NATIONAL CLINICAL GUIDELINES

THE DIAGNOSIS & MANAGEMENT OF DEPRESSION

Ministry of Public Health

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المبادئ الإرشادية السريرية لدولة قطر
NATIONAL CLINICAL GUIDELINES FOR QATAR

وزارة الصحـــــة العامـــــة
Ministry of Public Health
State of Qatar • دولـــة قطـــر

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Abbreviations

The abbreviations used in this guideline are as follows:

CBT	Cognitive Behavioural Therapy
cCBT	Computerised Cognitive Behavioural Therapy
ECG	Electrocardiography
EEG	Electroencephalography
IPT	Interpersonal Therapy
MAOI	Monoamine Oxidase Inhibitor
MDD	Major Depressive Disorder
MDE	Major Depressive Episode
NASSA	Noradrenergic and Specific Serotonergic Antidepressant
NARI	Selective Noradrenaline Reuptake Inhibitor
NDRI	Norepinephrine–Dopamine Reuptake Inhibitor
NMDA	N-methyl-D-aspartate
NSAID	Non-Steroidal Anti-Inflammatory Drug
PHQ-2	Patient Health Questionnaire Two-Question Tool
PHQ-9	Patient Health Questionnaire Nine-Question Tool
SARI	Serotonin Antagonist and Reuptake Inhibitor
SNRI	Serotonin Norepinephrine Reuptake Inhibitor
SPARI	Serotonin Partial Agonist-Reuptake Inhibitor
SSRI	Selective Serotonin Reuptake Inhibitor
TCA	Tricyclic Antidepressant

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1 Information about this Guideline

1.1 Objective and Purpose of the Guideline

The purpose of this guideline is to define the appropriate diagnosis and management of depression in adults over 18 years old and elderly aged over 65. The objective is to improve the appropriate recognition, management and referral of patients presenting to any provider organisation in Qatar. It is intended that the guideline will be used primarily by physicians in primary care and outpatient settings.

1.2 Scope of the Guideline

The following aspects of care are included within this guideline:

- Screening and investigation of suspected depression.
- Diagnostic criteria for Major Depressive Disorder.
- Summary of psychological therapy options.
- Summary of the pharmacological treatment options.
- Referral criteria to Specialist Care.

Aspects of care not covered in this guideline, include:

- Depression in the perinatal and postpartum period.
- Management of depression in bipolar or other psychiatric conditions.
- Management of depression in children and adolescents.

1.3 Editorial Approach

This guideline document has been developed and issued by the Ministry of Public Health of Qatar (MOPH), through a process which aligns with international best practice in guideline development and localisation. The guideline will be reviewed on a regular basis and updated to incorporate comments and feedback from stakeholders across Qatar.

The editorial methodology, used to develop this guideline, has involved the following critical steps:

- Extensive literature search for well-reputed published evidence relating to the topic.
- Critical appraisal of the literature.
- Development of a draft summary guideline.
- Review of the summary guideline with a Guideline Development Group, comprised of practising healthcare professionals, subject matter experts and patient representatives, from across Qatar.
- Independent review of the guideline by the National Clinical Guidelines & Pathways Committee, appointed by the MOPH, from amongst stakeholder organisations across Qatar.

Whilst the MOPH has sponsored the development of the guideline, the MOPH has not influenced the specific recommendations made within it.

1.4 Sources of Evidence

The professional literature has been systematically queried using specially developed, customised, and tested search strings. Search strategies are developed to allow efficient yet comprehensive analysis of relevant publications for a given topic and to maximise retrieval of articles with certain desired characteristics pertinent to a guideline.

For each guideline, all retrieved publications have been individually reviewed by a member of the Editorial Team and assessed in terms of quality, utility, and relevance. Preference is given to publications that:

1. Are designed with rigorous scientific methodology.
2. Are published in higher-quality journals.
3. Address an aspect of specific importance to the guideline in question.

Further information about the literature search and appraisal process is included in *Appendix B*.

1.5 Evidence Grading and Recommendations

Recommendations made within this guideline are supported by evidence from the medical literature and where possible the most authoritative sources have been used in the development of this guideline. In order to provide insight into the evidence basis for each recommendation, the following evidence hierarchy has been used to grade the level of authoritativeness of the evidence used, where recommendations have been made within this guideline.

Where the recommendations of international guidelines have been adopted, the evidence grading is assigned to the underlying evidence used by the international guideline. Where more than one source has been cited, the evidence grading relates to the highest level of evidence cited:

- **Level 1 (L1):**
  - Meta-analyses.
  - Randomised controlled trials with meta-analysis.
  - Randomised controlled trials.
  - Systematic reviews.

- **Level 2 (L2):**
  - Observational studies, examples include:
    - Cohort studies with statistical adjustment for potential confounders.
    - Cohort studies without adjustment.
    - Case series with historical or literature controls.
    - Uncontrolled case series.
  - Statements in published articles or textbooks.

- **Level 3 (L3):**
  - Expert opinion.
  - Unpublished data, examples include:
    - Large database analyses.
    - Written protocols or outcomes reports from large practices.

In order to give additional insight into the reasoning underlying certain recommendations and the strength of recommendation, the following recommendation grading has been used, where recommendations are made:

- **Recommendation Grade A (RGA):** Evidence demonstrates at least moderate certainty of a net benefit from the recommendation.
- **Recommendation Grade B (RGB):** Evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended.
- **Recommendation Grade C (RGC):** Evidence demonstrates potential harm that outweighs benefit; additional research is recommended.
- **Recommendation of the GDG (R-GDG):** Recommended best practice on the basis of the clinical experience of the Guideline Development Group members.

1.6 Guideline Development Group Members

The following table lists members of the Guideline Development Group (GDG) nominated by their respective organisations and the National Clinical Guidelines & Pathways Committee. The GDG members have reviewed and provided their feedback and approval of the guideline document. Each member has completed a declaration of conflicts of interest, which has been reviewed and retained by the MOPH.

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1.7 National Clinical Guidelines & Pathways Committee Members

The following table lists members of the National Clinical Guidelines & Pathways Committee (NCGPC), appointed by the MOPH. The NCGPC members have reviewed and provided their feedback and approval of the guideline document. Each member has completed a declaration of conflicts of interest, which has been reviewed and retained by the MOPH.

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Shk Dr Mohammed Hamad J. Al Thani	Co-Chair of the NCGPC, Director of Public Health	Ministry of Public Health
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Dr Egon Toft	VP and Dean of College of Medicine	College of Medicine, Qatar University

