Guidelines for the treatment and management of depression by primary healthcare professionals

This report is published by the National Advisory Committee on Health and Disability as advice to the Minister of Health on best practice for the treatment of depressive disorders and the clinical terms of access to the various treatment modalities.

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NATIONAL HEALTH COMMITTEE
NATIONAL ADVISORY COMMITTEE ON HEALTH AND DISABILITY
HUNGA KAITITIRO I TE HAUORA O TE TANGATA

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Foreword from the National Advisory Committee on Health and Disability

In our first report to the Minister of Health in October 1992, we, the National Health Committee (formerly the Core Services Committee) recommended that the provision of a comprehensive and co-ordinated network of mental health services, ranging from inpatient services to primary mental health services, was a top priority for RHAs.

In 1994 the Minister of Health outlined a commitment to the development of a comprehensive mental health strategy (in "Looking Forward: Strategic Directions for the Mental Health Services"). To date, the Committee has given specific recommendations to the Minister on secondary specialist mental health services, including the use of minor tranquillisers, the management of major psychoses and the treatment of people with drug and alcohol problems. This report marks the beginning of what the Committee hopes will be an increased focus on primary mental health services.

The Committee notes with some concern that, to date, mental health policies and service funding have focused on the 3% of the population who experience a serious mental disorder, or on the 1% for whom access is defined under the terms of the Mental Health Act. There has been little policy emphasis on the development of mental health services at the level of primary health services, where the majority of people with mental health problems first present and are treated. Consequently many people with ongoing or unremitting mental health disorders, which are not serious enough for access to specialist secondary services, seem to be getting inadequate access to publicly funded treatment.

The Committee believes that the essential component to strengthening mental health provision is to take a co-ordinated approach to mental health service provision across the range of health services offered. This means that while maintaining and improving the current secondary services, attention also needs to be given to strengthening mental health provision in the primary health sector.

In 1995 we commissioned a working party to develop these guidelines for the treatment and management of depression, as an example of how mental health services might be better provided in the primary health sector. These guidelines are the first stage in the development of a "primary mental health package" which could be extended to include anxiety disorders and substance abuse (the three most commonly presenting mental health conditions to the primary sector, seriously affecting more than 15% of people at any given time).

In outlining good clinical practice the guidelines highlight current shortfalls in, and barriers to, the provision of primary mental health care. Since receiving the draft guidelines in February 1996, the Committee has been working with the Minister, Ministry and RHAs to identify changes in policy and funding which will reduce these barriers and promote improved access to primary health services. Unfortunately, at the time of releasing these guidelines, many of these barriers still exist.

Depression is associated with considerable costs both to the health sector and society as a whole. These costs include sickness benefits, lost earnings, inappropriate medical tests for somatic complaints, and avoidable admissions to hospital due to poor detection and inadequate treatment of depression. The human costs are also considerable. Depression results in lost confidence, and impacts upon families. The implementation of these guidelines will lead to the better treatment, at an earlier stage, for people who have developed depressive illnessess. While adherence to these guidelines will result in an increase in costs to the health sector, the resultant reduction in relapse and improved treatment outcomes will result in significant economic and social benefits to the community as a whole in the medium term.

In our view, strengthening the capacity of the primary mental health sector in treating depression and related disorders will result in a reduction in acute admissions for depression and for readmissions to secondary care. This will improve the equity of access to services for people with mental health problems.

The key to the treatment of depression is that people are offered treatments that have proven efficacy. The literature that the working party has reviewed indicates that treatment is most effective when targeted at people with moderate to severe depressive disorders. For people with a depressive disorder of mild severity, the more appropriate intervention is supportive management, including problem solving, supportive counselling

When planning treatment, it is important that the patient be informed about the known efficacy of both psychological interventions and medication based treatments, the costs, risks and benefits of each, and then allowed to agree on a treatment.

The Committee considers that the choice of the most beneficial treatment will involve a consideration of the cost to the individual and the government. While these guidelines provide information and advice, the final decision will be made by the RHAs, the clinician and the patient.

The treatment services outlined in these guidelines, if implemented, are likely to lead to a significant improvement in the detection and treatment of depressive disorders. While this will be associated with an increase in immediate expenditure, long term savings due to fewer deaths and illness (associated with decreases in inappropriate general medical procedures, in general medical utilisation, in work absenteeism and lost productivity) will at least in part offset these.

In the view of the Committee, better primary care management of mental illness such as depression will have considerable downstream benefits in reduced need for secondary care services. It will also result in a reduction in the inequity of service provision that currently characterises mental health service provision, whereby only the most seriously mentally ill are able to access services.

This document has been prepared at the request of the National Advisory Committee on Health and Disability to assist in the consideration of equitable provision of health care in the treatment of depression. It has been developed through a series of meetings and limited discussion with key individuals (see Appendix 10 for the process used in the development of the guidelines and Appendix 11 for the membership of the working party), and is intended to document current good practice, rather than aspiring to ideal or utopian service delivery.

We have attempted to base recommendations on research evidence and have been considerably influenced by a similar document prepared for the US Department of Health after an exhaustive literature review.

We recommend that any final publication of these guidelines should include information for the person with the depressive disorder and a summary of the key information for health professionals (including the algorithms, assessment tools and indications for the various treatments).

We have identified a number of issues arising from current health policies which the National Health Committee may wish to consider further.

The direct costs of depressive illness to the health care system are considerable. An episode of severe depression treated in the community (with no involvement of inpatient facilities) costs up to $2000 over the first 6 months. The wider economic costs in terms of sickness benefit, lost wages, reduced tax income, etc, are much greater, even before the human costs in terms of loss of confidence, impact on the family and possible impaired parenting, are considered. All the evidence we have considered indicates that depression is significantly under treated in New Zealand. While adherence to these guidelines is likely to increase the short term cost to the health sector, we consider that this will result in significant economic benefits to the community as a whole in the medium term.

The literature that we have reviewed clearly indicates that there is no benefit in prescribing medication or formal psychological therapy for every person with a depressive disorder of mild severity. For this reason we have recommended that once it is established that there is no risk of harm to self or others and any grief, substance abuse or other mental health disorder is addressed, those experiencing a mild depressive disorder should receive supportive management (including education, problem solving, supportive counselling and investigation of life style issues) and be monitored for six weeks. If there is no improvement after six weeks then treatment should be considered. People experiencing a moderate or severe depressive disorder should receive supportive management and based on the duration, severity and presence of any melancholic features, be offered antidepressants and/or psychological therapy. All treatment should be monitored regularly (frequency depending upon the severity of the disorder) and reviewed every six weeks.

The relative cost of medications must be balanced against their relative side effects. The newer antidepressants are generally more tolerable than the older tricyclic antidepressants. Therefore they are more likely to be taken and so more likely to provide effective treatment. There are a number of economic analyses of this issue which tend to this conclusion, although the subcommittee was mindful of the possible publication bias in this literature. The present restrictions on who may prescribe these new medications will need to be reviewed if these guidelines are to be adopted in their present form.

Some overseas protocols suggest that medication should be the first treatment considered. We believe it is more consistent with the principles of consumer choice to offer psychological therapies of proven benefit in the treatment of depression as an alternative first line choice, despite the cost implications of this. It is possible that such therapies may confer some protection against future relapses.

Currently there is considerable inequity in the funding of treatment for depressive disorders. The working party recommends that the National Advisory Committee on Health and Disability consider the following issues:

- The draft guidelines recommend that most cases of depression can be treated within primary healthcare services. However, currently general practitioners receive the same subsidy regardless of the length of the consultation. Mental health consultations typically take twice as long as those for a physical disorder. Consequently, there is a disincentive for general practitioners providing treatment services for people with depression.
- Except in the case of capitation funded general practice, there is currently no targeted funding arrangement akin to General Medical Services

[1] Relapse refers to a subsequent episode of depression within six months of returning to premorbid levels of functioning.

Benefit (GMS) for the services provided by other health professionals working in the primary mental health sector and who make a cost effective contribution to the treatment of depression. New Zealand Income Support Services' Disability Allowance is used in some instances to subsidise "counselling" costs but access to this funding is variable around the country and is limited to a maximum of $40.61 per week. Consequently, it is currently more expensive for the patient and the primary health worker (ie a nurse or counsellor) to monitor and use problem solving techniques as a treatment for mild to moderate depression, than if drugs were prescribed, because patients will have to pay for part or all of each consultation.

- The treatment of depression can currently be very expensive for the consumer depending upon the nature of the depression and where treatment is provided. It is estimated that the cost of treatment for a severe episode of depression in the primary sector can be as much as $2,000. While some people will have access to a community services card and receive a subsidy on visits to the GP and for medication, most will have to pay a significant amount of the cost and some will have to pay the full cost. But if the person has experienced any sexual abuse (an acknowledged risk factor for depression) almost all treatment costs are paid by ACC. Some people may gain access to the income tested Disability Allowance for "counselling" services. If the person also abuses alcohol and drugs and is referred to a substance abuse treatment service (for treatment including any comorbid depressive disorder) then treatment is likely to be free. Significantly, access to publicly funded or subsidised treatment services for depressive disorders is not equitable with other mental health disorders of similar severity. (Note: If the depression is severe a referral may be made to a CHE mental health service where treatment is free to the person, although availability is likely to be limited).

- The guidelines shift the focus from which antidepressants may be prescribed for patients by general practitioners to what are the elements of a comprehensive treatment package required for a particular person (which may include antidepressants). The cost of the new antidepressants is only a minor part of the overall costs of treating depression. Depending on the particular antidepressant used, the cost will vary between 4% and 29% of the total cost of treating a case of severe depression over six months (the cost of antidepressants varies from $61.60 to $651.56 for a six month treatment). Newer drugs are between two and seven times more expensive than the older range of drugs but have less side effects which can mean that patients are more likely to continue taking them. There are also situations where the newer drugs are clearly safer and more effective. The decision about which antidepressant to use should be made after a careful and thorough diagnosis and consideration of all the treatment options (including not using antidepressants). Any review of who may prescribe the newer and more expensive antidepressants should take account of them being only one part of a comprehensive treatment package.

The treatment services outlined in these draft guidelines, if implemented, are likely to lead to a significant improvement in the detection and treatment of depressive disorders. However, this is likely to cost the Government significantly more in the short term, especially if access to treatment services for depression is to be provided on an equitable basis irrespective of causative or associated factors (ie alcohol and drug or prior sexual abuse) and with affordable user part charges.

We would like to thank the National Advisory Committee on Health and Disability for establishing the policy framework within which it has been possible to develop these guidelines for the treatment and management of depressive disorders. We look forward to consumers having improved access to the services which are necessary to restore and maintain the quality of life taken for granted by most New Zealanders.

Peter Ellis

Chairperson

Depression Working Group

27 February 1996

1. Introduction

Intent of the guidelines

These guidelines are for primary healthcare workers[2] in general and general practitioners in particular. They are intended to describe rather than prescribe good clinical practice. Almost all people experiencing a depressive disorder will present to their primary healthcare worker first and most treatments can be provided in the primary care setting.

Depression is a common disorder. On average, a general practitioner can expect to see one person experiencing a depressive disorder during each surgery session. Community based primary mental health workers can expect to see more people suffering depressive disorders than any other mental health disorder (including substance abuse). Depressive disorders, together with substance abuse, are the most likely conditions seen as contributing to, or comorbid with, other mental and physical disorders. However, there is considerable evidence that depressive disorders are often not recognised in people presenting to primary healthcare workers (Goldberg, 1984). When a depressive illness is recognised, it is likely to be treated with antidepressants, even among individuals who have depressive disorders that do not meet the criteria of a Major Depressive Episode, and for whom non medication based interventions are more likely to be successful.

Depression is a multifaceted disorder. There are many different treatment options and combinations of interventions that may be used to target the various symptoms. These guidelines have been based on a detailed analysis of the research on which treatments are most effective and under what conditions. Only those interventions that are supported by published research indicating their efficacy have been included in these guidelines.

The guidelines are based on the premise that the best results will be achieved if the healthcare worker and the depressed person work together. Accordingly, there are consumer information pamphlets which provide a summary of information contained in these guidelines and a summary for clinicians. People suffering from depression have a right to information on their treatment options, including their effectiveness and possible side effects.

There is increasing evidence that depression is a recurrent disorder which once diagnosed, requires monitoring, treatment(s) and interventions which will minimise relapse. These guidelines recommend that a first episode of Major Depressive Disorder should be actively managed for at least nine months and second or subsequent episodes for three years.

The use of similar guidelines for the treatment of depression in primary healthcare services has led to improved treatment outcomes for people with a major depressive disorder (significantly better adherence to treatment and more favourable outcomes) but not for those with a less severe depressive disorder (Katon et al, 1995).

More detailed information can be obtained from other guidelines such as Depression in Primary Care (US Department of Health and Human Services, Agency for Health Care Policy and Research, 1993), the WHO handbook for the management of Affective Disorders (Hunt, Andrews and Sumich, 1995) and a number of other guidelines for the treatment of depressive disorders (Practice Guidelines for Major Depressive Disorder in Adults, APA,Vols 1 and 2, 1993; WPA Dysthymic Disorder Working Group, 1995). An excellent overview of depression and other affective disorders has been published by a group of New Zealand mental health specialists (Joyce et al, 1995).

What is depression?

The term depression is commonly used to describe both a frequent human emotion as well as a disorder or illness. As an emotion it is usually a normal experience, often related to things going wrong in life. However, one in seven people will at some stage of their life develop a depression that will disrupt their ability to engage in normal activities. The resulting Major Depressive Disorder requires professional help but in about half the cases, although people visit a primary healthcare professional, their depression will not be recognised as such. This is because the initial presentation may be a vague sense of distress, a somatic complaint, or an associated physical or mental disorder.

It is important to distinguish between sadness and unhappiness, which are common occurrences, and the specific depressive disorders of a Major Depressive Episode and Dysthymic Disorder. While sadness and grief are important issues in themselves, the therapeutic strategies differ from those relevant to the treatment of a Major Depressive Episode or Dysthymic Disorder. The emphasis in these guidelines is on the more serious

[2] This would include for example: community social workers, school counsellors, Maori and Pacific Islands health workers, etc.

of these disorders - the Major Depressive Episode, which is more commonly known as the illness of depression. However, in recent years the state of a chronic low level of depression, Dysthymic Disorder, has attracted greater attention because of the high likelihood of people with this disorder also developing Major Depressive Disorder (the so-called "double depression").

Not everyone suffering from Major Depressive Disorder will complain of sadness or a depressed (dysphoric) mood, although they often acknowledge not being their usual self. Similarly, people who experience depression for the first time often comment that what they are experiencing is not what they thought depression would be like. It has also been noted that people who have experienced grief and, on a separate occasion, suffered from a severe depressive episode, will describe the two experiences as quite different. They tend to emphasise the sadness of grief but comment on the lack of motivation and pleasure, the physical and mental slowing and the cognitive disturbances of depression.

Major Depressive Episode

For a diagnosis of a Major Depressive Episode at least five of the following symptoms (including either 1 or 2) must be present during a two week period and must represent a change from previous functioning:

1. depressed mood most of the day, nearly every day
2. markedly diminished interest or pleasure in normal activities
3. significant weight loss or gain
4. insomnia or hypersomnia
5. psychomotor agitation or retardation
6. fatigue or loss of energy
7. feelings of worthlessness or excessive guilt
8. diminished ability to think or concentrate, or indecisiveness
9. recurrent thoughts of death or suicidal thoughts/ actions.

(from the DSM-IV)

A Major Depressive Disorder is diagnosed when the person has had a clinical history of one or more Major Depressive Episodes in the absence of manic features, and not caused by the physiological effects of substance abuse or a medical condition.[3]

Dysthymic Disorder

Dysthymic Disorder is a chronic low grade depression that occurs over a period of two years. The person presents as being gloomy, withdrawn, lethargic, without any sense of pleasure in their life and with low self-confidence. In cases with onset in the teens and early twenties it is likely that such symptoms lead to patterns of behaviour, such as social avoidance, which affect the development and personality of the individual. Its symptoms are similar to those of a Major Depressive Episode, but differ in duration and severity.

While the symptoms of Dysthymic Disorder are less severe than those of a Major Depressive Disorder, it is a significant health problem because sufferers are at risk of harming themselves (eg by suicide) (Parker, 1993) and 75% are likely to experience other disorders such as Major Depressive Disorder, an anxiety disorder or substance abuse during their lifetime (Weissman et al, 1988).

Bipolar Disorders

Bipolar disorders are cyclic disorders characterised by episodes of mania and depression. Bipolar I disorder is characterised by one or more Manic or Mixed Episodes[4] and usually one or more Major Depressive Episodes. Bipolar II disorder is characterised by one or more Major Depressive Episodes and at least one Hypomanic Episode[5]. The frequency of the "cycles" can vary from two or three episodes in a lifetime to three or more a year. The greater the frequency of the episodes the more severe the disorder is likely to be and the poorer the prognosis.

Criteria for a Manic Episode (as described in the DSM-IV) are:

- A distinct period of abnormal and persistently elevated, expansive or irritable mood lasting at least one week (or any duration if hospitalisation is necessary)
- During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
  - inflated self-esteem or grandiosity
  - decreased need for sleep (eg feels rested after only 3 hours of sleep)
  - more talkative than usual or pressure to keep talking

[3] These terms are taken from the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) published by the American Psychiatric Association. Reference can also be made to the International Classification of Disease (ICD 10 or ICD 9CM), which have slightly different terminology, but essentially the same classification of Major Depressive Disorder.

[4] Characterised by the criteria of both Manic Episode and Major Depressive Episode being met for a period of at least one week.

[5] A distinct period of persistently elevated, expansive, or irritable mood lasting throughout at least 4 days, that is clearly differentiated from the usual nondepressed mood.

- flight of ideas or subjective experience that thoughts are racing
- distractibility (ie attention too easily drawn to unimportant or irrelevant external stimuli)
- increase in goal directed activity or psychomotor agitation
- excessive involvement in pleasurable activities that have a high potential for painful consequences (eg unrestrained buying spree, sexual indiscretions, or foolish business investments).

The above symptoms should:

- not meet criteria for a Mixed Episode
- be sufficiently severe to cause marked impairment in occupational and social functioning or necessitate hospitalisation to prevent harm to self or others, or occur in conjunction with psychotic features
- not be due to the direct physiological effects of a substance or a general medical condition.

If there is any indication of the presence of a bipolar disorder the person should generally be referred for specialist assessment and treatment.

Adjustment Disorder with Depressed Mood

The essential features of Adjustment Disorder with depressive mood are the development of significant depressed mood, tearfulness and feelings of hopelessness within three months of an identifiable stressor or stressors. A diagnosis is made when the person's distress exceeds the level expected, given the nature of the stressor, and/or when social or occupational functioning is impaired, but the criteria for a Major Depressive Episode or Dysthymic Disorder are not met. This diagnosis will not generally include prolonged mourning or bereavement where the reaction is an expected response to the death of a loved one, or Post Traumatic Stress Disorder. The value of this diagnosis is that it allows practitioners to identify distressed people, who may need follow up to check whether symptoms remit or develop into a Major Depressive Disorder or Dysthymic Disorder. The initial treatment should follow that recommended for a mild Major Depressive Disorder with emphasis on monitoring, problem solving and supportive counselling.

The other subgroups of Major Depressive Disorder are shown in Table 1.

How common is depression?

About one in every seven people and one in every five women in New Zealand will develop a depressive disorder at some stage during their lifetime. One person in eight will have a Major Depressive Episode (Wells et al, 1989).

Depression, anxiety disorders and substance abuse are the most common mental health disorders and frequently these may co-exist (Oakley-Browne et al, 1989; Joyce et al, 1990). In any two week period, one in twelve people (8.5%) will have a Depressive Disorder: 6.4% will have Dysthymic Disorder and 3.7% will have a Major Depressive Episode (Oakley-Browne et al, 1989). While substance abuse is less common than depressive disorders (two week prevalence of 6.9%), men are more likely to experience (and recover from) a substance abuse disorder at some stage of their life (lifetime prevalence of 33.6% for males, 8.7% for females and 21% overall). Women are more likely to experience a depressive disorder than men: lifetime prevalence of 19.4% for females, 10% for males and 14.7% overall (Wells et al, 1989).

There is now widespread recognition that disorders resembling adult depression can and do occur in childhood. Prospective studies of a cohort of New Zealand children have found increasing prevalence of depressive disorders with age in the teenage years, with about equal prevalence among boys and girls until 15 years, after which there is a greater prevalence in females (McGee et al, 1992).

In New Zealand the prevalence of depression increases from 0.5% for a Major Depressive Episode and 0.9% for Dysthymic Disorder at age 11 to 3.4% for Major Depressive Episode and 3.2% for Dysthymic Disorder at age 18 (McGee et al 1992; Feehan et al 1993).

Depressive illnesses have always been common amongst the elderly and may reflect their increased exposure to chronic illnesses and losses.

Aetiology and risk factors

The concept of depressive disorders can be traced back to the earliest periods of recorded history. Hippocrates wrote of melancholia and the literal translation of Dysthymic Disorder is "ill humoured". However, it was not until 1972 that the term "Major Depressive Disorder" was first introduced as a category in the Feighner Diagnostic Criteria. This concept was included in the DSM-III which brought together all the affective

Table 1. Essential features of other subgroups of Major Depressive Disorder are:

Subgroup	Essential features	Diagnostic implications
Psychotic Depression	Hallucinations, Delusions.	More likely to become bipolar than non-psychotic types especially for people under 25 years. May be misdiagnosed as Schizophrenia.
Melancholic Depression	Includes **either** loss of pleasure in all or almost all activities **or** lack of reactivity to usually pleasurable events **and** mood is distinctly different, regularly worse in the morning, with early morning awakening, marked psychomotor retardation or agitation, significant weight changes and excessive or inappropriate guilt.	May be misdiagnosed as Dementia when cognitive impairment and psychomotor retardation are prominent. More likely in older patients.
Atypical Depression	Overeating, oversleeping, weight gain, a mood that still responds to events, extreme sensitivity to interpersonal rejection, feeling of heaviness in arms and legs, anxiety symptoms (including difficulty in falling asleep, phobic symptoms, symptoms of sympathetic arousal).	Common in younger patients. May be misdiagnosed as a Personality Disorder.
Postpartum Depression	Anxiety, spontaneous crying, lack of interest in the new infant, insomnia and lack of concentration are common symptoms. Mood may fluctuate. Incidence is 10-15:100 births.	30-50% chance of recurring in next Postpartum period.
Postpartum Psychosis	Acute onset (<14 days) in the period after the birth. Severe, labile (unstable) mood symptoms. Psychotic features present. Both Postpartum Depression and Psychosis may be characterised by obsessional thoughts and suicidal ideation. Incidence is 1-2:1000 live births.	30-50% chance of recurring in next Postpartum period.
Seasonal Affective Disorder	Typically, onset in autumn and remits in spring. Summer episodes may also occur.	Recurrent.

conditions into a classification based on symptoms rather than underlying personality.

Kendler et al (1993) have retrospectively calculated the risks contributing to a particular episode of Major Depressive Disorder in a large group of female twins and found that there is a complex interaction of the following factors:

- Stressful life events and difficulties in the last three months, eg financial difficulties
- History of traumatic events, including abuse (physical, sexual and emotional), divorce and social isolation
- Exposure to dysfunctional parenting
- Premature parental loss
- Previous history of depression
- Genetic factors
- Neuroticism[6]
- Poor social support.

Brown and Moran (1994) and Brown et al (1994) found that childhood adversity (including parental indifference, family violence and sexual abuse) and current interpersonal difficulties were predictors of a chronic course of depression among working class mothers living in inner London and clients treated for depression at two London hospitals. Substance abuse has also been observed as a factor in predicting the chronicity of some depressive disorders, especially amongst men.

