



# Identification of Common Mental Disorders and Management of Depression in Primary Care

## Key messages

- Mental disorders are common in primary care and are a major cause of disability
- All assessment, support and treatment of mental disorders in primary care should be culturally appropriate
- Routine psychosocial assessment is the key to improving the recognition of common mental disorders
- The use of verbal 2–3 question screening tools is recommended as a support for clinical assessment, when targeting adults at high risk for common mental disorders
- A high index of suspicion is needed for substance use disorder which is common but often hard to recognise as it is relatively less disabling than other mental disorders
- Most young people and adults with depression can be managed within primary care using a ‘stepped care’ approach. A good outcome depends on partnership between the patient and practitioner and on provision of active treatment and support for a sufficient length of time
- Planned treatment for depression should reflect the individual’s values and preferences and the risks and benefits of different treatment options
- Use of self-management strategies for depression should be encouraged and supported by practitioners
- Psychological and pharmacological therapies are equally effective for treating adults with moderate depression, on the basis of current evidence
- Brief psychological interventions such as structured problem-solving therapy should be available in the primary care setting
- Where antidepressant therapy is planned, selective serotonin reuptake inhibitors are first-line treatment, with few exceptions

# Introduction

This guideline addresses the identification of common mental disorders and the management of depression in primary care in all age groups. Special issues pertaining to older adults and mental disorders in the antenatal and postnatal period are also addressed in the full guideline. Among young people the focus is largely on adolescents as the prevalence of mental disorders is high in this group. Mental disorders are common in the primary care setting, with the Mental Health and General Practice Investigation (MaGPIe study) reporting as many as one-third of adults attending primary care were likely to have met the criteria for a DSM-IV® diagnosis within the previous 12 months.

Management options for depression in primary care sit on a continuum from simple advice and monitoring to intensive multidisciplinary intervention. The guideline advocates a 'stepped care' approach to management which entails choosing the least intensive intervention required to achieve clinical change for an individual. The stepped care model guides treatment using a combination of evidence-based principles and continuous clinical assessment. Progression through levels of care is determined on the basis of patient response, with support for self-management a major feature.

All information contained in this summary is based on a careful appraisal of the available research evidence. Full references and details of the evidence summaries are available in the full guideline ([www.nzgg.org.nz](http://www.nzgg.org.nz)).

## Guideline development

New Zealand Guidelines Group convened a multidisciplinary guideline development team (GDT) to develop the guideline. Members were selected to represent professional, cultural and consumer perspectives. The key issues and questions addressed by the guideline were developed by the GDT within the parameters specified by the Ministry of Health. Details of the clinical questions, comprehensive search strategy and evidence tables are available online at [www.nzgg.org.nz](http://www.nzgg.org.nz).

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This guideline has received endorsement from the following organisations:



The Royal New Zealand  
College of General Practitioners



Te Ao Maramatanga  
New Zealand College of Mental Health Nurses (Inc.)  
Partnership, Voice, Excellence in Mental Health Nursing



NZCCP  
The New Zealand College  
of Clinical Psychologists



# Recognition and assessment of common mental disorders in young people/rangatahi/tamariki

All recommendations on the recognition and assessment of common mental disorders in young people/rangatahi/tamariki (up to 18 years of age) contained in the guideline are presented here.

Recommendations*	
A young person with serious suicidal intent, psychotic symptoms or severe self-neglect should be referred immediately to secondary care mental health services	C
A young person with severe depression should be referred urgently to secondary care mental health services	C
Every interaction with a young person in primary care should be regarded as an opportunity to assess their psychosocial as well as physical wellbeing. Both strengths and difficulties should be taken into account	C
Psychosocial wellbeing in adolescents should routinely be assessed using a standardised format, such as the HEEADSSS acronym ( <b>H</b> ome, <b>E</b> ducation/ <b>E</b> mployment, <b>E</b> ating, <b>A</b> ctivities, <b>D</b> rugs, <b>S</b> exuality, <b>S</b> uicide, <b>S</b> afety) <sup>†</sup>	C
Adolescents presenting in primary care should routinely be offered individual time with a practitioner	C
Brief tools may be used as optional aids to the practitioner's clinical assessment. Valid brief tools include: <ul style="list-style-type: none"> <li>• the Strengths and Difficulties Questionnaire (SDQ)</li> <li>• the Short Moods and Feelings Questionnaire (SMFQ)</li> <li>• Reynolds Adolescent Depression Scale (RADS)</li> <li>• the Substance Use and Choices Scale (SACS)</li> <li>• the CRAFFT acronym</li> </ul>	C