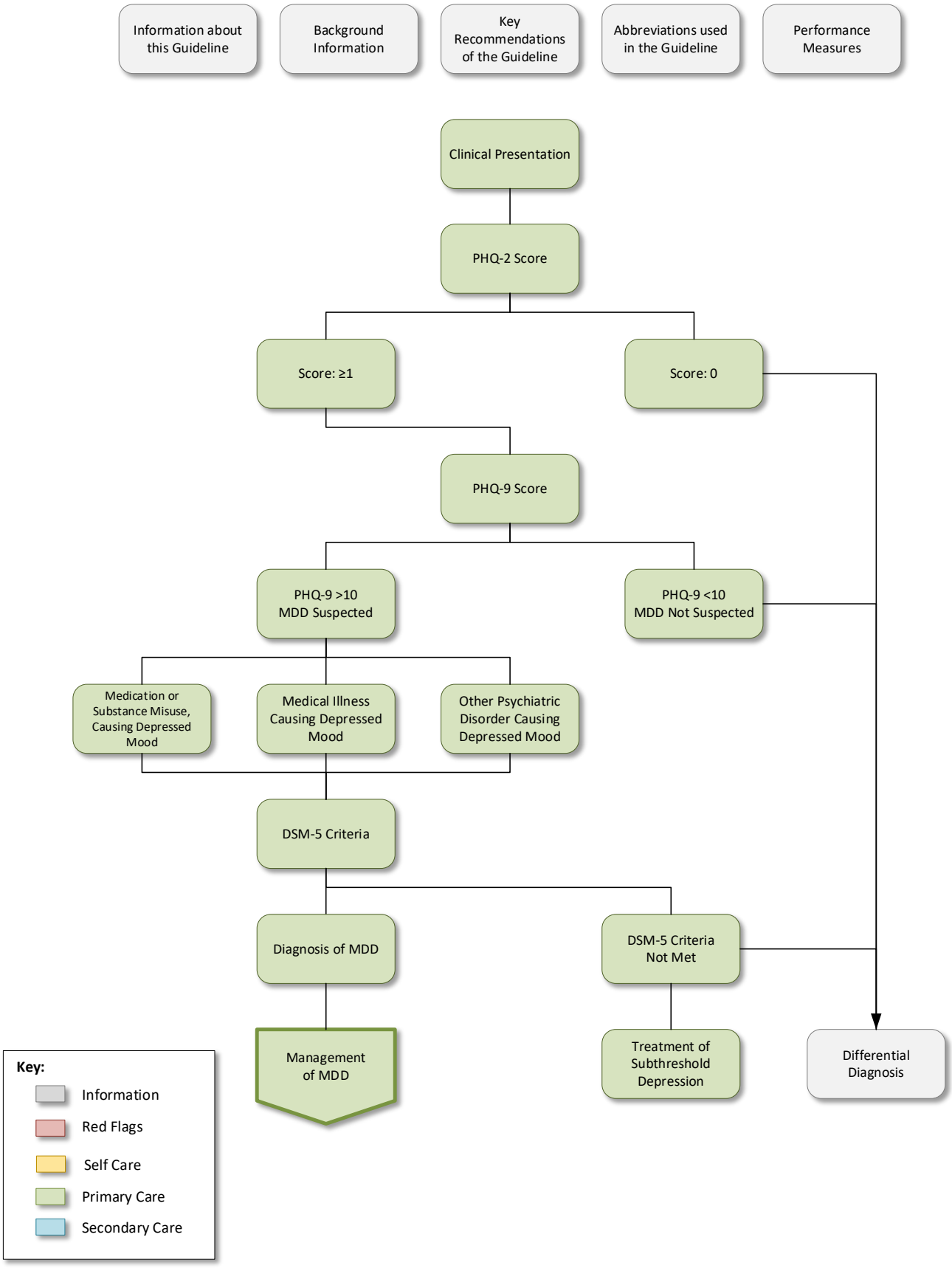
1.8 Responsibilities of Healthcare Professionals

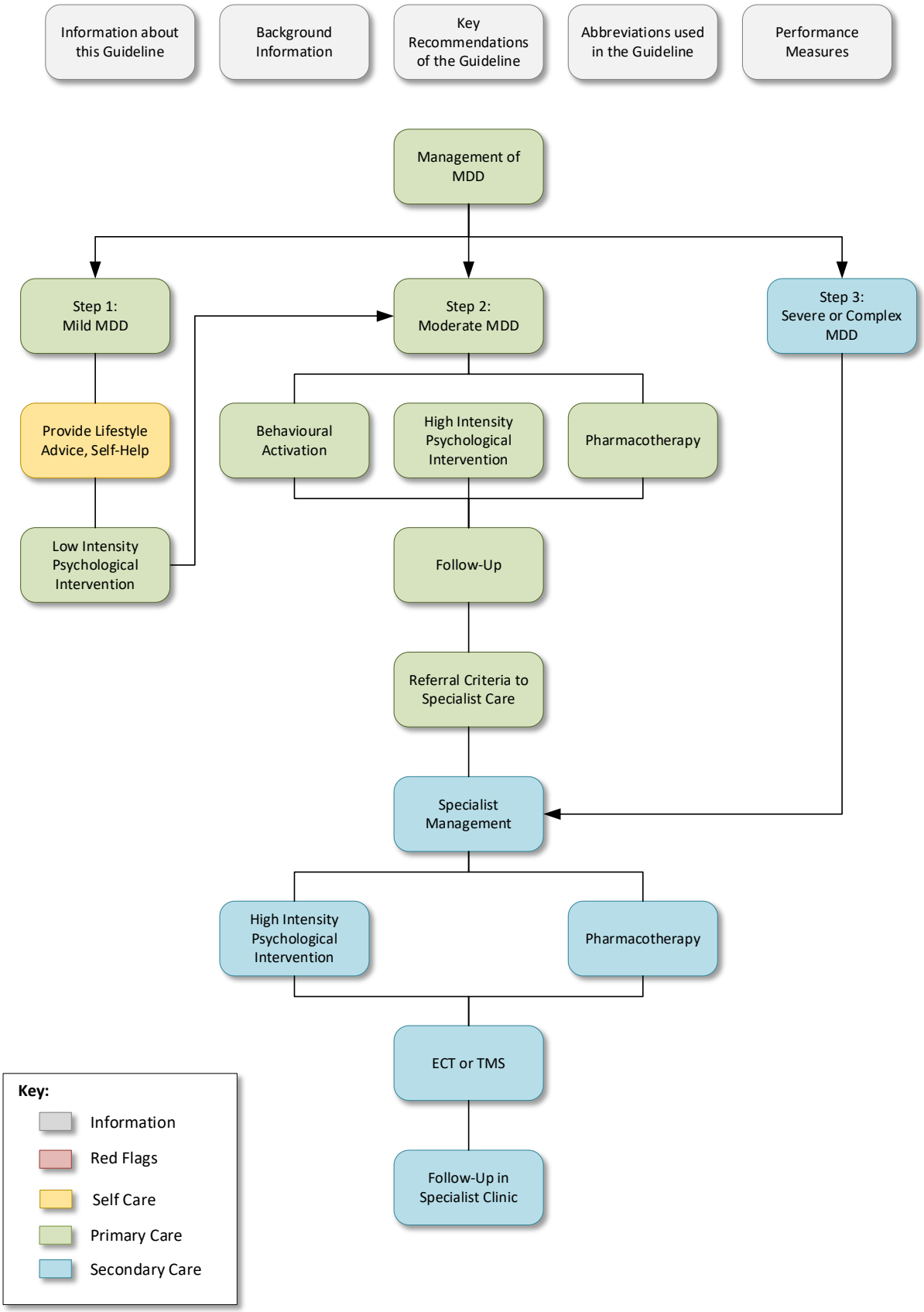
This guideline has been issued by the MOPH to define how care should be provided in Qatar. It is based upon a comprehensive assessment of the evidence as well as its applicability to the national context of Qatar. Healthcare professionals are expected to take this guidance into account when exercising their clinical judgement in the care of patients presenting to them.

The guidance does not override individual professional responsibility to take decisions which are appropriate to the circumstances of the patient concerned. Such decisions should be made in consultation with the patient, their guardians, or caregivers and should consider the individual risks and benefits of any intervention that is contemplated in the patient's care.

2 Depression Diagnosis & Management Pathway

Click on a box below to see the relevant page of the Pathway.