The Otago Women's Health Survey found the following factors to be associated with the onset of psychiatric illness (anxiety and depression): being separated/ divorced, coming from a large family, having poor social networks, living alone, having few social responsibilities, financial difficulties and poor physical health. When assessed at the 30 month follow up, they discovered that middle aged women (45-64) were less likely to have recovered than either their younger or older counterparts. They considered that a factor contributing to this is the social role adjustment that women have to make once their child rearing responsibilities have ended (Romans et al, 1993, 1993a).

Similar risk factors are likely to be operative in the aetiology of Dysthymic Disorder.

The diathesis-stress model suggests that mental illness is a product of the interaction between a predisposition towards an illness/disorder and stressful events (Davison and Neale, 1990). A person may be predisposed genetically and psychologically (ie hold negative beliefs and attitudes about themselves and the world) towards developing a Major Depressive Disorder. If sufficient stressors occur (the relative impact of these being determined by the person's coping skills), the disorder develops. These stressors may include physiological stressors (eg experiencing a closed head injury) and psychological stressors (eg experiencing a traumatic event).

There are also protective factors that will decrease the likelihood of developing a depressive episode:

- Perceived parental warmth
- Social support
- Coping skills and personality style.

The clinical course of Major Depressive Episodes and Dysthymic Disorder

Major Depressive Episode

A Major Depressive Episode may begin at any age. Prodromal symptoms, including generalised anxiety, panic attacks, phobias, or depressive symptoms that do not meet diagnostic thresholds, may occur over the preceding months. However, depression may also develop suddenly (such as when associated with severe psychosocial stress).

It is estimated that over 50% of people who have one episode of depression will eventually have another episode. People with Major Depressive Disorder superimposed on Dysthymic Disorder are at greatest risk of having a recurrence[7]. The pattern of recurrence is variable: some will have episodes separated by years, others have clusters of episodes and still others have increasingly frequent episodes as they grow older. There is evidence of seasonal variation in some cases, particularly when onset is related to the winter months and shorter days.

People usually recover fully between episodes, but in 20-30% of cases there is only partial remission persistent residual symptoms and social and occupational impairment.

If untreated, depression is associated with an increased risk of suicide and other violent acts. It has also been

[6] As defined by the Eysenck Personality Inventory.

[7] Recurrence refers to an episode of depression at least 6 months after a full recovery from the previous episode.

[8] Remission refers to the person's functioning having returned to the premorbid level.

estimated that up to 10-15% of those ever admitted to hospital with a severe Major Depressive Disorder will commit suicide - a rate approximately 30 times higher than for the general population (Black et al, 1988; Hyman and Arana, 1990; Jamison, 1986). Suicide attempts have been reported in 25-50% of those with a Major Depressive Disorder (Jamison, 1986). Untreated or prolonged depression can result in occupational and social dysfunction, especially within the family and at work.

Any Major Depressive Disorder should be treated energetically and the response monitored carefully to reduce the risk of suicide and suicide attempts.

Dysthymic Disorder

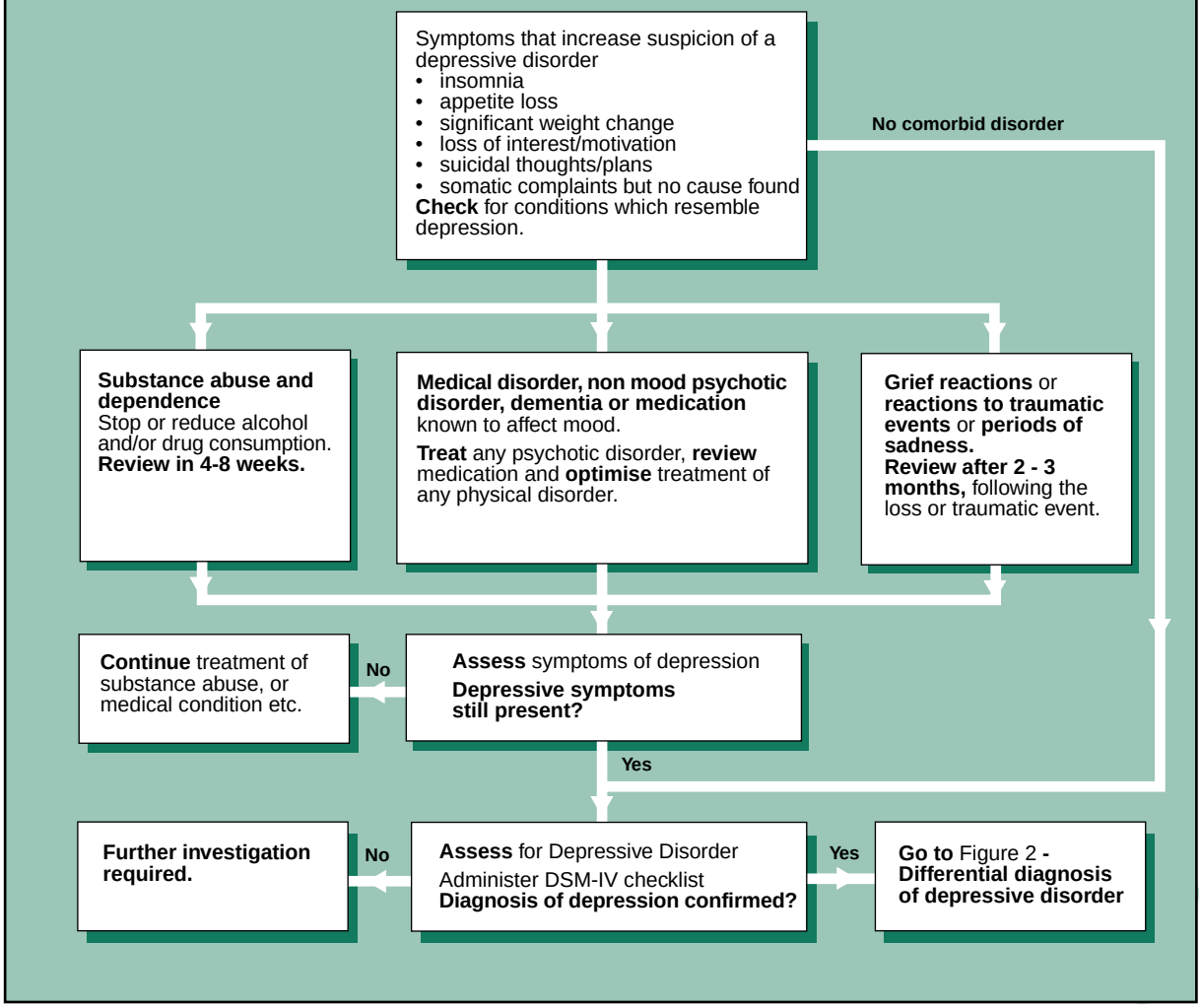
Dysthymic Disorder occurs twice as often amongst women as men, but is equally common among boys and girls. The rate of Dysthymic Disorder increases with age, reaching about one in ten people in the 45 - 64 age group (Oakley-Browne et al, 1989). The required period for diagnosis for children and adolescents is one year (as opposed to two for adults). A period of Dysthymic Disorder is also an additional risk factor for early relapse of Major Depressive Disorder.

Research consistently reports that one in thirteen (6-8%) of all people presenting to primary care have a Major Depressive Disorder.

Many studies have commented that depressive disorders are poorly recognised and under-treated. The Christchurch Psychiatric Epidemiology Study found that the six month prevalence of depression and Dysthymic Disorder was 11.7%. However, although 85% of this group reported visiting a health agency during the previous six months, only 40% reported discussing mental health issues (Bushnell, 1994). Consequently, healthcare workers need to maintain a high index of suspicion and not rely on the person to raise the possibility they are suffering from a mental health problem.

Primary healthcare professionals should be aware of particular demographic factors that may influence an individual's risk of developing Major Depressive Disorder or influence response to treatment (eg gender, age, culture, sexual orientation). Sections on these special issues (pg 32 - 39) should be read in conjunction with the main text.

Figure 1. Stages in DETECTING a depressive disorder



Maintain a high index of suspicion and evaluate risk factors

The single most important factor in detecting Major Depressive Disorder is to maintain a high index of suspicion. Women (especially Postpartum) and people under the age of 40 have a higher likelihood of the disorder. Although sadness is frequently a presenting sign of Major Depressive Disorder, not all people complain of sadness, and many who are sad do not have Major Depressive Disorder.

Patients rarely present complaining of Major Depressive Disorder. Their symptoms are often vague, with a larger physical than affective component. In reviewing these symptoms, the physician should not rule out the possibility of there being an underlying, or coexisting psychiatric complaint. This index of suspicion should be maintained regardless of the patient's age, eg teenagers are not always morose, nor elderly people sad. A systematic review of the following factors is suggested as a first step.

Look for the following symptoms suggestive of Major Depressive Disorder:

- Insomnia or hypersomnia - particularly changes in sleeping pattern
- Appetite loss, including changes in eating patterns
- Significant weight loss or gain
- Loss of interest and motivation
- Suicidal thoughts and plans
- Noticeable changes in behaviour eg irritability, withdrawn attitude etc
- Fluctuations in mood
- Unexplained somatic complaints
- Symptoms of fatigue and malaise
- Feelings of hopelessness eg "nothing ever changes"
- Pain - including headaches, abdominal pain and other body pain - especially if, after examination, there is no apparent physiological cause
- Sexual complaints - problems with sexual functioning and desire
- A mood of apathy, irritability, or anxiety alone, or in addition to, overt sadness.

Review additional risk factors:

- Prior history of Major Depressive Disorder
- A family history of Major Depressive Disorder or Bipolar Disorder
- A personal or family history of suicide attempts
- Chronic or severe physical illness
- Concurrent substance abuse
- Recent stressful life events and lack of social supports (stress should not be used to "explain away" Major Depressive Disorder; stress may precipitate Major Depressive Disorder in some cases)
- Childhood trauma including: childhood abuse (physical, sexual and emotional), parental conflict and deficient parental care
- Recent childbirth (within 4 months) or other family changes eg, divorce, children leaving home etc
- Responsibilities for caring for others, eg for elderly relatives.

[adapted from Major Depressive Disorder in Primary Care, Vol. 1, Section 6, US Department of Health and Human Services,1993]

Consider the differential diagnosis

A check should be made of other conditions which can resemble a depressive disorder (as outlined in Figure 1. See also Appendix 1 for the full DSM-IV criteria for the diagnosis of Major Depressive Episode and Dysthymic Disorder).

Substance abuse

There has recently been increased recognition of the relationship between alcohol and drug abuse or dependency and other mental health disorders, such as Major Depressive Disorder. A major survey of the incidence of mental illness in the United States (the United States National Institute of Mental Health Epidemiological Catchment Area study, Helzer and Pryzbeck, 1988) found that Major Depressive Disorder is almost twice as likely to occur amongst those with an alcohol use disorder compared to the total population. Among those people who had Major

Depressive Disorder and another mental health problem, 10% were alcohol dependent. For those with Dysthymic Disorder and another mental health disorder, 30% were alcohol dependent (reported in the US Guidelines: Depression in Primary Care, Vol 1, 1993).

Depressive symptoms may be due to the acute effects of an alcohol use disorder. Davidson (1995) reports that while 67% of those referred to a clinic for alcohol problems reached criteria for a Major Depressive Disorder prior to detoxification, only 13% met criteria following this. Other studies suggest most depressive symptoms experienced by people admitted to an alcohol treatment programme do not last beyond two to four weeks.

The idea that people with Major Depressive Disorder self medicate and therefore become alcohol dependent seems to be untrue for men but is a possibility for women. Women are also more likely than men to develop Major Depressive Disorder as a consequence of their prolonged heavy drinking.

Other psychiatric disorders

There are a number of other psychiatric disorders which may affect the likelihood and course of a depressive episode or Dysthymic Disorder. In each case the differential diagnosis should be considered, treatment for the primary disorder initiated and the secondary disorder reviewed regularly. If there is not a clear principal diagnosis or the person fails to respond to treatment, referral for specialist assessment should be considered.

Psychiatric disorders that commonly occur together with depressive disorders are:

- Anxiety Disorders, including: Panic Disorder, Obsessive-Compulsive Disorder, Post Traumatic Stress Disorder and other Anxiety Disorders
- Eating Disorders, including: Anorexia Nervosa and Bulimia Nervosa
- Personality Disorders
- Adjustment Disorders
- Conduct Disorder - in children and adolescents
- Impulse Control Disorders eg pathological gambling.

If an anxiety or personality disorder coexists with a depressive disorder, the Major Depressive Disorder should be treated first followed by treatment for the other disorder.

Anxiety Disorders: About 30% of people with a Major Depressive Disorder will also experience a Generalised Anxiety Disorder and 10-20% will experience panic attacks concurrent with their Major Depressive Disorder. Depressive episodes are also relatively common amongst people with anxiety disorders (up to 30%) - often with melancholic features. It is often difficult to determine which is the primary disorder or indeed whether the symptoms are part of a single disorder. The primary disorder should be identified on the basis of the symptoms that began first in the current episode, the most incapacitating symptoms, and family history. Treatment for the primary disorder should be initiated and the response monitored closely (bi-weekly as for a severe depressive disorder). There should be a careful assessment of the risk of suicide as there is evidence that this is twice as high in cases where panic attacks and Major Depressive Disorder occur together, compared to Major Depressive Disorder alone.

***Obsessive-Compulsive Disorders*:** Depressive symptoms are common in people suffering from Obsessive-Compulsive Disorders (OCD). A distinction needs to be made between cases of severe depressive disorder with obsessive features, and a Major Depressive Episode which develops after the onset of Obsessive-Compulsive Disorder. In general, if the OCD is the primary disorder it should be treated first.

Major Depressive Disorder is also prevalent in people presenting with the disorder of pathological gambling. Treatment for the primary gambling disorder should occur in conjunction with any treatment for Major Depressive Disorder.

Eating Disorders: About one third to one half of those with an eating disorder also suffer from a concurrent depressive disorder. It is recommended that any young woman presenting with a depressive disorder should be asked about symptoms of Anorexia Nervosa and Bulimia Nervosa. If an eating disorder is present this should treated first.

***Personality Disorders*:**[9] Major Depressive Disorder is relatively common among people with Personality Disorders. This tends to lead to more frequent and longer depressive episodes, as well as poorer inter-episode recovery[10]. However, sometimes features initially considered to be maladaptive personality traits will disappear with effective treatment of Major Depressive Disorder.

[9] The DSM-IV defines personality disorder as "an enduring pattern of inner experience and behaviour that deviates markedly from t of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, distress or impairment" (1994, page 629).

[10] Recovery refers to return to the premorbid level of functioning for at least 6 months.

***Adjustment Disorders*:** Adjustment Disorders include the development of clinically significant emotional or behavioural responses to identifiable psychosocial stressors, but do not include a grief reaction or a period of sadness following a loss. In earlier classification systems, depressed mood in response to an identifiable stress would have been called a reactive or neurotic Major Depressive Disorder. While there are no controlled trials of treatment of an Adjustment Disorder with depressed mood, treatment with psychological therapies or antidepressants, as for a mild to moderate Major Depressive Disorder, is recommended.

***Somatisation*:** In primary care settings many depressed people present with medically unexplained symptoms rather than low mood. This varies between cultural groups and may be more common among children and the elderly. If there are more than two unexplained pain complaints, a formal assessment for mood disorders is recommended. The presentation of somatic (physical) symptoms as part of a depressive illness needs to be distinguished from Somatisation Disorder, where a person repeatedly presents with a wide range of different somatic symptoms without any clear disturbance of mood.

Dementia in older people

In older people, care needs to be taken to differentiate a depressive disorder from grief, demoralisation and the apathy which often accompanies dementia. It is also important to rule out secondary Major Depressive Disorder resulting from under-treated illnesses or side effects of medications.

If there is a suggestion of cognitive impairment the relationship between Major Depressive Disorder and Dementia needs to be borne in mind:

- Older people frequently present saying their memory is failing, and with symptoms consistent with developing dementia. In some cases they will be correct. However, if they seem to have reasonable memory functioning, the problem is likely to be Major Depressive Disorder. In those cases where the memory function does not significantly improve with treatment it is likely that the Major Depressive Disorder was the mode of presentation of a dementia.
- Many older people with Major Depressive Disorder have an associated mild cognitive impairment (eg inability to complete familar tasks, memory loss, confusion). This will clear, often completely, with treatment of the Major Depressive Disorder. However, amongst those successfully treated for Major Depressive Disorder a higher percentage than would be expected will later develop a dementing illness.
- Occasionally a person with severe Major Depressive Disorder will present as totally disorganised and appear to have a dementing illness. After treatment for Major Depressive Disorder their “dementia” resolves. This is usually called “depressive pseudo-dementia”. In practice this happens extremely rarely.
- People with early dementia often become apathetic and lose interest in their surroundings and previous activities. This apathy is often mistaken for Major Depressive Disorder.
- It is common for people suffering dementia to develop Major Depressive Disorder. While people with a dementia are more susceptible to the side effects of antidepressants, the Major Depressive Disorder can usually be effectively treated.

General medical conditions and medications

Clinically significant depressive symptoms are detectable in approximately 12-36% of patients with another non-psychiatric general medical disorder. At times the medical condition seems to directly cause the depressive disorder (eg hypothyroidism), at other times the mood may be related to medication for the condition (eg propranolol) and at times the psychological impact of the illness may cause Major Depressive Disorder (eg cancer). However, the concurrent presence of a medical condition does not make the diagnosis or treatment of the depressive symptoms less important.

Appendix 2 lists medical conditions that are commonly associated with symptoms of Major Depressive Disorder. Where the Major Depressive Disorder is a consequence of the impact of the medical disorder, then the Major Depressive Disorder and the medical disorder should be treated concurrently.

Although some medications can cause Major Depressive Disorder, this is fairly uncommon. When this possibility is being considered, it is important to

clarify the relationship between the onset of the Major Depressive Disorder and the commencement or change in dosage of the suspected medication. The most common medications causing alteration in mood are:

- centrally acting anti-hypertensive agents (eg ∂-methyl dopa)
- lipid soluble ß-blockers (eg propranolol)
- benzodiazepines or other central nervous system depressants
- some anti-inflammatory drugs (especially prednisone).

If a specific medication is considered to have caused the depression, it should be, where possible, discontinued and another drug substituted. When there are no satisfactory alternatives, the drug dose should be reduced to the minimum clinically effective level.

However, when it is suspected that the depressive symptoms are the result of a medical condition, treatment should be initiated for the medical disorder. Once this medical disorder has stabilised, treatment of any remaining symptoms of Major Depressive Disorder should be considered.

Grief reaction or periods of sadness

Depressive symptoms are common during periods of grief. Normally a grief reaction begins within two to three weeks of the death of a loved one and will resolve without treatment, although for severe distress supportive counselling and practical support for daily activities might be indicated.

If persistent pervasive symptoms continue beyond a period of two months after the bereavement or loss then assessment for a Major Depressive Episode is indicated.

Diagnosis of depressive disorders

Deciding whether there is a depressive disorder

If after an initial assessment a person has been identified as probably having a Major Depressive Disorder, the primary healthcare worker should proceed to take a personal history and to assess the signs and symptoms of Major Depressive Disorder outlined in the DSM-IV criteria (Table 2 provides a check-list of these symptoms and the full criteria are in Appendix 1). A check should be made for the presence of symptoms, their pervasiveness (present throughout the day or for only a few hours) and their duration (specifically, for more than two weeks or more than two years).

The key subtypes of depressive disorders are:

- Major Depressive Episode
- Dysthymic Disorder
- Bipolar Disorder
- Adjustment Disorder with depressive mood.

In addition to the diagnosis it is important to establish whether the disorder is current, in partial remission or in full remission.

Additional factors to be considered for older people

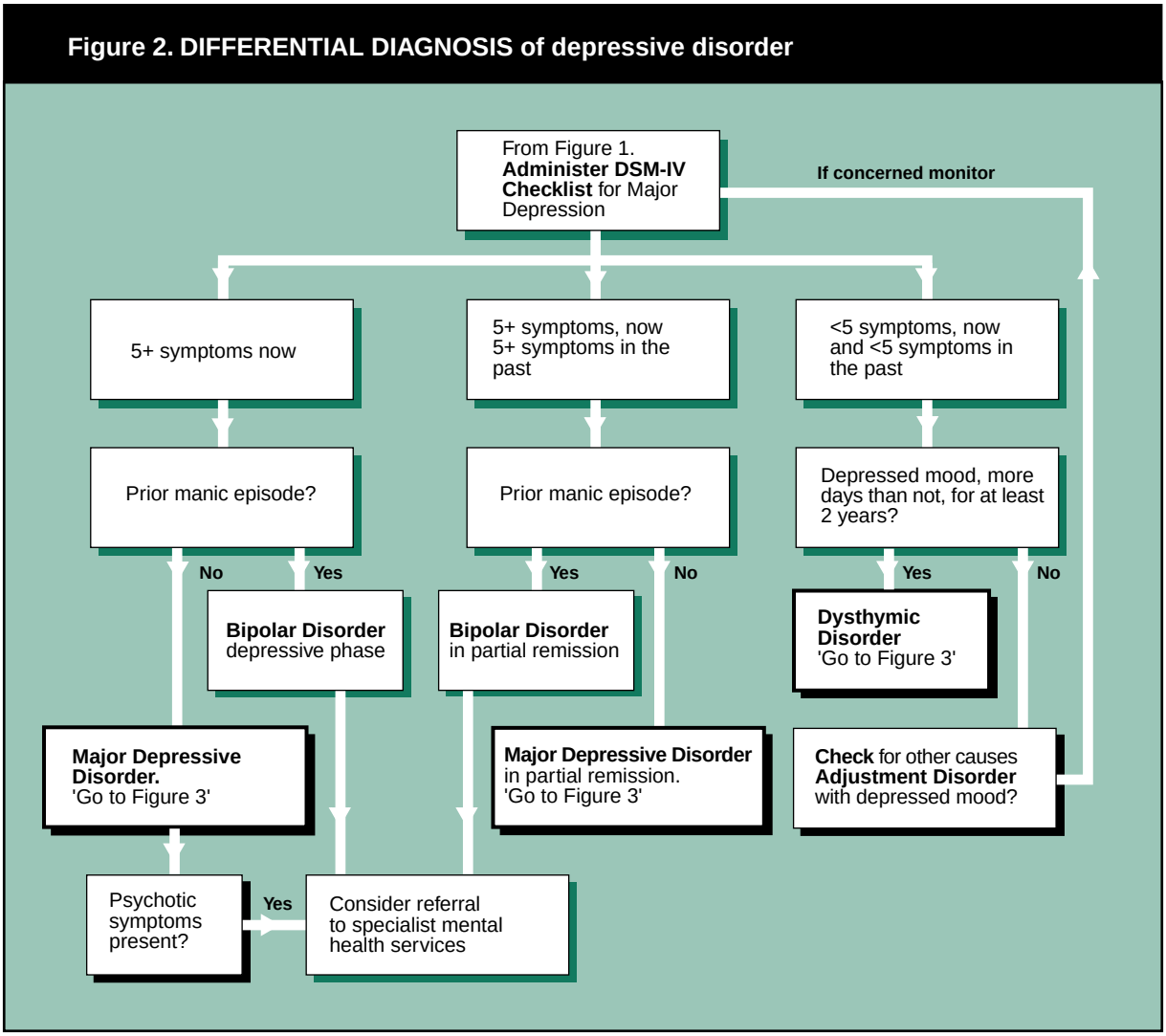
Healthcare workers should have the same high index of suspicion of Major Depressive Disorder in the older individual as for younger people and be unwilling to accept that unhappiness is an inevitable consequence of aging. Many elderly people with Major Depressive Disorder have a past history of depressive episodes. For others, the first episode of Major Depressive Disorder develops in older age and is often associated with serious physical illness, chronic stressors and cerebral impairment (dementia).

The basic principles of diagnosis are the same as for a younger person but the following points should be noted:

- General medical conditions and their treatments can often mimic at least some of the symptoms of Major Depressive Disorder (eg tiredness, anorexia and insomnia)
- Demoralisation and hopelessness are associated with chronic illnesses
- Older people are likely to accept their “unhappiness” and direct inquiry about their mood may lead only to such replies as “No, I have nothing to be depressed about”.