Good practice points*	
A young person with suspected bipolar disorder should be referred urgently to secondary care mental health services	✓
Practitioners involved in the assessment of young people for mental disorders should endeavour to build a supportive and collaborative relationship with the young person and their family/whānau	✓
Practitioners should discuss the right to confidentiality and exceptions to confidentiality with the young person	✓
In young children, a standardised format such as the HEARTS acronym ( <b>H</b> ome, <b>E</b> ducation, <b>A</b> ctivities, <b>R</b> elationships, <b>T</b> emper, <b>S</b> ize) <sup>†</sup> should be used for routine assessment of psychosocial wellbeing	✓
Practitioners should be aware of the cultural identity and health care preferences of young people in their care	✓

\* See key, page 6.

† See page 4.

## HEEADSSS

The HEADSS acronym<sup>i</sup> updated in 2004<sup>ii</sup> to HEEADSSS or HE<sup>2</sup>ADS<sup>3</sup> is a well-known prompt to structure a psychosocial assessment in adolescents. It has the advantage of progressing from routine questions to more probing ones, giving the practitioner a chance to establish rapport before approaching the most difficult areas. However, the order of the interview depends on the dictates of common sense and clinical instinct and the young person's presenting complaint should be addressed as a priority.<sup>ii</sup>

**Home:** relationships, communication, anyone new?

**Education/Employment:** ask for actual marks, hours, responsibilities

**Eating:** body image, weight changes, dieting, exercise

**Activities:** with peers, with family

**Drugs:** tobacco, alcohol, other drugs – use by friends, family, self

**Sexuality:** sexual identity, relationships, coercion, contraception, pregnancy, sexually transmitted infections (STIs)

**Suicide and depression:** sadness, boredom, sleep patterns, anhedonia

**Safety:** injury, seatbelt use, violence, rape, bullying, weapons

Issues of ethnic identity may also be critical domains, particularly among adolescents/rangatahi from minority cultures.\*<sup>iii</sup>

\* The earlier version, HEADSS, has been adapted for New Zealand.<sup>iv</sup>

### Sources:

i Goldenring JM, et al. *Contemp Pediatr*. 1988;5(75).

ii Goldenring JM, et al. *Contemp Pediatr*. 2004;21(64):1–20.

iii Ministry of Social Development. *Cultural identity: the social report*. Wellington: Ministry of Social Development; 2007.

iv Ministry of Health. *Family violence intervention guidelines: child and partner abuse*. Wellington: Ministry of Health; 2002.

## HEARTS

Currently, there is no well-established acronym that can be used to structure a psychosocial interview with young children and their family/whānau. However, the HEARTS acronym is suggested by the GDT.

**Home:** conduct, general behaviour, 'manageability'

**Education:** any concerns about behaviour/progress

**Activities:** attention span, ability to finish tasks, friendships

**Relationships with peers/parents:** any big changes in the family, any bullying

**Temper:** mood

**Size:** weight gain, appetite

Children tend to provide different information from their parents, so it is helpful to gather information from both sources.

# Recognition and assessment of common mental disorders in adults/pakeke

All recommendations on the recognition and assessment of common mental disorders in adults/pakeke contained in the guideline are presented here.

Recommendations*	
An adult with serious suicidal intent, psychotic symptoms or severe and persistent self-neglect should be referred immediately to secondary care mental health services	C
Targeted screening for common mental disorders is indicated for adults not well-known to the practitioner and for: <ul style="list-style-type: none"> <li>• people with chronic illness, a history of mental disorder or suicide attempt, multiple symptoms or a recent significant loss</li> <li>• other high prevalence groups, such as Māori (especially Māori women) and older adults in residential care</li> <li>• women in the antenatal and postnatal period</li> </ul>	C
Targeted screening for depression and anxiety should include the use of verbal 2–3 question screening tools <sup>†</sup>	B
Practitioners should consider the use of a tool such as the Patient Health Questionnaire for Depression (PHQ-9) for assessment of the severity of depression	B

