In association with

Department of Social Protection

Depression

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1. Overview and Definition of the Condition

1.1 Overview

This protocol is designed to support the Department's Medical Assessors in the completion of their work in evaluating disablement in relation to the entitlement for the various Scheme benefits.

Depression and other mental health disorders are major factors in functional impairment, and disability and absence from work, with depression being the primary cause of absence in many occupational sectors.

The World Health Organization projected that, by 2020, depression would be the second leading cause of disability and disease burden in the developed world, with the age group of adults age 15-44 already having reached that level (WHO, 2009). However recent studies suggest that this ranking may well rise even sooner, with depressive illnesses soon becoming the highest cause of disability worldwide (Rost, 2009)

The risk for secondary physical and psychiatric illness is raised in persons suffering from depression, as is the risk of injuries and accidents. However, of the 121 million suffers of depression worldwide, less than 25% of those have access to effective treatments (WHO, 2009).

In work terms, the economic cost of depression is considerable. Figures in the UK in 2000 estimate the cost of adult depression to exceed £9 billion including direct treatment costs, with 109 million working days lost annually (Thomas, 2002). More recent evidence from the Independent Research Service of the House of Commons Library in the UK estimates that this burden is rising with estimates that depression is costing the economy £8.6 billion per year *excluding* treatment costs to the NHS (Reported in the Independent, June 2009). In Ireland the economic cost of depression is estimated at €280 million annually with lost working days costing €170 million annually (Aware, 2009).

According to the National Disability Survey (Ireland) in 2006, of all persons reporting a disability (393,800 people); 35% indicated difficulty with remembering and concentrating. Emotional, psychological and mental health at 34% also indicated a high prevalence of disability (CSO Ireland, 2008).

1.2 Definition of the condition

Depression, or depressive illness, is categorised as one of a group of conditions that are known collectively as mood disorders. Mood disorders encompass a spectrum of conditions which range in severity from single episodes of major depressive illness at one end of the spectrum, to bipolar type 1 disorder as the more severe end of the spectrum. This spectrum of conditions is depicted in ***Diagram 1*** below.

- *[Dysthymia]*
- **Single major depressive episode**
- **Chronic major depressive disorder**
- **Psychotic major depressive disorder**
- **Recurrent major depressive disorder**
- Cyclothymia
- Hypomania and depression (Bipolar disorder type II)
- Mania and depression (Bipolar disorder type I)
- *[Schizoaffective disorder]*

Diagram 1: Spectrum of conditions which can be considered as Mood Disorders

This protocol deals with **unipolar mood disorders.** These are characterised by recurrent episodes of depression without intervening episodes of mania or hypomania. The protocol does not make specific reference to bipolar disorders, persistent mood disorders (including cyclothymia and dysthymia), schizoaffective disorders or anxiety disorders in the absence of depression.

Unipolar mood disorders may be primary, or secondary (e.g. medical conditions or misuse of alcohol and other substances).

Primary unipolar mood disorders can be divided into:

- Depressive episode - single episode
- Recurrent depressive disorder - recurrent episodes
- Mixed anxiety and depressive disorder.

Each depressive episode may be:

- Moderate or severe
- If severe, with or without psychotic symptoms.

This protocol also includes as appendices:

- Other specific mood disorders (**Seasonal Affective Disorder, Antenatal and Postnatal Depression and Depression in the Elderly**)

And

- **Suicide and Deliberate Self-Harm** and **Bereavement** which may be associated with mood disorders as well as other psychiatric disorders

The distinction between mood and affect is sometimes blurred and the terms are sometimes used interchangeably. It is helpful to review the definitions from DSM IV:

- *Affect*. **A pattern of observable behaviours** that is the expression of a

subjectively experienced feeling state (emotion). Common examples of affect are euphoria, anger and sadness. Affect varies over time, in response to changing emotional states.

- *Mood*. **A pervasive and sustained emotion** that colours the person's thinking and perception of the world. Common examples of mood include inappropriate depression, elation and anxiety.

1.2.1 Diagnostic and Statistical Manual of Mental Disorders 4th Edition Text Revision (DSM-IV-TR) Classification

The National Institute of Clinical Excellence guidance on depression published in 2009 suggests that depression is classified according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fourth Edition text revision (American Psychiatric Association, 2000) (usually referred to as DSM-IV TR) definitions, stating that 'enables specific interventions to be better targeted for more severe degrees of depression; its definition of severity also makes it less likely that a diagnosis will be made solely on symptom counting' (NCCMH, 2009).

1.2.1.1 Major Depressive Episode

The DSM-IV criteria for a Major Depressive Episode are:

- Five (or more) of the following symptoms have been present during the same 2-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.

NB: Symptoms should not be included that result from a general medical condition, or mood-incongruent delusions or hallucinations.

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
- 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)
- Significant weight loss when not dieting or weight gain (e.g., 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.
- Insomnia or Hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day (observable by

others, not merely subjective feelings of restlessness or being slowed down)

- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- 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

- The symptoms do not meet criteria for a Mixed Episode (see p. 335).
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

1.2.1.2 Major Depressive Disorder

The DSM-IV criteria for a Major Depressive Disorder: Recurrent are:

- The presence of two or more Major Depressive Episodes – note there must be an interval of at least 2 months between each individual episode in which the criteria are not met for a major depressive episode.
- The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode. This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

Further diagnostic classification can be applied to specify:

- Severity/Psychotic/Remission Specifiers
- Chronic
- With Catatonic Features
- With Melancholic Features
- With Atypical Features
- With Postpartum Onset

Longitudinal Course Specifiers (With and Without Interepisode Recovery) and seasonal pattern specifiers may also be applied.

1.2.2 International Classification of Diseases; 10th Edition (ICD-10) Classification

A simplified classification based on the World Health Organisation International Classification of Diseases diagnostic criteria (10th Edition) is detailed in *Appendix E*.

1.3 Severity of depressive illness

Depression has a range of meanings from a lay description of normal unhappiness, to a medical description of a psychotic illness. Research studies using symptom-rating scales have shown that about 10 symptoms are sufficient to characterise depressive states. These can be divided into core symptoms and other symptoms.

Core Symptoms	1.	Depressed mood	Most of the day, nearly every day
	2.	Loss of interest and enjoyment	Most of the day, nearly every day
	3.	Loss of energy, fatigue	Nearly every day
Other Symptoms	1.	Poor self confidence and low self esteem	Nearly every day
	2.	Ideas of guilt and unworthiness	
	3.	Ideas or acts of self-harm or suicide	
	4.	Poor concentration,	

attention and indecisiveness

5. Psychomotor agitation or retardation
6. Disturbed sleep
7. Disturbed appetite

Diagnosis of a mild depressive episode requires at least two of the three core symptoms, plus two of the seven other symptoms. Over a period of more than 2 weeks, the symptoms should be present nearly every day, for most of the day, and cause disruption of the person's normal activities.

Diagnosis of moderate depression requires five or six of the ten symptoms listed above. Negative beliefs such as loss of self-esteem and inappropriate guilt are the core symptoms of major depression.