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3 Key Recommendations of the Guideline

The key recommendations of this guideline are as follows:

Screening and Assessment of Depression (*Section 6.1*):

- The Patient Health Questionnaire 2-question tool (**PHQ-2**) is recommended for routine screening for depression [**L1, RGA**] [1–3].
- Patients who screen positive to PHQ-2 should be evaluated further using PHQ 9-question tool (**PHQ-9**)[3,4].
- Take a full psychiatric history and undertake relevant investigations according to the clinical presentation[1,2,5].
- Review the patient's mental state[1,2,5].
- If MDD is suspected, examine whether the patient meets DSM-5 criteria required to make the diagnosis[1,2,5].

NB:

- The PHQ can be used in making a diagnosis of MDD and to assess the severity of depression[3,4].
- A provisional diagnosis of MDD is made if 5 or more of the 9 symptoms are present for "most of the day, nearly every day" in the past two weeks and one of the symptoms is depressed mood or little interest or pleasure in doing things (questions 1 and 2 on the PHQ-9) [3,4].
- In terms of severity, a score of 10 and above is usually taken to indicate moderate depression [**R-GDG**].

Diagnostic Criteria (*Section 7*):

- DSM-5 criteria listed in *Section 7* should be used to diagnose MDD[6]:

Management (*Section 8*):

- Choice between pharmacological and non-pharmacological treatments for depression should be informed by the evidence base, individual patient characteristics, patient preferences and treatment availability. Healthcare professionals should follow the below **Stepped-Care Model** to efficiently manage people with MDD and to ensure the most effective interventions [2,5]:
    - **Step 1: Management of Subthreshold Symptoms and Mild MDD.**
        - Lifestyle improvement and psychoeducation.
        - Self-help and support groups.
        - Low-intensity psychosocial interventions (e.g. CBT online or CBT guided self-help, Behavioural Activation).
        - Structured physical activity programmes.
    - **Step 2: Management of Moderate MDD.**
        - Lifestyle improvement and psychoeducation.
        - Behavioural Activation.
        - High intensity psychological interventions (e.g. CBT, Group CBT, IPT, MBCT).
        - Pharmacological treatment.
    - **Step 3: Management of Severe and Complex MDD.**
        - Lifestyle improvement and psychoeducation.
        - Behavioural Activation.
        - Higher-level psychological treatment (e.g. CBT, IPT, MBCT).
        - Pharmacological treatment.
        - Other interventions (e.g. ECT, TMS).

Psychological Therapies (*Section 8*):

- Psychological and behavioural treatments should be administered by appropriately trained practitioners. The following psychological therapies should be considered for the treatment of MDD:
    - Individual guided self-help programmes based on principles of CBT (*Section 8.2*).
    - Individual CBT (*Section 8.3*).
    - Group CBT (*Section 8.4*).
    - Behavioural Activation (*Section 8.5*).
    - Interpersonal Therapy (*Section 8.6*).

Pharmacotherapy (*Section 8.8*):

- If pharmacological treatment is required, select one of the following medications according to the setting[7–10] [**L1, RGA**]:
    - **Medications to be considered in Primary Care (**See section 8.8 for details):
        - Selective serotonin reuptake inhibitors (SSRIs).
        - Serotonin norepinephrine reuptake inhibitors (SNRIs).
    - **Medications to be considered in Secondary Care:**
        - Selective serotonin reuptake inhibitors (SSRIs).
        - Serotonin norepinephrine reuptake inhibitors (SNRIs).
        - Atypical antidepressants:
            - Mirtazapine.
            - Agomelatine.
            - Vortioxetine.
            - Bupropion
        - Tricyclic antidepressants or maprotiline:
            - For patients who do not benefit from or cannot tolerate first-line medication i.e. those drugs listed above [2,8] [**L1, RGB**].
        - Monoamine oxidase inhibitors (MAOIs)[1][**L1, RGC**]:
            - Should be restricted to patients who do not respond to other pharmacotherapies [1,8] [**L1, RGB**].

Electroconvulsive Therapy (*Section 8.9*)

- Consider ECT for acute treatment of severe MDD that is life-threatening and when a rapid response is required or when other treatments have either failed or are contraindicated[3].
- ECT should only be administered by a specialist with appropriate credentials, licensing and experience, with the support of an anaesthetic team with experience of ECT [**R-GDG**].
- Organisations that offer ECT should have the following in place [**R-GDG**]:
    - Robust local evidence-based protocols, which align with international guidance.
    - Effective clinical governance mechanisms, to ensure safe and effective practise.

Transcranial Magnetic Stimulation (*Section 8.10*):

- Transcranial magnetic stimulation (TMS) is an evidence-based treatment for MDD, but it is not a first-line treatment [**R-GDG**].
- TMS shows no major safety concerns but the clinical response is variable[1,2,8].
- TMS should only be administered by a specialist with appropriate credentials, licensing and experience [**R-GDG**].
- Organisations that offer TMS should have the following in place [**R-GDG**]:
    - Robust local evidence-based protocols, which align with international guidance.
    - Effective clinical governance mechanisms, to ensure safe and effective practise.

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Assessing Suicide Risk (*Section 8.11*):

- Treatment of depression is the most important factor in preventing suicide in patients with MDD. It is important to carry out a suicide risk assessment in all patients with MDD[2].
- Enquiring about suicidal ideation, does not increase the risk of suicide [**R-GDG**].
- Assess suicidal intent in all patients with MDD by actively seeking out symptoms of hopelessness and suicidal ideation[2].
- Suicide attempts are more frequent in the first two weeks after hospital discharge[1].

Depression in Elderly Patients (*Section 11*):

- Older individuals usually require lower doses of antidepressants, adjusted for hepatic or renal dysfunction[8] [**L1, RGC**].
- They are also particularly sensitive to medication side effects[2,8] and drug interactions with antidepressant[1].
- TCAs should be avoided in elderly patients because of the high incidence of orthostatic hypotension, sedation, cognitive problems, and cardiac side effects [1] [**L2, RGC**].
- Consider referral to Old Age Psychiatry specialist services if the patient requires specialist assessment and management and depending on the local availability of those services [**R-GDG**].

4 Background Information

4.1 Definition

Central to the diagnosis of depression is a low mood and/or loss of pleasure in most activities. Severity of the disorder is determined by both the number and severity of symptoms, and the degree of functional impairment.

A formal diagnosis of Major Depressive Disorder requires the DSM-5 criteria, listed in *Section 7,* to be met.

Subthreshold depression is defined as at least one key symptom of depression but with insufficient other symptoms and/or functional impairment to meet the criteria of MDD. Persistent symptoms are those that continue despite active monitoring and/or low-intensity intervention for several months

4.2 Classification

Major Depressive Disorder (MDD) can be classified by the number and severity of symptoms[2].

- **Mild form**:
  - At least 5 symptoms of MDD are present (see Diagnostic Criteria in *Section 7*).
  - The intensity of symptoms is distressing but manageable.
  - Symptoms result in minor social or occupational functioning.

- **Moderate form**:
  - The number of symptoms, their intensity, and the degree of functional impairment are between those specified for 'mild' and 'severe' MDD.

- **Severe form**:
  - The number of symptoms is substantially in excess of the 5 required to make the diagnosis (see *Section 7*).
  - The intensity of symptoms is seriously distressing and unmanageable.
  - Symptoms markedly interfere with social and occupational functioning.
  - Can occur with or without psychotic symptoms.