Excessive guilt, loss of ability to feel pleasure, uncharacteristic low self-esteem, a feeling of hopelessness and loss of their “fighting spirit” are particular indications of Major Depressive Disorder in the elderly.

Figure 2. DIFFERENTIAL DIAGNOSIS of depressive disorder



Additional issues for interviewing children and adolescents

Depressed children and adolescents often present with symptoms that differ from those traditionally described. For example, behavioural disturbances and decline in academic performance are common manifestations of Major Depressive Disorder in children and adolescents. It is important when assessing an adolescent that the GP does not assume that being morose is a part of normal “adolescent turmoil”.

Although interviewing children and adolescents about their feelings can be difficult, the young person is likely to provide the best information about the extent and severity of their Major Depressive Disorder. Children are twice as likely to report symptoms associated with quality of mood, and are rather more likely to report suicide attempts than their parents (Barrett et al, 1991). However, prepubertal children are likely to have difficulty describing the duration of their symptoms, and adolescents are likely to be reluctant to let others know

about their inner feelings. Children and adolescents are also more likely to under-report appetite reduction and suicidal ideation if asked in front of their parents.

Children and adolescents are best able to report internalising symptoms[11], whereas externalising symptoms[12] are best reported by teachers and parents. Therefore it is important to seek additional information from others, such as parents, teachers and other adults. A good assessment should incorporate both individual interviews and family assessments.

It is suggested that, especially for older children and for more subjective symptoms, emphasis should be given to the report of the young person separate from that of their parent(s). Moretti et al (1985) have also found that parents of children with behavioural disturbances tend to overestimate their Major Depressive Disorder. Care should also be taken to distinguish the effects of any Major Depressive Disorder experienced by the parent.

Parents rarely report Major Depressive Disorder in their child when it is not present according to the children themselves. Clinicians should take the parents' report seriously and most likely as an under-estimate of the actual severity of the Major Depressive Disorder.

All prepubertal children recognised as suffering from Major Depressive Disorder should be referred to a specialist child and family service.

Table 2. DSM-IV Check-list for Major Depressive Episode and Dysthymic Disorder

Major Depressive Episode Symptoms present most of day, daily for last 2 weeks		Dysthymic Disorder Symptoms present most of the day, most days, for at least two years[13]	
A. Depressed mood as indicated by subjective feeling (eg feels sad or empty) or observation (eg appears tearful). Also irritable mood in children and adolescents		A. Depressed mood as indicated by subjective feeling (eg feels sad or empty) or observation (eg appears tearful). Also irritable mood in children and adolescents	
Insomnia/hypersomnia		Insomnia/hypersomnia	
Fatigue (loss of or low energy)		Fatigue (loss of or low energy)	
Poor concentration and difficulty in making decisions		Poor concentration and difficulty in making decisions	
B. Markedly diminished interest or pleasure in almost all activities (subjective or observation by others)		Does not apply to Dysthymic Disorder	
Significant weight loss/gain (change of more than 5% in a month)			
Psychomotor agitation/retardation (observable to others, not merely subjective)			
Feelings of worthlessness or excessive or inappropriate guilt (not merely self-reproach or guilt about being sick)			
Recurrent thoughts of death (not just fear of death), recurrent suicidal ideation, a plan or attempt			
Does not apply to Major Depressive Episode		Poor appetite or overeating and weight loss/ gain	
		Low self-esteem	
		Feelings of hopelessness	
Number of symptoms checked If A or B checked and five or more symptoms, the criteria for a Major Depressive Episode are probably satisfied (See Appendix 1 for more details)		Number of symptoms checked If A is checked and two or more other symptoms, Dysthymic Disorder is likely (See Appendix 1 for more details)	

[11] These are the symptoms that are experienced "within" the person, eg feelings of sadness, thoughts of hopelessness etc.

[12] These are symptoms of depression that are reflected behaviourally and are observable, eg a child doing unexpectedly poorly in s crying etc

[13] For children or adolescents check if present for 1 year.

Table 5. Symptoms of major depessive disorder experienced by children

Symptoms	% of children reporting symptoms	% of parents reporting symptoms in their child
Guilt	69	29
Feelings of emptiness	65	23
Self dislike	60	20
Sense of failure	56	25
Self denigration	49	20
Quality of mood	49	22
Fears and phobias	47	22
Suicidal attempts	33	0

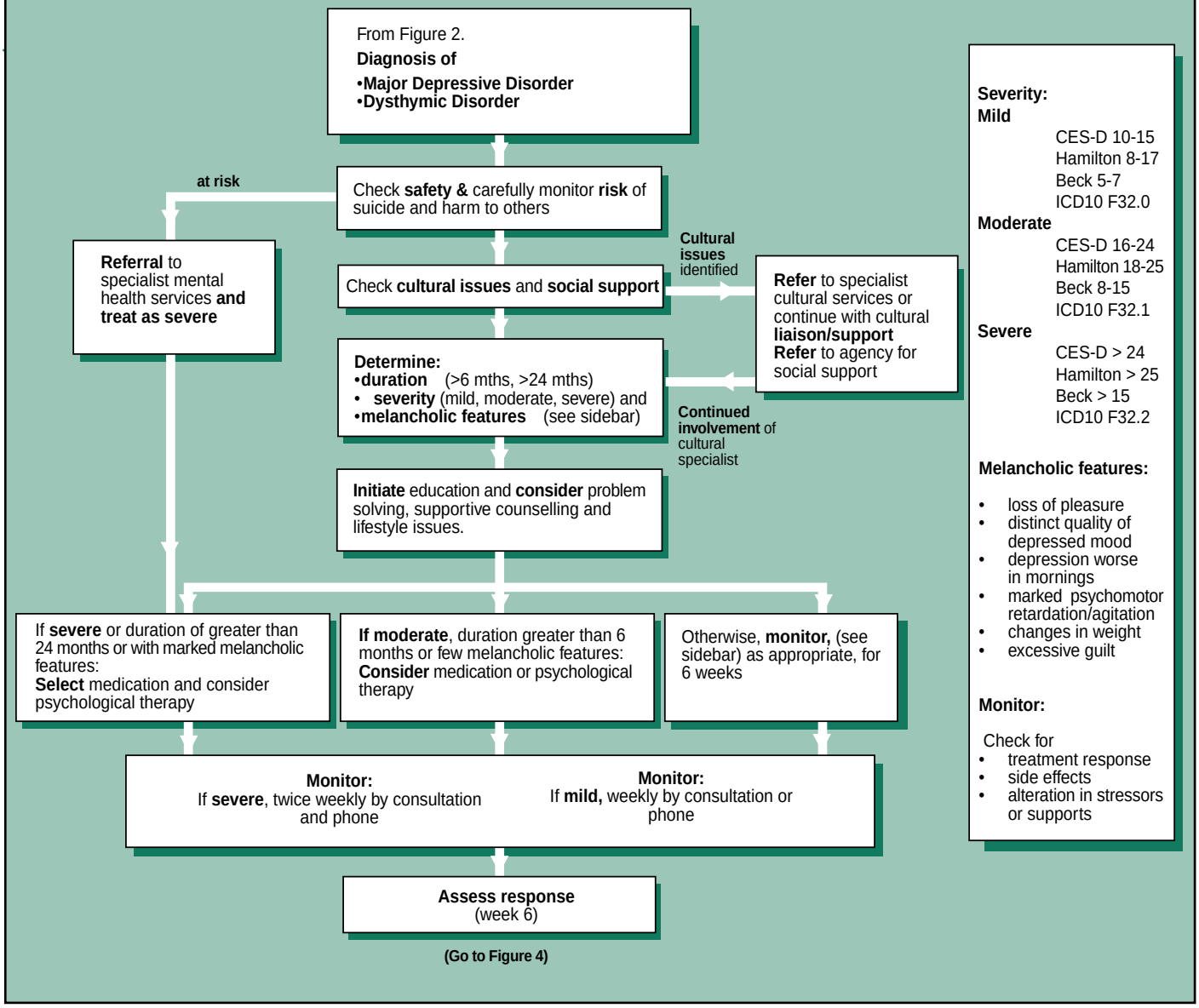
Table adapted from Barret et al, 1991.

3. Assessment

The key steps in the treatment of a depressive disorder are:

- the assessment of risk of harm to self and others (especially any dependent children)
- development of a therapeutic relationship
- due attention to social networks and supports
- due attention to cultural aspects
- the assessment of the severity of the disorder
- the assessment of melancholic features
- due attention to aspects of special populations eg gender, age, sexual orientation
- duration of symptoms
- development of a full biopsychosocial formulation of the depressive illness in the context of the individual as a whole
- development of a treatment plan in consultation with the depressed person.

Figure 3. Outline of key factors in the ASSESSMENT and TREATMENT of Major Depressive Disorder



Options may include:

- monitoring the level of mood and providing information and support
- assisting the person to identify and change elements of their life style which are contributing to the Major Depressive Disorder or which may reduce the severity of the Major Depressive Disorder
- selection of a medication to treat the Major Depressive Disorder
- choosing a psychological therapy approach and therapist to change their self-concept, improve relationships and increase their ability to cope with, avoid, or change factors which cause or aggravate the disorder.

If the person has a severe Major Depressive Disorder or is at high risk of suicide or causing harm to others, consideration should be given to whether this requires a referral to specialist mental health services. In less urgent situations, consultation with specialist or secondary mental health services, to discuss treatment plans, may be helpful.

Assessing the nature and severity of the depressive disorder

Assessing the risk of suicide and likelihood of harm to others

Suicide attempts are relatively common amongst people suffering from Major Depressive Disorders and are even higher for those with Delusional Major Depressive Disorder. During their lifetime 25-50% of those who experience Major Depressive Disorder will attempt suicide and up to 15% of those hospitalised for depression will die by suicide. The risk for suicide amongst inpatients with Delusional Major Depressive Disorder has been reported to be 5.3 times higher than non-Delusional Major Depressive Disorder (Black et al, 1988). The suicide rate is lower for patients in a manic phase of a Bipolar Disorder but in the depressed phase the risk is similar to that of unipolar Major Depressive Disorder.

The issue of safety of others must also be considered, especially if the depressed person has psychotic beliefs. The current or past perpetrators of abuse against the person (physical, sexual or emotional) may also be at risk of harm.

Safety is a particular concern in Postpartum Depression. A woman's feelings towards her baby should always be explored.

Patients may not communicate their thoughts about suicide directly to their doctor, even if specifically asked (Fawcett et al, 1990). However, they are likely to make indirect references to this especially to relatives. In one report 68-86% made such references (Jamison, 1986). Where the possibility of suicide is a particular concern, it is important to speak with relatives. While it is desirable to obtain the permission of the person, if there is a serious and imminent threat to the life or health of the individual this is not essential (refer to Rule 11(2d) Health Information Privacy Code 1994).

Specific factors that have been associated with an increased risk of suicide are:

- current severity of the Major Depressive Disorder
- a history of prior attempts
- current alcohol abuse/ dependency
- social isolation (living alone, being unmarried, unemployed, lack of family support)
- loss by separation (but not loss by death)
- the presence of physical illness, especially in the elderly
- being an older male.

(Hyman and Arana, 1990; Duggan et al 1991).

Unfortunately, no combination of these risk factors provides adequate sensitivity or specificity for predicting suicide. Therefore a clinical decision needs to be made on an individual basis following a thorough assessment.

A person who is considering suicide may have ambivalent feelings about actually dying. They often have a core commitment to life that can be utilised in forming a therapeutic alliance. However, their degree of suicidality, and therefore actual wish to die may fluctuate, and consequently needs to be closely monitored. It is usually most appropriate to inquire about current suicidal ideas in a series of questions, rather than abruptly and directly asking about suicide. It is normal for people with a depressive disorder to have thoughts about suicide. Inquiring about thoughts of

suicide has been shown not to precipitate a suicide attempt. Suggested questions are:

- Do you see any future for yourself?
- Do you think a lot about death?
- Have you thought you would be better off dead?
- Have you ever thought about suicide?
- Have you ever tried to kill yourself before?
- How did you do it?
- What are your plans as to how you would kill yourself? *and*
- Do you think you will carry them out?
- Have you thought about the effect your death would have upon your family or friends?
- What has stopped you from acting on your thoughts so far?
- What are your thoughts about staying alive?
- What help could make it easier for you to cope with your problems at the moment?
- How does talking about this make you feel?

When a person is identified as being at risk of suicide, the first concern must be for their safety. If they are at very high risk over the next few hours or days, then they should be in a safe environment where they are closely and continually supervised. Management out of hospital may be possible if the key health professional has confidence that the individual or their social network can ensure safety and appropriate monitoring. The development of a good relationship between the key health professional and both the person and their social network will be an important factor facilitating safety in the short term. Those involved in such monitoring will need explicit instructions on how to do this.

In extreme circumstances treatment may be necessary under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

When there is a significant risk of suicide, treatment should begin immediately (as with severe Major Depressive Disorder). As part of this, it is important to take measures to remove lethal weapons, pills and poisons from the patient's home and to prevent ready access to these. If the risk is low then there may be advantages in taking more time to complete a thorough assessment of the person to determine the underlying mood state, which may differ from the level of distress at the time of presentation.

Outpatient treatment of people who are suicidal

When it is decided to manage the person in their usual living situation, it is vital to ensure that adequate resources are available. The following matters should be considered:

- Information on the current mental state of the person, medication, precipitants of the suicide act and the degree of risk of suicide. The person's GP should have details of treatment.
- The need for 24 hour supervision and support.
- The level of supervision which the person requires.
- Ongoing access to professional assessment of the person by a multi-disciplinary team, with specific appointments for review. Specialist mental health follow up for patients indicating chronic suicidality should be a priority.
- The ability to respond to changes in the state of the person. They should be aware that the Mental Health Act can be used as a resource to set boundaries for the person and that the police may be called in emergencies.
- The safety of the person's physical environment.
- The availability of others living in the home to offer support, given that they may also be under considerable stress.

Community residential agencies may not have sufficient resources to provide 24 hour specialised care for suicidal patients (their principal function is to offer accommodation and rehabilitation, with the aim of increasing their clients' independence and facilitating reintegration into the community). Where the person is living in supported accommodation or a rehabilitation facility, the following factors may also need to be considered:

- The ability of the facility to access appropriate support.
- The availability of extra staff and their ability to respond to emergencies.
- The potentially distressing and unsettling effect on other residents.

- Any difficulties in removing potentially harmful objects/ substances (eg poisons) from the environment.

Development of a therapeutic relationship - working together

It is important that a treatment plan for Major Depressive Disorder is developed with the depressed person to ensure their full co-operation and the best outcome. This relationship should be developed during the assessment phase as information is sought about the nature and severity of the Major Depressive Disorder. During this, the health professional should take time to explain the nature of the disorder and other relevant information, such as the side effects of any proposed medication. An explanation of the course of a depressive disorder, emphasising both the expected outcome and the need to persist with treatment, may also help.

Assessment of severity

Once Major Depressive Disorder has been identified, its severity should be assessed. An episode of Major Depressive Disorder may be classified as mild, moderate or severe. The severity can be determined from the number of symptoms from the DSM-IV criteria present, where someone with five symptoms generally has a mild Major Depressive Disorder, and someone with nine, a severe Major Depressive Disorder. However, the severity of each of these symptoms and the impact on the person's life must also be considered.

The assessment of severity can be enhanced by using a number of Major Depressive Disorder rating scales. When these are used to monitor the progress of Major Depressive Disorder, they can be handed out for completion prior to the follow up consultations by non-medical staff. It is important to note that these scales are not diagnostic (as they can be elevated for conditions other than Major Depressive Disorder) and should not be used as screening instruments to detect the likelihood of a depressive disorder. Caution also needs to be taken when interpreting the results of Maori and Pacific Islands respondents, as norms are currently not available for these groups. The results of such scales provide corroborative evidence in addition to the clinical interview.

Two scales are recommended as valid methods of assessing the severity of any depressive disorder. These are the:

- Hamilton Rating Scale (HRS) (Hamilton, 1967) - a 17 item structured interview for use by clinicians familiar with its use (Appendix 3).
- CES-D Major Depressive Disorder (CES-D) - a 20 item self-report inventory that samples mood over the past week (Appendix 4). This may be used by any health professional.

Copies of the HRS and CES-D and the instructions for their use are contained in Appendices 3 and 4. The scales vary in the degree to which they measure particular aspects of Major Depressive Disorder - for instance: depressive thoughts and beliefs, somatic symptoms, behaviours etc. These scales are not intended to be used as diagnostic tools, but are limited to measuring severity of depression once it has been identified. Diagnostic criteria and severity rating scale scores, including for the Beck Depression Inventory - BDI (Beck, 1976) are listed in Table 4.

Assessment of melancholic features

The presence of melancholia is indicated by symptoms which include:

- loss of pleasure
- pervasive depressed mood
- marked psychomotor agitation or retardation[14]
- changes in weight
- excessive guilt.

The presence of these symptoms is usually indicative of a more severe Major Depressive Disorder, and the use of antidepressant medication is suggested.

Assessment of duration of the depressive disorder

It is important to determine the duration of the depressive illness. The advantage of antidepressant medication over placebos is significantly greater in less severe Major Depressive Disorders when they are of longer duration.

Assessment of cultural issues

The presentation, course and treatment outcome of Major Depressive Disorder will vary from person to person (Kirmayer, Young and Robbins, 1994). A number of factors influence this, including cultural factors. Appreciation and consideration of sociocultural

[14] The DSM-IV defines psychomotor agitation as excessive, repetitious and pointless motor activity that is associated with feelings of tension. Examples include behaviours such as pacing, fidgeting, wringing hands and an inability to sit still. Psychomotor retardation is the converse of this and is characterised by a slowing of general functioning including thinking, attention, speech and general movements.

Table 4. Assessing the severity of depression

Severity	Diagnostic Criteria DSM-IV	Scores on Inventories HRS	CES-D	BDI
Mild	presence of 5-6 depressive symptoms causing either a mild decrease in functioning, or normal functioning that requires greater effort	8-17	10-15	5-7
Moderate	severity that is intermediate between mild and severe	18-25	16-24	8-15
Severe	presence of most of the criteria symptoms and clear cut observable disability (eg inability ot work)	>25	>24	>15

factors is important for all people in improving treatment outcomes and the health of the community. In New Zealand there are Treaty responsibilities to support the culture and provide culturally appropriate treatment options for Maori.

In this section, the focus is on those ethnic groups which have different views of the cause and treatment of a "depressive disorder". It also applies to the diverse views that exist within society in general which are expressed in terms of spirituality and religion.

The more the clinician is able to appreciate the cultural perception of the individual to whom they are offering assistance, the better the therapeutic relationship will be. Consequently, compliance with - and the effectiveness of - the treatment will increase.

These guidelines recommend that where there is a significant difference between the cultural view of the disorder held by the person and the healthcare worker, the clinician should endeavour to liaise with or make a referral to a culturally appropriate service or specialist. This is clearly the case where the person's primary culture (eg Maori) is not that of the health professional, but could also include situations where religious beliefs and values differ. The offer to arrange and be supportive of a referral should come from the health professional.

Having made a referral, the health professional should continue to be available to and supportive of the person. Due to the scarcity of specialist cultural treatment services, most people are likely to be referred back to their primary healthcare worker for ongoing monitoring and treatment. Wherever possible, joint responsibility for treatment, preferably with written agreement on roles and responsibilities, should be arranged.

It is often helpful to seek guidance about issues and beliefs from the family, religious organisations and community leaders when dealing with an unfamiliar culture and/or religion. It may also be appropriate to seek the services of a local cultural adviser. Particular attention should be paid to the individual's own beliefs and values within this context. Caution must be taken to maintain confidentiality when seeking input from such sources.

Maori

In recent years the links between culture and illness, particularly mental illness, have become more widely recognised. This is particularly so for Maori as language and culture have become increasingly recognised as important for the identity and well-being of the individual. Durie (1977) noted that even for westernised Maori, cultural heritage is important in shaping ideas, attitudes and reactions, particularly during times of illness. Explanations of illness based on a possible breach of tapu continue to have meaning for Maori and therefore have implications for health workers in the management of Maori patients (Durie, 1994). For Maori, the western distinction between the physical, mental and the spiritual is not as relevant: the word used most commonly for spiritual health, Wairua, has the literal meaning of the mixing of the two waters, physical and mental/spiritual. There are also phenomena, such as Whakama (Sachdev, 1990) which, while similar to Major Depressive Disorder, do not have an exact western equivalent.

"Maori live in diverse cultural worlds. There is no reality nor is there any longer a single definition that will encompass the range of Maori life styles. Some Maori

are closely linked to established Maori institutions: marae, hapu, iwi. Others are involved in new institutions, strongly Maori, but not in any traditional sense, not always readily distinguishable from the institutions of other New Zealanders. A Maori identity, even when vigorously defended, cannot be presumed to mean a conventional Maori lifestyle. Nor should it be forgotten that, for many Maori, cultural identity is a sophistication; it is more than enough simply to get through each day" (Durie, 1994, p214).

Appropriate cross-cultural communication is critical if any health professional is to elicit the information that they require in order to identify Major Depressive Disorder and develop the rapport and co-operation necessary to instigate any treatment (Tipene-Leach, 1977). Any assessment of Maori must recognise that there are a number of sensitivities in the relationship between the health worker and the turoro (person being treated). These are:

- it is not appropriate to immediately ask patients to reveal their name (or personal information) without any preliminary remarks to establish rapport
- direct eye to eye contact is not appropriate especially when discussing sensitive issues. Such eye to eye contact with an older person is considered a sign of haughtiness or disrespect
- a family member who answers questions on behalf of a person is not necessarily being dominant; often it will be both appropriate and helpful to all parties. Younger people may feel embarrassed or intimidated.

Signs of depressive disorders

In addition to the symptoms of Major Depressive Disorder (listed on page 15) there are a number of other signs that are particularly indicative of a depressive disorder for Maori. To identify these will require careful and respectful probing by the health professional and the development of considerable trust on the part of the person.

These signs may include[15]:

- suggestions of breaches of cultural protocols
- preoccupation with a close relative who has recently died
- irritability and/or uncharacteristic aggression
- issues of injustice (especially cultural), experienced by the person or their whanau, which have resulted in:
  - intense internalised shame or guilt (Puuhi)
  - intense externalised shame or guilt (sometimes described as Whakama - although this does not have a negative connotation)
- unresolved grief or loss - of persons or status
- somatic complaints with no apparent physiological cause.

Once there are indications of any of these signs, especially any involving tapu and death, serious consideration should be given to involving Maori health workers and/or Maori elders adept and experienced in Maori mental health and spiritual issues. Assistance may be found from Maori community health workers and Maori health units of the local CHE. Roles and responsibility for aspects of the treatment and care of the person will need to be carefully and respectfully negotiated between the parties involved (including the person and their family).

Pacific Islands Cultures

Traditionally, Pacific Islands people view health in terms of wellness rather than illness. Illness is perceived as an altered state of wellness. The Pacific Islands model of health (Pulotu-Endemann, 1995) has several dimensions that contribute to the holistic perception of a Pacific Islands person's wellbeing.

The following description is of the traditional Samoan view of holistic health. While other Pacific Islands nationalities may have similar views, it will be important that the health worker appreciates the specific cultural differences.

The *base foundation* (Fa'avae), represents the dimensions of *extended family* (Aiga). This encompasses the nuclear and extended family that is the basis for the social organisation of Pacific Islands people. The base foundation also provides support for the *four main posts* (Pou-tu).

