Assessment of **depression** in **adults** in primary care

Adapted from: Identification of Common Mental Disorders and Management of Depression in Primary care. New Zealand Guidelines Group [1]

The questions and tools described here are adjuncts to screening and monitoring and none are diagnostic tools for common mental disorders or depression. In assessing a mental disorder, it is important that clinicians explore potential reasons for the disorder to get some understanding about what is going on behind the symptoms. Addressing these triggers or contributing factors is an essential part of treatment.

Short two to three question screening tools (see Verbal Screening Tools box opposite) can be viewed as initial case-finding. These can then be followed up with formal screening using the structured questions in one of the assessment tools.

This publication focuses on the assessment and management of depression in primary care, but initial screening and assessment should always consider common co-morbidities such as anxiety. For this reason a tool such as the K10 may be preferred to the PHQ-9 for initial assessment as the latter is specific for depression.

Screening for mental disorders in primary care

Every consultation in primary care provides the opportunity for screening for mental health problems. New Zealand research has shown that up to a third of people who attend a GP consultation are likely to have mental health issues.

There are several groups that are at high risk of depression and related disorders that can be targeted for simple screening:

- People with chronic illness, e.g., cardiovascular disease, diabetes, respiratory disease (especially COPD), chronic pain, dementia, Parkinson's disease, rheumatoid arthritis
- People with multiple symptoms and comorbidities
- People with a terminal illness
- People with physical and intellectual disability
- Māori, particularly Māori women
- People from ethnic minorities, especially recent immigrants
- People with a history of mental disorder or suicide attempt

- People with a history of substance misuse (including alcohol) or addiction
- People with a significant personal loss such as bereavement, relationship change or a major negative life event
- Older adults in residential care
- Women in antenatal or postnatal period

Many mental illnesses start in childhood (e.g. anxiety, disruptive behaviour) and adolescence, (depression, substance abuse) so screening should also be considered in these groups. The New Zealand Guidelines[1] has a specific section on the assessment of common mental disorders and the management of depression in young people. This will also be covered in a subsequent edition of Best Practice Journal.

Questions for targeted screening

Simple screening questions can help to identify people who would benefit from a more formal assessment for a mental disorder and are quick and easy to administer (for an example of simple screening questions, see Box: Verbal screening tools). Some practitioners may prefer a less structured approach and even a simple question such as "so how are you coping with all the changes in your life at the moment?" may provide useful insight.

Verbal screening tools

Verbal two to three question screening tools for common mental disorders (NZGG)[1]

Questions for depression

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

If **yes** to either question, ask Help question below

Question for anxiety

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

If **yes**, ask Help question below

Questions for alcohol and drug problems*

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

* These two questions have been shown to pick up about 80% of current drug and alcohol problems

If **yes** to either question, ask Help question below

The Help question

- Is this something that you would like help with?

CHAT

The Case-finding and Help Assessment Tool (see CHAT – Appendix 9) is a case-finding questionnaire for general lifestyle assessment developed in New Zealand.[9] It has been validated in primary care to case-find for nicotine dependency, alcohol and other drug misuse, problem gambling, depression, anxiety, stress, abuse and other lifestyle issues. Patients can be asked to complete it in the waiting room, and hand it to the clinician at the beginning of the consultation. This allows the clinician to move directly to an appropriate screening and assessment tool in the consultation. The CHAT tool is in the *bestpractice* decision support module.

Accurate assessment of acuity and severity of depression and anxiety is important for its management in primary care or referral.

Assessment (Formal Screening) Tools for General Practice

Following simple screening questions, using a brief but more formal validated primary care assessment tool offers significant advantages:

- They provide structure and prompts for assessment
- They give a score or rating to guide treatment or referral
- They provide a baseline score for gauging effectiveness of interventions and treatment
- A standardised assessment means a range of health professionals can carry out repeat assessments

A wide range of tools is available. The *bestpractice* decision support module includes:

- Kessler 10 (K10) for the assessment of depression, anxiety and general mental health
- Patient Health Questionnaire (PHQ-9) for depression
- GAD-7 for anxiety
- AUDIT for assessment of problem drinking

The K10 and PHQ-9 are the most widely used and validated assessment tools in primary care. The questions in the K10 cover depression, anxiety and general mental health and this tool is usually preferred for use as an initial assessment to the PHQ-9 which is specific for depression. Factors such as individual preference, experience and local policies may also determine which tools are used.

In the *bestpractice* decision support module, the K-10, PHQ-9 and the other assessment tools can be selected from the menu. A combination of tools can be used, for example the K10 in combination with AUDIT to specifically assess problem drinking.