4.3 Epidemiology

MDD remains one of the most common mental health disorders in Qatar[11,12]. Recent data suggest that the 12-month prevalence of MDD in Qatar may be as high as 18%[11]. Most patients with MDD seen in Primary Care in Qatar present with mild MDD symptoms (58.9%). Moderate (31.1%) and severe (10%) cases are less frequent[11].

MDD is a common comorbidity in patients with long term health conditions and treatment of depression can improve the prognosis of the physical condition [**R-GDG**].

4.4 Risk Factors

MDD is a multi-factorial condition. The established risk factors for MDD are as follows[1,6]:

- Personal or family history of depressive disorder.
- Traumatic and stressful life events (e.g. car accidents, recent loss, divorce).
- Major life changes (e.g., job change).
- Adverse childhood events.
- Pregnancy and postnatal period (refer to *Obstetric Psychiatry Guideline* for details).
- Domestic abuse or violence.
- Comorbid psychiatric disorder.
- Long term health conditions (e.g., obesity, diabetes, cancer).
- Substance use.
- Use of particular medication (see *Section 6.3*).
- Neuroticism (negative affectivity).
- Insomnia and other sleep disorders.
- Low Socioeconomic Status.
- Low self-esteem, perfectionism and sensitivity to loss and rejection.

4.5 Prognosis

The risk of life -time recurrence of a Major Depressive Episode (MDE) is 50% after one episode, 70% after two episodes, 90% after three episodes[1]. The relapse usually occurs within the first 6 months following recovery from an MDE[8]. A premature discontinuation of antidepressant treatment increases the risk of relapse/recurrence of symptoms to 77%[1].

5 Clinical Assessment

5.1 Screening for Depression

Standardised instruments that quantify baseline intensity should be used to screen for depression and to document future progress (i.e., response to treatment and remission rates)[1,2].

The Patient Health Questionnaire 2-question tool (**PHQ-2**) is recommended for routine screening for depression [**L1, RGA**][1–3]. Ask the patient:

- During the last month, have you often been bothered by:
  - Feeling down, depressed or hopeless?
  - Having little interest or pleasure in doing things?

If the answer is "yes" to either of these two questions[1,2,5]:

- Administer:
  - PHQ 9-question tool (**PHQ-9**)[3,4].
  - Available online at: http://www.multiculturalmentalhealth.ca/en/clinical-tools/assessment/screening-for-common-mental-disorders/phq-in-different-languages/
- Take a full psychiatric history and undertake relevant investigations according to the clinical presentation.
- Review the patient's mental state.

If MDD is suspected (PHQ-9 Score >10), examine whether the patient meets DSM-5 criteria required to make the diagnosis [**R-GDG**] (see *Section 7*).

5.2 Initial Investigations

If depression is suspected, the following set of basic laboratory tests may be considered to exclude treatable underlying causes. Investigation should however be guided by the history and examination for an underlying physical condition[13]:

- Complete Blood Count (CBC).
- Erythrocyte Sedimentation Rate (ESR).
- Calcium, Magnesium and Electrolytes.
- Liver Function Tests.
- Thyroid Stimulating Hormone (TSH).
- Vitamin D level [**R-GDG**].
- Drug screening.
- Other tests may sometimes include:
  - CT scan or brain MRI.
  - Electrocardiography (ECG).
  - Electroencephalography (EEG).

5.3 Medication Causing Depressive Symptoms

The following medication may cause depressive symptoms or exacerbate a depressive episode and should be considered within the clinical assessment[6]:

- Corticosteroids (cortisone, methylprednisolone, prednisone, triamcinolone).
- Cardiovascular drugs (beta-blockers, clonidine, guanethidine, methyldopa, reserpine).

- Sedatives, hypnotics, or anxiolytics (alprazolam, diazepam, estazolam, flurazepam, lorazepam, temazepam, triazolam).
- Medications for hormonal therapy (oral contraceptives, gonadotropin-releasing hormone antagonists, tamoxifen).
- Chemotherapeutics (e.g., temozolomide, erlotinib, tamoxifen, asparaginase, etc.).
- Hallucinogens (e.g., phencyclidine).
- Antiparkinsonian drugs (e.g., l-dopa).
- Anticonvulsants (carbamazepine, gabapentin, lamotrigine, pregabalin, topiramate).
- Anti-infective agents (including antibiotics).
- Non-steroidal anti-inflammatory drugs (NSAIDs).
- Inhalants.
- Stimulants (e.g., amphetamine, cocaine, caffeine).
- Opioids.

If a medication is suspected to contribute to depressive symptoms, optimisation of medication should be considered in consultation with specialists [**R-GDG**].

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6 Diagnosis

6.1 Diagnostic Criteria

The DSM-5 criteria should be met to diagnose MDD[6]: These include:

- 5 or more symptoms should be present most of the day, nearly every day during the same two-week period and represent a change from previous functioning:
    - Depressed mood (patient's report or observations).
    - Diminished interest or pleasure in activities (patient's report or observations).
    - Significant changes in appetite leading to weight loss or gain (>5% of body weight in a month).
    - Insomnia or hypersomnia.
    - Psychomotor agitation or retardation (observations by others).
    - Fatigue or loss of energy.
    - Feelings of worthlessness or excessive/inappropriate guilt (e.g., guilt about being sick).
    - Diminished ability to think or concentrate (patient's report or observations).
    - Recurrent thoughts of death, suicidal ideation with or without a specific plan; suicide attempt.
- At least one of symptoms is:
    - Depressed mood; or
    - Loss of interest or pleasure.
- The symptoms cause clinically significant distress or impairment in daily functioning.
- The MDE is not due to the physiological effects of a substance or another medical condition.
- The occurrence of MDE is not better explained by schizophrenia, delusional disorder or other psychotic disorders.
- There has never been a manic or hypomanic episode (not applicable to substance-induced episodes or to the physiological effects of another medical condition).

When possible, specify the severity (see *Section 4.2*), features (with or without melancholic, psychotic, atypical, mixed features; catatonia), seasonal pattern, and remission[6]. For women, specify if MDD has a peripartum onset[6].

Persistent depressive disorder is a DSM V disorder with specific diagnostic criteria including:

- Duration of at least 2 years.
- Continuous depressed mood.

6.2 Differential Diagnosis

When diagnosing MDD, consider alternative diagnoses which may present with similar symptoms. These include:

- Normal emotional response to grief or loss[6].
- Adjustment disorder as an emotional or behavioural reaction in response to an identifiable stressor[1].
- Substance/medication-induced depressive disorder[6].
- Bipolar disorder[1].
- Somatoform disorder[1].
- Personality disorders.
- Thyroid function abnormalities[1].
- Anaemia.
- Electrolyte imbalances.

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7 Management

Healthcare professionals should follow the below **Stepped-Care Model** to efficiently manage people with MDD and to ensure the most effective interventions[2,5].

- Step 1: Management of Subthreshold symptoms and Mild MDD.
- Step 2: Management of Moderate MDD.
- Step 3: Management of Severe and Complex MDD.

Step	Severity	Intervention
1	**Subthreshold symptoms or; Mild MDD**	• Lifestyle improvement and psychoeducation. • Self-help and support groups. • Low-intensity psychosocial interventions (e.g. CBT, Group CBT, Behavioural Activation).
2	**Moderate MDD**	• Lifestyle improvement and psychoeducation. • Behavioural Activation. • High intensity psychological intervention (e.g. CBT, Group CBT, IPT). • Pharmacological treatment.
3	**Severe & Complex MDD**	• Lifestyle improvement and psychoeducation. • Behavioural Activation. • High intensity psychological interventions (e.g. CBT, Group CBT, IPT). • Pharmacological treatment. • Other interventions (e.g. ECT, TMS).