The Pou-tu represent the dimension of *spirituality* (Fa'aleagaga). This is the sense of inner wellbeing and encompasses beliefs revolving around Christianity or traditional spiritual beliefs such as aitu or spirits and the continuance with nature or some combination of

[15] These may also apply to people of other cultures.

these. The *physical* dimension (Fa'aletino) is the wellbeing of the body and is measured by the absence of illness and pain. The *mental* dimension (Mafaufau) is the wellbeing of the mind, and the last Pou-tu represents the dimension of *other* (O Isi Mea), which encompasses areas such as finance, gender, education, employment, age, and sexual orientation to name but a few. Above the main Pou-tu is *the roof* (Falealuga) which represents the dimension of *culture* (Aganu'u). This encompasses the philosophies and methodologies pertaining to traditional values and beliefs. Surrounding these dimensions of health are *context, environment and time*, which all need to be taken into consideration when addressing the health needs of Pacific Islands people.

These dimensions are interwoven and intricately inter-related with each other. There is no exact equivalent term for Major Depressive Disorder in Pacific Islands cultures, but such problems may be described in the dimension of spirituality. The degree to which a person experiences Major Depressive Disorder is dependent on how affected the other dimensions are. In most cases, Major Depressive Disorder is often the symptom of altered states of wellness in the other dimensions, especially those of family and other, which impact on the mental, the physical and the cultural dimensions. Issues of traditional values and beliefs versus New Zealand born values and beliefs also impact on spirituality.

Signs and symptoms of Major Depressive Disorder vary greatly between the Pacific Islands cultures, so what may be true for one person, may very well be different for another. In addition to the symptoms identified in the DSM-IV are the parameters of shame and guilt, which can add to and complicate the clinical picture. Furthermore, "*Hauntings*" (Ma'i Aitu) over long periods of time, coupled with guilt and shame, can be mistaken for a depressive disorder. There is a growing awareness that Pacific Islands people's health needs, in particular mental health, are not being adequately met by mainstream services. This has resulted in the mobilising of numerous Pacific Islands agencies specialising in various health areas nationwide. Respectful negotiation with these agencies, the client and their families, will overcome the cultural barriers that can impede treatment if service provision is not open to alternative ways of treating the client.

To ensure appropriate assessment, it is important to include a Pacific Islands health worker throughout the process. This worker must not only be skilled in clinical assessment, but also where possible, be gender, age, culture and sub-culture appropriate. In some situations it is more appropriate to use a Pacific Islands worker who can speak the language, but who may not be of the same specific cultural background, especially in situations where the patient may have limited relationships with their immediate family.

In summary, for any health work with Pacific Islands people there needs to be:

- an appreciation of the different background(s) of the client
- a recognition of the specific ethnic identity/identities of the client, as each of the Pacific Islands nations has its own cultural values and beliefs, language(s), lores and laws, verbal and non-verbal codes, customs, practices and protocols
- a willingness to refer to people with specialised knowledge about the various Pacific nations views of mental health
- an awareness of the health-oriented issues for Pacific Islands communities - such as economic survival, unemployment, immigration restrictions, educational opportunities, opportunities to maintain their culture and collective development
- there is usually ethnic-specific knowledge about a Pacific Islands client which is useful and vital to a Pacific Islands healthcare professional - such as languages(s) of communication, village(s) of origin, geographical features of the country concerned, relevant family stories, religious affiliations and belief, family members and respectful titles of address.

It is important that the health worker should be accepted, supported and respected by the clients in the Pacific Islands community.

Assessment of other issues

Gender issues

The higher rate of Major Depressive Disorder in women compared to men is real and not an artefact of help seeking behaviour (Weissmann and Klerman, 1977). Women, particularly in the 45-64 age bracket are also more likely than men to suffer from Dysthymic Disorder (Weissman et al, 1988). This increased rate of

depressive illness is probably a result of an interaction of biological and social factors (Halbreich and Lumley, 1993; Ruble et al, 1993; Kendler et al, 1993). Signs and symptoms are generally similar for men and women (Angst et al, 1990).

Emotional, physical and sexual abuse are often important factors in the development of a depressive disorder. Women whose Major Depressive Disorder is triggered by discrete traumatic events (eg physical and sexual abuse) may also have symptoms of Post-Traumatic Stress Disorder (Alexander, 1994). Women abusing or dependent on alcohol are more likely to have a pre-existing mood disorder and to develop Major Depressive Disorder (Weissman et al, 1988). If women develop Major Depressive Disorder, it is more likely to be persistent and women are more likely than men to remain depressed at the one year follow up (Weissman and Meyers, 1978).

Postnatal Depression

Women suffer from particular forms of depression associated with pregnancy/ childbirth postpartum mood symptoms. These can be divided into blues, Major Depressive Disorder and psychosis.

'Maternity Blues': Brief episodes (1-4 days) of unstable mood and tearfulness occurring in 50-80% of women within 1-10 days of delivery. Treatment is reassurance and "time" (Kendell, 1985).

Postnatal Major Depressive Disorder: 10-15% of women will suffer from Major Depressive Disorder within the first 3-6 months after childbirth (O'Hara, 1987). The risk is higher for women with a psychiatric history, relationship problems, a higher number of "life events" in previous years or postpartum thyroiditis (Harris, 1994). Risk is lower in those who are psychologically healthy at the start of pregnancy and who have good social support networks (Coble et al, 1994). See Table 5 for a summary of risk factors. Postpartum Depression may be persistent when there are continuing family and marital pressures (Cox et al, 1993). The Edinburgh Postnatal Major Depressive Disorder Rating Scale is a useful tool for identifying the presence and severity of Postpartum Major Depressive Disorder (Schaper et al, 1994). It is recommended that the scale be incorporated in routine postnatal followups (see Appendix 5 for a copy of the scale).

Postpartum Psychosis: This relatively rare disorder (incidence = 1-2:1000) can be divided into depressed and manic types. The depressed type shows more psychotic, disorientated, agitated and emotionally unstable features, as well as more psychomotor retardation than other types of Major Depressive Disorder. Cognitive impairment is often prominent. Symptoms develop rapidly, within 2-3 days after delivery. The period of risk is within the two weeks following delivery (Dean and Kendell, 1981). The safety of the infant and other children must be a priority and an urgent specialist referral is strongly recommended. Women with a history of Schizophrenia, Psychosis or Bipolar Disorder are at a risk of developing Postpartum Psychosis (Marks et al, 1992).

Mothers tend not to volunteer difficulties with coping, and need to be asked about this directly. The sleep disturbance and other features of Postnatal Depression are frequently attributed to normal changes in life style following child birth. Specific questions about going back to sleep after feeding are needed. Administering the Edinburgh Scale during routine postnatal follow ups, eg when the baby attends for its five month injection, is a useful way of elicting any difficulties the mother may be having. However, if the mother is potentially at risk of developing Postnatal Depression, she should be monitored closely during the first four weeks and before the routine six week Postnatal check up.

A review of research indicates that Postpartum Depression is indistinguishable from Non-Postpartum Major Depressive Disorder in terms of course and remission rates, but symptoms may vary. Irritability directed towards the partner or baby and other children is more common than a pervasive feeling of sadness and lowered mood. Often the mother's mood is lower towards the end of the day. Commonly, women tend to feel guilty and ashamed about being depressed in the postpartum period, tending to see the depression not as an illness, but more as a sign of weakness in themselves.

Pacific Islands women very seldom report Major Depressive Disorder, they complain of feeling tired, not sleeping well, and lack of motivation to perform daily activities. On closer examination, these women are often refusing to sleep with their partners which often leads to domestic violence, which exacerbates the depressive symptoms. Little if any research exists on Pacific Islands women's incidence of "Maternity Blues" or Postnatal Major Depressive Disorder. Amongst Pacific Islands communities, it is perceived as a New

Table 5. Risk factors and indicators of the development of postnatal depression

Antenatal (Before Birth) indicators	Indicators related to the birth process and management	Postnatal indicators related to mother's mood/baby's behaviour
• **Severe premenstrual syndrome** • Previous difficulties with pregnancies/birth eg miscarriage, still birth • **Relationship difficulties** • **Poor social support** • **Vulnerable personal history of psychiatric illness** • Recent bereavement • **Marked depression in pregnancy** • Family/personal history of psychiatric illness • Present pregnancy is unwanted • Previous antenatal or postnatal anxiety or depression • Stressful life events	• **Delivery complications eg birth by caesarean section** • Handicapped or ill baby • Baby not of desired gender • **The birth did not fulfil expectations (eg unwanted intervention)**	• Continuing postnatal blues • Not wanting to hold the baby • Detached or negative feelings about the baby • Lack of direct eye contact with the baby • Inability to sleep or excessive sleep • Feeding difficulties • Anger about life's circumstances • Withdrawn behaviour • A temperamental baby • Presence of colic or reflux in the baby

Table adapted from Hunt et al, 1995 (bold indicates particularly important indicators of high risk of postnatal depression)

Zealand born issue that arises from mixed marriages, however there is an increase of Pacific Islands women reporting symptoms of Major Depressive Disorder especially following childbirth where domestic violence occurs. The dimensions affected are spirituality (Fa'aleagaga), physical (Fa'aletino) and other (O Isi Mea). Again, shame and guilt coupled with one's sense of duty may prevent women from following through with treatment or medication plans.

Women with a history of Bipolar Disorder or a previous Postpartum Major Depressive Disorder may benefit from prophylactic antidepressant treatment, and this should be discussed as a treatment option.

Violence issues

Women suffering emotional and/or physical abuse from their partners often present with symptoms of Major Depressive Disorder. A Dunedin study (Mullen et al 1988) found that 16% of women reported that they had experienced physical abuse as adults. The mental health effects of such violence can include post traumatic shock, extreme apathy, Major Depressive Disorder, and even suicide.

Violence and other forms of abuse are often undetected at primary health care level. General practioners should not be reluctant to ask direct questions about suspicious bruising in a depressed person eg "were you hit?", who did it?", "was it your partner/parent?" Other primary health care professionals should routinely inquire about how conflicts are handled, and if violence or emotional abuse is ever present when conflicts occur.

People perpetrating the violence are also likely to present with acute symptoms of Major Depressive Disorder particularly leading up to the violence, or immediately after a separation precipitated by the violence.

When violence has occured, the safety of the women and children takes precedence over other interventions. The Major Depressive Disorder of either the victim or

the perpertrator should be treated as if it were severe (ie referring to community mental health services).
When the person is experiencing abuse:

- employ reflective listening skills to encourage disclosure
- when examining injuries look for discrepancies between what is said and what is seen
- validate the person's experience and pespective on the abuse
- review safety issues associated with the disclosure and negotiate future action
- provide information on women's refuge services and encourage attendance at specialist support groups.

When the person is perpetrating abuse:

- speak frankly about the abuse, referring to the effects on family members. Include a discussion of the wider issues of power and control in the relationship
- take care not to support justifications and rationalisations for violence (anger, drunkenness, provocation etc)
- refer to local 'stopping violence' group programmes where available. Where such groups are not available, consider referring them for individual counselling. At this stage couple counselling is not recommended. Couple counselling is more useful after the person has stopped being violent and has learnt to control their anger. If couple counselling is undertaken before this, it may support the abusive cycle.

It is also important to establish the safety of those being abused. In some cases it may be necessary to breach confidentiality (note GPs should explain confidentiality as being in place UNLESS the person confides in them an intention to cause themselves or others harm, in which case confidentiality may be breached, but in such situations this would be discussed with the patient).

Sexual orientation

Gay and lesbian people face particular stresses in terms of acceptance by society and their family of their sexual orientation. These play a big part in their own self-acceptance and self-esteem. A number of studies indicate a higher rate of suicide and Major Depressive Disorder amongst young lesbians and gay men (McGrath et al, 1990).

When there is any indication of 'confusion about sexual identity' this should be explored sensitively. Sexual identity confusion may be an important contributor to Major Depressive Disorder.

When such confusion is present, value-free information should be given together with support and reassurance about conflicting feelings about self and family attitudes/ relationships. Referral to an appropriate support service should be considered (see Appendix 8).

In some Pacific Islands cultures there is a formal acceptance of differences in sexuality. For example, in Samoa there exists a third culture called Fa'afafine (ways of women) that describes difference in male sexuality. New Zealand's different social values and beliefs have affected the acceptance of Fa'afafine in New Zealand. Acceptance of gay and lesbian lifestyles has affected the Fa'afafine culture in the sense that the majority of New Zealand born identify as gay. The Pacific Islands counterpart, Fa'afafine, while accepted in the Islands, are less well accepted in New Zealand. Issues for both Fa'afafine and Pacific Islands gays are the same as for other cultures; self-acceptance and self-esteem.

Once the depressive disorder has been diagnosed and the duration, severity and presence of any melancholic features assessed, attention should be given to offering a range of initial treatments (as outlined in Figure 3). All people experiencing depression, and their families and social networks, should receive information and education about Major Depressive Disorder. Consideration should be given to increasing problem solving skills and identifying lifestyle changes which may assist a recovery and contribute to the prevention of relapse or recurrence. Every person experiencing depression should be monitored at least weekly for the first six weeks (more frequently if the Major Depressive Disorder is more than moderately severe).

Involvement of others

Effective treatment of the depressed person will generally include the involvement of their partner, family, whanau or other support networks. Support should be encouraged without overwhelming the individual, intruding upon their privacy, or their wish not to involve their family.

Family involvement is particularly important if there is a risk of suicidal behaviour. Information about risk factors should be sought from family, and specific instructions given about minimising potential risks, such as access to lethal substances or firearms.

Privacy and confidentiality should be maintained as far as possible but may need to be balanced against the need to share information if there is a real risk of suicidal behaviour.

Monitoring

Close monitoring of the depressed person is essential regardless of the intervention selected. This may be done at follow up consultations, at the person's home or by phone between consultations. It should include inquiry into:

- level of mood, alteration in symptoms and negative thoughts
- suicidal thinking and physical safety
- social situation, social support
- any side effects of drugs if these have been prescribed. (This provides an opportunity to give encouragement to continue medication)
- feelings about the therapist and the effectiveness of the therapy, if attending psychological therapy.

Encouragement about the expectation of a positive outcome should always be offered.

Frequency of monitoring

This will depend on the severity of the Major Depressive Disorder. If the depressive symptoms are of moderate severity the following guidelines are useful:

- first week: review during the week by phone at least once. This should be more often if using tricyclic antidepressants, to discuss their side effects. See the person at the end of the week
- subsequently, see weekly for first six weeks
- if the six week review identifies a good response to treatment, then continue to monitor every one or two weeks depending on severity and any risk of suicide or harm to others
- if the six week review identifies a limited or poor response to treatment, continue to monitor at least weekly, or more frequently if there is a change in the treatment or a deterioration in the Major Depressive Disorder.

Monitoring by a competent and appropriate person will need to be more frequent if the person is severely depressed. If the person is mildly depressed, or is progressing well in the recovery process, monitoring may be less frequent.

Initial Interventions

Education

Education is an important component of the management of any Major Depressive Disorder and especially valuable in clarifying the person's uncertainty and misconceptions. The information provided will allow most people to gain greater control over their disorder and be able to recognise actions they can take, and when they need additional assistance from a healthcare worker. Where appropriate, and with the individual's permission, family members should also receive information that will help them to provide support through the treatment period and enable them to act appropriately should there be any relapse.

Education should be provided in short five minute sessions over a number of appointments and should be tailored to the individual's level of understanding and culture. Handouts and information pamphlets are particularly helpful. The following information is important:

- Major Depressive Disorder is not a weakness or a character defect
- Recovery is the rule not the exception
- Treatment is effective and there are many treatment options available. There is a suitable treatment for almost every person
- The goal of treatment is to get well (100%) and be better placed to cope with emotional problems in the future
- The rate of recurrence is quite high: 50% of people who have had one episode of Major Depressive Disorder will relapse, 70% of people who have had two episodes will relapse, and 90% of people who have had three episodes will relapse. Therefore continuation with treatment[16] to avoid relapse is important
- The individual and their family can be taught to recognise early warning signs of Major Depressive Disorder. By seeking early treatment after recognising these warning signs, the severity of the episode may be greatly reduced.

There are also a number of self-help books available that provide useful information about depression and strategies for both the person with depression and their friends and families for coping with it. These are available through public libraries and general book stores. Some examples of books include:

The Silver Lining: How to Conquer Depression. A NZ Perspective (1989), by Margaret Mourant. (Published by William Collins, Auckland).

This book includes a chapter on how other people can help the depressed person.

The Depression Workbook (1992), by Mary-Anne Copeland. (New Harbinger).

This book includes information for people with Bipolar Mood Disorder.

I Can See Tomorrow (1995), by Patricia Owen.

This can be purchased from book stores for around $29.95, and is also available through Tandem Press (PO Box 34272 Birkenhead, Auckland, Ph 09 480 1452).

Sharing the Load (1996), by Gwendoline Smith. (Published by Random House).

Lifestyle

There is research that suggests that lifestyle changes may help to:

- reduce the risk of recurrence of mild to moderate unipolar Major Depressive Disorder
- relieve symptoms of mild to moderate Major Depressive Disorder
- possibly reduce the risk of moderate Major Depressive Disorder becoming more severe.

Lifestyle changes that have been shown to be of some benefit include:

- *stress management (Aro, 1994)*
- *reducing drug and alcohol use*
  abuse of alcohol (Schuckit, 1994; Bartels et al, 1992; Petty, 1992) has been associated with increased rates of Major Depressive Disorder. A person who is depressed should ideally stop using alcohol or at least reduce consumption to no more than two standard drinks a day and no more than one standard drink per hour. Note that other drugs, such as cannabis, can also have an effect on mood and their consumption should be discouraged, especially if the person is taking medication.
- *sleep patterns*
  there is some evidence for a relationship between the disruption of circadian rhythms and Major Depressive Disorder (Healey and Williams, 1988; Linkowski and Mendlewicz, 1993). The development and maintenance of good sleep patterns may be an important adjunct for the treatment of Major Depressive Disorder and prevention of relapse.
- *a balanced diet*
  ensure that the person has a balanced diet which includes complex carbohydrates and vitamins. Some evidence exists that carbohydrate-enriched foods improve mood (Wurtman, 1993; Wallin and Rissanen, 1994).
- *physical exercise*
  Martinsen (1994) reviewed ten experimental and two quasi-experimental studies and concluded that

[16] Continuation refers to treatment after the return to premorbid levels of functioning, but prior to a recovery (not exceeding 6 months).

despite some methodological shortcomings, all studies point in the direction of aerobic exercise being more effective than no treatment.

People may find it hard to implement lifestyle changes while continuing to experience depressive symptoms and should be encouraged to make changes as and when possible.

Problem solving

Problem solving treatment has been shown to be effective, feasible and acceptable to patients as a treatment for Major Depressive Disorder in primary care. In one study it was found that problem solving was as effective as amitriptyline, (a tricyclic antidepressant) and more effective than a placebo when given over six sessions by general practitioners who have taken a short course to learn the relevant skills. Patient satisfaction was high and showed a low drop-out rate (Mynors-Wallis et al, 1995).

Problem solving interventions teach the person to use their own skills and resources to cope with both present and future problems. It has several stages:

1. identifying and clarifying the problem
2. setting clear achievable goals
3. brainstorming to generate solutions
4. selecting the preferred solution
5. evaluating progress.

Training in problem solving for general practitioners includes a short theoretical course that entails reading relevant papers, role playing in clinical scenarios, and watching a training videotape.

Use of antidepressants and psychological interventions

Antidepressants

Antidepressants are an effective treatment for most moderate and severe depressive disorders. When an antidepressant is indicated, select a particular antidepressant (based on the criteria following) and prescribe an adequate dose (see Appendix 6) for a period of at least four to six weeks[17]. Monitor to ensure any side effects are tolerable and that the person continues to take the prescribed dose. Review the response at four to six weeks and if the Major Depressive Disorder has not improved, select another antidepressant or consider adding psychological therapy. Once an effective medication and dose level has been identified, continue for nine months. If the person has experienced more than one episode in the recent past, consider continuing the medication for up to three years.

Mild Major Depressive Disorder

Antidepressants are generally not indicated for mild Major Depressive Disorder unless monitoring, lifestyle changes and psychological therapies have been unsuccessful.

Indications for using antidepressants for mild Major Depressive Disorder are:

- when the individual has a history of severe depressive episodes
- for Dysthymic Disorder, when it has been persistent and disabling.

Moderate and Severe Major Depressive Disorder

For severe depressive disorders with melancholic features, tricyclic antidepressants are probably still the initial drug of choice providing they are prescribed at an adequate dose and the person can tolerate the side effects. The alternative for those patients who cannot tolerate tricyclic antidepressants or do not have melancholic features are the Selective Serotonin Re-uptake Inhibitors (SSRIs) and other newer antidepressants. For moderate depressive disorders, tricyclic antidepressants and newer agents are equally indicated. The choice of an antidepressant should be made with due consideration for contraindications and the person's ability to tolerate side effects.

Contraindications for using selective serotonin re-uptake inhibitors for moderate depressive disorders:

- in view of the limited information on teratogenicity, caution should be exercised for women who are pregnant or breast feeding
- where the patient has had previous intolerance of side effects of SSRIs.

Contraindications for using tricyclic antidepressants:

- where there is a substantial risk of suicide by overdosing on the tricyclic antidepressants

[17] Nierenberg (1995), in a study considering the time required to adequately trial antidepressants, demonstrated that with regard responders at 8 weeks to Prozac, 36% were nonresponders at 2 weeks, 19% were nonresponders at 4 weeks and 7% were nonresponders at 6 weeks.

- coronary artery disease, serious cardiac arrhythmias or similar cardiac problems. Ideally a person over the age of 40-45 should have an ECG before a tricyclic is prescribed [18]
- glaucoma or prostatism
- elderly patients at special risk of postural hypotension
- where the person needs to drive[19] or operate machinery and the tricyclic antidepressants would impair their performance
- inability to moderate alcohol (or other drug) intake, or
- when the person cannot tolerate the side effects.

Specialist Treatment (Lithium and ECT)

Lithium Carbonate (Lithium) is the most commonly prescribed drug for Bipolar Mood Disorder[20]. While it is an effective mood stabiliser and is useful as a maintenance medication, it has some important limitations. It takes 7-14 days for the drug action to be effective after first prescription and is therefore often ineffective in treating acute mania. Antipsychotic medication may be more appropriate. Common side effects are: upset stomach and diarrhoea (common symptoms that usually settle after a few weeks), weight gain, mild difficulty in concentrating, increased thirst and a metallic taste in the mouth.

Because Lithium can cause serious toxicity, serum lithium levels need to be regularly monitored, every 5-7 days at the beginning of treatment. Lithium toxicity can be caused by dehydration, urinary tract infections and gastroenteritis. Early symptoms include nausea, vomiting, unsteadiness, forgetfulness/mild confusion and diarrhoea.

Electroconvulsive therapy (ECT) is an effective form of treatment for people with depression who have concurrent psychotic symptoms, or severe somatic (melancholic) features. It may also be useful for people who have benefited from it in the past, have not responded to other forms of treatment (including medication and psychological therapy), if medication is contraindicated, or if a rapid response to treatment is required (eg in cases of high suicide risk). ECT has been demonstrated to have a more rapid effect than antidepressant medication. Common side effects include headaches, confusion and short periods of memory loss.

ECT involves a brief application of electric current to carefully selected sites on the scalp (after the patient has been given a short acting anaesthetic and muscle relaxant) and is only administered by specialists trained in its application.

Factors in selecting a specific antidepressant

Details of the therapeutic dose, cost, side effects profile, other adverse effects, contraindications and precautions for each of the antidepressants available in New Zealand can be found in Appendix 6.

All drugs cause some side effects, and antidepressant and mood-stabilising medications are no exception. Appendix 6 gives some indication of the relative frequency of the more common side effects caused by different antidepressants. However, careful inquiry into side effects at each appointment is important as any individual may suffer significantly from an uncommon side effect for a given drug, or may attribute features of the Major Depressive Disorder itself to the medication. Appropriate consideration and management of these side effects will assist the effectiveness of treatment. Consideration should be given to common drug interactions and other co-existing medical disorders, as with any prescribing.

When a person is unable to tolerate conventional therapeutic doses of a given antidepressant, the dose may be reduced (temporarily or permanently) or the antidepressant may be changed. It is important to consider whether a dosage reduction to reduce side effects will also reduce the therapeutic benefit of the antidepressant.