Good practice points*	
An adult with suspected new-onset bipolar disorder should be referred urgently to secondary care mental health services	✓
Every interaction with an adult in primary care should be regarded as an opportunity to assess their psychosocial as well as physical wellbeing. Both strengths and difficulties should be taken into account	✓
The practitioner should strive to establish and maintain a good therapeutic relationship with the patient, as this increases the likelihood that mental disorders will be identified	✓
Targeted screening for substance abuse should comprise a verbal 2–3 question screening tool <sup>†</sup>	✓
Targeted screening should be conducted annually	✓

\* See key, page 6.

† See page 7.

continued over...

Good practice points* continued...	
Brief tools are optional aids for use by the primary care practitioner as an adjunct to clinical assessment. Examples of brief tools include: <ul style="list-style-type: none"> <li>• the Kessler 10 (K10)</li> <li>• the Patient Health Questionnaire for Depression (PHQ-9)</li> <li>• the Generalised Anxiety Disorder Scale (GAD-7)</li> <li>• the Alcohol Disorder Use Identification Test (AUDIT)</li> <li>• the Case-finding and Help Assessment Tool (CHAT)</li> </ul>	✓
When assessing the severity of depression in an adult and planning management, practitioners should consider symptom severity, symptom persistence, functional impairment, response to any previous intervention and also the wider psychosocial context, identifying factors that may impact positively or negatively on outcome	✓
Practitioners should be aware of the cultural identity and health care preferences of people in their care	✓

\* See key below.

### Key: Grading of recommendations

Key to recommendations	
The recommendation is supported by good evidence (based on a number of studies that are valid, consistent, applicable and clinically relevant)	A
The recommendation is supported by fair evidence (based on studies that are valid, but there are some concerns about the volume, consistency, applicability and clinical relevance of the evidence that may cause some uncertainty but are not likely to be overturned by other evidence)	B
The recommendation is supported by international expert opinion	C
Grades indicate the strength of the supporting evidence, rather than the importance of the evidence	

Key to good practice points	
Where no evidence is available, best practice recommendations are made based on the experience of the Guideline Development Team, or feedback from consultation within New Zealand	✓

Further detail about the grading system is available in the full guideline online, at [www.nzgg.org.nz](http://www.nzgg.org.nz) or [www.moh.govt.nz](http://www.moh.govt.nz)

## Verbal 2–3 question screening tools for common mental disorders

### Screening questions for depression<sup>i,ii</sup>

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

If Yes to either question, ask [Help question<sup>v</sup>](#) (below)

### Screening question for anxiety<sup>iii</sup>

- During the past month have you been worrying a lot about everyday problems?

If Yes, ask [Help question<sup>v</sup>](#) (below)

### Screening questions for alcohol and drug problems<sup>iv</sup>

- Have you used drugs or drunk more than you meant to in the last year?
- Have you felt that you wanted to cut down on your drinking or drug use in the past year?

If Yes to either question, ask [Help question<sup>v</sup>](#) (below)



#### Help question<sup>v</sup>

Is this something with which you would like help?

Options: no / yes, but not now / yes

### Further action

A positive response to one of the screening questions detects most cases of the relevant disorder.

If a person responds positively to a screening question and identifies that they want help to address the issue, the GDT recommends that the practitioner proceeds with further clinical assessment, reschedules a further consultation or refers the person to their general practitioner/practice nurse team, as appropriate.

#### Sources:

- Arroll B, et al. *BMJ* 2003;327(7424):1144–6.
- Kroenke K, et al. *Med Care* 2003;41(11):1284–92.
- Goodyear-Smith F, et al. *Br J Gen Pract* 2008;58(546):26–31.
- Brown RL, et al. *J Am Board Fam Pract* 2001;14(2):95–106.
- Arroll B, et al. *BMJ* 2005;331(7521):884.