NB: The psychological therapies outlined below should only be provided by appropriately trained and licensed personnel with the necessary privileges [**R-GDG**].

7.1 Lifestyle Improvement and Psychoeducation

The following lifestyle improvement measures can help in reducing symptoms of depression and helping people recognise symptoms [**R-GDG**]:

- Healthy diet and avoidance of alcohol/substances.
- Structured physical activity programmes.
- Sleep hygiene.
- Reducing social isolation.
- Mindfulness and relaxation.
- Education regarding MDD and early warning symptoms.

7.2 Individual Guided Self-Help Programmes

Individual guided self-help programmes based on principles of CBT should[2]:

- Be supplied with written materials.
- Be supported by a trained specialist, who facilitates the self-help programme and reviews progress and outcome.
- Consist of 6-8 sessions over 9-12 weeks, including follow-up.

7.3 Individual CBT

CBT is focused on determining distorted negative thinking patterns [14]. It reduces depressive symptoms by challenging and reversing irrational beliefs and distorted attitudes and by encouraging patients with MDD to change their maladaptive behaviours in real life [8,15].

7.4 Group CBT

Group CBT can be offered, where available in Qatar and acceptable to patients [**R-GDG**]. When offered to patients with MDD, group CBT should ideally[2]:

- Be based on a structured model such as *'Coping with Depression'.*
- Be delivered by two trained and competent practitioners.
- Consist of 10-12 meetings of 8-10 participants.
- Take place over 12-16 weeks, including follow-up.

7.5 Behavioural Activation

Behavioural Activation is focused on providing rewarding experiences in daily life. It can be used in patients with cognitive impairment and may be effective for older adults with comorbid anxiety[16].

Treatment should ideally include 16-20 sessions over 3-4 months and possible 3-4 follow-up sessions over the following 3-6 months[2]. Consider providing more intense therapy (2 sessions/week) for the first 2-3 weeks for patients with moderate to severe MDD[2].

7.6 Interpersonal Therapy

Interpersonal Therapy (IPT) is beneficial for patients who experience a MDE due to:

1. Significant life changes (e.g., losses and role transitions)[8,14].
2. Unresolved disagreements in interpersonal relationships (e.g., deficits in social skills)[8,14].
3. Lack of life events (e.g., social isolation)[8,14].
4. IPT is recommended to maintain the remissive state[8] [**L1, RGA**].

IPT should ideally[2,17]:

- Resolve interpersonal problems.
- Be supported by a trained specialist, who reviews progress and outcome.
- Include 16 to 20 sessions over 12-16 weeks, including follow-up.

Consider providing more intense therapy (2 sessions/week) for the first 2-3 weeks for patients with severe MDD[2].

7.7 Mindfulness-Based Cognitive Therapy

Mindfulness-Based Cognitive Therapy (MBCT) should normally be delivered in groups of 8 to 15 participants and consist of weekly 2-hour meetings over 8 weeks. 4 follow-up sessions should also be provided in the 12 months after the end of treatment to prevent relapse[2] [**L1**].

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7.8 Pharmacotherapy

If pharmacological treatment is required, select one of the following medications according to the setting[7–10] [**L1, RGA**]:

- **Medications to be considered in Primary Care:**
  - Selective serotonin reuptake inhibitors (SSRIs). These include:
    - Citalopram
    - Escitalopram
    - Fluoxetine
    - Fluvoxamine
    - Paroxetine
    - Sertraline
  - Mirtazapine (NASSA) if sedation required
  - Serotonin norepinephrine reuptake inhibitors (SNRIs).

- **Medications to be considered in Secondary Care:**
  A range of antidepressants can be used to treat depression. Antidepressant medications that can be used include:

  - Selective serotonin reuptake inhibitors (SSRIs) as above.
  - SNRIs- Venlafaxine, Desvenlafaxine, Duloxetine and Levomilnacipran.
  - Serotonin antagonist and reuptake inhibitor (SARI)-Trazodone and Nefazodone.
  - Serotonin modulator – Vortioxetine.
  - Serotonin partial agonist-reuptake inhibitor (SPARI) - Vilazodone
  - Tricyclic antidepressants:
    - For patients who do not benefit from or cannot tolerate first line medication[2,8] [**L1, RGB**].
  - Tetracyclic antidepressants -Maprotiline.
  - Melatonergic agonist – Agomelatine.
  - Norepinephrine–dopamine reuptake inhibitor (NDRI) – Bupropion.
  - Noradrenergic and specific serotonergic antidepressant (NASSA) - Mirtazapine, Mianserin.
  - Selective noradrenaline reuptake inhibitor (NARI)– Reboxetine.
  - Nonselective monoamine oxidase inhibitors (MAOIs)[1][**L1, RGC**].
    - Should be restricted to patients who do not respond to other pharmacotherapies[1,8] [**L1, RGB**].
  - Non-competitive N-methyl-D-aspartate (NMDA) receptor antagonist– Esketamine.

NB [**R-GDG**]:

- Assess the efficacy and risks of each alternative treatment option against the severity and risks associated with the individual's depression, the degree of treatment resistance and past treatments that have been tried.
- There is some evidence that switching within a drug class is effective but switching between classes is preferable.
- For treatment-resistant depression, recommended strategies include augmentation with lithium or an antipsychotic or the addition of a second antidepressant.
- Psychological therapy can be added to pharmacotherapy at any stage in treatment, even with the first course of an antidepressant.

7.8.1 Prescribing Considerations

If prescribed for patients <25 years old, close monitoring is required when initiating therapy, due to the possibility of increased frequency of suicidal thoughts and a desire to self-harm in individuals prescribed the medication[8,10]. This should not however prevent patients from receiving medication if indicated.
NB:

- Match choice of antidepressant drug to individual patient requirements as far as possible, considering likely short-term and long-term effects [**R-GDG**].
- In the absence of special factors, choose antidepressants that are better tolerated and safer in over-dose [**R-GDG**].
- Lower starting doses should be considered for elderly patients[8] [**L1, RGC**].
- All MAOIs require specific dietary restrictions[8,18].
- The doses and preparations of bupropion for MDD demand higher caution, due to associated risk of seizures[19] [**L1, RGA**].
- Take into account toxicity in overdose when choosing an antidepressant for patients at risk of suicide[2]:
    - Consider prescribing smaller volumes of medication in patients at risk of overdose.
    - Consider asking a relative to look after the medication if the patient consents to this.
    - TCAs (except for lofepramine) are associated with the highest risk in overdose.
- SSRIs:
    - Are associated with an increased risk of upper GI bleeding in the elderly and in those taking NSAIDs[2].
    - Are associated with an increased risk of hyponatraemia in the elderly and people with long term health conditions [**R-GDG**].
    - Paroxetine is associated with the highest incidence of discontinuation symptoms among SSRIs[2].

7.8.2 Medication Side Effects

Patients should be informed of common side effects and rare but serious side effects prior to stating an antidepressant. The table below outlines common side effects associated with antidepressant medications. The Qatar National Formulary and product literature should however be consulted for further details.