An increasingly important factor in the selection of the appropriate medication is the cost, both to the health sector and the person. This should never be a primary factor in whether or not to use a particular type of medication but is important for selecting any particular medication within a category. Eccleston (1993) has recently noted that the question of choice of medication has been made more difficult because of the almost six-fold difference in the cost of the various medications available. Currently in New Zealand, the cost of medication for a thirty day treatment varies from $15.17 for Doxepin to $99.36 for Moclobemide (see Appendix 6). The cost of any medication needs to be considered in the context of other, mainly staff, costs. Treatment of an episode of severe Major Depressive Disorder over a period of six months (following the recommendations outlined in Figures 3 and 4) includes staff input costs

[18] Young patients who have pre-existing cardiac conduction defects or a prolonged PR interval on ECG, ie a PR interval equal to or greater than 0.21 seconds, or a QRS equal to or greater than 0.12 seconds, should not be prescribed tricyclic antidepressants.

[19] Where the person drives frequently, and/or as part of their occupation.

[20] If a Bipolar Mood Disorder is suspected, immediate referral to a psychiatrist is indicated. Lithium is best prescribed in consultation with a psychiatrist.

of about $1,600[21] and medication costs varying from $92.28 to $851.06[22] depending upon the medication used (the cost of the medication being between 4% and 29% of the total cost of treatment). Treatment of an episode of Major Depressive Disorder of moderate severity includes staff input costs which reduce to about $370[23], resulting in the cost of the medication being between 11% and 57% of the total cost of treatment.

Risks of suicide using antidepressants

Approximately 1% of people who suffer from a depressive disorder kill themselves using an overdose of their prescribed medication (Henry, 1992). Henry et al (1995) provide an index of lethality based on an analysis of the number of recorded completed suicides due to acute poisoning by a single antidepressant in the United Kingdom for the period 1987 to 1992[24]. Their data show that the safest medications, in terms of antidepressants being used by people to suicide, are selective serotonin re-uptake inhibitors (SSRIs) and that there is a wide variation in the lethality of the tricyclic antidepressants.

Jick et al (1995), however, report that overdose with antidepressants accounts for only 14% of suicides amongst a sample of 172,598 people prescribed antidepressants during the period 1988 to 1993 in the United Kingdom. This indicates that the prescribed medication makes little impact on actual suicide rate. It is not possible to suicide by overdose using SSRIs, but people prescribed SSRIs may use other means to suicide.

Frequent dispensing of medication may also be an option when the person presents at risk for suicide. Alternatively, medication can be held in a secure manner by a trusted family member or friend.

However, it must be stressed that if there is a significant risk that suicide will be attempted, referral to mental health services for specialist treatment is indicated. Prescription of a lower risk medication is not an alternative to a referral for specialist assessment.

Combining antidepressants with psychological therapies

There is evidence for combining psychological therapies with the use of antidepressants and clinical management in cases where:

- the prior course of the illness is chronic or characterised by poor inter-episode recovery (for example Dysthymic Disorder with acute Major Depressive Episodes)
- where antidepressants alone have been only partially effective and where negative cognitions (pessimistic thoughts), low self-esteem and/or relationship difficulties are identified
- where there is a history of chronic psychosocial problems, both during and between episodes of Major Depressive Disorder
- where there is a history of reluctance to persist with treatment
- when there are residual symptoms that are largely psychological.

Psychological therapies

Psychological therapies, like pharmacotherapy, consist of a number of distinct interventions that are of varying value for different people. In psychological therapy a trained professional, in collaboration with the person, undertakes an assessment, formulates the problem, and initiates change utilising appropriate techniques that have been clinically researched and found to be effective in changing mood and behaviour.

Professionals who are competent to provide specialised psychological therapies outlined in these guidelines would have the following attributes: a tertiary qualification which included a theoretical understanding of personal and interpersonal behaviour, dysfunction and techniques for effecting change; have undertaken personal development examining their own values, beliefs, emotions and relationships; satisfactorily completed experiential learning of skills required to apply appropriate techniques to change mood and behaviour; be a current member of a professional association which has acceptable ethical standards and disciplinary procedures; and have ongoing professional supervision to maintain the quality of their work. These professionals will typically be psychiatrists, psychologists, psychotherapists or qualified counsellors (Refer to Appendix 9 for a list of professional bodies involved in psychological therapy).

In this document, the term “counselling”, while including some elements of techniques used in psychological therapies, is mostly used to cover techniques such as supportive listening, providing information and problem solving to encourage people to make decisions and act in ways that will improve their situation. Such counselling will form part of the repertoire of most primary health workers, such as general practitioners and nurses. These guidelines recommend that counselling of this type should be part of the initial

[21] Including an initial GP consultation ($31), a specialist assessment ($250), 9 consultations for monitoring and 3 for problem solving and education ($372), 8 sessions of psychotherapy ($800) and 6 consultations for follow up/ monitoring over three months ($186).

[22] Doxepin $92.28, Imipramine $156.76, Fluoxetine $391.70, Paroxetine $424.92, Moclobemide $604 .44, Desipramine $851.06.

[23] Includes an initial GP consultation ($31), 6 consultations for monitoring and 2 for problem solving and education ($248) and 3 consultations for follow up/monitoring over three months ($93).

stages of treatment for any person presenting with identified depressive disorders or symptoms of Dysthymia.

A psychological view of depression holds that both previous and current environmental factors play the most important role in the development of depression. The influence of these factors on a person's emotional response is mediated by psychological (attitudes and beliefs that the person holds about themselves and the world), genetic and biological factors. In some people, the tendency towards low mood or mood swings may be triggered more easily by events in the environment.

In each person different events and history may trigger a depressive episode. Therefore treatment and prevention packages should be individually tailored to the person. If the person relapses, questions should be asked about what was not resolved in any previous therapy, what lifestyle changes have not been made, and what are current stressors in the person's life? Concurrent and long-standing issues that are considered risks for depression (eg abuse) are addressed in therapy. Psychological therapy is seen as an appropriate and effective intervention for both moderate and severe depression.

The following is an overview of therapy outcome research and is offered as an informative guide to practice rather than a prescription. Experienced trained therapists tailor their treatment to the person seeking help according to the initial full assessment and collaborative formulation of the problem.

There are two principal categories of psychological therapy which have been shown to be most effective in the treatment of people with depressive disorders: Cognitive-Behavioural Therapy (simply, a therapy that combines cognitive therapy and behavioural therapy's principles and techniques) and Interpersonal Psychotherapy. An analysis of research studies published up to 1991 and reported in the US Department of Health and Human Services Clinical Practice Guidelines, No 5, Major Depressive Disorder in Primary Care, Vol 2, 1993, pages 74 - 82 found the following:

- Cognitive therapy alone had an overall efficacy of 46.6%. There is some debate on whether it is more effective when delivered on a one to one basis or in a group setting. The literature tends to suggest that individual therapy is more effective. It was 9.4% more effective than placebo pills with clinical management and was slightly more effective than medication alone
- Behavioural therapy had an overall efficacy of 55.3%, was slightly more effective when delivered on a one to one basis (57.7%) than in a group (51.1%), was 9.1% more effective than other psychological therapies and 23.9% more effective than medication alone
- Interpersonal Psychotherapy had an overall efficacy of 52.3%, was 13.2% more effective than cognitive therapy, 12.3% more effective than imipramine, and 22.6% more effective than placebo with clinical management. Involvement of the spouse had no greater effect on depressive symptoms although marital satisfaction improved
- Brief Dynamic Psychotherapy had an overall efficacy of 34.8%, was less effective than other psychological therapies but 8.4% more effective than medications alone.

Cognitive-Behavioural Therapy

Cognitive-Behavioural Therapy is based on the premise that the person's negative thoughts lead to a negative appraisal of themselves, the future and the world, and other 'unhelpful' beliefs (Beck, 1976). As the person's mood becomes depressed, physiological symptoms may develop, which further exacerbate the low mood, negative thoughts and unhelpful beliefs. Cognitive-Behavioural therapists postulate that if each element (eg negative thoughts and/or actions) is targeted in therapy, then this will lead to an overall improvement in the depression, including the physiological state. There are a number of related treatment packages developed by behavioural psychologists based on either a functional analysis of behaviour or social learning theory. Examples of these are activity scheduling, therapy targeted at teaching self-control, including stress management, social skill training and problem solving.

Interpersonal Psychotherapy

Interpersonal Psychotherapy is a focused, time-limited treatment (of approximately 16 sessions) which emphasises current interpersonal relationships. The therapy aims to clarify and resolve one or more interpersonal difficulties such as the following: role confusion (confusion about identity), social isolation, prolonged grief reaction and role transition (eg becoming a mother). The therapist and presenting person work together to identify the interpersonal difficulties which are either causing, exacerbating or

[24] Henry's (1992) lethality index (deaths per 1 million prescriptions): Amoxapine, 157.2; Desipramine, 75.8; Nortripyline, 51.8; Dothiepin, 47.9; Amitripyline, 38.9; Imipramine, 31.5; Tranylcypromine, 27.9; Doxepin, 24; Trimipramine, 13.9; Clomipramine, 7.3; Phenelzine, 7.9; Paroxetine, 2.6; Fluoxetine, 0.7. No information was reported for Maprotiline, Mianserin or Moclobemide.

maintaining the depressive disorder, then focus therapy on resolving the difficulties that have been identified (Frank et al, 1991).

Certain other therapies have also been found to have some value in the treatment of Major Depressive Disorder:

- Group psychotherapy has been found to be effective in the treatment of the depressed elderly, particularly as an adjunct to medication (Clark & Vorst, 1994). It may also be useful in treating Major Depressive Disorder associated with chronic illness and bereavement (American Psychiatric Association Practice Guidelines for Major Depressive Disorder in Adults, 1993). Studies have shown that brief dynamic psychotherapy groups (resolving core conflicts based on personality and situational variables) can also be useful in treating Major Depressive Disorder (Steuer et al 1984; US Department of Health and Human Services: Major Depressive Disorder Guideline Panel, 1993).
- Family and marital therapy may reduce depressive symptoms and the risk of relapse in people with marital and family problems eg conflict, or when depressed children are the symptom bearers of unhelpful family dynamics (Jacob et al, 1987; Friedman, 1975; Yager 1992).

The effectiveness of Cognitive-Behavioural Therapy or Interpersonal Psychotherapy will depend upon both the skills of the particular therapist and the engagement of the individual in the therapeutic process. It is essential that any therapist using psychological therapies be both trained in the particular techniques and supervised by a colleague who is qualified and experienced in the same therapies. The ability of any person experiencing Major Depressive Disorder to engage in therapy will depend upon their capacity to examine and assess their beliefs and views of themselves and their environment and their ability to discuss this with the therapist. This will also be influenced by their language skills, insight, intellectual abilities and cultural and spiritual beliefs.

The effectiveness of therapy can also be influenced by the following key characteristics of the therapist and the individual in relation to each other:

- language (ideally both should have the same primary language and at the very least the therapist should be aware of the limitations of working with a person in other than their primary language)
- a common culture, or at least the therapist having in-depth understanding and acceptance of the person's culture
- acceptance and understanding of the person's spiritual and religious beliefs
- safety, especially for patients who have been sexually abused. Therapists should be aware of their responsibilities and behaviour.

Primary healthcare workers should not generally provide psychological therapy for their patients unless specifically trained and experienced in the particular technique required. Referral to an appropriately skilled psychotherapist should be arranged as necessary.

When to use psychological therapy

In general, psychological therapy is indicated if:

- the presenting person with mild to moderate depression chooses psychological therapy as their first line treatment. Psychological therapy should not be considered as an initial treatment on its own if the Major Depressive Disorder is chronic or there are features of psychosis or melancholia
- the person has had a partial response at week six or twelve and the residual symptoms are largely psychological
- there are continuing issues with family and work situations or cognitive beliefs that significantly increase the likelihood of relapse.

A prerequisite for therapy is that the person is able to participate in a therapeutic relationship.

Table 6 outlines general guidelines of the types of psychological therapies that are indicated in various circumstances.

In all cases, psychological therapy should only be contemplated if a competent trained therapist, skilled in the particular techniques required, is available.

How to use psychological therapy (alone or with medication)

Most people begin to feel better after 2 months of psychological therapy. Research suggests at least 8 sessions over approximately 6 weeks of therapy, or 16 weeks if the person is severely depressed, may be indicated (Shapiro et al, 1994). Therapeutic effectiveness should, in any case, be reviewed after 8 sessions,

Table 6. Indications for the selection of an appropriate psychological therapy

Primary Objectives	Examples
1. Symptom removal	Cognitive-Behavioural and Interpersonal Psychotherapy
2. Restoration of normal psychosocial and occupational functioning	Case management; Cognitive-Behavioural, psychoeducational, occupational, marital or family therapy
3. Prevention of relapse/recurrence	Maintenance[25] therapy (Cognitive-Behavioural, interpersonal, other)
4. Correction of "causal" psychological problems with secondary symptom resolution	Marital, family, cognitive, interpersonal, brief dynamic, and other therapy
5. Increased adherence to medication	Clinical case management; specific Cognitive-Behavioural, or other psycheducational techniques or packages.
6. Correction of secondary consequences of the major Depressive Disorder (eg marital discord, low self-esteem)	Occupational, marital, family interpersonal, cognitive therapy, other therapies focused on specific problems.

Adapted from Table 10, Major Depressive Disorder in Primary Care: Volume 2. Treatment of Major Depressive Disorder. Agency for Health Care Policy and Research, US Department of Health and Human Services, 1993.

and if there is no positive change in the person's symptoms, the management plan should be reviewed and alternative therapeutic possibilities be considered, if the person agrees. However, when the person is suffering from severe depression and/ or has multiple issues, therapy may need to be extended for 6 months or longer, possibly in combination with other treatments.

If the person is receiving income support or is on a low income, they may qualify for a Disability Allowance of up to $40.61 per week from New Zealand Income Support Services towards the cost of psychological therapy.

The psychological therapies referral

When psychological therapy is selected as a treatment, the following principles may be useful:

- the referral should be made to therapists who are experienced and trained to work with people with depressive disorders[26], such as clinical psychologists, psychiatrists, psychotherapists, and qualified counsellors. It is strongly recommended that referrals are only made to therapists who are members of a recognised professional organisation which has documented ethical guidelines, professional conduct procedures and requirements for supervision
- in making a referral it is important to consider the ethnic and cultural background of the therapist and other factors influencing the effectiveness of psychological therapies outlined earlier
- it is helpful when making a referral to indicate the needs of the person and their suspected problem areas, the expectations of the referral and the ongoing responsibilities for management and crisis management
- the psychological therapy should generally be time-limited, focused on those current problems identified with the depressed person and aimed at symptom resolution
- assessment of symptom response is useful for planning the next step in treatment. To ensure that adequate feedback is received from the therapist, the referrer should specify that they want a report on progress, after a specified period of time. This sharing of information should be done with the person's consent but also in accordance with accepted principles of confidentiality. Where issues of safety are relevant, client consent is desirable but not mandatory (Privacy Act)
- there is a need to measure and monitor the outcome of psychological therapies whenever treatment is initiated. This is especially important if psychological therapies alone are being used and the person fails

[25] Maintenance refers to ongoing treatment after return to premorbid levels of functioning for at least 6 months.

[26] Organisations that are able to supply a list of therapists who are experienced and appropriately trained include the New Zealand Psychological Society, New Zealand Association of Counsellors, New Zealand Association of Psychotherapists, the New Zealand Association of Social Workers, the New Zealand College of Clinical Psychologists and the New Zealand Association of Child Psychotherapists. Universities or Polytechnics who have training programmes for clinicians may also be a source of information on appropriate practitioners. Community Mental Health Centres are also a source of information, as well as offering the assessment and treatment skills of a multidisciplinary team for moderately and severely depressed people.

to show any improvement in depression by six weeks, or marked improvement by twelve. In such situations, a re-evaluation of the process, in conjunction with the therapist, should occur.

Treatment issues for special populations

Older people

The treatment and management of depressive disorders in older people is essentially along the same lines as for the younger patient, while acknowledging the social, cultural and age specific needs of the person. Cultural issues will be particularly important for older people who have immigrated to New Zealand and whose cultural values and expectations are significantly different (eg Pacific Islanders, Eastern Europeans and Asians).

While the efficacy of various treatments for depression among the elderly is approximately equal to that found in adults in general, there are a number of factors that potentially make treating an elderly depressed person more difficult. Elderly people have a high rate of comorbid medical disorders, and are often more sensitive to side effects of medication. Lack of social support, and personal forgetfulness may also make them less likely to take their medication.

Psychological therapy has been generally found to be effective with older people, but may be less acceptable to them than medication. If medication is prescribed, the practitioner may need to monitor plasma antidepressant levels, as slower metabolism may increase plasma levels of medication and lower doses may be required.

For Major Depressive Disorder of moderate severity without melancholic features, selective serotonin reuptake inhibitors are indicated as first line treatment. Severe or melancholic Major Depressive Disorders are best treated with a tricyclic antidepressant if the patient does not have any contraindication. The secondary amines (ie nortryptiline) and desipramine have significantly fewer side effects and are indicated as the first line of treatment. Tertiary amine tricyclic antidepressants such as amitrityline and doxepin are not indicated for older people as their anticholinergic effects can cause delirium, constipation and prostatism, they are sedating and they cause postural hypotension. However, any tricyclic antidepressant is likely to impair cardiac conduction, and if there is any suggestion of cardiac disease the person should have an ECG before a tricyclic antidepressant is prescribed.

Severely depressed older people frequently have psychotic symptoms and their illnesses may rapidly worsen to the point where they refuse fluids and become dehydrated. Early recognition of psychosis is therefore essential. When psychotic symptoms are present the person should be promptly referred to specialist mental health services for evaluation and treatment. Dehydration secondary to Major Depressive Disorder requires immediate hospitalisation. Psychotic Major Depressive Disorder can be treated with combined antidepressant and anti-psychotic medication or electroconvulsive treatment (ECT).

If the elderly person is being treated in their own home, consideration of the needs of the elderly person's care givers must be taken into account. Agitation (a common feature of depression in the elderly) is exhausting for the carer. It must be ensured that care givers (particularly elderly carers) have adequate support to cope with the burden of care.

Children and adolescents

The occurrence of Major Depressive Disorder in this group is often complicated by co-morbid disorders, parental dysfunction and relationship factors. The diagnosis must also be made in the context of the individual's stage of development and culture. Organic causes and alcohol and drug abuse (especially in adolescents) must also be considered in the differential diagnosis. All of this serves to highlight the fact that making the diagnosis of Major Depressive Disorder in children and adolescents can be difficult.

A major consideration in assessment is that of the risk of suicide. It is very difficult to make an accurate assessment of this with any certainty, but previous attempts, particularly those with high lethality, indicate the need for specialist consultation. Amongst adolescents, the various co-morbid disorders such as conduct disorder and substance abuse increase the risk of suicide. Certainly, expressions of suicidal intent are an important marker for the level of distress experienced by the individual.

The process of assessment and treatment of children and adolescents requires active involvement with the

family/whanau, school, and other relevant resources in the community (eg New Zealand Children and Young Persons Service, Child and Family Clinics, etc). The first line of treatment should be a comprehensive approach that includes working with the family/whanau, co-ordination with their school and individual and/or group psychotherapy.

When a child is diagnosed as experiencing a depressive episode, referral to a specialist for treatment should be considered. If there is evidence of more severe depression such as a Major Depressive Episode, multiple episodes, risk of attempted suicide, self harm or violence to others, or non response to the treatment, referral to a specialist child and adolescent mental health service is strongly recommended.

Depending upon the age of the adolescent and the severity of the depression, the general practitioner may be able to manage the depression in conjunction with specialist advice. The literature does not support the view that tricyclic antidepressants are effective with this group and there are significant risks associated with their use, including cardiovascular hazards. There is limited preliminary support for the use of fluoxetine, but further studies are required before this can be recommended. If antidepressant medication is being considered in this age group, specialist child psychiatric advice should be sought.

Women

If the assessment has indicated abuse (emotional, physical or sexual), unresolved issues in relation to stressful life events, then referral to specialised therapy, counselling or support groups should be considered, in addition to any other forms of treatment (support networks and organisations for specific issues are listed in Appendix 8).

There are a number of special concerns about selecting antidepressants for women, especially in relation to childbirth. Women who are taking birth control medication may require higher doses of tricyclic antidepressants because of the induction of hepatic enzymes responsible for drug metabolism. When treatment with an antidepressant is being considered during pregnancy, or when there is a likelihood of pregnancy, tricyclic antidepressants are preferred to newer antidepressants because of the greater knowledge of the apparently low teratogenic risk with these compounds. The amount of tricyclic medication that is secreted in breast milk appears too small to be harmful, but nevertheless should be discussed with the depressed mother.

Lithium however is secreted in breast milk, as is Fluoxetine (at about one fifth to one quarter of the concentration in maternal plasma). Breast feeding while taking these drugs should be avoided.

When a pregnant woman's Major Depressive Disorder is of moderate severity, psychological therapies should be offered as an alternative. If at all possible, antidepressants should be avoided in the first trimester and when breast feeding.

Some of the specific risk factors that need to considered when assessing depression in women are: lack of social support, lack of opportunities (ie education and employment), poverty and poor health (McGrath, 1990).

Support groups for women suffering from Postnatal Major Depressive Disorder have been found useful (Gruen, 1990; Handford, 1985). Information about local support networks, including those available for women and their partners, is likely to be available from local Community Mental Health Centres.

Sexual Orientation

If assessment has indicated that stressors associated with the Major Depressive Disorder relate primarily to sexual identity or acceptance of sexual identity, then in addition to other treatments, referral to a specialised counselling agency, 'coming out' networks and support groups should be considered. The risk of suicide should continue to be monitored carefully as the person may not have family support. Support services that can provide information are listed in Appendix 8.

Cultural issues

Appreciation of how the person views their depressive disorder is critical for any successful treatment. When working with people of the health professional's own ethnic group it is important not to assume that they subscribe to the same cultural or world views.

Respectful inquiry into how the person views their depressive disorder and what treatments they consider are appropriate will go a long way towards ensuring selection of treatments which the person will accept and follow. The presence of a family member or support person can be useful in enabling the person to speak

about these issues. If there is a specialist health service for the person's cultural group, the health professional should offer to involve this service in the treatment process.

Maori

In treating a depressed Maori person, it is important to establish at an early stage whether any cultural factors are contributing to aspects of the presenting disorder. If they are, then serious consideration should be given to involving a Maori health worker or skilled Maori elder in the assessment and treatment stages, or to making a referral to a specialist Maori Health Service.

In referring a person to another service, or making contact with a Maori health worker or elder, the primary healthcare worker should ensure that they:

- obtain the patient's permission to release information to another person (as prescribed in the Privacy Act)
- where possible, someone from the health centre should accompany the person to the consultation. When this is not possible, a family member or close friend should accompany the person. It is not appropriate that the person go alone. This form of collaboration does not however imply that the primary healthcare worker ceases to have any responsibility for the client.

If the treatment of the person is to take place jointly with a Maori elder or Maori health service, then there should be clear definition of the respective roles and responsibilities, ongoing sharing of information from both specialists and attention to clarification of terms and concepts from the different perspectives. This is likely to work best when there is an existing relationship between the healthcare provider and Maori services, preferably established before any particular patients are referred for assessment or joint treatment.

It is particularly important for Maori that any treatment and ongoing support involve the whole range of people and activities with which they have, or could potentially have, contact. This will include the family/ whanau, the marae, and perhaps also sports clubs, peer support groups, local consumer groups, social activities and the work place.

Pacific Islands People

When treatment for Major Depressive Disorder is indicated for a Pacific Islands person, a number of factors need to be taken into account when selecting the appropriate intervention and provider:

- the person should be offered the option of an appropriate Pacific Islands healthcare worker(s).
- guidance from a Pacific Islands service or recognised local and community organisation is recommended
- inclusion of a religious minister, pastor or priest (Faifeau, Akoako) may be offered. Elder (Matua) intervention may be offered if requested by the depressed person
- alternative healing such as traditional healers (Fofo, Taulasea) may be offered, particularly if requested by the depressed person
- inclusion of a support person(s), advocate, family or significant others for the depressed person is vital.