In cases of **severe depression**, with seven or more of the ten symptoms, hallucinations and/or delusions may occur, the content being consistent with the depressive mood (e.g. auditory hallucinations expressing derogatory comments or delusions of guilt). These cases are described as **major depression with psychotic features**.

There is a strong association between the severity of the depression and the level of resulting disability. Kruijshaar (2003) found that three significant groups of major depression could be distinguished, based on the associated degree of disability: 'mild', 'moderate to severe' and 'severe with psychotic features'.

In both ICD 10 and DSM IV, major depressive states can be further categorised by the presence of physical symptoms indicating a somatic syndrome.

Somatic (or endogenous) depression is characterised by:

- Anhedonia
- Loss of emotional reactivity to pleasurable surroundings and events
- Early waking (>2 hours early)
- Psychomotor retardation or agitation
- Marked loss of appetite
- Weight loss of >5% of body mass in one month
- Loss of libido.

Reactive Depression means depression in which emotional reactivity to events is preserved. It does not mean depression that is a reaction to circumstances.

Depression is commonly associated with anxiety disorders. Many patients do not fall neatly into categories of either anxiety or depression, so the concept of mixed

anxiety and depression is now recognised. The differential diagnosis between generalised anxiety disorders and depressive disorders is listed in the appendices.

2. Epidemiology

2.1 Prevalence

Depressive disorders are among the most common psychiatric disorders, and are currently ranked as the fourth highest cause of disability worldwide – a figure that is expected to rise over the next 20 years to become the second highest cause of disability by 2020 [Murray and Lopez, 1997a; Murray and Lopez, 1997b).

Major depressive disorder amongst working-age adults in the UK has an estimated point prevalence of 2.1% (males 1.7% females 2.5%), whilst the prevalence of wider depressive illnesses (classified with the ICD-10 term of '**mixed depression and anxiety**') is 9.8% ((males 7.1%, females 12.4%) (NICE, 2004). Similar prevalence rates have been noted in the US (see http://www.mdguidelines.com/depression-major). However it has been suggested that actual rates of depression may be much higher (Andrews et al, 2005), with researchers noting that only one-third of adults experiencing depression seek treatment (Steffens, 2000).

In the UK, depressive illnesses account for around one third of the reasons that patients attend GP consultations. Between 5% and 10% of patients attending their GP meet the criteria for major depression, and two to three times as many people have depressive symptoms but do not meet the criteria for major depression (NHS CRD, 2002; Butler et al, 2004).

Lifetime Risk rates for depressive illness have recently been called into question (Patten, 2009) with the suggestion that actual rates may be twice that suggested by previous literature which estimate lifetime risks rates to be around 10% to 25% for women and 5% to 12% for men in developed countries (NICE, 2004, http://www.mdguidelines.com/depression-major).

In excess of 300,000 people in Ireland experience depressive illness at any one time and estimates suggest that approximately one in fourteen workers are affected.(Aware, 2009)

The 2006 National Disability Survey in Ireland reports that of the 34% of disabled people expressing an emotional, psychological and mental health disability; 53% were female and 47% male (Central Statistics Office Ireland, 2008).

In Ireland, people in the age groups 18-64 (i.e. of working age) accounted for 68% of those reporting this type of disability.

40% of those with emotional, psychological and mental health disability indicated they were suffering from an illness. Of those depression was the most frequently reported illness at 28% (Central Statistics Office Ireland, 2008).

2.2 Age patterns

Depressive disorders can start at any age. The patterns of prevalence for each age group are different for men and women. In women, the highest prevalence occurs between 35 and 45 years. In men, the prevalence rises with increasing age.

Recent trends suggest that depression is becoming more common (or at least being diagnosed more commonly) in younger age groups.

In Ireland 68% of those reporting emotional, psychological and mental health disabilities are of working age (18-64years age group) (CSO Ireland, 2008)

2.3 Gender differences

Unipolar depressive illness is much more common in women than men (Weissman et al, 1993), however due to the increasing prevalence with age in men, the gender ratio reverses after the age of 55 (Bebbington, et al 1998).

Various explanations for the sex difference have focused on social hypotheses relating to women's role and status in society and biological differences in hormonal effects. However as these differences are evident in community studies, consistent across cultures and persistent over time, the results are unlikely to represent biases in help-seeking behaviour

2.4 Socio-economic Factors

Socio-economic factors also significantly affect the prevalence rate. Depression is more common among unemployed people, those in lower socio-economic groups, and those who occupy rented accommodation. Depression is also more common in areas of social deprivation, the homeless and in asylum seekers (Nice, 2004).

2.5 Depression and Employment

A number of factors influence the prevalence of depressive illnesses, although the relationship between these factors is complex. Age, socio-economic factors, gender and health all have an impact on the ability of a person to continue to function in a work environment. For example, Elinson (2004) found that a person with depression who continued to function at in an employed capacity tended to be younger, male, have a higher standard of education and income, and either lived alone or with a non relative in a non-rural location.

2.6 Co-morbidity

Depression is more commonly encountered in people who have chronic medical conditions such as diabetes, chronic obstructive pulmonary disease, and cardiovascular disease.

Mood disorders are also commonly found in patients with other psychiatric disorders. In one study of American psychiatric outpatients with unipolar major depressive disorder, 65.4% had at least one other psychiatric disorder (McDermut, mattia and Zimmermarn 2001).

Co-morbidity is associated with a longer duration of the depressive episode, greater psychiatric morbidity and more social and occupational impairment. The greater the number of co-morbid conditions, the greater the psychiatric and psychosocial impairment (McDermut, Mattia and Zimmerman 2001).

3. Aetiology

3.1 Genetics

- Vulnerability to the development of major depression has strong genetic determinants (Levinson, 2005).
- There is now a substantial evidence base indicating that the influence of genetic factors plays a major role in predisposing an individual to major depressive disorders. heritability of major depression has been estimated at about 40%, however estimates of up to 70% have been quoted (Joyce, 2009)
- Some research suggests that exhibition of genetic or biochemical causal beliefs for mood disorders can result in fatalistic or pessimistic attitudes and behaviours (Cunningham, Sirey and Bruce, 2007).

3.2 Childhood Experience

- Lack of parental care (as opposed to loss of a parent) is a consistent risk factor for the development of a depressive disorder as an adult (Joyce, 2009; Bifulco, Brown and Harris 1987)
- Childhood sexual abuse is a risk factor for adult major depression.
- Cumulative childhood disadvantage poses a greater risk of depressive disorder than any single childhood variable in isolation.

3.3 Marital Status

- For men, being married is associated with the lowest rate of depression, whilst separated or divorced men have the highest rates of major depression. In women the association is less clear. (Joyce, 2009; Brown and Moran, 1997), and it has been argued that marital status has no effect on female depression rates (Langlieb and Depaulo, 2008)
- The nature of the association between marital status and depression is less clear. Depression may contribute to marital breakdown, or the stress of separation or divorce could precipitate a depressive episode.