Side Effects	SSRI	SNRIs	NDRI	NASSA	Serotonin modulators	TCA	MAOI
Headache							
Delirium							
Insomnia							
Nausea and vomiting							
Fall risk							
Seizures							
Myoclonus							
Visual changes							
Hallucinations	Rarely				Rarely		
Sedation							
Serotonin syndrome*							
Hypertension							
Hypertensive crisis							
Arrhythmias							
Orthostatic hypotension							
Increase in cholesterol							
Hyponatremia**	Elderly						
Diarrhoea or constipation							
Gastrointestinal bleeding							
Urinary hesitancy							

Side Effects	SSRI	SNRIs	NDRI	NASSA	Serotonin modulators	TCA	MAOI
Hepatotoxicity					Nefazodone		
Osteopenia							
Akathisia							
Diaphoresis							
Dry mouth							
Bruxism							
Weight gain							
Sexual dysfunction							
Priapism					Trazodone		

Table 7.8.2: Common side effects of antidepressants[8,10,20].
* Concurrent use of certain medications (e.g., intravenous methylene blue or linezolid) and other serotonin modulators along with antidepressants increases the risk of serotonin syndrome[1,10,18,20,21].
** The most serious cases of hyponatremia can result into a coma[10].

7.8.3 Monitoring

If there is no response to treatment after 2-4 weeks of treatment[2,10] [**L1, RGA**]:
- Check medication adherence.

If there is no response to treatment after 3-4 weeks of treatment[2,10] [**L1, RGA**]:
- Consider adjusting the dose or switching to another antidepressant.

If there has been some improvement after 4 weeks[2] [**L1, RGA**]:
- Continue treatment for another 2 to 4 weeks; or
- Consider switching to another antidepressant if:
    - There are troublesome side effects.
    - The patient prefers to change treatment.

7.8.4 Duration of Treatment

If a patient has benefited from taking an antidepressant[1,2,8]:
- Continue medication for at least 6 months after remission (total resolution of symptoms).
- Review the necessity of treatment beyond 6 months after remission.
- Advise to continue antidepressants for beyond 6 months if the patient is at risk of relapse.
    - People with MDD on long-term maintenance treatment should be regularly re-evaluated.
- Consider indefinite medication treatment if the patient has:
    - Persistent depressive disorder; or
    - More than 3 episodes of MDD; or
    - 2 episodes of MDD with complicating factors such as:
        - Rapid recurrent episodes.
        - More than 60 years of age at onset of major depression.
        - Severe episodes or family history.

7.8.5 Discontinuation of Antidepressant Treatment

When pharmacotherapy is being discontinued[1,8]:
- Antidepressant medications should not be stopped abruptly.
- Slow tapering of medications should continue over at least several weeks (especially for paroxetine and venlafaxine).

- If a patient has experienced severe and troublesome discontinuation symptoms when stopping SSRI, consider switching to fluoxetine, in order to reduce the risk of discontinuation syndrome.

Patients should be informed of[8,10]:

- Possible withdrawal symptoms, which typically resolve over 1-2 weeks:
  - Gastrointestinal problems.
  - Flu-like symptoms (such as nausea, headache, chills, and body aches).
  - Anxiety.
  - Dizziness.
  - Insomnia.
  - Paraesthesia.
- A plan for seeking treatment in the event of recurrence of depressive symptoms[8].

7.8.6 Add on Therapy (Augmentation and Combination Strategies)

Following factors should be considered if there is inadequate treatment response [**R-GDG**]:

- Check the adequacy of treatment including dose and non-adherence
- Review diagnosis including the possibility of other medical or psychiatric diagnoses which should be treated in addition and the presence of symptoms suggesting unrecognised bipolarity, psychosis or atypical symptoms.

Other treatment options include:

- Dose Increase.
- Switching antidepressants.
- Augmentation/combination treatments.

Consider adding a second drug to the current antidepressant for patients who have[**L1**]:

- Failed to achieve remission with an adequate trial of therapy and two different classes of antidepressants at adequate duration and dosage.
- Partial response to current antidepressant medication.

Add-on medications which can be considered include[1][**L1**]:

- Lithium augmentation with TCAs or with SSRI.
- Atypical antipsychotic-antidepressant combinations (e.g. quetiapine-aripiprazole).
- Bupropion or buspirone-SSRI combination.
- Mirtazapine-SSRI combination.
- Mirtazapine-venlafaxine combination[22,23] [**L2, RGB**].
- Levothyroxine augmentation of antidepressants.

NB: Augmentation and combination strategies can lead to new side effects appearing and these need to be monitored for [**R-GDG**].

The following strategies should not be used routinely[2,5]:

- Augmentation of an antidepressant with a benzodiazepine for more than 2 weeks as there is a risk of dependence.
- Augmentation of an antidepressant with buspirone, carbamazepine, lamotrigine or valproate as there is insufficient evidence for their use.
- Augmentation of an antidepressant with pindolol or thyroid hormones as there is inconsistent evidence of effectiveness.

7.9 Electroconvulsive Therapy

Electroconvulsive Therapy (ECT) is an effective and rapid treatment for severe MDD. It is however, associated with risks of general anaesthesia and possible cognitive side effects[3]. When considering ECT, ensure that the treatment is offered in concordance with principles of informed consent and local mental health legislation [**R-GDG**].
Consider ECT for acute treatment of severe MDD that is life-threatening and when a rapid response is required or when other treatments have either failed or are contraindicated[3]. This may include patients with MDD and any of the following[2,8] [**L1, RGA**]:

- High suicidal risk.
- Severe psychomotor retardation and associated symptoms such as refusal or reduced food fluid intake.
- Life threatening malignant catatonia.
- Treatment resistant depression which has responded to ECT in the past.
- Psychotic features.
- Patients who experience severe side effects from the psychotropic medications.

NB:

- ECT should only be administered by a specialist with appropriate credentials, licensing and experience, with the support of an anaesthetic team with experience of ECT [**R-GDG**].
- The patient should be fully informed of the risks and benefits of ECT including the discussion about the risks, side effects and the prognosis if the treatment is withheld.
- During ECT treatment, patient should be assessed for adverse effects and treatment response between each treatment session [**R-GDG**].
- Patients memory and orientation should be re assessed after the first treatment and then at regular intervals using standardised cognitive assessment tools.
- Organisations that offer ECT should have the following in place [**R-GDG**]:
    - Robust local evidence-based protocols, which align with international guidance.
    - Effective clinical governance mechanisms, to ensure safe and effective practise.

7.10 Transcranial Magnetic Stimulation

Transcranial magnetic stimulation (TMS) is an evidence-based treatment for MDD, but it is not a first-line treatment [**R-GDG**]. TMS shows no major safety concerns but the clinical response is variable[1,2,8]. It is less effective than ECT for treatment of psychotic depression[24].

When considering TMS, ensure that the patient with MDD[2]:

- Is informed about the other treatment options available.
- Understands the possibility the procedure may not give them benefit.

Repetitive TMS may be considered[8,25] [**L1, RGB**]:

- For patients with MDD that does not respond to antidepressant treatment.
- For patients in whom antidepressants are not suitable.

NB:

- TMS should only be administered by a specialist with appropriate credentials, licensing and experience [**R-GDG**].
- Organisations that offer TMS should have the following in place [**R-GDG**]:
    - Robust local evidence-based protocols, which align with international guidance.
    - Effective clinical governance mechanisms, to ensure safe and effective practise.

7.11 Assessment and Management of Suicide Risk

Treatment of depression is the most important factor in preventing suicide in patients with MDD. It is important to carry out a suicide risk assessment in all patients with MDD[2].

NB: Enquiring about suicidal ideation, does not increase the risk of suicide [**R-GDG**].
Assess suicidal intent in all patients with MDD by actively seeking out symptoms of hopelessness and suicidal ideation[2]. Suicide attempts are more frequent in the first two weeks after hospital discharge[1].