# Algorithm 1

## Management of depression in young people in primary care

### Immediate referral\*

Refer at any stage if:

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

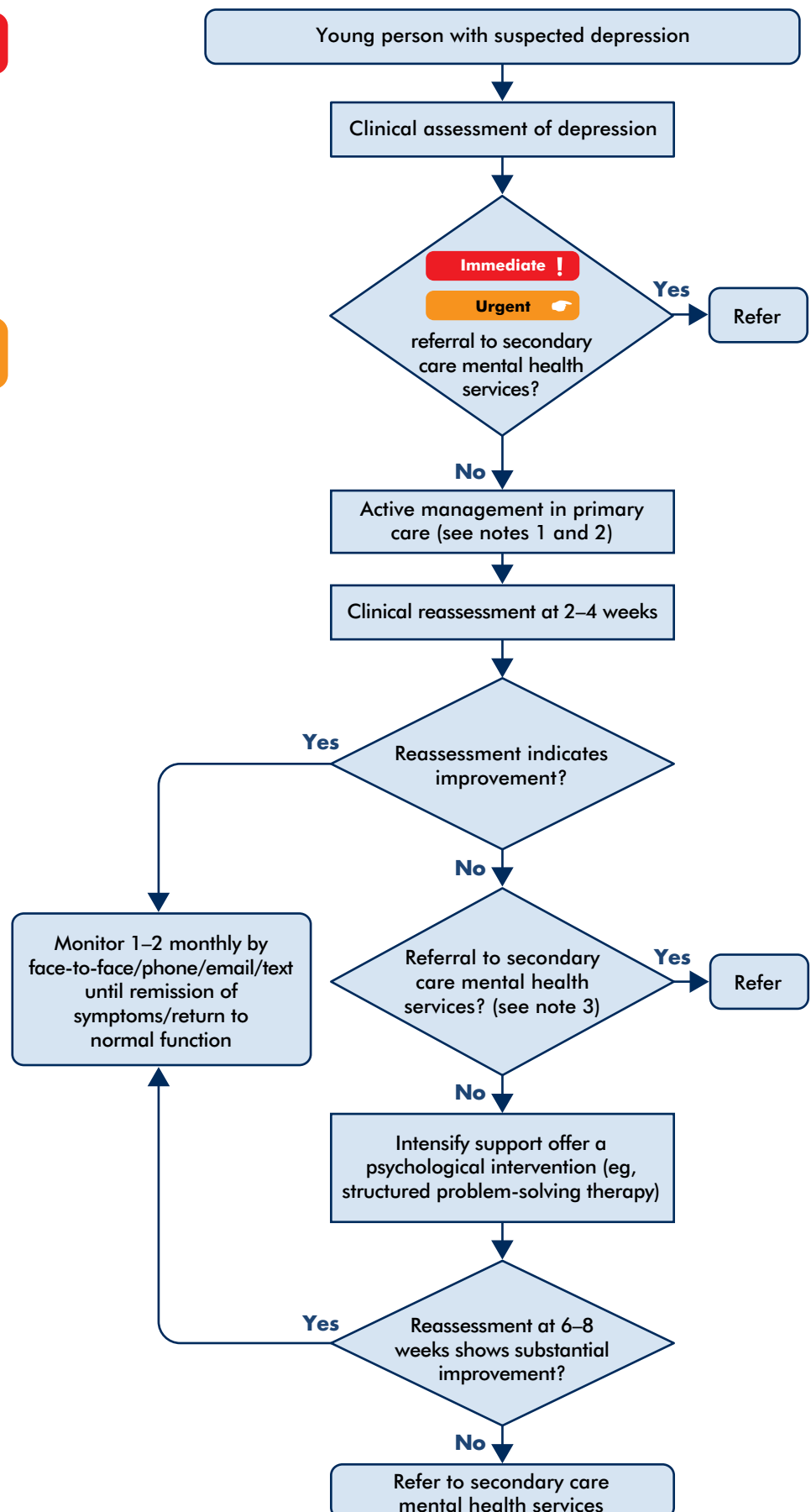
\* **Immediate referral:** referral is to be made by the primary care practitioner that day with the expectation of a same-day response to the referral

### Urgent referral†

Refer at any stage if:

- severe depression
- persistent symptoms
- profound hopelessness
- other serious mental or substance use disorders
- significant functional impairment (eg, unable to do most daily activities)
- suspected bipolar disorder.

† **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



### Note 1

Initial management should include active listening, problem identification, advice about simple self-management strategies and active follow-up (2-weekly monitoring by face-to-face/phone/text/email).