3.4 Social Environment

- The risk of depression increases in women who have three or more children at home, a lack of paid employment and the lack of a confidant (Brown and Harris, 1978; Brown and Bifulco, 1990; Brown, Harris and

Eales 1993; Bifulco et al,1998). Subsequent studies have shown only lack of a confidant to be a consistent risk factor (Joyce, 2009)

- Adverse life events, especially those characterised by loss, increase the risk of a major depressive episode (Brown and Prudo 1981). The increased vulnerability to a depressive episode lasts for a period of 2-3 months following such an event (Kendler Kessler and Walters, 1995)

- Many people experiencing adverse life events do not go on to suffer a depressive episode. Moreover some episodes of depressive illness do not have any identifiable adverse event.

4. Diagnosis

The clinical features of a depressive episode can be subdivided into the biological characteristics of depression and manifestations of a disturbed mental state which are frequently revealed in examination.

4.1 Biological (or Somatic) Symptoms

Sleep disturbance	a) Characteristically early morning wakening (middle or terminal insomnia) – occurs 2 – 3 hours before the patient's usual time. b) Initial (or onset) insomnia – difficulty and delay in falling asleep. c) Some depressed patients sleep excessively – but still feel un-refreshed on waking.
Change in appetite	Characteristically loss of appetite; less commonly increased appetite.
Change in weight	Characteristically loss of body weight (at least 5% in a month); less commonly increased weight.
Change in bowel habit	Constipation
Change in menstrual cycle	Amenorrhoea
Loss of (or markedly reduced) libido	
Change in psychomotor activity	a) Common in the elderly. b) Characteristically psychomotor retardation (slowed up). c) Sometimes agitation.
Diurnal variation in mood	a) Characteristically worse in the morning – patients wake up feeling very depressed and possibly suicidal. b) Mood gradually lifts during the day, but is sometimes worse again in the evening.
Anhedonia	Total lack of interest in and enjoyment of hobbies / pleasurable activities and work.
Loss of interest in work	

Reduced energy and drive	Manifesting as fatigue / tiredness, listlessness and reduced activity

4.2 Other history

Depression may be more likely to be present if there is a history of:

- Previous depression or of other mental health problems
- Unspecified 'breakdowns' or attempts at self-harm or suicide
- Any history of abuse (sexual, physical, or substance)
- Previous presentations with multiple symptoms that are difficult to diagnose
- Frequent, often unscheduled visits to the GP or to the emergency department, often for reasons that are unclear
- A chronic pain syndrome (e.g. fibromyalgia, migraine, gastrointestinal or pelvic pain)
- Significant physical illness causing disability
- A family history of psychiatric illness

[AHCPR, 1993; NICE, 2004a; University of Michigan Health System, 2004]

4.3 Mental State Examination

There are a number of published versions of the Mental State Examination which differ from author to author and according to local policy (Cooper and Oates, 2009; Gelder et al, 2009). The common components of such examinations are detailed below.

4.3.1 Appearance

- Unkempt
    a) Neglected dress and grooming
    b) Poor self-care and personal hygiene
- Facial features / depressive facies
    a) Sagging / turning down of the corners of the mouth
    b) Tearfulness
    c) “Knitted brow” – vertical furrowing of the centre of the forehead, between the eyebrows

d) Downward gaze - poor eye contact and reduced rate of blinking

e) Pancity of change in facial expression.

But - some patients maintain a smiling exterior while depressed.

- Weight loss.
- Reduced gestures.
- Shoulders bent and head inclined forwards.

4.3.2 Speech

- Poverty of speech and/or speaking in a monotone.
- Slow and hesitant – long delay before questions are answered.

4.3.3 Mood

- Low and sad – often one of misery.
- Qualitatively different from one of unhappiness.
- Loss of reactivity to circumstances.
- Anxiety, irritability and agitation and restlessness may occur.

4.3.4 Thought

Morbid/pessimistic thoughts

- *Concerned with the past*: – often taking the form of unreasonable guilt and self-blame about minor matters, e.g. feeling guilty about past trivial acts of dishonesty (such as taking home an office pencil many years ago). Such minor misdemeanours may be exaggerated out of all proportion and used as "proof" that the patient is "evil" and does not deserve his current status in life.
- *Concerned with the present*: -

  a) Pessimism - the patient sees the dark or unhappy side of every event.

  b) Thought of failure in everything done and considered a failure by other people.

  c) Low self-esteem - no longer feels confident, and discounts any success as a chance happening for which no credit can be taken.

- *Concerned with the future* (which seems bleak)*:*

a) Ideas of hopelessness and helplessness - the patient expects the worst.

b) Often accompanied by the thought that life is no longer worth living and that death would come as a welcome release.

c) May progress to thoughts of, and plans for, suicide.

d) Homicidal thoughts may occasionally occur: - e.g. a depressed mother may decide the future is equally bleak for her children and plan to kill them before committing suicide; or a depressed elderly man may persuade his wife to enter into a suicide pact. This is rare in depression without psychotic features.

Poverty of thought

Few thoughts – these lack variety and richness, and seem to move slowly through the mind.

4.3.5 Cognition

- Impaired attention and concentration.
- Poor memory – not permanent, as is often feared by the patient.
- In the elderly, depressive pseudodementia may occur.

4.3.6 Physical Symptoms

- Aching discomfort anywhere in the body.
- Increased complaints about any pre-existing physical disorder.
- Subjective complaints (eg: tiredness, fatigue, abdominal discomfort)

4.3.7 Psychotic Features of Depression

These occur in more severe episodes of depression: -

1. Delusions

a) Concerning themes of worthlessness, guilt, ill health (especially cancer) or poverty.

b) Concerning persecution (e.g. that others are going to take revenge on him); the supposed persecution is often accepted as having been brought on themselves.

2. Hallucinations

a) Usually mood-congruent, derogatory, second-person auditory hallucinations – voices addressing repetitive words and phrases to the patient, confirming his ideas of worthlessness (e.g. “You are an evil sinful man; you should die”), making derisive comments or urging suicide.

b) A few patients experience visual hallucinations, such as scenes of death and destruction.

4.3.8 Depressive Stupor

- Episodes of being unresponsive, akinetic, mute and fully conscious. Rare with modern treatment.
- After an episode of stupor, the patient can recall events that took place and their mood at the time.
- Periods of excitement may intervene between episodes of stupor.

4.3.9 Other Psychiatric Symptoms

- Features of anxiety, e.g. tension, apprehension and phobic, obsessional or hysterical symptoms.
- Hypochondriacal preoccupations
- Depersonalisation

4.4 Investigations

Major depressive episodes and episodes of psychotic depression may have some or all of the following investigations performed, in order to exclude the differential diagnoses listed under section 5. The list below is not exhaustive.

1. Urea and electrolytes, full blood count, thyroid and liver function tests.
2. A drug screen –particularly if psychoactive substance use was suspected as a cause.
3. Vitamin B_{12} and folate levels; syphilitic serology.
4. EEG and/or CT scan
5. In the elderly, hearing and vision tests - to exclude sensory deprivation (paraphrenia).