If a patient with MDD is deemed to be at risk of suicide[1,2]:

- Take into account toxicity in overdose when prescribing medication.
    - If necessary, limit the amount of medication available to the patient.
- Consider increasing the level of support:
    - More frequent follow-up appointments.
    - Telephone contact between appointments.
- Consider urgent referral to specialist mental health services.

7.12 Complementary and Alternative Medicine

The following treatments may be used as adjunctive strategies for MDD. However, they are not recommended as monotherapies and should not replace antidepressant or psychological treatment[1,2,8][**L1, RGC**].

- Music therapy[26,27] [**L1, RGA**].
- Mindfulness-based stress reduction[28] [**L1, RGB**].
- Yoga and meditation[1] [**L1, RGA**].
- Light therapy[1,8] [**L1, RGB**].
- Omega-3 fatty acids[29] [**L1, RGA**].

NB: Computerised CBT can be used in the management of mild and moderate depression in primary and secondary care, but not recommended in management of severe depression[30].

Physical activity programmes are recommended for people with persistent subthreshold depressive symptoms or mild to moderate MDD[1,2] [**L1, RGA**]. They should[2]:

- Be provided by a competent practitioner.
- Be delivered in groups.
- Consist of 3 sessions/week of moderate duration (45 minutes to 1 hour) over 10-14 weeks.

7.13 Treatments Not Recommended in Depression

The following *are not recommended* to treat depression:

- Dosulepin should not be prescribed[2].
- St. John's wort (*Hypericum perforatum*):
    - Primary Care Physicians should not prescribe or advise its use by people with MDD [**L1, RGC**][2,31].
    - It should not be taken in combination with antidepressant medications[1,8] [**L1, RGC**].
- Acupuncture[8,31] [**L1, RGB**].
- Hormonal treatments (e.g., oestrogen or progesterone)[1] [**L1, RGB**].
- S-adenosylethione (Sam-E)[1,31] [**L1, RGB**].
- Vitamin D[1] [**L1, RGB**].

View Pathway

8 Follow-Up

Healthcare professionals involved in the care of the depressed patient should anticipate and address the patient's needs at regular intervals. Individualised management plans should be developed in conjunction with the patient [**R-GDG**].

For short-term subclinical and mild cases of MDD, follow-up and monitoring are still needed[1]. Make contact if the person does not attend follow-up appointments[2].

For patients started on antidepressants who *are not considered* to be at increased risk of suicide, follow-up appointments should be ideally be scheduled as follows[2]:

- After first 2 weeks.
- At intervals of 2-4 weeks in the first 3 months.
- At longer intervals if response is good.

For patients started on antidepressants who *are considered* to be at increased risk of suicide or younger than 30 years, follow-up appointments should be scheduled[2]:

- After 1 week.
- Frequently thereafter as appropriate.

It is important that patients are informed on how to access help in a crisis e.g. through Emergency Department or a dedicated walk-in-clinic [**R-GDG**]

After discontinuation of pharmacotherapy, patients should be monitored for several months[8]. If symptoms recur, another course of treatment should be provided [**L1, RGA**][8].

View Pathway

9 Referral Criteria to Specialist Care

Consider referral to Specialist Care if a patient with MDD:

- Is at significant risk of self-harm or self-neglect
- Presents significant immediate risk to others.
- Has severe agitation or psychotic symptoms.
- Has a history suggestive of bipolar disorder.
- MDD has failed to respond to Step 1 or Step 2 interventions provided in primary care.
- Has learning difficulties or social and communication difficulties.
- Requires an expert opinion on treatment and management.

10 Depression in Elderly Patients

Older Adults with depression may present with atypical symptoms including unexplained physical symptoms, cognitive symptoms. Compared to the younger population, older adults more often present with subthreshold depression which has a significant impact on their quality of life.

Hence a comprehensive assessment should be carried out involving the MDT, patients and their carers wherever possible. Consider using the *Geriatric Depression Scale* (GDS) rather than PHQ-9 to screen for depression in elderly patients (>65 years)[32].

A short form of the GDS is available which could be used in primary care setting to screen for depression[**R-GDG**].

Older individuals usually require lower doses of antidepressants, adjusted for hepatic or renal dysfunction[8] [**L1, RGC**]. They are also particularly sensitive to medication side effects[2,8] and drug interactions with antidepressant[1]. TCAs should be avoided in elderly patients because of the high incidence of orthostatic hypotension, sedation, cognitive problems, and cardiac side effects[1] [**L2, RGC**].

Consider referral to Old Age Psychiatry specialist services if the patient requires specialist assessment and management and depending on the local availability of those services [**R-GDG**].

NB:

- When screening for depression in patients with Dementia, other screening tools should be considered [**R-GDG**].

11 Key Considerations for Patient Preferences

Patient preferences refer to patient perspectives, beliefs, expectations, and goals for health and life, and to the steps employed by individuals in assessing the potential benefits, harms, costs, and limitations of the management options in relation to one another. Patients may have preferences when it comes to defining their problems, identifying the range of management options and selecting or ranking the outcomes used to compare these options.

It is important for healthcare professionals to develop an understanding of the patient as an individual and the unique way in which each person experiences a condition and its impact on their life.

The following recommendations are therefore made for physicians and other healthcare professionals regarding general principles of patient care in Qatar:

- **Respect Patients:** Treat patients with respect, kindness, dignity, courtesy and honesty. Ensure that the environment is conducive to discussion and that the patient's privacy is respected, particularly when discussing sensitive, personal issues. Ask the patient how they wish to be addressed and ensure that their choice is respected and used.

- **Maintain Confidentiality:** Respect the patient's right to confidentiality and avoid disclosing or sharing patients' information without their informed consent. In this context, students and anyone not directly involved in the delivery of care should first be introduced to the patient before starting consultations or meetings, and let the patient decide if they want them to stay.

- **Clarify Third-Party Involvement:** Clarify with the patient at the first point of contact whether and how they like their partner, family members or carers to be involved in key decisions about their care or management and review this regularly. If the patient agrees, share information with their partner, family members or carers.

- **Obtain Informed Consent:** Obtain and document informed consent from patients, in accordance with MOPH policy and guidance.

- **Encourage Shared Decision Making:** Ensure that patients are involved in decision making about their own care, or their dependent's care, and that factors that could impact the patient's participation in their own consultation and care including physical or learning disabilities, sight, speech or hearing impairments and problems with understanding, reading or speaking English are addressed.

- **Disclose Medical Errors:** Disclose errors when they occur and show empathy to patients.

- **Ensure Effective Communication:** Explore ways to improve communication including using pictures, symbols or involving an interpreter or family members. Avoid using medical jargon. Use words the patient will understand and confirm understanding by asking questions.

- **Ensure Continuity of Care:** Provide clear and timely sharing of patient information between healthcare professionals especially at the point of any transitions in care.

12 Performance Measures

A list of performance measures is given in the table below [3,33,34]. Healthcare organisations are encouraged to monitor service performance using the indicator definitions below.

Ref	Numerator	Denominator
DEP01	Number of patients from the denominator who have a PHQ-9 Score recorded at diagnosis.	Number of patients aged ≥18 years with a diagnosis of MDD.
DEP02	Number of patients within the denominator with a record of suicide risk assessment at each consultation.	Number of patients aged ≥18 years with a diagnosis of MDD.
DEP03	Number of patients within the denominator who attempt suicide during the current episode of MDD	Number of patients aged ≥18 years with a diagnosis of MDD.
DEP04	Number of patients within the denominator who remained on an antidepressant medication treatment for at least 84 days.	Number of patients aged ≥18 years with a diagnosis of MDD, who were treated with antidepressant medication.
DEP05	Number of patients within the denominator who had been referred to a specialist	Number of patients aged ≥18 years with a diagnosis of MDD.