### Note 2

Consider involving support services such as school guidance counsellors or family services.

### Note 3

Review whether referral is indicated at this point given lack of improvement or other concerns.

## Algorithm 2

# Management of depression in adults in primary care

### 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.

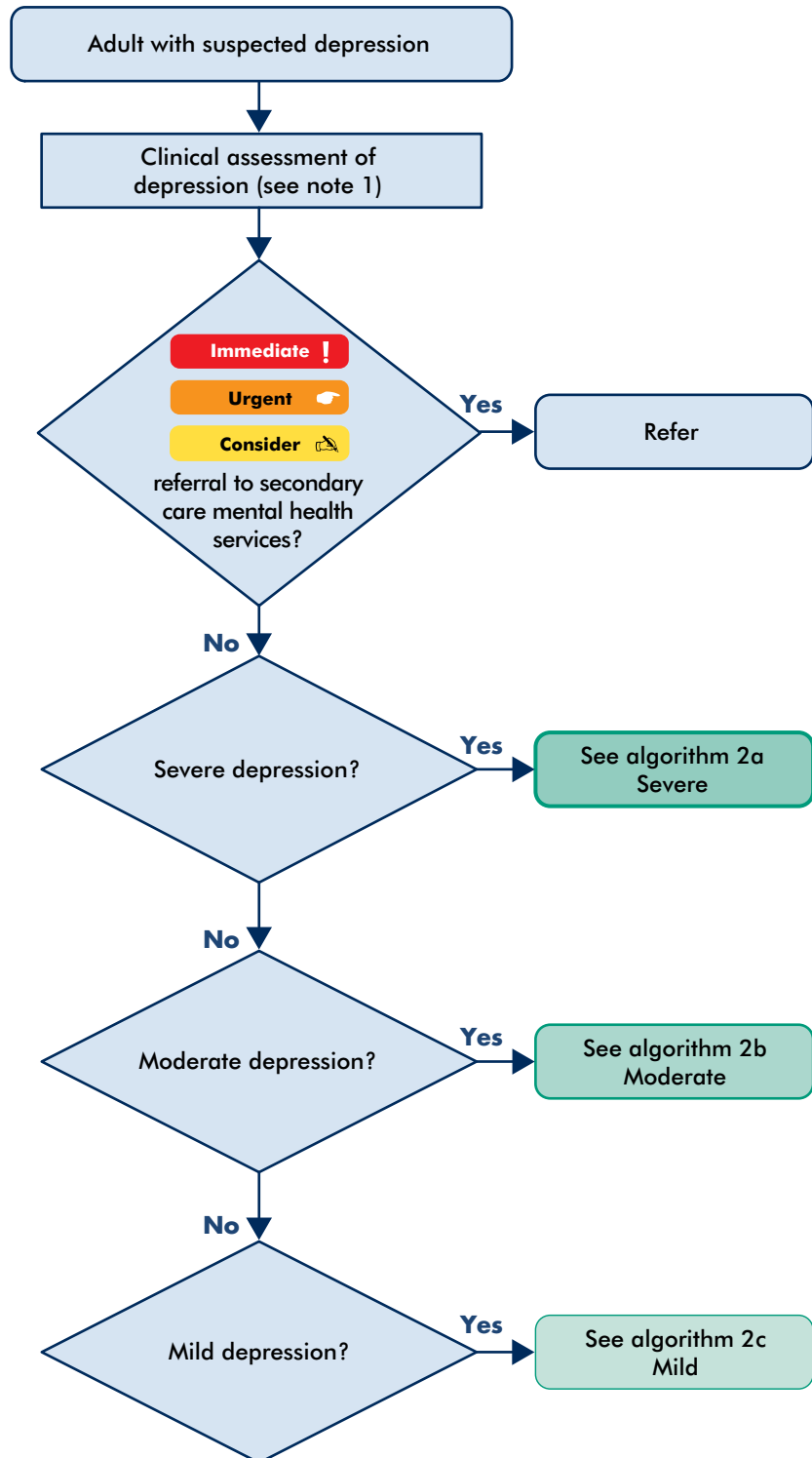
### Note 1

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

\* In addition, question 10 about difficulty at work or home or getting along with others should be answered at least 'somewhat difficult'