5. Differential Diagnosis

Secondary mood disorders can occur in conjunction with various psychiatric and physical conditions described in separate protocols. In such cases, the primary illness should be identified and treated, with symptomatic treatment being given for the secondary mood disorder:

Organic Disorders	Cushing's disease, dementia, hypothyroidism or carcinoma.
Substance Use Disorders	Alcohol or drug misuse.
Schizophrenia	"Negative symptoms" and the pre-morbid phase of schizophrenia may be difficult to distinguish from depression. In such cases, a careful search should be made for other features of depression, such as the biological symptoms. . Depression is commonly co-morbid with schizophrenia, both in the acute phase and after an episode of schizophrenic illness – post-schizophrenic depression.
Neuroses	The appendices include a table describing the differential diagnosis between generalised anxiety and depressive disorders.
Pharmacological adverse effects	Drug adverse effects are an uncommon cause of depression – these may include centrally acting anti-hypertensives, lipid-soluble beta-blockers, benzodiazepines or other central nervous system depressants and opiate analgesics.
	Other types of depression such as post-natal depression and other circumstances where features of depression may be present such as bereavement and grief are addressed in the appendices to this protocol.

6. Treatment

The large majority of depressive episodes can be treated in the community by GPs. Referral to Mental Health Teams or Psychiatric outpatients is indicated if the depression is severe, failing to respond to treatment or complicated by other factors such as personality disorders. Patients suffering from psychotic and severe mood disorders may require inpatient treatment in hospital. Compulsory admission may be necessary in cases of high suicidal risk or where poor intake of food and fluids is life threatening.

Rost (2009) has suggested a three stage approach to optimising treatment of depression in the primary care setting, involving i) systematic screening programs, ii) initial evidence based treatment, and iii) monitoring compliance and response to treatment over 2 years. Rost presents evidence that 'primary care practices re-engineered to improve depression management can make a substantial contribution to reducing depression-associated disability'.

Mild, moderate and severe depressions are treated in similar ways and the principal decision is whether to treat with antidepressant drugs or a psychological therapy. Surveys in primary care have shown that most patients would prefer the latter.

Antidepressant medication and cognitive behaviour therapy are equally effective in treating mild to moderate depression. In severe depression, antidepressant drugs are more effective.

90% of those with a mental health disability according to the 2006 National Disability Survey in Ireland used some form of aid or support. This was the highest proportion reporting use of aids for any of the nine disability types. The main aids or supports used were;

- Medical services (77%) and medication (69%)
- Psychiatrist (32%)
- Exercise or relaxation therapies (29%)
- Counselling (25%)

6.1 Antidepressant Medication

Drug treatment becomes more effective as the severity of moderate and severe episodes of major depressive disorder increases (Anderson et al., 2008; Kirsch et al., 2008). Drug treatment is therefore recommended as a first line treatment for individuals who have a depressive episode of moderate severity or above (NCCMH, 2009).

However, of the patients treated by GPs, almost half will have a mild episode of a major depressive illness and there is currently no evidence to show that antidepressant medication is more effective than placebo in this group. There are

several categories of patients with mild or sub-threshold depression in whom antidepressant treatment should be considered however. These include individuals with a past history of moderate or severe depression; individuals with sub-threshold depression which has persisted over a long period (>2 years) and most importantly those individuals who have sub-threshold or mild depression that have not responded to other interventions (NCCMH,54; NCCMH, 2009)

Where drug treatment is effective, it has also been shown that recommended first-line agents prescribed at recommended doses are significantly associated with return to work, and that early intervention was associated with a shortened disability period in those patients who did return to work. (Dewa CS. Hoch JS. Lin E. Paterson M. Goering P. - 2003).

There is a wide and increasing range of antidepressant drugs available, varying in their side effects, toxicity and cost.

Most available antidepressants are equally effective if given at an adequate dose for a sufficient period of time (Hale, 1997).

Non compliance with antidepressants may reach 50% (Hale, 1997)

The recommended duration of antidepressant treatment for an initial major depressive episode has increased over recent years. Guidelines produced by the British Association for Psychopharmacology suggest antidepressant treatment should be continued for a minimum of 6 months following remission (12 months for older people) with no reduction in dosage (Paykel 2001; Young, 2001) Following this, antidepressants should be withdrawn gradually over 3 months. Discontinuation symptoms are usually transient and self-limiting but, if severe, treatment can be restarted.

Antidepressants are effective prophylaxis for recurrent depression and are indicated where there is clear risk of further episodes. The risk of further depressive episodes increases with the number of depressive episodes experienced and increasing age of onset of depression. In those with onset of a major depressive episode after 50 years of age, or with three previous episodes of depression, it is recommended that antidepressant medication is continued indefinitely (Hale, 1997).

There are two main classes of antidepressant in common use, the selective serotonin re-uptake inhibitors (SSRIs) and the tricyclic antidepressants (TCADs). A third group, the monoamine oxidase inhibitors (MAOIs) have become less popular recently as safer alternatives are now available. They all achieve an antidepressant effect by increasing monoamine activity in the central nervous system. All have a slow onset of action, so patients should be warned that it might be 2-3 weeks before they start to notice any benefit. The dose should be titrated to the maximum dose tolerated before considering a different drug.

6.1.1 Selective Serotonin Re-uptake Inhibitors

- For example Fluoxetine, Paroxetine, Sertraline, Citalopram and Fluvoxamine.
- Act by inhibiting the re-uptake of serotonin into the pre-synaptic nerve cell.

- Have little or no effect upon noradrenergic processes: no daytime sedation in most cases, far less anticholinergic and clinically significant cardiovascular side effects than TCADs. Hence they are better tolerated and safer in overdose; also, their onset of action is more rapid.

- Side effects include nausea, diarrhoea, headache, insomnia, agitation and sexual dysfunction.

6.1.2 Tricyclic Antidepressants

- Widely used since the 1950s, and still commonly prescribed. They act by inhibiting the re-uptake of the monoamine neurotransmitters noradrenaline and serotonin into the pre-synaptic nerve cell.

- Sedative (e.g. amitriptyline, clomipramine and dothiepin): useful for agitation and initial insomnia.

- Less sedative (e.g. imipramine & lofepramine): useful when lethargy and apathy are problems.

- Side effects - Arrhythmias, heart block, postural hypotension, drowsiness, convulsions, paralytic ileus and blood dyscrasias – hence dangerous in overdose and can cause death. Their anticholinergic actions cause blurred vision, dry mouth, constipation and urinary retention, so they are contra-indicated in glaucoma, pyloric stenosis and prostatic hypertrophy. All of these impair compliance, and some can be dangerous for patients being treated in the community, such as drowsiness and blurred vision for those who drive, operate machinery or work at heights.

6.1.3 Comparison of TCADs and SSRIs

As TCADs and SSRIs are equally effective, the choice of drug for each patient depends on other factors such as side effects, safety in overdose and cost, as well as the range of presenting symptoms.

SSRIs are generally recommended as first line therapy because there is a lower risk of the therapy being discontinued due to side effects (NICE 2007).