Table 12.1: Performance measures.

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Appendix A: Screening Tools for MDD in English & Arabic

The following documents are included in *Appendix A*:

- PHQ-9 Scoring Tool in English.
- PHQ-9 Scoring Tool in Arabic.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

View Pathway

NAME: _____ **DATE:** _____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- **Not difficult at all** _____
- **Somewhat difficult** _____
- **Very difficult** _____
- **Extremely difficult** _____

View Pathway

Fold back this page before administering this questionnaire

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.

2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

3. ***Consider Major Depressive Disorder***
—if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
—if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.

2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3

3. Add together column scores to get a TOTAL score.

4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.

5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

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

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

View Pathway

استبيان عن صحة المرضى - 9 (PHQ-9)

خلال الأسبوعين الماضيين، كم مرة عانيت من أي من المشاكل التالية؟ *(ضع علامة "✓" للإشارة لجوابك)*	**ولا مرة**	**عدة أيام**	**أكثر من نصف الأيام**	**تقريبا كل يوم**
1. قلة الاهتمام أو قلة الاستمتاع بممارسة بالقيام بأي عمل	0	1	2	3
2. الشعور بالحزن أو ضيق الصدر أو اليأس	0	1	2	3
3. صعوبة في النوم أو نوم متقطع أو النوم أكثر من المعتاد	0	1	2	3
4. الشعور بالتعب أو بامتلاك القليل جداً من الطاقة	0	1	2	3
5. قلة الشهية أو الزيادة في تناول الطعام عن المعتاد	0	1	2	3
6. الشعور بعدم الرضا عن النفس أو الشعور بأنك قد أخذلت نفسك أو عائلتك	0	1	2	3
7. صعوبة في التركيز مثلاً أثناء قراءة الصحيفة أو مشاهدة التلفزيون	0	1	2	3
8. بطء في الحركة أو بطء في التحدث عما هو معتاد لدرجة ملحوظة من الآخرين / أو على العكس من ذلك التحدث بسرعة وكثرة الحركة أكثر من المعتاد	0	1	2	3
9. راودتك أفكار بأنه من الأفضل لو كنت ميتا أو أفكار بأن تقوم بإيذاء النفس	0	1	2	3

_____ + _____ + _____ + ___0___ = **Total Score:** _____ **(FOR OFFICE CODING)**

إذا أشرت إلى أية من المشاكل أعلاه، فإلى أية درجة صعّبت عليك هذه المشاكل القيام بعملك، الاعتناء بالأمور المنزلية، أو الانسجام مع أشخاص آخرين؟

ليست هناك أي صعوبة	**هناك بعض الصعوبات**	**هناك صعوبات شديدة**	**هناك صعوبات بالغة التعقيد**
☐	☐	☐	☐

Appendix B: Detailed Description of the Literature Search

A systematic search for existing literature on depression was performed in the period July 1st - July 14th, 2019.

The search for clinical practice guidelines on dementia diagnosis and/or management was performed in the *PubMed* database and websites of relevant organisations and societies including the *American Psychiatric Association (APA)*, *Beyond Blue: The National Depression Initiative (Australia),* and *American Academy of Family Physicians (AAFP)*. The present guideline is primarily based on UK NICE, Institute for Clinical Systems Improvement (ICSI), and APA guidelines and is supplemented with other relevant studies. The stepped care approach was adopted from the most recent UK NICE guideline.

Peer-reviewed scientific publications were found in PubMed and via *Google Scholar* Internet search engine. Non-peer reviewed studies were identified in *bioRxiv*. Books were checked in PubMed. Personal opinions of healthcare professionals, information published on medical websites, and drug prescribing information sheets were found via Google search engine.

The included publications were identified using the combination of terms "depression AND adult" and specified with the following terms:

Guideline, epidemiology, aetiology, prevalence, risk factors, presentation symptoms, DSM-5 criteria, management, treatment, psychological/pharmacological/alternative/music therapy, SSRI, SNRI, TAC, CBT, cCBT, IPT, antipsychotics, SAM-E, distress thermometer, contradictions, augmentation.

Figure B.1 below demonstrates graphically the results of the search and application of exclusion criteria.

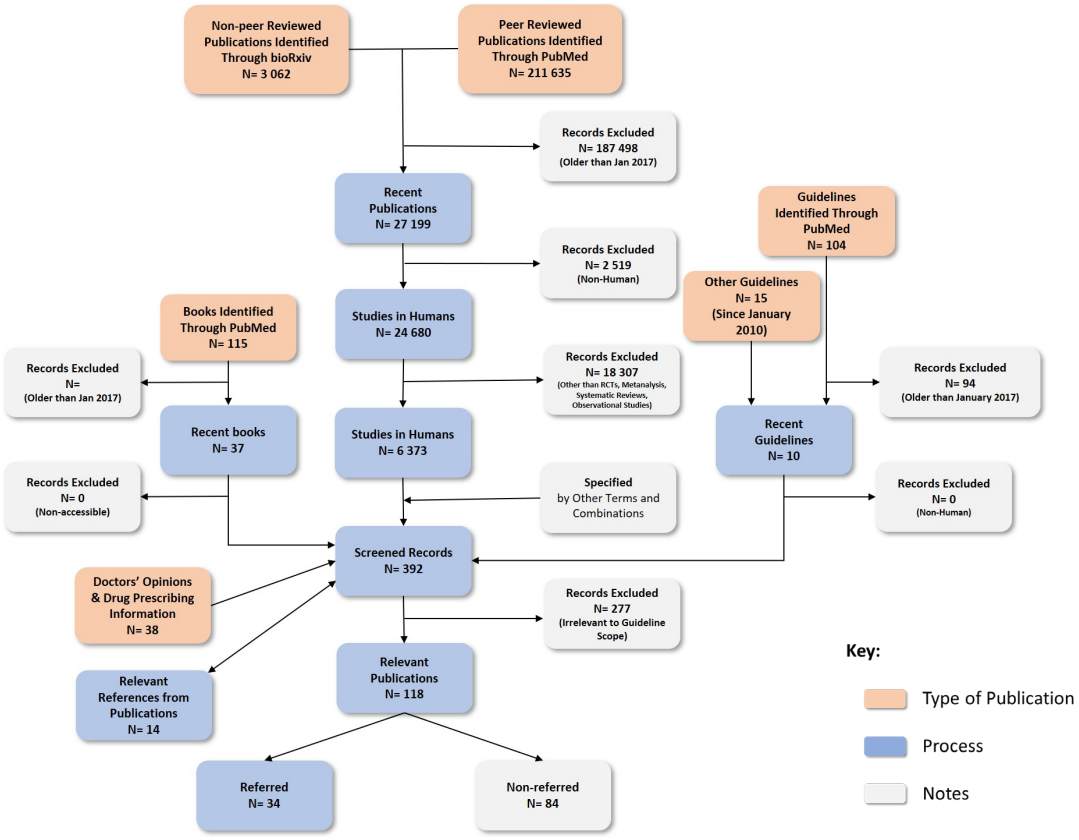

Fig B.1: Literature search results and application of exclusion criteria.

Acknowledgements

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