Pacific Islands Elderly (Matua) go through acclimatising to New Zealand's values and beliefs to varying degrees. In the Pacific the Matua's position in families is revered and honoured. In New Zealand their roles are centred around the home and childcare. Socio-economic factors such as both parents needing to work to generate an income, children whose first language is English and whose priorities are different from that of the Island born, impact on how the Matua is treated within the home. The gradual erosion of the Matua's status is evidenced in the dimensions of spirituality (Fa'aleagaga) which invariably will affect all the other dimensions depending on severity, and eventually leads to symptoms of Major Depressive Disorder. Lack of outwardly shown respect, humility and reverence (Fa'aaloalo) is very much perceived by the Island born, and to some degree first generation New Zealand born, as abuse.

Nearly half of the total Pacific Islands population in New Zealand (47%) is under the age of 20 years (The Health of Pacific Islands People in New Zealand, 1994). Pacific Islands youth (both Islands and New Zealand born) have the highest suicide rate in the OECD (*The Progress of Nations* UNICEF Report, 1994). Thus youth suicide is a major concern for Pacific Islands people. The dimensions affected are spirituality (Fa'aleagaga), culture (Aganu'u) and other (O Isi Mea). Conflict between these three dimensions will invariably affect the mental (Mafaufau) dimension and if the conflict is left unresolved, suicide or attempted suicide

becomes an alternative. Issues of conflict can range from sexuality, acceptance, peer pressure, unrealistic expectations, self-esteem, tradition versus western-isation, religion and most importantly success versus failure. Signs and symptoms preceding attempts or successful suicides are not readily recognised, mainly due to the fact that Pacific Islands people tend to rely on non-verbal communication over oral communication.

Assessment and intervention require gender, age and culturally appropriate intervention. Access to services needs to be streamlined and early prevention and detection in schools, such as Intermediates and Colleges, requires a high profile. Use of anti-depressants or counselling and mainstream psycho-logical interventions seldom has an effect on Pacific Islands youth due to poor compliance coupled with guilt and shame issues surrounding talking to someone outside of the family.

After starting treatment, the primary task becomes monitoring progress and, as necessary:

- facilitating adherence to treatment(s)
- adjusting treatment(s) as necessary
- augmenting the primary treatment if necessary
- referring to specialist mental health services if symptoms worsen or there is a significant risk of harm to self or others (especially people caring for young children).

While it is suggested that there is a major review every six weeks, significant adverse change during this period should lead to appropriate action as soon as possible.

Monitoring

The frequency and method of monitoring each person's depressive condition should be decided in consultation with them. Ideally a balance should be sought which minimises intrusiveness and cost to the individual while ensuring that the health professional has reliable and accurate information about the treatment response, any negative side effects that may reduce compliance and any significant alteration in the stressors or supports which may worsen the depressive disorder.

Monitoring will be most effective if carried out in the context of an open and honest relationship. Regular (weekly or fortnightly) monitoring is best done by the same person who should have appropriate clinical training and experience. Regular (less frequent) monitoring should continue for at least 12 months from the recovery from a depressive episode and the cessation of medication.

The most accurate means of monitoring the person's mood is to use one of the rating scales provided in Appendices 3 to 5 (Hamilton, CES-D or Edinburgh Postnatal Major Depressive Disorder Scale). These rating scales take as little as 5 - 10 minutes to complete, ensure all aspects of the depressive disorder are considered and provide the opportunity to make a comparison over time. The Hamilton rating scale is the most comprehensive and is best carried out as part of a face to face consultation. The CES-D provides a reliable estimate of the level of Major Depressive Disorder and is suitable for use by nurses and counsellors. The CES-D can also be used in the course of a telephone call or in some cases completed by the person themselves and delivered to the health centre. The Edinburgh scale is specifically designed for mothers experiencing a depressive disorder following childbirth and can be used in a telephone consultation.

While questionnaires are important tools which allow comparison of severity of Major Depressive Disorder over time, it is critical that the healthcare worker also be aware of other signs which arouse suspicion about increasing severity of the Major Depressive Disorder or any thoughts of harm to the person or others. People do not always find it easy to communicate disturbing feelings. If there appear to be unspoken concerns, increase the frequency of the monitoring and consider a referral to a more experienced colleague or the mental health services.

Continuation of treatment

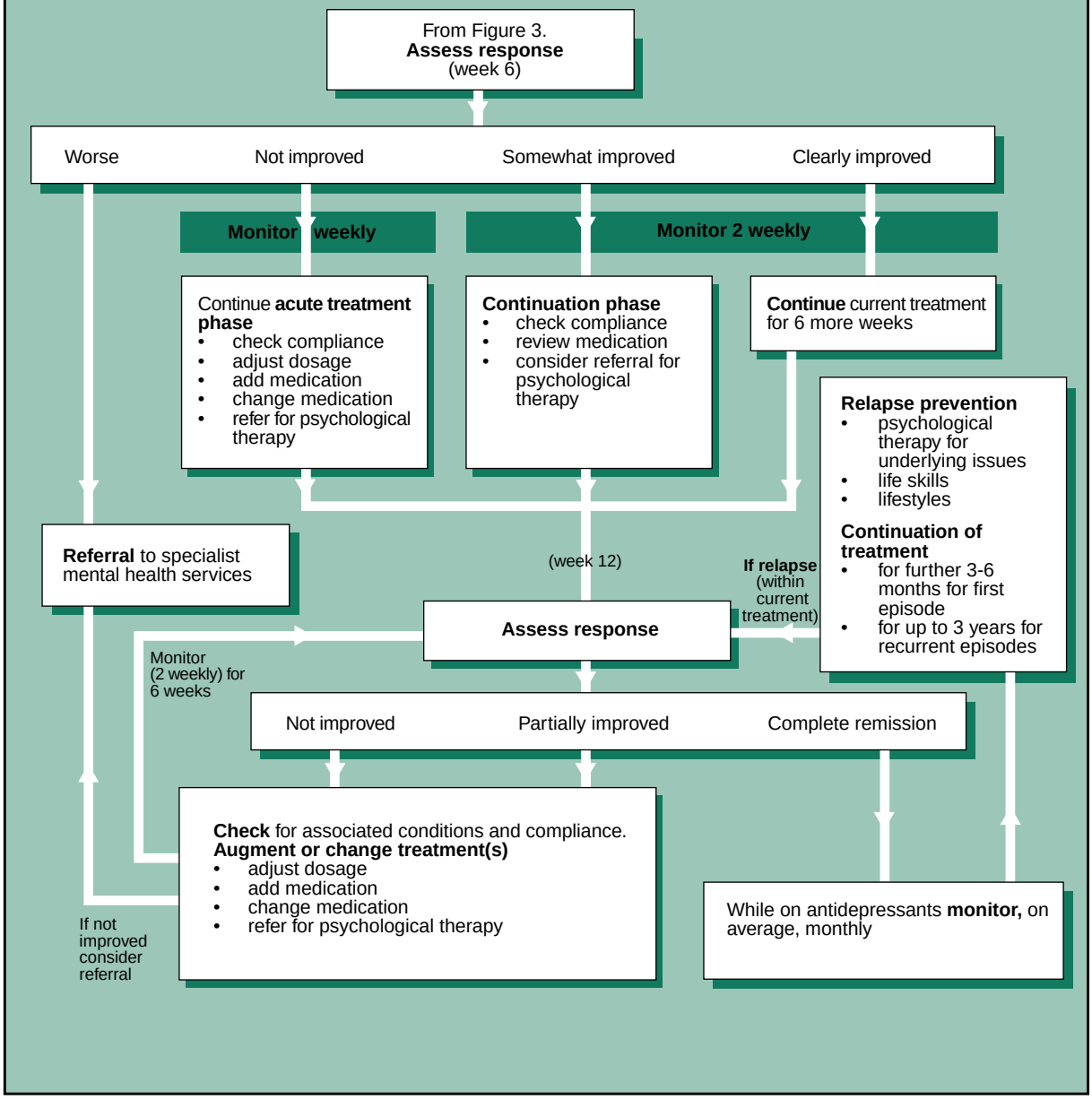
In general, it is important that treatment continue after initial relief from the acute symptoms. The person is at risk of relapse during the early stages of recovery and therefore requires continued monitoring and active treatment until they have fully recovered from their Major Depressive Disorder. The frequency of monitoring will depend upon the phase of treatment (more often during early stages or when the Major Depressive Disorder is more severe).

While the majority of people can expect to recover from the index episode of Major Depressive Disorder, some 20% will experience a partial remission and continue to experience continuing symptoms. An exceptional group are those who had Dysthymic Disorder prior to developing the depressive disorder (the so-called "double depression") who recover from the Major Depressive Disorder but not their Dysthymic Disorder. While this group seem to recover more quickly from their depressive disorder, they are at very high risk of relapsing into another depressive episode - consequently having significantly faster cycles of recovery and relapse (WPA, 1995). Keller and Lavori (1984) report that after two years, 97% of those with "double depression" recovered from their depressive disorder but only 39% had recovered from their underlying Dysthymic Disorder.

Effective treatment for the continuation phase

The general rule is that the treatment which was effective during the acute treatment phase should be continued. Medication should be maintained at the full dosage required to attain symptom remission in the acute treatment phase.

Figure 4. Outline of key factors in CONTINUING TREATMENT



There is some indication that regular psychological therapy will at least delay the onset of the next episode (Frank et al, 1990) and that Cognitive-Behavioural Therapy during the treatment phase, on its own or in combination with imipramine, is as effective as continuing imipramine during a two year post-treatment phase (Evans et al, 1992).

Changing treatments

Clinical experience indicates that wherever possible, other supportive care should be provided in the period during and immediately following discontinuation of medication or psychological therapy. The nature of this support will depend upon the needs of the person. It may involve a social worker and could include

Table 7. Factors to be considered in prescribing maintenance medication

Features of the depressive disorder	Strength of indication that maintenance medication should be prescribed
1. Three or more episodes of major depressive disorder	Very strongly recommended
2. Two episodes of Major Depressive Disorder and	Strongly recommended
a. Family history[27] of Bipolar Disorder	Strongly recommended
b. History of recurrence within 1 year after previously effective medication was discontinued	Strongly recommended
c. A family history of recurrent Major Depressive Disorder	Strongly recommended
d. Early onset (before age 20) of the first episode	Strongly recommended
e. Both episodes were severe, sudden or life threatening in the past 3 years	Strongly recommended
3. Previous or current Dysthymic Disorder (Shea et al 1992)	Recommended

Adapted from Table 16 in Major Depressive Disorder in Primary Care: Volume 2. Treatment of Major Depressive Disorder. Clinical Practice Guideline 5, US Department of Health and Human Services, 1993, page 111.

maximised income support, housing, involvement in work or meaningful activities, regular contact with support groups etc.

Maintenance

Maintenance therapy is indicated for those people who have the highest risk of developing a new episode of Major Depressive Disorder. It assumes that there has been successful treatment of the previous depressive episode (if not, continuation rather than maintenance therapy is indicated).

The indications for continuation of medication are listed in Table 7. This information is based on a 1985 National Institute of Mental Health consensus conference and a limited number of studies. The appropriate length of maintenance treatment may vary from one year to, in some cases, lifetime, depending upon the history and ongoing assessment of risk of recurrence in the individual. However, there should be continuing discussion about the management of the depression.

It is recommended that maintenance treatment with tricyclic antidepressants should be at the full therapeutic dose, as research studies indicate reduced dosage is associated with poorer outcomes. Selective serotonin re-uptake inhibitors should also be continued at the full therapeutic dose, however, this is based on clinical experience rather then research evidence.

How to maintain outcomes and prevent relapse

Subsequent treatment for Major Depressive Disorder will differ depending upon:

- whether this is the first or a subsequent episode of a Major Depressive Disorder. For the first episode, any antidepressant treatment should be continued for six to nine months in total (ie three to six months after the person has experienced remission). For second or subsequent episodes, antidepressants should continue to be taken for up to three years after remission. The exact period of time will vary depending upon factors such as whether they also suffer from Dysthymic Disorder, the level of stressors and/or supports and any outstanding psychosocial issues that have not responded to psychological therapy
- the presence of Dysthymic Disorder. A Dysthymic Disorder should be treated with antidepressants for a period of up to three years together with appropriate life skills training and psychological therapy (WPA, 1995). The exact form of psychological therapy indicated will depend upon the social and interpersonal disabilities that the person experiences. Teaching problem solving skills, improving life skills and acquisition of skills to cope with symptoms and situations should be considered in all cases. Depending upon the person's

[27] A positive, clear-cut history in one or more first degree relatives.

circumstances there may be value in also including Interpersonal Psychotherapy, Marital Therapy (including related social work), Family Therapy and Cognitive-Behavioural Therapy.

Self-help groups

The role of family and friends is very important in the recovery from Major Depressive Disorder and in providing a supportive environment in the months and years ahead. However, not everyone has such support. Self-help groups can offer valuable support for such people and provide an opportunity for those who have suffered from Major Depressive Disorder to offer assistance to others.

A list of self-help groups can be found in Appendix 8. Some are specifically for people who suffer or have suffered from a particular disorder. Others are open to any person who has experienced a mental health disorder.

Psychological therapies

As previously indicated, there is evidence that some psychological therapies are as effective as anti-depressants for mild to moderate Major Depressive Disorder and where there are no significant melancholic features.

If psychological therapy was the primary treatment in the initial treatment phase (first six weeks) and symptoms persist, another eight sessions might be considered. However, more than 16 sessions of psychological therapy is not generally recommended. If there is continuing significant depression, either antidepressants may be prescribed or a specialist mental health assessment may be obtained before any additional sessions of psychological therapy are contemplated.

If the initial treatment was monitoring alone or antidepressants, then psychological therapy might be considered for treatment of residual symptoms. Psychological therapy is also useful when there are significant interpersonal issues contributing to the depressive disorder or evidence of significant and persistent negative thoughts. Eight sessions of Interpersonal Psychotherapy, Cognitive-Behavioural Therapy or Marital/ Family therapy is recommended initially. This may be extended to 16 sessions if progress is being made towards resolution of significant psychosocial issues.

Discontinuation of medication

There is growing evidence that rapid cessation of any antidepressant can cause a withdrawal syndrome with onset after a few days and resolving within about four weeks. In general all medications should be tailed off over a four week period. This is probably not necessary for fluoxetine due to its extended half-life. A useful strategy is to try and determine how low a dose is required to "keep you well". Patients should be informed of this and advised not to suddenly cease treatment.

Specialist treatment

When to refer to mental health services or a psychiatrist**:**

- When there is a serious risk of suicide (or risk to others)
- When melancholic features are so severe that the individual is unable to look after him or herself and has inadequate community support (eg lives alone with little social support)
- When there are psychotic symptoms
- When the diagnosis is unclear and needs further evaluation
- When the Major Depressive Disorder has failed to respond adequately to recommended treatment within 12 weeks
- When there are complex problems that are difficult to manage in the primary care setting (for example, when it has not been possible to establish a therapeutic alliance; when the person suffers another psychiatric disorder as well as Major Depressive Disorder; when inadequate resources prevent suitable support/treatment, etc)
- When considering enhancements of antidepress-ants by lithium, or the use of mood stabilisers in bipolar affective disorder or for treatments unavailable in the primary sector (eg ECT)
- When the depressed person is under the age of 13 years.

Valuable information when referring

The mental health professional seeing the depressed person suffering from Major Depressive Disorder for the first time gains only a cross-sectional view of their problems which may be coloured by the circumstances of the moment, such as a desire to minimise problems

to avoid possible admission to hospital. It is also difficult to assess premorbid personality strengths or difficulties in such a situation. The primary care practitioner usually has valuable longitudinal information about the person's usual personality and coping abilities and medical history that can greatly assist the assessment. It is best if this is documented in writing to ensure that the information is utilised to the full.

The following topics are especially helpful in formulating information from primary care:

- symptoms of Major Depressive Disorder (evolution, duration, severity)
- safety concerns (self-harm, risk to others, degree of self neglect)
- current and previous treatments for this episode and their effectiveness, including exact doses and duration of medication
- previous psychiatric history (diagnoses, treatments, effectiveness)
- contributing stressors
- available supports
- premorbid personality and strengths
- the nature of assistance required by the referring practitioner (ie to take over management, to offer an opinion and advice about further treatment, to participate in joint management).

APPENDICES

Appendix 1 DSM-IV criteria for the diagnosis of Major Depressive Episode and Dysthymic Disorder [28]

Criteria for Major Depressive Episode (DSM-IV)

A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

   Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

   (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (eg feels sad or empty) or observation made by other (eg appears tearful). **Note**: In children and adolescents can be irritable mood.

   (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

   (3) significant weight loss when not dieting or weight gain (eg a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note**: In children, consider failure to make expected weight gains.

   (4) insomnia or hypersomnia nearly every day.

   (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

   (6) fatigue or loss of energy nearly every day.

   (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

   (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

   (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (eg a drug of abuse, a medication) or a general medical condition (eg hypothyroidism).

E. The symptoms are not better accounted for by bereavement, ie, after the loss of a loved one, the symptoms persist for longer than two months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

[28] Printed with permission of the American Psychiatric Association, 1400 K Street, N.W., Washington, DC, United States of America 20005.

Criteria for Dysthymic Disorder (DSM-IV)

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least two years. Note: In children and adolescents, mood can be irritable and duration must be at least one year.

B. Presence, while depressed, of two (or more) of the following:

(1) poor appetite or overeating

(2) insomnia or hypersomnia

(3) low energy or fatigue

(4) low self-esteem

(5) poor concentration or difficulty making decisions

(6) feelings of hopelessness.

C. During the two year period (one year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. No Major Depressive Episode has been present during the first two years of the disturbance (one year for children and adolescents); ie, the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, in partial remission.

Note: There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder. In addition, after the initial two years (one year in children or adolescents) of Dysthymic Disorder, there may be superimposed episodes of Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for a Major Depressive Episode.

E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.

F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.

G. The symptoms are not due to the direct physiological effects of a substance (eg, a drug of abuse, a medication) or a general medical condition (eg, hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Early onset: if onset is before age 21 years

Late onset: if onset is age 21 years or older

Specify if:

With Atypical Features

Appendix 2. Medical conditions that commonly have associated symptoms of Major Depressive Disorder

Medical conditions that commonly have associated syptoms of Major Depressive Disorder are listed in the table below:

Medical Conditions	Relationship with Depressive Disorder
Stroke	There appears to be a sub group of depressed post-stroke patients whose Major Depressive Disorder is causally related to the extent of the brain injury; a family history of Major Depressive Disorder; premorbid subcortical atrophy; and premorbid or ongoing social factors.
Dementia	Symptoms of Major Depressive Disorder are often seen in patients with, or antecedent to, both cortical and subcortical dementia. In selecting treatment, it is prudent to assume that these symptoms are part of a depressive disorder until proven otherwise. If the symptoms do not reduce with treatment, a primary diagnosis of dementia should be entertained.
Metabolic and Endocrinological diseases (eg diabetes thyroid, parathyroid renal disease and vitamin B12 deficiency)	Major Depressive Disorder is more common in populations with metabolic and endocrinological disorders and is likely to be unrecognised and untreated. As Major Depressive Disorder will reduce compliance and effectiveness of the treatment of the primary disorder it is recommended that all patients are screened and, as necessary, assessed and treated for Major Depressive Disorder.
Coronary Artery Disease especially post myocardial infarction (heart attack)	The relationship between Major Depressive Disorder and increased morbidity and mortality is well documented in both post-myocardial infarction and in coronary artery disease without myocardial infarction. Given this higher morbidity and the fact that most patients do not develop a Major Depressive Disorder, screening and, as necessary, assessment and treatment is indicated.
Cancer	Major Depressive Disorder occurs in approximately 25% of patients with cancer and is even more common in advanced cancers. Symptoms of persistent dysphoria, feelings of helplessness and worthlessness, loss of self esteem, and wish to die are the most reliable indicators of clinical Major Depressive Disorder in this setting. Depressed mood is a common side effect of the drugs used to treat cancer.
Chronic Fatigue Syndrome	Neuropsychiatric and neuroendocrine features associated with CFS may mirror those of Major Depressive Disorder, including: apathy, withdrawal, loss of energy, and approximately 20% of patients with CFS will have experienced a depressive disorder. A thorough assessment is required to differentiate between a depressive disorder and the formal Chronic Fatigue Syndrome.
HIV - AIDS	Depression is common in these conditions, particularly following the initial positive HIV test and around the formal diagnosis of AIDS, although it can occur at any stage of the disorder. Those ill with AIDS are more prone to side effects of antidepressants.
Fibromyalgia	Research suggests significantly higher rates of Major Depressive Disorder in patients with Fibromyalagia. Assessment is indicated in all cases of Fibromyalgia and any Major Depressive Disorder treated separately from the physical disorder.

Adapted from the US Department of Health Guidelines Major Depressive Disorder in Primary Care.

Appendix 3. Structured Interview guide for the Hamilton Major Depressive Disorder Rating Scale

Pt's Name: **Pt's ID:**

Stroke **Date:**

Overview: I'd like to ask you some questions about the past week. How have you been feeling since last (day or week)?

---

1. What's your mood been like the past week?

Have you been feeling down or depressed?

Sad, hopeless?

In the last week, how often have you felt (own equivalent)**? Every day? All day?**

If scored 1-4 above ask: How long have you been feeling this way?

Depressed mood (sadness, hopeless, helpless, worthless):

0- absent
1- indicated
2- spontaneously reported verbally
3- communicated non-verbally
4- virtually only: this in spontaneous verbal and non-verbal communication

---

2. Have you been especially critical of yourself this past week, feeling you've done things wrong, or let others down?

If yes: in what way? Name your thoughts. Have you been feeling guilty about anything that you've done or not done?

Have you thought that you've brought (this Major Depressive Disorder) **on yourself in some way?**

During this past week, have you had any thoughts that life is not worth living, or that you'd be better off dead? What about having thoughts of hurting or even killing yourself?

If yes: What have you thought about? Have you actually done anything to hurt yourself?

Feelings of guilt:

0- absent
1- self reproach, feels he/she has let people down
2- ideas of guilt or rumination over past errors or sinful deeds
3- present illness is a punishment
4- hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations.

Suicide:

0- absent
1- feels life is not worth living
2- wishes he /she was dead or any thoughts of possible death
3- suicidal ideas or gestures
4- attempts at suicide

---

3. How have you been sleeping over the last week?

Have you had any trouble falling asleep at the beginning of the night? (Right after you go to bed, how long has it been taking you to fall asleep?)

How many nights this week have you had trouble falling asleep?

Insomnia early:

0- no difficulty falling asleep
1- complains of occasional difficulty falling asleep (ie more than 1/2 an hour)
2- complains of nightly difficulty falling asleep

4. During the past week, have you been waking up in the middle of the night?

If yes: Do you get out of bed? What do you do? (Only go to the bathroom?)

When you get back in bed, are you able to fall right back asleep?

Have you felt your sleeping has been restless or disturbed some nights?

Insomnia middle:

0- no difficulty falling asleep
1- complains of being restless and disturbed during the night
2- waking during the night - any getting out of bed (except to void)

5. What time have you been waking up in the morning for the last time, this past week?

If early: Is that with an alarm clock , or do you just wake up yourself? What time do you usually wake up (that is, before you got depressed?).

Insomnia late:

0- no difficulty falling asleep
1- waking in early hours of morning but goes back to sleep
2- unable to fall asleep again if gets out of bed

Appendix 3. Structured Interview guide for the Hamilton Major Depressive Disorder Rating Scale

6. How have you been spending your time this past week (when not at work)?

Have you ever felt interested in doing (those things), or do you feel you have to push yourself to do them?

Have you stopped doing anything you used to do? If yes: Why?

Is there anything you look forward to?