	TCADs	SSRIs
Onset of action	Take 2-3 weeks for benefit to start.	Effect begins within 1-2 weeks.
Side effects	Sedation (may provide relief for patients with marked insomnia or anxiety). Autonomic effects (dry mouth,	Generally better tolerated – no cognitive impairment, weight gain or anticholinergic effects. Nausea, GI disturbance,

	postural hypotension, urinary hesitancy, constipation, sexual dysfunction)	headaches and sexual dysfunction may occur
Safety in overdose	Cardiotoxic, may cause death if taken in overdose. (Lofepramine is an exception.)	Safe in overdose and the treatment of choice for patients at risk of suicide.
Compliance	Worse - more side effects.	Better – fewer side effects.
Cost	Cheap.	Expensive. Benefits due to improved compliance and reduced cardiotoxicity may offset some of the additional cost.

6.1.4 Other re-uptake inhibitors

Selective Serotonin and Noradrenaline Re-uptake Inhibitors (SNRIs) - e.g. venlafaxine. Compared with TCADs, SNRIs have far fewer side effects. Their more rapid onset of action (within 2–4 weeks) makes them especially effective for depressives with melancholia, anxiety, retardation or agitation. Patients taking venlafaxine require monitoring of their blood pressure on initiation and with any increase in dosage. Uncontrolled hypertension and signs of cardiac dysfunction should be monitored and appropriate action taken, including reduction of dosage or discontinuation of the drug. It should not be prescribed to patients with recent myocardial infarction or high risk of arrhythmias (NICE 2007).

Selective Noradrenaline Re-uptake Inhibitors (NARIs) - e.g. reboxetine, are useful for alleviating the negative symptoms of depression. There is a relative lack of data on side effects of reboxetine.

Noradrenaline and Selective Serotonin Antidepressants (NaSSAs) - e.g. mirtazapine. Side effects of nausea, insomnia, anxiety, agitation or sexual dysfunction reported less commonly, although it has been reported to cause sedation and weight gain.

6.1.5 Monoamine Oxidase Inhibitors (MAOIs)

E.g. phenelzine. *Irreversibly* inhibit MAO-A and MAO-B, preventing the breakdown of monoamine neurotransmitters and prolonging their action. To prevent a potentially life-threatening hypertensive crisis, they require adherence to an α-tyramine free diet (excluding, for example, hard cheeses, yeast extracts, broad bean pods, and red wine) which is unpopular with patients; as well as avoidance of certain drugs, e.g. SSRIs, pethidine, l-dopa and amphetamine. Their use has been superseded by:

Reversible Inhibitors of Monoamine-Oxidase type A (RIMAs)

E.g. moclobemide, brofaromine, cimoxatone, & toloxatone. Fewer systemic effects: less risk of drug or dietary interactions than MAOIs; shorter washout period needed for transfer to other antidepressants.

6.1.6 Other Antidepressant Drugs

5HT$_2$ antagonists have beneficial effects on sleep architecture and sexual function compared with SSRIs.

Tetracyclic antidepressants (e.g. mianserin, maprotiline) have a sedative profile, but cardiovascular and anticholinergic side effects much less than with TCADs; also rarely cause convulsions, so they are safer in overdose.

Trazodone has anti-serotonin and α_2-receptor antagonist properties, but does not block noradrenaline re-uptake. It has fewer anticholinergic side effects than TCADs and a sedative effect useful against concomitant anxiety.

Flupenthixol in low dosage can relieve symptoms of apathy, lowered mood, asthenia, despondency, and lack of initiative or inertia.

6.1.7 When to Change Treatment

Recent guidance from the National Instutute for Clinical Excellence suggests that evidence supports an earlier beneficial effect from anti-depressants than was traditionally thought. It is suggested that beneficial effects occur as early as one week in to treatment, and that the rate of improvement in symptoms falls off by 6-8 weeks into treatment (NCCMH, 2009). There is also evidence to suggest that a better outcome is achieved if a individual is seen more frequently between 2 and 6 weeks of commencing treatment.

Their recommendation on the assessment of benefit of treatment is that a patient who is not showing an improvement of symptoms two weeks after commencing therapy should be seen weekly, with consideration to a change in medication if no response is achieved in 3-4 weeks. In individuals who show an initial improvement which then slows, consideration should be given to a change in medication after 6 weeks (NCCMH, 2009).

6.2 Mood Stabilisers - Lithium

The evidence for using lithium in unipolar / recurrent depression is less clear than in bipolar disorders. It can be effective in the acute stage of depression when other measures have failed, e.g. in patients who have not responded to a cyclic antidepressant drug. It enhances the effect of TCADs and MAOIs.

Lithium has a number of adverse effects however, and the varying bioavailability of lithium in different preparations can result in patients receiving either a sub-

therapeutic or a toxic dose.

Adverse are more common if the plasma level of lithium increases above 1mmol/l. Effects can include:

- Initial Effects:
  - Nausea, diarrhoea, vertigo, muscle weakness, feeling of being 'dazed'. These symptoms often abate as therapy continues.
  - Fine hand tremors, polyuria, and polydipsia. These do not tend to abate
- Longer term effects
  - Hyperthyroidism
  - Hyperparathyroidism
  - Hypothyroidism
  - Nephrotoxicity

Lithium toxicity can occur with an apparently normal plasma level, but is more common in plasma levels above 1.5mmol/l, with severe toxicity occuring above 2mmol/l.

Signs of toxicity include increasing adverse effects such as diarrhoea, vomiting, anorexia, muscle weakness, lethargy, giddiness, ataxia, lack of coordination, tinnitus, blurred vision, coarse tremor of the extremities and lower jaw, muscle hyper-irritability, choreoathetoid movements, dysarthria, and drowsiness.

Signs of severe toxicity include include hyper-reflexia and hyperextension of limbs, syncope, toxic psychosis, seizures, polyuria, renal failure, electrolyte imbalance, dehydration, circulatory failure, coma, and occasionally death.

The following conditions increase the risk of lithium toxicity occurring: hypertension, diabetes, congestive heart failure, chronic renal failure, schizophrenia, or Addison's disease.

(Sweetman et al, 2005; NHS Institute for Innovation and Improvement, 2010)

6.3 Electroconvulsive Therapy (ECT)

ECT entails administrating an electric charge to the head of a patient under a general anaesthetic in order to produce a generalised convulsion. The therapeutic agent is the convulsion; a normal course is 6–12 treatments at a rate of 2-3 per week.

The risk of death is similar to that of general anaesthesia for minor procedures,

about 2 deaths per 100,000 procedures. There is no evidence that it causes brain damage or permanent intellectual impairment. Unilateral ECT is less likely to cause memory loss.

ECT is reserved for cases of resistant depression unresponsive to pharmacotherapy, especially those with psychotic or marked biological symptoms. The presence of biological and psychotic features of depression predicts a good response to ECT.

ECT produces a more rapid resolution of depression compared to antidepressant medication and may be lifesaving in severe depression. However antidepressant medication should be continued following a successful course of ECT.