## Algorithm 2a

# Management of severe depression in adults in primary care

### 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

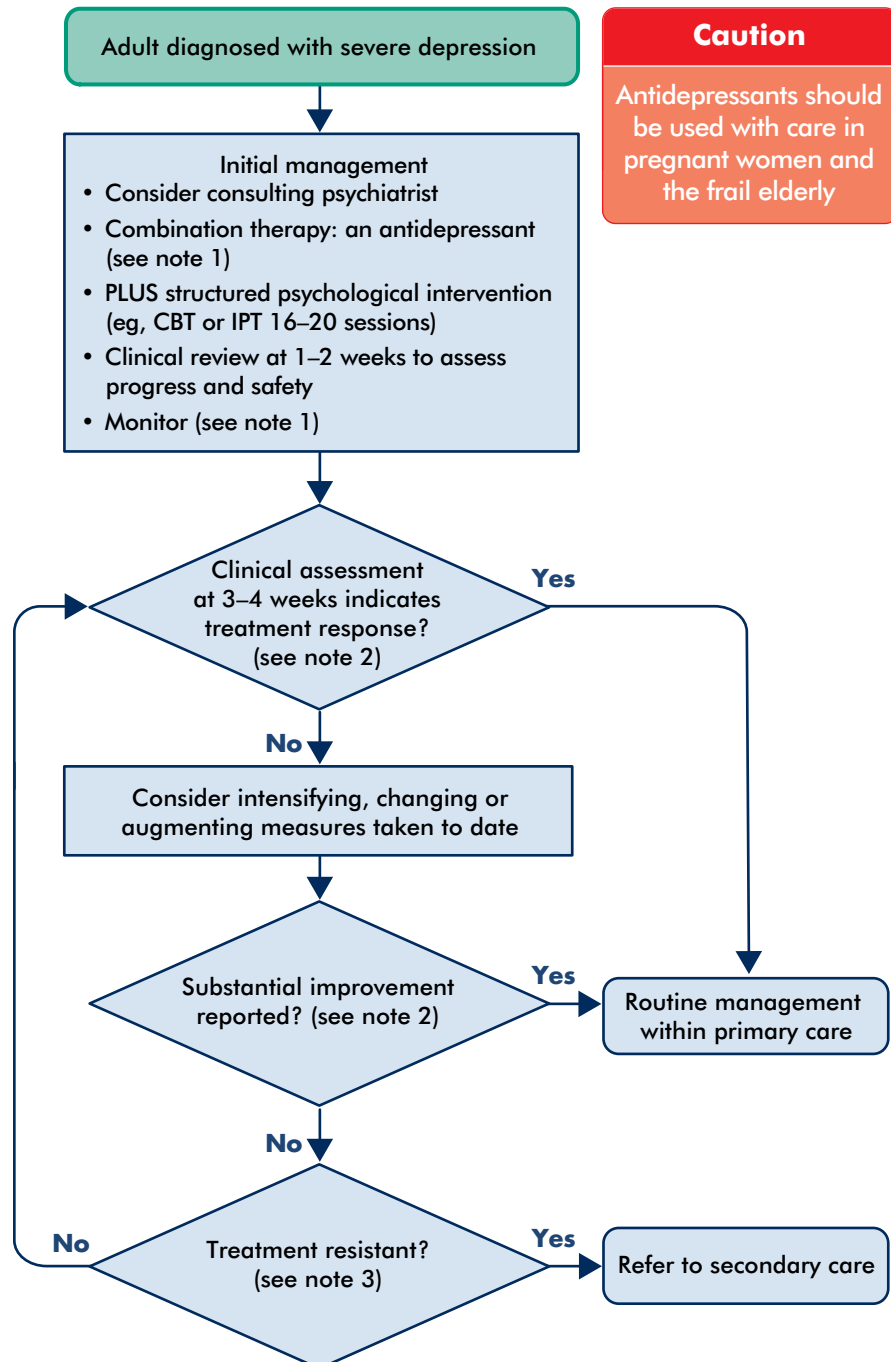
### Consider referral

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 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.