(At follow up: Has your interest been back to normal?)

Work and Activities

0- no difficulty
1- thoughts and feelings of incapacity, fatigue or weakness related to activities, work or hobbies
2- loss of interest in activities, hobbies or work - by direct report of the person or indirect in listlessness, indecision and vacillating (feels he/she has to push self to work or activites)
3- decrease in actual time spent in activities or decrease in activities (hospital job or hobbies)
4- stopped working because of present illness. In hospital no activities except ward chores, or fails to perform ward chores unassisted

7. Rating based on observation during interview

Retardation: (slowness of thought and speech; impaired ability to concentrate; decreased motor acivity):

0- normal speech and thought
1- slight retardation at interview
2- obvious retardation at interview
3- interview difficult
4- complete stupor

---

8. Rating based on observation during interview

Agitation:

0- none
1- fidgetiness
2- playing with hands, hair etc
3- moving about, can't sit still
4- hand-wringing, nail biting , hair pulling, biting of lips

9. Have you been feeling especially tense or irritable this past week?

Have you been worrying a lot about little un-important things, things you wouldn't ordinarily worry about?

If yes: **Like what, for example?**

Anxiety psychic:

0 - no difficulty
1 - subjective tension and irritability
2 - worrying about minor matters
3 - apprehensive attitude apparent in face or speech
4 - fears expressed without questioning

10. In this last week, have you had any of these physical symptoms?

Read list adjacent, pausing after each section for reply.

How much have these things been bothering you this past week?

Anxiety Somatic: Physiological concomitants of anxiety, such as:

Gastro-intestinal: dry mouth, gas, indigestion, diarrhoea, cramps, belching
Cardio vascular: heart palpitations, headaches
Respiratory: hyperventilating, sighing, having to urinate frequently, sweating

11. (How bad have they been? How much of the time, or how often, have you had them?)

0 - absent
1 - mild
2 - moderate
3 - severe
4 - incapacitating

Appendix 3. Structured Interview guide for the Hamilton Major Depressive Disorder Rating Scale

12. How has your appetite been this past week? (What about compared to your usual appetite?)

Have you forced yourself to eat?

Have other people urged you to eat?

Somatic Symptoms Gastrointestinal:

0 - absent
1 - loss of appetite but eating without encouragement
2 - difficulty eating without urging

13. How has your energy been this past week?

Have you been tired all the time?

This week, have you had any backaches, headaches, or muscle aches?

Somatic Symptoms General:

0 - none
1 - heaviness in limbs, back or head backaches, headache, muscle aches. Loss of energy and feeling fatigued
2 - any clear-cut symptoms

14. How has your interest in sex been this week? (I'm not asking about perfomance, but about your interest in sex - how much do you think about it.)

Has there been any change in your interest in sex (from when you were not depressed)?

Is it something you've thought much about? If not: Is that unusual for you?

General Symptoms (such as loss of libido, menstrual disturbances):

0 - absent
1 - mild
2 - severe

15. In the last week, how much have your thoughts been focused on your physical health or how your body is working (compared to your normal thinking)?

Do you complain much about how you feel physically?

Have you found yourself asking for help with things you could really do yourself?

***If yes*: Like what, for example? How often has that happened?**

Hypochondriasis:

0- not present
1- self-absorption (bodily)
2- preoccupation with health
3- frequent complaints, requests
4- hypochondriacal delusions

16. Rating based on observation

Insight:

0- acknowledges being depressed and ill or not currently depressed
1- acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc
2 - denies being ill at all

17. Have you lost any weight since this (Major Depressive Disorder) began?

***If yes:* How much?**

***If not sure:* Do you think your clothes are any looser on you?**

***At follow up:* Have you gained the weight back?**

Loss of weight: (Rate either A or B)

A When rating by history
0 - no weight loss
1- probable weight loss associated with present illness
2 - definite (according to point) weight loss
3 - not assessed

B On weekly ratings by ward staff, when actual weight changes are measured:
0 - less than 500gm loss in week
1 - more than 500gm loss in week
2 - more than 1kg loss in week
3 - not assessed

Generally a score of 14 or more (out of a total possible score of 50) is seen as indicating a level of depression justifying treatment, and 6/7 or less as indicating remission. Hamilton (1982, cited in Williams et al, 1992) suggests that when the score on the HRS has been reduced to less than a third of its pretreatment level, patients feel that their treatment was successful.

Appendix 4

CES-D Major Depressive Disorder Scale

Circle the score (0,1,2 or 3) for each statement that best describes how often you felt this way during the past week.	Rarely or none of the time (< 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me	0	1	2	3
2. I did not feel like eating; my appetite was poor	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family and friends	0	1	2	3
4. I felt that I was just as good as other people	3	2	1	0
5. I had trouble keeping my mind on what I was doing	0	1	2	3
6. I felt depressed	0	1	2	3
7. I felt like everything I did was an effort	0	1	2	3
8. I felt hopeful about the future	3	2	1	0
9. I thought my life had been a failure	0	1	2	3
10. I felt fearful	0	1	2	3
11. My sleep was restless	0	1	2	3
12. I was happy	3	2	1	0
13. I talked less than usual	0	1	2	3
14. I felt lonely	0	1	2	3
15. People were unfriendly	0	1	2	3
16. I enjoyed life	3	2	1	0
17. I had crying spells	0	1	2	3
18. I felt sad	0	1	2	3
19. I felt that people disliked me	0	1	2	3
20. I could not 'get going'	0	1	2	3

* Developed by Radloff, L.S. (1977). The CES-D scale: a self report Major Depressive Disorder scale for research in the general population. Applied Psychological Measurement, 1, 385-401.

Appendix 5 Edinburgh postnatal major depressive disorder scale

The aim of the EPDS is to assist primary care teams in detecting mothers with Postnatal Major Depressive Disorder. Cox et al, who developed the scale, referred to published work demonstrating that 10-15% of the mothers experience a marked depressive illness in the months following childbirth. At least half had not recovered by the end of the postpartum year, and the children of such depressed mothers may show behaviour disturbance at three years or cognitive defects at four years.

The EPDS is a simple ten-item questionnaire intended to be capable of completion in five minutes. It is best administered during the second or third month postpartum. The mother should not be given the opportunity to discuss her answers with others, as this may influence results.

Scores for each item range from 0-3 according to severity.

The authors suggested a threshold score of 12/13; women scoring above this are most likely to be suffering from a depressive illness and therefore should be assessed further to confirm whether or not clinical Major Depressive Disorder is present. A threshold of 10 was suggested for routine use by primary care workers.

Instructions

As you have recently had a baby, we would like to know how you are feeling now. Please UNDERLINE the answer that comes closest to how you have felt IN THE PAST WEEK, not just how you feel today.

Here is an example, already completed.

I have felt happy:

Yes, all the time

Yes, most of the time

No, not very often

No, not at all

This would mean “I have felt happy most of the time” during the past week. Please complete the other questions in the same way.

EPDS score interpretation guide

Response categories are scored 0, 1, 2 and 3 according to increased severity of the symptom. Items marked with an asterisk (*) are reverse scored (ie, 3, 2, 1 and 0). The total score is calculated by adding together the scores for each of the ten items.

Appendix 5. Edinburgh postnatal depressive disorder scale

Patient Name: *Date:*

In the past week

1 I have been able to laugh and see the funny side of things:

As much as I always could

Not quite so much now

Definitely not so much now

Not at all

2 I have looked forward with enjoyment to things:

As much as I ever did

Rather less than I used to

Definitely less than I used to

Hardly at all

***3 I have blamed myself unnecessarily when things went wrong:**

Yes, most of the time

Yes, some of the time

Not very often

No, never

4 I have been anxious or worried for no good reason:

No, not at all

Hardly ever

Yes, sometimes

Yes, very often

***5 I have felt scared or panicky for no very good reason:**

Yes, quite a lot

Yes, sometimes

No, not much

No, not at all

***6 Things have been getting on top of me:**

Yes, most of the time I haven't been able to cope at all

Yes, sometimes I haven't been coping as well as usual

No, most of the time I have coped quite well

No, I have been coping as well as ever

***7 I have been so unhappy that I have difficulty sleeping:**

Yes, most of the time

Yes, sometimes

Not very often

No, not at all

***8 I have felt sad or miserable:**

Yes, most of the time

Yes, quite often

Not very often

No, not at all

***9 I have been so unhappy that I have been crying:**

Yes, most of the time

Yes, quite often

Only occasionally

No, never

***10 The thought of harming myself has occurred to me:**

Yes, quite often

Sometimes

Hardly ever

Never

TOTAL SCORE

Adapted from the US Department of Health Guidelines Major Depressive Disorder in Primary Care.

A Guide To Selection Of Antidepressants

Drug	Recommended outpatient dose for a depressive episode[1]	Cost for 30 days treatment[2]		Side effect profile: sedative	Side effect profile: anticholinergic	Side effect profile: postural	Other adverse effects	Contraindications	Precautions
Tricylic antidepressents (TCAs)									
Amitriptyline	150 mg	$28.98		+++	+++	++	**(Apply to all TCAs)** Excessive sweating, carbohydrate craving, weight gain, insomnia, delirium, sexual dysfunction, ECG changes	Acute MI	**(Apply to all TCAs)** Cardiovascular disorders, hepatic impairment, hyperthyroidism, epilepsy, suicidal tendencies, prostatic hypertrophy, narrow angle glaucoma or increased intraocular pressure, schizophrenia, bipolar affective disorder (mania), MAOIs, abrupt withdrawal
Clomipramine	100 mg	$69.88	SR	++	++	+			
Desipramine	150 mg	$160.23	HP	+	+	+/++			
Dothiepin	150 mg	$16.94		+++	++	++			
Doxepin	150 mg	$15.17		+++	++	++			
Imipramine	150 mg	$25.77		++	++	++			
Nortriptyline	150 mg	$23.27		+	+/++	+/-			
Trimipramine	150 mg	$19.67		+++	++	++			
Selective serotonin re-uptake inhibitors (SSRIs)									
Fluoxetine	20 mg	$64.39 [3]		+/-	+/-	+/-	Insomnia, nausea, weight loss, rash, sexual dysfunction, hyponatraemia.	MAOIs Hypersensitivity to Paroxetine	Significant agitation, severe hepatic or renal impairment, mania, cardiac disease
Paroxetine	20 mg	$69.85 [3]	SR	+/-	+/-	+/-			
Atypical cyclic agents									
Amoxapine	300 mg	$60.80		+	+	+	Gynaecomastia, cardiotoxicity, extrapyramidal effects	Acute MI	Similar to the tricyclic antidepressants
Maprotiline	150 mg	$78.55	SR	++	+/-	+	Seizures, cardiotoxicity, rash	Epilepsy, acute MI, conduction disorders, narrow angle glaucoma, urine retention, MAOIs	Similar to the tricyclic antidepressants
Mianserin	60 mg	$80.73	SA	++	+/-	+	Hepatic dysfunction, blood dyscrasias	Mania, MAOIs	Bipolar depressive illness, narrow angle glaucoma, prostatic hypertrophy
Reversible MOA-A inhibitor (RIMA)									
Moclobemide	450 mg	$99.36	SR	+/-	+/-	+	Anxiety, headache, nausea, rash	Hypersensitivity to Moclobemide, acute confusional states, children.	**Large quantities of tyramine-rich foods,** thyrotoxicosis, phaeochromocytoma, excitation or agitation, bipolar affective disorder, cimetidine, pethidine
Monoamine oxidase inhibitors[4]									
Phenelzine	60 mg	$49.35		+/-	+/-	++	Insomnia, sexual dysfunction, agitation, hepatic dysfunction	Phaeochromocytoma, cerebrovascular or cardiovascular disease, sympathomimetics, pethidine, SSRIs, TCAs	**Require low tyramine diets;** epilepsy, liver disease, elderly, surgery, interactions with other medications; bipolar affective disorder (mania)
Tranylcypromine	30 mg	$56.97		+/-	+/-	++			

Key:
- +/- = rare or negligible
- + = uncommon or mild
- ++ = common or moderate
- +++ = frequent or severe
- SR = specialist recommendation required
- HP = hospital pharmacy only
- SA = available on special authority

Footnotes

1 Due to wide variation in metabolism and clinical response, doses need to be individually titrated.

2 Cost to person (and any subsidy) using the recommended dose rates in the previous column.

3 The difference in the price between Fluoxetine and Paroxetine is because there is a common price per dose (rather than per mg). Prices quoted reflect the higher (on average) dose of Fluoxetine prescribed in New Zealand, as it is also indicated for other disorders at a higher dose.

4 MAOIs may cause constipation, dry mouth, urinary difficulty by other than an anticholinergic mechanism.

Adapted from 'Antidepressant Drugs: A Guide to Selection' New Ethicals, 1994.

Appendix 7 Guidelines for the assessment and care of people in the community at risk of suicide [27]

Assessment of suicidal risk

It is vital that any suicide attempt is taken seriously. Suicidal thoughts and behaviour are closely associated with mental illness. Therefore the evaluation of such symptoms should always include a full psychiatric assessment. In general, this should be carried out by an appropriately trained team of mental health professionals. A multi-disciplinary team offers a greater range of skills to meet the differing needs of patients and can also provide supervision and support to its members in a particularly demanding aspect of mental health care. However in some situations, such as after hours or in private practice, it will not be possible for a multi-disciplinary team to provide an initial assessment of a person. In all circumstances there must be clear lines of clinical responsibility for each client or patient.

By the end of the assessment, there must be a clearly documented treatment plan that specifically includes the level of assessed risk to the person and steps to be taken to ensure their safety. This should be developed in partnership and collaboration with the person as soon as possible. (The clinician must consider whether the person's judgement is impaired due to mental illness. Where involuntary treatment is being considered, this can only proceed under the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992).

Family members and whanau can, and often wish to, provide important input into such assessments. Where the person gives their permission for such contact, this assistance should, in general, be actively sought. In a small number of cases, this may not be appropriate if the family is a contributing factor to the person's risk of suicide. Difficulties can arise if the person refuses permission for the assessing person to speak to their relatives, particularly when the person is an adolescent under 17 years.

The legislation related to seeking information about the person, as opposed to giving out information about the person, is not straightforward. The principles of confidentiality and respect for the person's wishes and rights must be adhered to. However, there will be situations where a comprehensive assessment cannot be completed without additional information from the family. This is particularly likely to be the case if the person is from Maori or Pacific Island cultures, or where a person is assessed for the first time and is reluctant to provide information. In these cases decisions must be made in the interest of the person's safety.

In an emergency, information should be sought if it is "necessary to save the person's life, to prevent serious damage to the health of the person or to prevent the person from causing serious injury to himself or herself or others" (S.62 Mental Health (Compulsory Assessment and Treatment) Amendment Act, 1992). This may be the case where information is sought on the medication that a person has used to overdose or about possible access to firearms, etc.

The person should always be informed of the steps which need to be taken for their safety. A decision to contact their family should also take into account the likely impact on the person's current and future relationships. When a person is unwilling for their therapist to contact their relatives, it may be appropriate for another member of the therapeutic team to be available to the family to try and assist with issues of concern to them, while preserving confidentiality about information relating to the person.

Possible conflicts about confidentiality issues need to be resolved early in the assessment and the limits of confidentiality established in each situation.

The influence of cultural factors must always be considered. The assessing professional may need to contact the person's family, appropriate community resources, church, or alternative health providers to gain an understanding of the person's difficulties. Again, issues of confidentiality and the rights of the individual need to be carefully considered. There may be conflict between the presumed right of the family to know about their ill member, to contribute to decision making and to be involved in treatment, and the wishes of the person, particularly among second generation Pacific Islands people. The use of cultural experts can be valuable in resolving such conflict.

[27] From the Guidelines on the management of suicidal patients, Mental Health Services, Ministry of Health, Wellington NZ, July 1993.

The points listed below are of particular relevance to the assessment of the degree of suicidal risk.

Information required for the assessment of suicidal risk

- Mental health status - depressed, psychotic, intoxicated
- History of previous attempts, previous suicidal ideation
- Family history of impulsive/destructive behaviour or other mental illness
- Supports or contacts
- If a suicide attempt has been made, the person's understanding of what they did and what they expected to happen
- Recent events contributing to the decision to attempt suicide
- The person's degree of 'future orientation' and hope of improvement or degree of hopelessness (assessing both direct and indirect evidence)
- The interviewer's clinical judgement about the quality of the person's responses
- Whether there is any risk to others associated with the person's suicidal plans
- The person's current suicidal ideation, plan/action, and the means available

Another factor that should be taken into account in the assessment of suicidal risk is whether the person has been sexually or physically abused. A recent New Zealand study of people who had attempted suicide showed that over one third had been sexually abused (Romans et al, 1995; Mullen et al, 1993). This is a sensitive issue and the assessing person must decide the most appropriate stage to explore this area with the person.

The use of specialised risk scales, such as the Beck Hopelessness Scale may be a useful supplement to clinical judgement but should not replace a thorough psychiatric and psychological evaluation.

It must also be recognised that suicidal ideation in particular, and mental state in general, can fluctuate considerably over relatively short periods of time. It is therefore necessary to assess their stability in any individual person and to determine the need for reassessment over the next few hours, days and weeks.

Mental Health (Compulsory Assessment and Treatment) Act 1992

This is a resource available for the management of mentally ill patients who are suicidal or seriously incapacitated in their self care, if their mental disorder falls within the definition of mental disorder in the Mental Health (Compulsory Assessment and Treatment) Act 1992. Duly Authorised Officers (DAOs) are available to provide information and assistance to patients and their families where compulsory assessment or treatment under the Act is being considered. If the patient is voluntary, whether in the community or in hospital, application can be made under section 8. If the resulting examination under section 10 of the Act finds that the patient should undergo compulsory treatment, then treatment can take place even if the patient cannot or will not consent, subject to the provisions of the Act. If the person is in the community, the Duly Authorised Officer may seek police assistance if necessary (section 41). Similarly, if the police are called to a situation where a person "is acting in a manner which gives rise to reasonable belief that he or she may be mentally disordered", the police may take the person to a hospital, police station or surgery for the purpose of a psychiatric assessment. This may lead to a section 8 application under the Act.

The purpose of the Duly Authorised Officer is to allow a more easily accessed "door" into the compulsory treatment provisions of the Mental Health Act. The DAOs are experienced mental health professionals who act as the front line operators of the Mental Health Act. Their role is to provide advice and assistance with assessments of whether compulsory treatment is required, to receive applications and to facilitate assessment, and they may provide assistance with transport to hospital. DAOs can be contacted by phoning the local mental health team.

Mental Health Consumer Groups:

ANOPS (Aotearoa Network of Psychiatric Survivors)

PO Box 46-018
Herne Bay
Auckland
Ph. 09 378 7477

ANOPS maintains a database of mental health consumer groups throughout New Zealand.

Northland Mental Health Trust

14 Second Ave
Whangarei
Ph. 09 438 5215

Waiheke Psychiatric Support Group

PO Box 124
Oneroa
Waiheke Island
Ph. 09 372 6688

Bridges

Pupuke Centre
North Shore Hospital
Ph. 09 466 1491 ext 2900

Bipolar Affective Disorder Groups

Ponsonby Care
Level 2,
13 Maidstone Rd
Ponsonby
Auckland
Ph. 09 376 1053

Dimensions

PO Box 66 305
Newton
Auckland
Ph. 09 376 2688

Grow NZ Inc

PO Box 8720
Symonds Street
Auckland
Ph. 09 846 6889

GROW is a 12 step programme, currently with 36 groups operating throughout New Zealand.

Psychiatric Survivors Inc

PO Box 78172
Grey Lynn
Auckland
Ph. 09 376 0041

Rainbow Youth Inc

C/- Youthline House
13 Maidstone Street
PO Box 5426
Ponsonby
Auckland
Ph. 09 376 4155

Waitakere Interlink

5 Ratanui Street
Henderson
Auckland
Ph. 09 836 1861

Centre 401

PO Box 1183
Hamilton
Ph. 07 838 0199

Manic Depressive Support Group

28A Walsh Street
Hamilton
Ph. 06 847 3560

Manic Depressive Support Group

76 Virginia Road
Hamilton
Ph. 06 345 2264

Patients Rights Advocacy

65 Tawa Road
Hamilton
Ph. 07 843 5837

Psychiatric Survivors

15A Thames Street
Hamilton

Tenants Group

C/- PO Box 307
Hamilton
Ph. 07 839 1566

Stepping Out - Whitianga

C/- Mercury Bay House Buffalo
Whitianga

Stepping Out - Hauraki

Waihi Post Office
Waihi

Beams

C/- PO Box 2078
Rotorua
Ph. 07 347 6091

Contact Rotorua

110 Eruera Street
Rotorua
Ph. 07 347 2940

Oranga Pai

111 18th Avenue
Tauranga
Ph. 07 578 4938

Pou Kaha Support Centre

C/- Community Mental Health
Pyne Street
Whakatane
Ph. 07 307 1179/ 308 4545

Opotiki Mental Health Support Drop In Centre

PO Box 591
Opotiki
Bay of Plenty
Ph. 07 315 5829

Wanganui Mental Health Consumers Union

C/- DPA PO Box 102
Wanganui
Ph. 06 347 1176

Kapiti Psychiatric Survivors

202A Matai Road
Raumati
Ph. 04 298 4616

Bipolar Support Group

Court Kowhai Centre
Hutt Hospital
Private Bag 31907
Lower Hutt
Ph. 04 566 6999 ext 8927

Manic Depressive Support Group

Wellington Adult Mental Health
Service
Capital Coast Health
PO Box 7902
Wellington South
Ph. 04 385 5802

Wellington Consumer Health Forum

PO Box 11 706
Wellington
Ph. 04 475 8343

Wellington Mental Health Consumers Union

PO Box 121 708
Wellington
Ph. 04 473 9998

Wellington Patients Association

47 Fairview Crescent
Wellington

Withertea House

PO Box 46
Blenheim
Ph. 03 577 1907

Nelson Bipolar Support Group

Trustbank Community House
19 Alma St
Nelson
Ph. 03 548 7005

New Horizons

Resource Centre
Ngawhatu Hospital
Private Bag 38
Ngawhatu
Ph. 546 1425

Psychiatric Survivors Trust

10 Sorensens Place
Richmond
Nelson

Survivors Fellowship

23 Romlly Street
Westport
Ph. 03 789 8016

Christchurch Psychiatric Survivors

C/- Lincoln Hostel
Private Bag 4733
Christchurch
Ph. 03 338 5059 ext 3404

The Manic Depressive Society Inc

PO Box 25 068
Christchurch
Ph. 03 358 3442

Matipo Social Club

Hereford Centre
243 Hereford Street
Christchurch
Ph. 03 366 2620

Otago Manic Depressive Support Group

4th Floor
14 Princess Street
Hallenstein Building
Dunedin
Ph. 03 477 2598

Patients Aid Community Trust

PO Box 1131
Dunedin
Ph. 03 477 7638/ 477 7364

Psych Users Network

C/- Pauline Hinds
PO Box
Karitane, Dunedin

Postnatal Depression Support Groups:

Postnatal Distress Support Network

PO Box 48
Waimauku
Auckland
Ph. 09 411 8516

Sexual Orientation Support Groups:

Gay/Lesbian Welfare Group

PO Box 3132
Auckland
Ph. 09 309 3268

Gayline/Lesbianline Auckland

Ph. 09 303 3584
Every evening 7.30 - 10pm

Lesbian Support Group (Coming Out Groups)

PO Box 3833
Auckland 1
Ph. 09 528 5119

Wellington Gay Welfare Association

PO Box 11-695
Wellington
Ph. 04 385 0674

Lesbian Link

PO Box 321
Nelson
Ph. 03 546 7776

Gayline

PO Box 25 165
Christchurch
Ph. 03 379 4796
Monday 8-9pm, Saturday 7.30 - 10pm

Gayline

PO Box 1382
Dunedin
Ph. 03 477 2077

Lesbian Line Dunedin

PO Box 6212
Dunedin
Ph. 03 477 2077
Tuesday 5.30 - 7.30pm

Domestic Violence:

New Zealand National Collective of Independent Women's Refuges

PO Box 51-36
Lambton Quay
Wellington
Ph. 04 499 1881

Local refuges have phone numbers listed at the beginning of local phone directories but unlisted addresses.

