactory response after trial of two antidepressants given sequentially at an adequate dose for an adequate time (with or without psychological therapy).

Appendix 3 Management of moderate depression in adults in primary care[1]

Immediate referral* !

Refer at any stage if:
- serious suicidal intent
- psychotic symptoms
- severe self-neglect.

* **Immediate referral:** referral is to be made by the primary care practitioner that day with the expectation of a same-day response to the referral

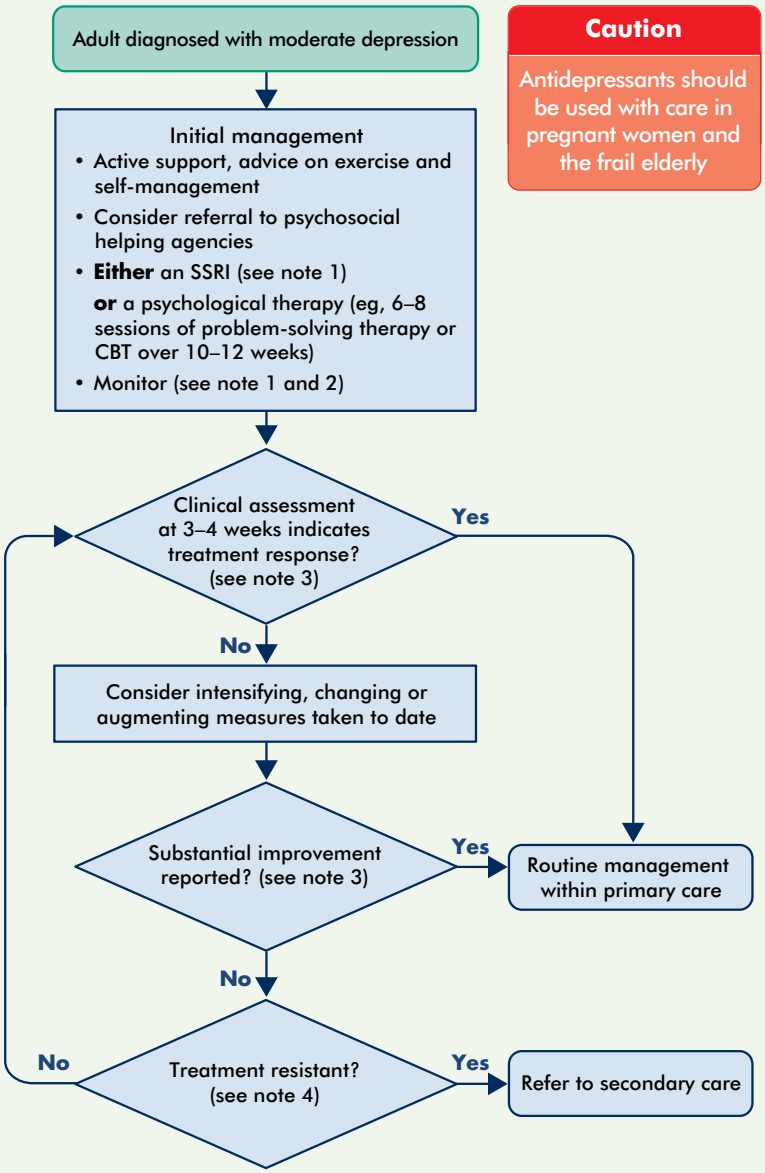
Urgent referral†

Refer at any stage if:
- significant but not immediate risk of harm to self/others
- suspected new-onset bipolar disorder
- treatment resistant.

† **Urgent referral:** referral is to be made by the primary care practitioner within 24 hours, with the expectation that the person referred will be seen within 7–10 days, or sooner depending on secondary care service availability

Consider referral

Refer at any stage if:
- comorbid medical condition that impacts on antidepressant use
- recurrent depression
- atypical depression resistant to initial treatment
- diagnostic uncertainty.



Caution

Antidepressants should be used with care in pregnant women and the frail elderly

Note 1: Monitoring

Initial monitoring

Monitor at 1–2 weeks by face-to-face/phone/text/email to:
- check severity
- gauge progress
- encourage treatment adherence
- take remedial action.

Note 2: Monitoring after initiation of an antidepressant

If at increased risk of suicide:

see at 1 week, monitor 1–2 weekly, preferably face-to-face, until the risk is not significant, then at least 2-weekly until clear improvement.