6.4 Psychosurgery

In extremely rare cases of chronic disabling depression, when all other treatments have failed, the extreme option of psychosurgery may be considered. The number of operations performed has fallen considerably in the last few decades. The UK is the only country in the UK where psychosurgery is still available, with only a small number of operations (<10) being performed at centres in Cardiff and Dundee over the last decade. No psychosurgical operations have been performed in England since 1999. (Fleischmann, 2001; Wikipedia, 2010).

Given the small extremely small numbers of individuals involved, there is no reliable evidence to indicate the efficacy of this type of surgery. It should also be noted that such treatments are irreversible (Mind, 2007).

6.5 Phototherapy

For patients with Seasonal Affective Disorder, where the onset of depression is in the autumn or winter months, treatment with high-intensity light is possible. A number of studies have concluded there is some beneficial effectiveness, however these studies are methodologically difficult to compare as they differ in terms of intensity of light, duration of exposure, and timing of exposure during the day. The National Institute of Clinical Excellence in the UK concluded that patients should be advised that the benefits and effectiveness of this form of treatment are uncertain (NHS Institute for Innovation and Improvement, 2010; NICE, 2010).

6.6 Psychosocial Treatments

6.6.1 Counselling

Much of the depression treated in primary care is amenable to simple counselling using problem-solving techniques, which can be performed either by the GP, a psychologist, CPN, or counsellor. Problem solving treatment is most likely to benefit patients who have a depressive disorder of moderate severity and who wish to

participate in an active psychological treatment. The combination of problem solving treatment and antidepressant medication is no more effective than either treatment alone.

Employing practice-based counsellors may enable patients with moderately severe depression to recover faster, and non-directive counselling appears to be as effective as cognitive behaviour therapy (CBT) within this setting· Ward E, et al, 2000)

6.6.2 Cognitive-Behaviour Therapy

Cognitive-behaviour therapy (CBT) refers to a group of therapies that include behaviour therapy, behaviour modification and cognitive therapy in various combinations.

Cognitive therapy explores how thoughts can alter feelings and behaviour. Therapy consists of identifying automatic negative thought patterns (such as hopelessness or guilt) and teaching the patient to recognise and challenge them. The aim is to enable the patient to counter the negative thoughts with alternative rational thoughts.

Behaviour therapy analyses behavioural aspects of the patient's problem, followed by the use of techniques to change behaviour, which are tailored to the individual patient.

CBT helps prevent further attacks of depression by teaching patients how to counteract a relapse in the early stages.

A full course of cognitive therapy consists of 10-20 one-hour sessions with an appropriately trained behaviour therapist and so is an expensive alternative to antidepressants. (Fennel M, 2000)

A short course of CBT or non-directive counselling has been shown to enable patients with moderately severe depression to recover more quickly and is more cost effective than usual GP care (discussion and medication) in the short term (<12 months). However there were no significant differences between treatments in either outcomes or costs at 12 months (Ward E et al, 2000 & Bower, P et al, 2000)

Severe depression has been shown to respond better to a combination of antidepressant therapy and individual CBT than either treatment on its own. (NICE 2007)

6.6.3 Other Psychotherapies

These include group therapy; brief focal psychotherapy (after bereavement or other specific trauma); befriending; problem-solving therapy; psychodynamic or psychoanalytic psychotherapy; and, when appropriate, family or marital therapy. All can be used in combination with pharmacotherapy.

Regarding the duration of different therapies, Knekt and Lindfors (2008) found that initially, short-term therapies benefitted work ability more quickly than long-term

therapy; but in the long run (after 3 years) long-term therapy was more effective than short-term therapies.

6.6.4 Increased Activity and Social Contact

Depressed patients should be encouraged not to withdraw totally from work and social activities, and should be encouraged to increase such activities (and exercise) as soon as their condition allows. Meeting other people and developing confiding relationships has a protective function in preventing relapse. Voluntary agencies can provide support and practical help with a variety of problems (e.g. by befriending), which promotes remission' (Harris T, et al 1999) and there are several self-help groups available for those with depressive disorder (e.g. Depressive Alliance) which provide information, support and an opportunity to make social contacts.

Some patients will benefit from the involvement of Community Welfare Officers, who can help with housing and financial problems:

1. **Accommodation:** There is a wide range of accommodation available to people with mental health disorders. Most patients live in independent accommodation. Supported accommodation (e.g. warden-controlled flat, hostel, group home or nursing home) is usually necessary only for those with severe illness, especially those who have required frequent or lengthy admission to hospital.

2. **Financial assistance:** Many depressed patients live in poverty and many more have financial problems of some sort. Financial worries can be precipitating or maintaining factors in depressive disorders. Depression can also be the cause of financial problems, as it reduces patients' ability to earn money and manage their financial affairs. They may need to improve their budgeting skills may require advice regarding managing debts.

6.7 Occupational Therapy

Patients with severe or chronic depression may have little to fill their time and if left with nothing to do, their depression is likely to deteriorate. Providing the patient with a structured programme of activity will help maintain their motivation and may distract them from their symptoms. Additional goals are to enable depressed patients to learn to cope with activities of daily living (such as personal and household care), and to improve their social and occupational skills. Such programmes are usually devised by Occupational Therapists, making use of community leisure and educational facilities as well as day centres and community outreach programmes provided specifically for patients with mental illness. Sheltered employment programmes provide a useful stepping-stone back to mainstream work.

6.8 Rehabilitation

Psychiatric rehabilitation services were introduced in the 1960s, as the large psychiatric asylums began to be closed down, to help institutionalised long-term patients adjust to life in the community. Even though patients now spend much shorter periods in hospital, institutionalisation still occurs, causing secondary disability that exacerbates the disability due to severe depression: so rehabilitation is often still needed before discharge. The aims are to teach patients the skills they need to cope outside hospital; then gradually to reintroduce them to life in the community, usually with psychosocial support as above. Some outpatients may also benefit from further rehabilitation, such as patients who are coping poorly in the community but do not yet need readmission, and those who are functioning well in a group home but want to move on to less supported accommodation.

7. Prognosis

The prognosis for individual episodes of mood disorder is generally good.

- Mild cases tend to improve with minimal intervention.
- About 70% with moderate to severe illness begin to respond to treatment within 6 weeks; without treatment, the majority can expect to recover eventually, although the natural course tends to be about 1-2 years.
- Non recovery at 1 year from a major episode of depression, is associated with the following baseline variables: higher state anxiety and depression scores, a lifetime anxiety disorder, higher scores on measures of personality functioning in clusters A and C and the reporting at baseline of life event stressors. (Parker G, et Al 2000)
- The presence of social support, increased security, and increased hope (arising from a lessening of a difficulty or deprivation) are associated with recovery or improvement in depression. (Brown et al 1992)
- "Fresh-start" experiences, absence of new severe stressors (life-events and other difficulties) and a standard attachment style (to husband or partner) are important predictors of remission (Harris T, et al 1999)

However, in the long term, the outcome is less favourable:

- 12-20% of patients with unipolar depression develop chronic depression, that is they remain fully symptomatic 2 years after the onset of the initial depressive episode.
- A cohort of patients followed for 15 years showed that of those who recovered from an initial depressive episode, 85% had a further depressive episode. Of those who remained well for 5 years following the index episode, 58% experienced a recurrence. (Mueller T, et al 1999)
- The median number of depressive episodes experienced is four.
- Predictors of a recurrence of a mood disorder which have been described are: female sex; (Mueller T, et al 1999), Riise T, et al 2001)a previous depressive episode, (Mueller T, et al 1999), Riise T, et al 2001)negative attitude to one's own occupation;32 increasing age at initial onset; (Simon G, 2000) and duration of depression prior to initiation of treatment (Simon G, 2000)
- Co-morbidity is an important prognostic factor. A co-existing anxiety disorder (especially social phobia) indicates risk for persistent depression in primary care patients with major depression. Gaynes B, et al, 1997) Another study suggests that it is the burden of co-morbidity (i.e. the number of co-morbid conditions) rather than any particular disorder that is strongly predictive of functional impairment (McDermut W, 2001)

In later life, depression doubles mortality, reflecting partly the association between depression and physical illness, and partly the increased incidence of suicide.