Sexual Abuse:

National Collective of Rape Crisis and Related Groups of Aotearoa Incorporated

PO Box 61-81
Te Aro
Wellington
Ph. 04 384 7028

Local Rape Crisis services are listed in local phone directories

Auckland Help Foundation
PO Box 10-34
Dominion Rd,
Auckland
Ph. 09 623 1700

Wellington Help Foundation

PO Box 11160
Manners St
Wellington
Ph. 801 8178

Note: Help Foundations in other regions are listed at the beginning of local phone directories. They can advise of other sexual abuse counselling agencies and private counsellors in their region.

Start Incorporated

PO Box 21-022
Christchurch
Ph. 03 355 4414

Appendix 9 Contact people/addresses of organisations involved in psychological therapy

The following organisations listed may be contacted by a General Practitioner who is considering making a referral for psychological therapy. These people will be able to advise the GP of who are appropriate mental health workers in their region.

NZ College of Clinical Psychologists

PO Box 16-033
Wellington South
Ph. 04 389 5605

NZ Association of Psychotherapists

Regional Supervisor Co-ordinators

- Auckland — Colleen Davison, 13 Elsted Place, Goodward Heights, Manukau, Auckland
- Wellington — Margie Barr-Brown, 41 Roy St, Wellington 2
- Christchurch — Charlotte Daellenbach, 8a Macmillan Ave, Christchurch
- Dunedin — Marianne Quinn, Otago University, PO Box 56, Dunedin

Note: not all members of the following three organisations would be trained and competent to provide psychological therapy for people with depressive disorders.

NZ Psychological Society

General Practitioners wishing to make a referral to a psychologist can either contact their local mental health centre/ psychiatric outpatient centre, or alternatively, contact the National Office of the New Zealand Psychological Society (NZPS)

The NZ Psychological Society
PO Box 4092
Wellington
Ph. 04 801 5414

The NZPS has recently compiled a list of its members who are able to treat depression. GPs can get copies of this list by contacting the secretary at the National Office.

NZ Association of Social Workers

The NZ Association of Social Workers does not have available listings of regional contact people. People wanting to make a referral to a social worker for psychological therapy for depression should contact their local mental health services for advice.

NZ Association of Counsellors

The NZAC has a National Executive Officer who maintains an updated list of national office holders and regional chairpersons who can act as resource people for information about suitably trained counsellors who can offer psychological therapy. The address is:

Jim Shepherd
National Executive Officer
New Zealand Association of Counsellors
PO Box 165
Hamilton
Ph. 07 847 8974

For each of the past three years the National Advisory Committee on Health and Disability has identified mental health services as one of the top priorities for new funding and development. In its annual report, '1995/96 Core Services' (published in September 1994) the Committee noted that developments to date had focused on the 3% of the population with the most serious mental health disorders, especially those receiving treatment under the Mental Health (Compulsory Assessment and Treatment) Act, 1992. The Committee considered that further work should be directed at an additional 5% of the population who have chronic mental health disorders but who are unlikely to gain access to the existing specialist mental health services. The Committee identified Major Depressive Disorder as the most prevalent mental health disorder and one that could appropriately be treated by primary health workers given adequate information and some changes to funding/purchasing arrangements.

These guidelines were developed using the following process:

- identification of existing best practice guidelines for the treatment of Major Depressive Disorder.
- a search of the international literature for the period 1993 to present (the assumption was made that the clinical practice guidelines produced by the United States Agency for Health Care Policy and Research had adequately reviewed the literature up to 1993). The New Zealand literature of Major Depressive Disorder was also identified.
- selection of a working party (members listed in Appendix 11) that would represent the various sectors: consumers, treatment agencies, professional groups and Maori. The working party then used the following process to draft the guidelines:
    - identified the audience for the guidelines (all health workers in the primary sector)
    - selected assessment tools and criteria for access to certain treatments
    - determined the outline of the guidelines
    - invited contributors for sections where the working party considered it did not have specific expertise
- circulation of draft guidelines to 200 - 300 individuals and groups requesting comment
- annotation of comments from the submissions into the document
- consulting mental health professionals in the form of an open hearing (ie members of the public were invited to observe) on the issue of which groups of therapists are able to provide appropriate interventions for the treatment of depression. The hearing was held before three members of the National Health Committee, and Professor Andrew Hornblow, who acted as an independent adviser. Representatives of six professional therapeutic bodies gave presentations at the hearing. Following this, a group of discussants (including GPs, a social worker, two practice nurses, a consumer advocate and community representative) were invited to debate the issues with the presenters. The working party was available to give comment on the guidelines and the reasoning for the recommendations made
- review and update of the guidelines to reflect feedback from the submissions and the hearing process.

The finalised guidelines were submitted to the National Health Committee for approval on 27 February 1996. The Committee endorsed the guidelines and recommended that the Minister of Health adopt them as the basis for purchasing treatment for depression in the primary health sector.

Appendix 11 Membership of the working party

Working Party

Peter Ellis (Chairperson)
Department of Psychological Medicine
Wellington School of Medicine

Bruce Adlam

Goodfellow Unit
School of Medicine
University of Auckland

Sue Fitchett

Community Mental Health Services
Waitemata Health

Peter Joyce

Department of Psychological Medicine
Christchurch Clinical School

Nick Judson

Mental Health Services
Ministry of Health

Winston Maniapoto

Community Services
Auckland Healthcare

Iwa Natana

Aotearoa Network of Psychiatric Survivors (ANOPS)

Don Smith (Project Manager)

National Health Committee Secretariat
Ministry of Health

Acknowledgments

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Alexander, RK. Post-traumatic stress disorder. Borne under stress. Nurse Times, 1994, 32(5),9 - 13.

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Ed (DSM IV). APA, Washington D.C., 1994.

American Psychiatric Association Practice Guidelines for Major Depressive Disorder in Adults. Supplement to the American Journal of Psychiatry, 1993, 150, 4, 1 - 26.

Angst, J, Merikangas, K, Scheidegger, P, & Wicki, W. Recurrent brief Major Depressive Disorder: a new subtype of affective disorder. Journal of Affective Disorders, 1990, 19, 87 - 98.

Barrett, ML, Berney, TP, Bhate, S, et al. Diagnosing childhood Major Depressive Disorder: Who should be interviewed - parent or child. The Newcastle Child Major Depressive Disorder Project. British Journal of Psychiatry, 1991, 159(Suppl.), 22 - 27.

Bartels, SJ, Drake, RE & McHugo, GJ. Alcohol abuse, Major Depressive Disorder and suicidal behaviour schizophrenia. American Journal of Psychiatry, 1992, 149, 394 - 395.

Beck, ATM. Cognitive Therapy and Emotional Disorders. New York, Guilford Press, 1976.

Beck ATM, Ward CH, Mendelson, M, et al. An inventory for measuring Major Depressive Disorder. Archives of General Psychiatry, 1961, 4, 561 - 571.

Black, DW, Winokur, G, Nasrallah, A. Effects of psychosis on suicide risk in 1,593 patients with unipolar and bipolar affective disorders. American Journal of Psychiatry, 1988, 145(7), 849 - 852.

Brown, GW, and Moran, P. Clinical and Psychosocial origins of chronic depressive episodes. I: A community survey. British Journal of Psychiatry, 1994, 165, 447 - 456.

Brown, GW, Harris, TO, Hepworth, C and Robinson, R. Clinical and psychosocial origins of chronic depressive episodes. II: A patient enquiry. British Journal of Psychiatry, 1994, 165, 457 - 465.

Bushnell, J. Epidemiology of mental illness in New Zealand in Barriers to Mental Health Care in the Community: Towards an Economic Model. Health Services Research Centre, Victoria University and University of Otago, Wellington, 1994.

Clark, WG & Vorst, VR. Group therapy with chronically depressed geriatric patients. Journal of Psychosocial Nursing, 1994, 32 (5), 9 - 13.

Coble, PA, Reynolds, CF, Kupfer, et al. Childbearing in women with and without a history of affective disorder: I Psychiatric symptomatology. Comprehensive Psychiatry, 1994, 35(3), 205 - 214.

Cox, JL, Murray, D, & Chapman, G. A controlled study of the onset, duration and prevalence of postnatal Major Depressive Disorder. British Journal of Psychiatry, 1993, 163, 27 - 31.

Davidson, KM. Diagnosis of Major Depressive Disorder in alcohol dependence: Changes in prevalence with drinking status. British Journal of Psychiatry, 1995, 166, 199 - 204.

Davison, GC and Neale, JM. Abnormal Psychology (5th Ed), 1990, John Wiley and Sons, New York.

Dean, C and Kendell, RE. The symptomatology of postpartum illness. British Journal of Psychiatry, 1981, 139, 128 - 133.

Duggan, CF, **Sham, P, Lee, AS and Murray, RM.** Can future suicidal behaviour in depressed patients be predicted? Journal of Affective Disorders, 1991, 22, 111 - 118.

Durie, MH. Maori attitudes to sickness, doctors and hospitals. New Zealand Medical Journal, 1977, 86, 483 - 485.

Durie, M. Whaiora: Maori Health Development. Auckland: Oxford University Press, 1994.

Eccleston, D. Introduction to 'The economic evaluation of antidepressant drug therapy.' British Journal of Psychiatry, 1993, 163 (Suppl 20), 5 - 6.

Evans MD, Hollon, SD, DeRubeis, RJ, et al. Differential relapse following Cognitive Therapy and pharmacotherapy for Major Depressive Disorder. Archives of General Psychiatry, 1992, 49, 802 - 808.

Fawcett, J, Scheftner, WA, Fogg, L, et al. Time related predictors of suicide in major affective disorder. American Journal of Psychiatry, 1990, 147, 1189 - 1194.

Feehan, M, McGee, R, Raja, SN and Williams, SM. DSM-III-R disorders in New Zealand 18 year olds. Australian and New Zealand Journal of Psychiatry, 1993, 28 (1), 87-99

Frank, E, Kupfer, DJ, Perel, JM, et al. Three year outcomes for maintenance therapies in recurrent Major Depressive Disorder. Archives of General Psychiatry, 1990, 47, 1093 - 1099.

Frank, E, Kupfer, DJ, Wagner, EF, et al. Efficacy of interpersonal psychotherapy as a maintenance treatment of recurrent Major Depressive Disorder. Archives of General Psychiatry, 1991, 48, 1053 - 1059.

Friedman, AS. Interaction of drug therapy with marital therapy in depressive patients. Archives of General Psychiatry, 1975, 32, 619 - 637.

Goldberg, D. The recognition of psychiatric illness by non psychiatrists. Australian and New Zealand Journal of Psychiatry, 1984, 18, 128 - 133.

Gruen, DS. Postpartum Major Depressive Disorder: a debilitating yet often unassessed problem. Health Social Work, 1990, 15 (4), 261- 270.

Halbreich U, & Lumley, LA. The multiple interactional biological processes that might lead to Major Depressive Disorder and gender differences in its appearance. Journal of Affective Disorders, 1993, 29, 159 - 173.

Hamilton, M. Development of a rating scale for primary depressive illness. British Journal of Social and Clinical Psychiatry, 1967, 6, 278 - 296.

Handford, P. Postpartum Major Depressive Disorder: what is it, what helps? Canadian Nurse, 1985, 81 (1), 30 - 33.

Harris, B. Biological and hormonal aspects of pastpartum depressed mood, working towards strategies for prophylaxis and treatment. British Journal of Psychiatry, 1994, 164, 288 - 292.

Helzer, JE and Pryzbeck, TR. The co-occurance of alcoholism with other psychiatric disorders in the general population and its impact on treatment. Journal of Studies on Alcohol, 1988, 49(3), 219 - 224.

Henry, JA. The safety of antidepressants. British Journal of Psychiatry, 1992, 160, 439 - 441.

Henry, JA, Alexander, CA and Sener, EK. Relative mortality from overdose of antidepressants. British Medical Journal, 1995, 310, 221 - 224.

Hunt, CJ, Andrews, G and Sumich, HJ. The management of mental disorders: Vol 3 Handbook for the Affective Disorders. WHO Training and Reference Centre for CIDI, Sydney, Australia, 1995.

Hyman, S and Arana, GW. Suicide and affective disorder. In Suicide: Understanding and Responding. Harvard Medical School Perspectives. (Eds Jacobs, D. and Brown, H.N.) International University Press, Madison, 1990, 171 - 181.

Jacob, M, Frank, E, Kupfer, DJ, et al. Recurrent Major Depressive Disorder: an assessment of family burden and family attitudes. Journal of Clinical Psychiatry, 1987, 48, 395 - 400.

Jamison, KR Suicide and Bipolar Disorder. Annals of the New York Academy of Science, 1986, 487, 301 - 315.

Jick, SS, Dean, AD and Jick, H. Antidepressants and suicide. British Medical Journal, 1995, 310, 215 - 218.

Joyce, PR, Oakley-Browne, MA, Wells, JE, Bushnell, JA and Hornblow, AR. Birth cohort in Major Depressive Disorder: increasing rates and earlier onset in New Zealand. Journal of Affective Disorders, 1990, 18, 83 - 89.

Joyce, PR, Romans, SE, Ellis, PM and Silverstone, TS. Affective Disorders. Department of Psychological Medicine, Christchurch, NZ. 1995.

Katon, W, Von-Korff, M, Lin, E, Walker, E, Simon, GE, Bush, T, Robinson, P & Russo, J. Collaborative management to achieve treatment guidelines: Impact on Major Depressive Disorder in primary care. JAMA, 1995, 273(13), 1026 - 1031.

Keller, MB and Lavori, PW. Double Major Depressive Disorder, Major Depressive Disorder and Dysthymic Disorder. Distinct entities or different phases of a single disorder? Psychopharmacology Bulletin, 1984, 20, 399 - 402.

Kendler KS, Kessler, RC, Neale, MC, et al. The prediction of Major Depressive Disorder in women: Toward an integrated aetiological model. American Journal of Psychiatry, 1993, 150, 863 - 870.

Kirmayer, LJ, Young, A and Robbins, JM. Symptom attribution in cultural perspective. Canadian Journal of Psychiatry, 1994, 39, 584 - 595.

Linkowski PL, and Mendelwicz, J. Sleep, electroencephalogram and rhythm disturbance in mood disorders: Current Opinion in Psychiatry. 1993, 6, 1130.

Marks, MN, Wieck, A, Checkley, SA & Kumar, R. Contribution of psychological and social factors to psychotic and nonpsychotic relapse after childbirth in women with previous histories of affective disorder. Journal of Affective Disorders, 1992, 24 (4), 253- 263.

Martinsen, EW. Physical activity and Major Depressive Disorder: clinical experience. Acta Psychiatrica Scandinavia, 1994, Suppl 377, 23 - 27.

McGee, R, Feehan, M, Williams, S and Anderson, J DSM-III Disorders from age 11 to 15 years. Journal of the American Academy of Child and Adolescent Psychiatry, 1992, 31(1), 50 - 59.

McGrath, E, Keita, CP, Strickland, BR, and Russo NE. Women and depression: Risk factors and treatment issues. American Psycholigical Association Monograph, 1990.

Moretti, MM, Fine, S, Haley, G, et al. Childhood and adolescent Major Depressive Disorder: Child report versus parent report information. Journal of the American Academy of Child Psychiatry, 1985, 24, 298 - 302.

Mullen, PE, Romans-Clarkson, SE, Walton, VA, et al. Impact of sexual and physical abuse on women's mental health. Lancet, 1988, 841 - 845.

Mullen, PE, Martin, JLl, Anderson, JC, Romans, SE, and Herbison, GP. Child sexual abuse and mental health in adult life. British Journal of Psychiatry, 1993, 163, 721- 732.

Mynors-Wallis, LM, Gath, DH, Lloyd-Thomas, AR, & Tomlinson, D. Randomised controlled trial comparing problem solving treatment with amitriptyline and placebo for Major Depressive Disorder in primary care. British Medical Journal, 1995; 310, 441- 445.

Oakley-Browne, MA, Joyce, PR, Wells, JE, Bushnell, JA and Hornblow, AR. Christchurch psychiatric epidemiology study, part II: Six month and other period prevalences of specific psychiatric disorders. Australian and New Zealand Journal of Psychiatry, 1989, 23, 327 - 340.

O'Hara, M. Post- partum "blues", Major Depressive Disorder and psychosis: a review. Journal of Psychosomatic Obstetrics & Gynaecology, 1987, 7, 205 - 227.

Parker, G. Presentation and course of affective disorders. Current Opinion in Psychiatry, 1993, 6(1), 4 - 9.

Petty, F. The depressed alcoholic. General Hospital Psychiatry, 1992, 14, 258 - 264.

Pritchard, CW. Smoking and depression. Journal of Epidemiology and Community Health, 1994, 48, 377 - 382.

Pulotu- Endemann, K. Strategic Directions for the Mental Health Services of Pacific Islands People. Ministry of Health, Wellington, NZ. 1995.

Romans, SE, Martin, JL, Anderson, JC, Herbison, GP and Mullen, PE. Child sexual abuse and deliberate self harm. American Journal of Psychiatry, 1995, 152, 1336 - 1342.

Romans, SE, Walton, VA, McNoe, B, Herbison, GP, and Mullen, PE. Otago women's health survey 30-month follow-up I: Onset patterns of non- psychotic psychiatric disorder. British Journal of Psychiatry, 1993, 163, 733 - 738.

Romans, SE, Walton, VA, McNoe, B, Herbison, GP, and Mullen, PE. Otago women's health survey 30-month follow-up II: Remission patterns of non- psychotic psychiatric disorder. British Journal of Psychiatry, 1993, 163, 739 - 746.

Ruble, DN, Greulich, F, Pomerantz, EM, & Gochberg, B. The role of gender-related processes in the development of sex differences in self-evaluation and Major Depressive Disorder. Journal of Affective Disorders, 1993, 29, 97 - 128.

Sachdev, PS. Behavioural factors affecting physical health of the New Zealand Maori. Social Science Medicine, 1990, 30(4), 431 - 440.

Schaper, AM, Rooney, BL, Kay, NR & Silva, PD. Use of the Edinburgh Postnatal Major Depressive Disorder Scale to identify postpartum Major Depressive Disorder in a clinical setting. Journal of Reproductive Medicine, 1994, 39(8), 620 - 624.

Schuckit, MA. Alcohol and Major Depressive Disorder: a clinical perspective. Acta Psychiatrica Scandinavia, 1994, 377, 28 - 32.

Shapiro, DA, Barkham, M, Rees, A, et al. Effects of treatment duration and severity of Major Depressive Disorder on the effectiveness of Cognitive-Behavioural and psychodynamic-interpersonal psychotherapy. Journal of Consulting and Clinical Psychology, 1994, 62(3), 322 - 324.

Shea, MT, Elkin, I, Imber, SD, Sotsky, SM, Watkins, JT, Collins, JF, Pilkonis, PA, Beckham, E, Glass, DR, Dolan RT & Parloff, MB. Course of depressive symptoms over follow- up: findings from the National Institute of Mental Health Treatment of Major Depressive Disorder Collaborative Research Program. Archives of General Psychiatry, 1992, 49, 782 - 787.

Steuer, JL, Mintz, J, Hammen, CL, Hill, MA, Jarvik, LF, McCarley, T, Motoike, P, & Rosen, R. Cognitive-behavioural and psychodynamic group psychotherapy in treatment of geriatric Major Depressive Disorder. Journal of Consulting and Clinical Psychology, 1984, 52 (2), 180 - 189.

Tipene-Leach, D. Maoris: Their feelings about the medical profession. Community Forum, 1978, Auckland.

UNICEF. The Progress of Nations. UNICEF, New York. 1993.

U.S Department of Health and Human Services. Clinical Practice Guidelines Number 5. Depression in Primary Care: Volume 1. Detection and Diagnosis. Agency for Health Care Policy and Research, Maryland. 1993.

Wallin, MS & Rissanen, AM. Food and mood: relationship between food, serotonin and affective disorders. Acta Psychiatrica Scandinavia, 1994, Suppl 377, 36 - 40.

Weissmann, MM and Klerman, GL. Sex differences in the epidemiology of Major Depressive Disorder. Archives of General Psychiatry, 1977, 34, 98 - 111.

Weissmann, MM, Leaf, PJ, Bruce, ML, et al. The epidemiology of Dysthymic Disorder in five communities: Rates, risks, comorbidity and treatment. American Journal of Psychiatry, 1988, 145, 815 - 819.

Weissmann, MM, & Myers, JK. Affective disorders in a US urban community: The use of research diagnostic criteria in an epidemiological survey. Archives of General Psychiatry, 1978, 35, 1304 - 1311.

Wells, JE, Bushnell, JA, Hornblow, AR, Joyce, PR. and Oakley-Browne, MA. Christchurch Psychiatric epidemiology study, Part 1: Methodology and lifetime prevalence for specific psychiatric disorders. Australian and New Zealand Journal of Psychiatry, 1989, 23, 315 - 326.

WPA Dysthymic Disorder Working Group. Dysthymic Disorder in clinical practice. British Journal of Psychiatry, 1995, 166, 174 - 183.

Williams, JMG. The psychological treatment of depression. A guide to the theory and practice of cognitive behavioural theory. Routledge, New York. 1992

World Health Organisation. International Statistical Classification of Diseases and Related Health Problems (10th Revision). World Health Organisation, Geneva.

Wurtman, JJ. Major Depressive Disorder and weight gain: the serotonin connection. Journal of Affective Disorders,1993, 29, 183 - 192.

Yager, J. Patients with mood disorders and marital/ family problems, in Annual Review of Psychiatry, (Vol 11). Edited by Tasman, A., Washington D.C., American Psychiatric Press, 1992.

Submissions on the draft guidelines were received from the following people and groups

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Heather McDowell, Auckland

Tony Ward, Canterbury University

Richard Segiert, Victoria University

John McDowell Victoria University

Bill Black, ALAC

Helen Mitchell-Shand, Wellington

Rob Chambers, Princess Margaret

Peter Johnson, Kiamarama

Jim Doak, Justice

Harry Love, Justice

Hamish Dixon, Justice

Sue Fitchett, Auckland

Diana Mason,Wellington

Guy Jenner, Wellington

Ron Mills, Picton

Janne Bills, Rotherham

Carl Jacobson, Whakatane

Gail Ratcliffe, Auckland

Sunny Collings, Wellington

Kathy Hepgood, Auckland

Sarah Romans, Dunedin

Debbie Wilson, Christchurch

Anthony Duncan, Wellington

Paul Merrick, Auckland

Ron Haydon, Auckland

Louise Webster, Auckland

Carol O'Connor, Wellington

Irving Baran, Wanganui

Brian Craig, Christchurch

David Tipene-Leach, Whakatane

Erihana Ryan, Christchurch

Taha Fasi, Auckland

Fuimaono Karl Pulotu-Endemann, Palmerston North

Filipo Motulalo, Waitakere

Leopino Foliaki, Auckland

Dr Sitaliki Finau, South Pacific Commission

Dr Barbara Disley, Auckland

Royal NZ College of General Practitioners

College of Psychiatrists

College of Clinical Psychologists

Psychological Society

NZ Association of Psychotherapists

NZ Association of Counsellors

ANOPS

Manic Depressive Society

Consumer Groups listed in Appendix 8

PHARMAC

Mental Health Managers of the RHAs

Four Departments of Psychological Medicine

Six Departments of Psychology (Clinical Course Directors)

Polytech Counselling Courses

Max Abbott

ACC

Social Policy Agency

Income Support

Polytech and University Nursing Courses

School of Occupational Therapists

Gavin Andrew, University of NSW

Prof Graham Burrows, Melbourne

A. John Rush, Chairperson of US Guidelines on Major Depressive Disorder

University of Leeds

Prof Brian MacAvoy, UK