If not at increased risk of suicide:

review within 1–2 weeks, then monitor at least 2-weekly until clear improvement.

Note 3: Antidepressants

At 3–4 weeks

If only a partial response, consider increasing the dose.

If no response or minimal response, or unacceptable side effects, consider changing antidepressant, or changing to or adding a psychological therapy.

At 4–6 weeks

If the person has not responded to treatment, consider increasing the dose, changing antidepressant, or changing to or adding a psychological therapy.

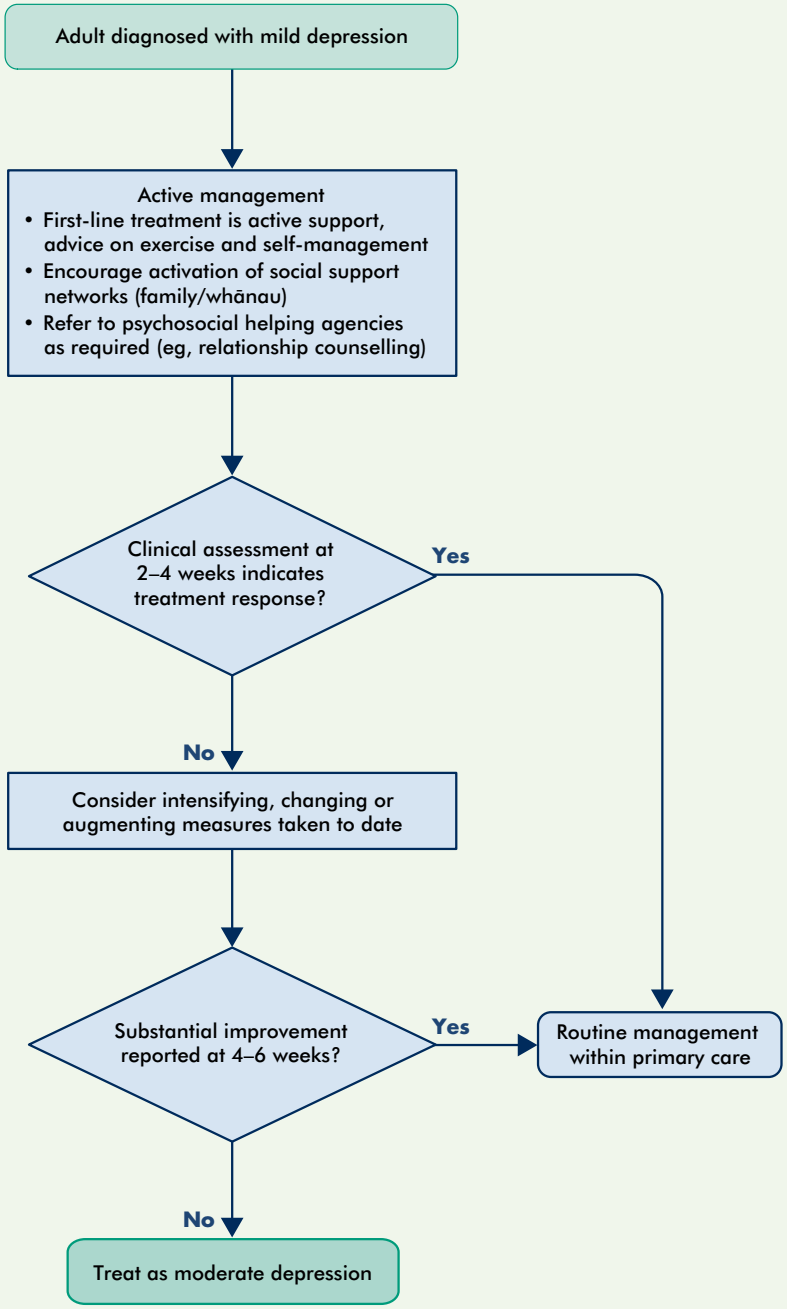
Antidepressants should normally be continued for at least 6 months after remission, to reduce the risk of relapse.

Note 4: Treatment resistance

Treatment resistance is defined as lack of a satisfactory response after trial of two antidepressants given sequentially at an adequate dose for an adequate time (with or without psychological therapy).