The lifetime risk of suicide is as high as 15% in those with severe depressive illness (Faulkner, A 1997)

A study by Rytsala and Melartin (2007) confirmed that patients with major depressive disorder were significantly more likely to be in receipt of a disability pension after 18 months if they:

- were older,
- were more hopeless,
- had worse social and occupational functioning, and
- spent more time depressed during follow-up.

8. Information Gathering at the In Person Assessment

8.1 Assessing the Claimant

The Medical Assessor should consider the information on file, informal observations, medical and psychiatric history, medication and other treatments, typical day, mental state examination and, in some cases, physical examination.

8.2 Mental Health Assessment

It is important to complete an appropriate mental health assessment. A detailed mental health history should be taken to include diagnosis, treatment, periods of hospitalisation etc. Medical Assessors may find validated scales in the appendix useful in this regard.

In mainstream medical practice options such as the Mini Mental State Examination (MMSE) for cognitive function, Hamilton Rating Scale for Depression and the Hospital Anxiety and Depression Scale are all in common usage.

8.2.1 Assessment of Ability/Disability

***The key areas to address in ability/disability assessment medicine relate mainly to functional ability in relation to day to day and workplace activities*.**

The recommended approach to assessing an individual's functional ability is to ask them to describe their average day. Taking a history of a claimant's average day, from the moment they awake to how they sleep, will allow an evaluation of the nature and severity of their disability in relation to simple tasks in terms of comprehension, learning, concentration, memory and motivation. It will also provide an indication of any need for guidance, prompting or supervision. This information along with the other evidence obtained or provided will facilitate an overall assessment of disability in relation to the criteria for various scheme benefits. This analysis stage is covered further in chapter 9 of the protocol.

A number of areas are suggested under the four key headings below that should be explored during the assessment, where relevant, through **open questioning** and observation.

Completion of tasks

- Answering the phone
- Setting an alarm clock
- Operating domestic appliances
- Reading a magazine or watching TV

- Driving a car
- Hobbies and Interests
- Accidents in the home – hazard awareness.

Daily living

- Rising, washing, dressing
- Care over appearance/Self-Neglect
- Frequent mood fluctuation causing distress or panic
- Need for alcohol early in the day
- Sleep pattern.

Coping with Pressure and Change

- History of Work related stress
- Concerns that work may aggravate illness
- Symptoms of fear and panic
- Avoidance of stressful activities – going out, driving a car
- Effect of changes in routine
- Fatigue/Apathy or Disinterest – effect on activities.

Interaction with People

- Capability for self care
- Irritability/Disruption/Aggression
- Communicating with people
- Fear of going out alone
- Avoidance of the company of other people.

9. Analysis of Effect on Functional Ability

Eligibility to the Department of Social and Family Affairs (DSP) various Illness-related schemes and the Activation Programme, is determined primarily by the degree of Ability/Disability and its expected duration.

The degree of Ability/Disability assessed, using the following Indicators, can be depicted on the Ability/Disability Profile illustrated below.

9.1 Indicators of Ability/Disability

Normal

- Not receiving antidepressant or psychological treatment.
- No biological symptoms of depression.
- Able to continue with their usual interests and hobbies.
- Enjoys social contact with friends and family.

Mild

- Finding life stressful
- Taking less interest in work and hobbies.
- Seeing friends less often.
- Finds concentrating to read more difficult.
- Sleeping poorly.
- Under observation by GP.
- Feeling unhappy.

Moderate

- Co-morbidity with drug or alcohol abuse or another psychiatric illness.
- Death of a partner, spouse or first-degree relative in the last 6 months.
- Attending psychiatric outpatient clinic.
- Under the supervision of a Community Psychiatric Nurse (CPN).
- Taking a course of antidepressants.
- Taking lithium treatment.
- Receiving a course of psychotherapy
- Loss of appetite.
- Early morning waking.
- Diurnal variation of mood.
- Anhedonia.

- Downcast gaze and poor eye contact.
- Unreasonable guilt.
- Impaired concentration and memory.

Severe

- Attending psychiatric day hospital.
- Attending with a CPN, social worker or support worker.
- Living in supported accommodation.
- Numerous recurrent depressive episodes or chronic depression.
- Unkempt appearance.
- Loss of weight.
- Poverty of speech.
- Severe mood disturbance.
- Hopelessness.
- Avoids social interaction.

Profound

- Attempted suicide in the last 6 months.
- Psychiatric hospital admission in the last year.
- Treated with ECT in the last year.
- Psychomotor retardation.
- Psychotic symptoms e.g. auditory & visual hallucinations
- Active suicidal thoughts.

In severe depressive disorder, continuous supervision is necessary in cases where there is substantial risk of suicide or self-harm. This can usually only be reliably provided on a 24-hour basis in a hospital setting.

In those people with severe depressive disorder displaying self-neglect, there may be an inability to maintain adequate levels of nutrition and cleanliness. Performing essential domestic tasks, or coping with day to day transactions and communicating with others generally are all likely to be significantly affected.

9.2 Ability/Disability Profile

Indicate the degree to which the Claimant's condition has affected their ability in ALL of the following areas.					
	Normal	Mild	Moderate	Severe	Profound
Mental health/Behaviour	☐	☐	☐	☐	☐
Learning/Intelligence	☐	☐	☐	☐	☐
Consciousness/Seizures	☐	☐	☐	☐	☐
Balance/Co-ordination	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Speech	☐	☐	☐	☐	☐
Continence	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐
Manual dexterity	☐	☐	☐	☐	☐
Lifting/Carrying	☐	☐	☐	☐	☐
Bending/Kneeling/Squatting	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Climbing stairs/Ladders	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐

10. Summary of Scheme Criteria

Drafting note: To be completed in conjunction with MRAS expert in the criteria for award of the various scheme benefits.

Appendix A - **Other Types of Depression**

A1: Postnatal Depression

Non-psychotic postpartum psychiatric disorders are usually taken to include those with an onset up to about 12 weeks after delivery.