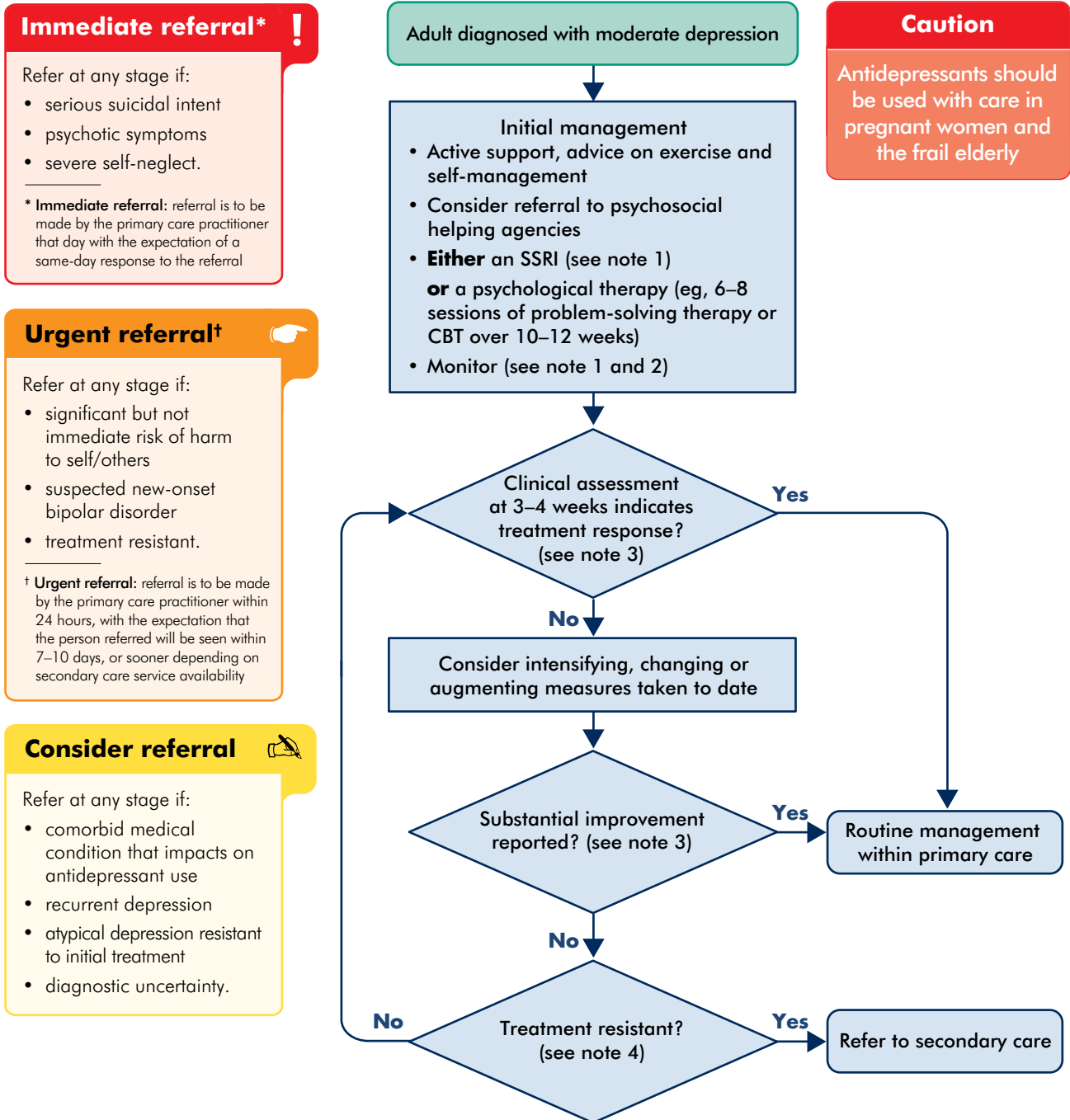
Antidepressants should normally be continued for at least 6 months after remission, to reduce the risk of relapse.