Management of mild depression in adults in primary care[1]

Appendix 4



Appendix 5

KESSLER 10 (K10)

KESSLER 10 Questionnaire					
The following ten questions ask about how you have been feeling in the **last four weeks**. For each question, select the option that best describes the amount of time you felt that way.					
In the last four weeks...	None of the time	A little of the time	Some of the time	Most of the time	All of the time
	1	2	3	4	5
1. About how often did you feel tired out for no good reasons?	○	○	○	○	○
2. About how often did you feel nervous?	○	○	○	○	○
3. About how often did you feel so nervous that nothing could calm you down?	○	○	○	○	○
4. About how often did you feel hopeless?	○	○	○	○	○
5. About how often did you feel restless or fidgety?	○	○	○	○	○
6. About how often did you feel so restless you could not sit still?	○	○	○	○	○
7. About how often did you feel depressed?	○	○	○	○	○
8. About how often did you feel that everything was an effort?	○	○	○	○	○
9. About how often did you feel so sad that nothing could cheer you up?	○	○	○	○	○
10. About how often did you feel worthless?	○	○	○	○	○

K10 provisional diagnosis

Scoring — add up answers to questions on K10

None of the time = 1; A little of the time = 2; Some of the time = 3; Most of the time = 4; All of the time = 5

Score between 10 and 19	This score indicates that the patient may currently not be experiencing significant feelings of distress.
Score between 20 and 24	The patient may be experiencing mild levels of distress consistent with the diagnosis of mild depression and/or anxiety disorder.
Score between 25 and 30	The patient may be experiencing moderate levels of distress consistent with the diagnosis of moderate depression and/or anxiety disorder.
Score between 30 and 50	The patient may be experiencing severe levels of distress consistent with the diagnosis of severe depression and/or anxiety disorder.

See **www.nzgg.org.nz/CMD-assessmenttools** for more information

Appendix 6

Patient health questionnaire for depression				
Over the last 2 weeks, how often have you been bothered by any of the following problems? For each question select the option that best describes the amount of time you felt that way.				
In the last 2 weeks	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

PHQ-9 provisional diagnosis

Scoring — add up answers to questions on PHQ-9

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

Total Score	Depression Severity
10–14	Mild
15–19	Moderate depression
≥ 20	Severe depression

See **www.nzgg.org.nz/CMD-assessmenttools** for more information

Appendix 7 GAD-7

Designed primarily as a screening and severity measure for generalised anxiety disorder, the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders - panic disorder, social anxiety disorder, and post-traumatic stress disorder

Generalised Anxiety Disorder Scale (GAD-7)

Over the **last two weeks** how often have you been bothered by any of the following problems?
For each question, select the option that best describes the amount of time you felt that way.

In last 2 weeks...	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Feeling nervous, anxious or on edge	◯	◯	◯	◯
2. Not being able to stop worrying	◯	◯	◯	◯
3. Worrying too much about different things	◯	◯	◯	◯
4. Having trouble relaxing	◯	◯	◯	◯
5. Being so restless it is hard to sit still	◯	◯	◯	◯
6. Becoming easily annoyed or irritable	◯	◯	◯	◯
7. Feeling afraid as if something awful might happen	◯	◯	◯	◯

GAD-7 provisional diagnosis

Scoring — add up answers to questions on GAD-7
Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Mild anxiety Score 5 - 9

A score of 5 represents a cutpoint for mild anxiety.

A recommended cutpoint for further evaluation is a score of 10 or greater.

Moderate anxiety Score 10 - 14

A score of 10 represents a cutpoint for moderate anxiety.

A recommended cutpoint for further evaluation is a score of 10 or greater.

Severe anxiety Score 15 - 21

A score of 15 represents a cutpoint for severe anxiety.

A recommended cutpoint for further evaluation is a score of 10 or greater.