A brief description of these tools follows. Refer to Appendices 5 to 9 for reproductions of the assessment tools with guidance on their interpretation.

A more complete range of assessment tools for mental disorders is available from:
www.nzgg.org.nz/CMD-assessmenttools

Kessler Psychological Distress Scale 10 (K10)

The K10 (Appendix 5) measures psychological distress, particularly anxiety and depression. Used widely in population surveys and secondary care clinical settings it has been validated for use in population surveys rather than in primary care.

Patient Health Questionnaire (PHQ-9)

For depression, the PHQ-9 has been widely used in New Zealand and the scores obtained are applied in the algorithms for the treatment of depression published in the New Zealand Guidelines (also available in the Appendices 1–4 of this publication).

The PHQ-9 (Appendix 6) quantifies the severity of depression. It consists of nine key symptoms of depression, and roughly how much they have been present over the last fortnight. The score indicates the severity of depression and thus guides treatment.

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

There are two versions of the PHQ-9. This document uses the simplified 3 category version, published in the New Zealand Guidelines. Some versions of the PHQ-9, including the widely circulated A4 card, have five severity categories. We recommend using the three category version.

Alcohol and Substance Abuse (AUDIT)

The AUDIT questionnaire (Appendix 8) is an accurate tool for identifying and assessing risky, harmful and hazardous drinking. This tool contrasts with the CAGE questionnaire which is used to assess alcohol dependence.

Anxiety (GAD-7 and GAD-2)

The GAD-7 (Appendix 7) is valid for detecting anxiety disorders. The GAD-7 score is calculated by assigning scores of 0, 1, 2 and 3 to the response categories of "not at all," "several days," more than half the days," and "nearly every day" respectively. The GAD-7 total for the seven questions ranges from 0 to 21.

The severity of the anxiety disorder is represented by the following scores:

5–9	mild anxiety
10–14	moderate anxiety
15–21	severe anxiety

The shortened GAD-2 consists of the first two questions of the GAD-7 and a score of 3 or more suggests a possible anxiety disorder and should be followed by the GAD-7.

Monitoring response to treatment

Assessment tools can be used to gauge and monitor the response to treatment. A baseline score can be recorded and compared with subsequent evaluations to determine the degree of response.

Remission: only minimal signs of illness remain

Response: a significant level of improvement; or a clinically relevant reduction in symptom severity of more than 50% on a scale such as the PHQ-9

Partial response: a reduction in symptom severity of at least 25% on a scale such as the PHQ-9

For example using the PHQ-9:

- A drop of 5 points or more from baseline after 4–6 weeks of initial treatment indicates an adequate response. The same treatment should be continued and followed up after 4 weeks.
- If the drop from baseline is only 2–4 points then treatment is probably inadequate and an increase in antidepressant dose or more intensive psychological therapy may be justified.
- A drop of only one point or no change indicates that the treatment response is inadequate, there is worsening of stressors or reduced support. This indicates the need for more intensive treatment, dose increase or augmentation, specialist referral or the addition of psychological therapy.

If people do not respond to treatment it is important to consider a review of the diagnosis and other factors such as compliance, co-morbid conditions or substance abuse.

Assessment of Suicide Risk[1]

Assessment of suicide risk can be challenging as there is no evidence for absolute markers that indicate presence or intensity of suicide risk. Assessment also only provides a snapshot of risk at a given time. Therefore assessment of suicide risk should be on-going during treatment as new triggers can emerge even if a person's mental state is improving or staying the same.

The most immediately important factors to consider are contextual triggering factors and current mental state:

- Intent/definite plan
- Lethality of likely means
- Access to means
- Presence of risk factors (e.g. mental or physical illness, chronic pain, alcohol use)
- Hopelessness
- Psychosocial triggers
- Lack or presence of protective factors

It is important to realise that any individual's suicide risk may increase as a consequence of an acute stressor or situation. For example chronic risk factors such as male gender, childhood adversity or chronic pain remain static but an acute stressor such as a relationship breakdown or drinking binges may rapidly elevate the person's risk of suicide. Therefore recognition of potential dynamic factors is important in any management plan.

Deliberate self-harm, such as cutting, is a non-suicidal behaviour which is used as an attempt to cope and manage. It must be recognised that the emotional distress that leads to self-harm can also lead to suicidal thoughts and actions.

Questions to assist in assessing suicide risk are available in the *bestpractice* decision support module and in Appendix C of the NZ Guidelines.[1]