#### 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).

## Algorithm 2b

# Management of moderate depression in adults in primary care



### 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.

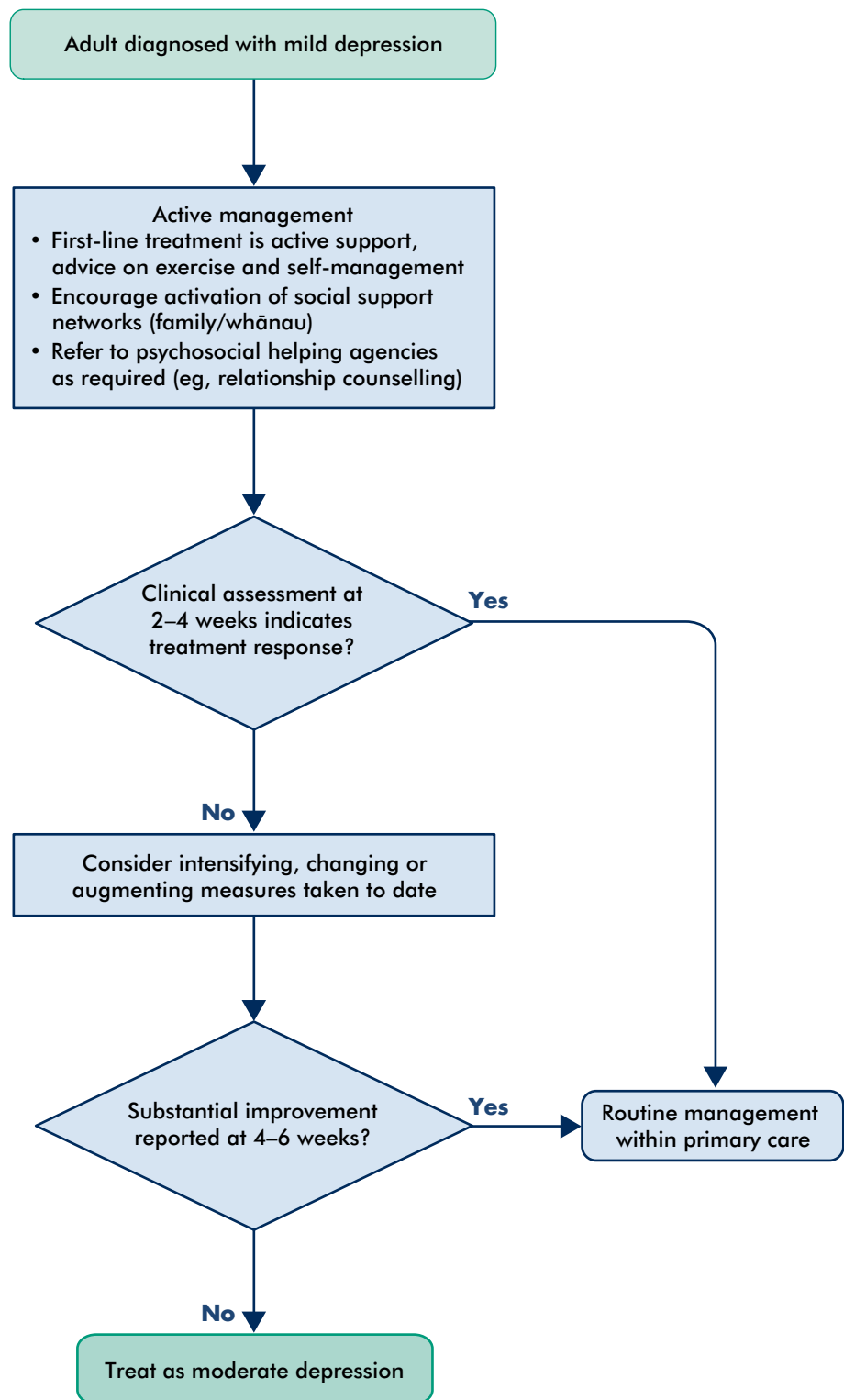
Antidepressants should normally be continued for at least 6 months after remission, to reduce the risk of relapse.

#### 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).

## Algorithm 2c

# Management of mild depression in adults in primary care



The guideline was developed and published by the New Zealand Guidelines Group.

An electronic copy of the full guideline and this summary can be downloaded free of charge from the Ministry of Health ([www.moh.govt.nz](http://www.moh.govt.nz)) and New Zealand Guidelines Group ([www.nzgg.org.nz](http://www.nzgg.org.nz)) websites, or a printed copy is available from Wickliffe 04 496 2277.

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