See **www.nzgg.org.nz/CMD-assessmenttools** for more information

Appendix 8

Alcohol Use Disorders Identification Test (AUDIT)		
PLEASE TICK THE ANSWER THAT IS NEAREST TO CORRECT FOR YOU		
1.	**How often do you have a drink containing alcohol?** ◯ Never ◯ Monthly or less ◯ 2 – 4 times a month ◯ 2 – 3 times a week ◯ 4 or more times per week	
2.	**How many drinks containing alcohol do you have on a typical day when you are drinking? (code number of standard drinks)** ◯ One to two ◯ 3 or 4 ◯ 5 or 6 ◯ 7 to 9 ◯ 10 or more	
3.	How often do you have six or more drinks on one occasion? ◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily	
4.	**How often during the last year have you found that you were not able to stop drinking once you had started?** ◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily	
5.	**How often during the last year have you failed to do what was normally expected from you because of drinking?** ◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily	
6.	**How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?** ◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily	
7.	**How often during the last year have you had a feeling of guilt or remorse after drinking?** ◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily	
8.	**How often during the last year have you been unable to remember what happened the night before because you had been drinking?** ◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily	
9.	**Have you or someone else been injured as a result of your drinking?** ◯ No ◯ Yes, but not in the last year ◯ Yes, during the last year	
10.	**Has a relative, friend or doctor, or other health worker been concerned about your drinking or suggested that you should cut down?** ◯ No ◯ Yes, but not in the last year ◯ Yes, during the last year	

Scores range from 0 to 4 for each question. See NZGG website below for more details.

AUDIT provisional diagnosis

A score of 8 or more for the whole questionnaire suggests your patient has a harmful pattern of drinking.

Section A: (questions 1, 2, 3) enquires about "at risk" alcohol consumption.
A score of **4 (or more) for women**, or **5 (or more) for men** suggests a level of drinking that places the person at risk of harm.

Section B: (questions 4, 5, 6) enquires about symptoms of dependence.
A score 4 (or more) indicates that person may be psychologically or physically dependent on alcohol.

Section C: (questions 7, 8, 9, 10) enquires about problems relating to drinking.
A score of 4 (or more) indicates significant problems already.

See **www.nzgg.org.nz/CMD-assessmenttools** for more information

Appendix 9

Case-finding and Help Assessment Tool (CHAT)
PLEASE TICK THE ANSWER THAT IS NEAREST TO CORRECT FOR YOU
How many cigarettes do you smoke on average a day?
◯ None ◯ Less than 1 a day ◯ 1–10 ◯ 11–20 ◯ 21–30 ◯ 31 or more
Do you ever feel the need to cut down or stop your smoking? (Tick no if you do not smoke)
◯ No ◯ Yes
Do you want help with your smoking?
◯ No ◯ Yes but not today ◯ Yes
Do you ever feel the need to cut down on your drinking alcohol? (Tick no if you do not drink alcohol OR do not feel the need to cut down)
◯ No ◯ Yes
In the last year, have you ever drunk more alcohol than you meant to?
◯ No ◯ Yes
Do you want help with your drinking?
◯ No ◯ Yes but not today ◯ Yes
Do you ever feel the need to cut down on your non-prescription or recreational drug use? (Tick no if you do not use other drugs OR do not feel the need to cut down)
◯ No ◯ Yes
In the last year, have you ever used non-prescription or recreational drugs more than you meant to?
◯ No ◯ Yes
Do you want help with your drug use?
◯ No ◯ Yes but not today ◯ Yes
Do you sometimes feel unhappy or worried after a session of gambling? (Tick no if you do not gamble OR do not feel unhappy about gambling)
◯ No ◯ Yes
Does gambling sometimes cause you problems?
◯ No ◯ Yes
Do you want help with your gambling?
◯ No ◯ Yes but not today ◯ Yes

Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?

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

Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?

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

Do you want help with this?

◯ No ◯ Yes but not today ◯ Yes

Over the last 2 weeks have you been worrying a lot about everyday problems?

◯ No ◯ Yes

Do you want help with your anxiety or worrying?

◯ No ◯ Yes but not today ◯ Yes

Is there anyone in your life of whom you are afraid or who hurts you in any way?

◯ No ◯ Yes

Is there anyone in your life who controls you and prevents you doing what you want?

◯ No ◯ Yes

Do you want help with any abuse or violence that you are experiencing?

◯ No ◯ Yes but not today ◯ Yes

Is controlling your anger sometimes a problem for you?

◯ No ◯ Yes

Do you want help with controlling your anger?

◯ No ◯ Yes but not today ◯ Yes

As a rule, do you do less than 30 minutes of moderate or vigorous exercise (such as walking or a sport) on 5 days of the week?

◯ No ◯ Yes

Do you want help with getting more exercise?

◯ No ◯ Yes but not today ◯ Yes

See **www.nzgg.org.nz/CMD-assessmenttools** for more information