Epidemiology

- Post-natal depression (PND) affects about 10% of women in the early weeks postpartum, with episodes typically lasting 2-6 months. Residual symptoms are common up to a year after delivery (Cooper, 1998).
- PND is more common with increasing maternal age and lower social class.
- Most receive no treatment at all, or treatment from their GP. Fewer than 1% see a psychiatrist.

Aetiology

- There is little evidence to support a biological basis for PND (Cooper, 1998).
- The presence of 'baby blues' in the immediate postpartum period appears to be related to the subsequent development of PND but no hormonal basis has been identified.
- Obstetric factors are important in a sub group of vulnerable women. Women with a previous history of depressive disorder who experience complications during delivery have higher rates of postnatal depression.
- The major aetiological factors are of a psychosocial nature. Stressful life events, unemployment, marital conflict, and the absence of social and personal support have all been shown to raise the risk of PND. The absence of social support and a history of depression approximately double the baseline risk of developing PND (Cooper, 1998).
- Women who experience PND as their first experience of a mood disorder are at greater risk of developing PND in subsequent pregnancies (but not of non-postpartum depression. (Cooper, 1995)).

Clinical features

- Despondency, tearfulness and irritability are typically seen.
- Fatigue, anxiety and phobias often occur (e.g. fears about inability to cope with her baby and her own health).
- Feelings of inadequacy and confusion, as well as difficulty in sleeping and concentrating are common.

- A poor appetite is also common, as is decreased libido (which may be the main symptom).
- The depression itself may be mild and somatic symptoms may be more prominent.
- Symptoms are often worse at night, creating a vicious cycle of worry and insomnia.

Management

- Improved detection of PND can been facilitated by the use of the Edinburgh post-natal depression scale. The scale is used as a screening device by health visitors in the post-natal period (Cooper, 1998).
- In 90% of sufferers, PND is a self-limiting condition, often lasting less than a month, even without treatment.
- Non-directive counselling provided by trained health visitors has been shown to be effective (Cooper, 1998).
- There is no systematic evidence to support the use of progesterone.
- Fluoxetine has been shown to be effective in the treatment of PND (Cooper, 1998).

Prognosis

- In about 6%, the depression lasts at least 6 weeks, but in less than 5% does it persist for longer than a year.

Antenatal Depression

Worthy also of mention is antenatal depression which is not widely recognised in research but some sources indicate that the prevalence is high, around 13%. Risk factors are similar to those for PND i.e. young age, low income, lower educational attainment, history of depression, a history of miscarriage and pregnancy termination, and a history of childhood sexual abuse, concomitant high anxiety in pregnancy, low self-esteem and low social support. Untreated antenatal depression can lead to other problems, ranging from an increased likelihood of miscarriage & premature labour to self-neglect and suicide.

A2: Seasonal Affective Disorder

- In some people, there is a regular relationship between the onset of depressive episodes and a particular time or season of the year. Depression usually starts in the autumn or winter and ends as daylight hours increase in the spring or summer. This pattern is widely known as seasonal affective disorder (SAD), but is more correctly termed seasonal mood disorder.

- Variations in day length are thought to modulate the rhythmic secretion of melatonin by the pineal gland. Patients with SAD (and bipolar depressive disorder) have been found to have an increased sensitivity of melatonin biosynthesis to inhibition by phototherapy (Rodin, 1997).

- During depressive episodes patients with SAD frequently exhibit an increase in appetite and weight, often with carbohydrate craving, hypersomnia and a reversed diurnal variation in mood (at its lowest later in the day), which are opposite to the somatic symptoms of other forms of depression (Rodin, 1997).

- SAD does not include cases in which distinctive seasonal psychosocial stressors, such as regular winter unemployment, cause depressive episodes each winter.

A3: Mixed Anxiety and Depressive Disorder (Anxiety Depression)

- Anxiety-depression (AD) is frequently seen in primary care but rarely seen by a psychiatrist.
- Symptoms of anxiety and depression are both present but do not reach diagnostic criteria for either a depressive episode or anxiety disorder.
- Mixed anxiety and depressive disorder is frequently misdiagnosed as a generalised anxiety disorder.
- If the symptoms are strongly associated with a stressful life event, then a diagnosis of adjustment disorder or PTSD should be considered.
- Treatment is best undertaken by counselling, cognitive therapy or psychotherapy, especially interpersonal therapy
- Antidepressant medication, especially the selective serotonin re-uptake inhibitor antidepressants (SSRIs), may be used.

A4: Depression in the Elderly

In older patients, depression **may present with atypical features** including:

1. *Agitated depression* – with purposeless activity due to anxiety (e.g. pacing the floor or fidgeting); this contrasts with the retardation more commonly seen in younger patients.
2. *Masking of symptoms* – by physical illness or minimisation / denial of low mood.
3. *Hypochondriasis* – complaints disproportionate to organic pathology / pain of unknown aetiology.
4. *Complaints of loneliness*.
5. *Onset of neurotic symptoms*.
6. *Behavioural disturbance* – e.g. food refusal, aggressive behaviour, shoplifting or alcohol abuse.

Management.

Treatment with *Antidepressant* medication is usually tried first, but the higher risk of adverse reactions needs to be considered.

Lower doses of tricyclic antidepressants (TCADs) are needed owing to a longer half-life (reduced distribution-volume and clearance); their anticholinergic side effects

reduce compliance and worsen pre-existing somatic problems, such as: postural hypotension (falls, myocardial or cerebral infarction); dry mouth (dentures difficult); urinary retention (anuria); impaired concentration and memory (delirium).

The SSRIs and RIMAs are generally better tolerated than TCADs (see Treatment section for further details). In resistant cases, *ECT* (to which elderly depressed patients respond particularly well) is used. Socially isolated elderly depressed patients are at a very high risk of committing suicide, so they need close observation and energetic treatment.

Appendix B - **Suicide**

B1: Overview

Suicide accounts for about 1% of all deaths every year. In Ireland in 2005 the suicide rate was 9.7 per 100,000 according to WHO data. The rate is substantially higher for males than females in all age groups.

All mental disorders apart from learning disability and dementia have a significantly raised standardised mortality rate (SMR) for suicide (Harris E, et al 1997) Considering psychiatric illness as a whole, in all treatment settings, the mortality risk for suicide was 10 times that expected. Considering major depression (as defined by DSM III) the mortality risk was 21 times that expected. (Harris E, et al 1998)

Psychological autopsy studies collect all available relevant information on the suicide victim's life preceding his or her death, which is then used to construct an overview of suicide. A recent study in the UK in young suicides, showed a psychiatric disorder to have been diagnosed in 70.4% of subjects, commonly depressive disorders (55.5%), followed by personality disorders (29.6%). Co morbidity of psychiatric disorders was found in a third of subjects. (Houston K et al, 2001)

B2: Epidemiological Trends

Worldwide (excluding China), the male suicide rate is 2-4 times higher than the female.

The suicide rate is higher in the elderly, however in the developed world, rates are declining in this age group due to improved social and health services. Traditionally, suicide rates were low in younger age groups, however suicide rates in young males increased by over 80% between 1980 and 1992, and although rates have declined in recent years, they remain higher than previously. In contrast, the rate in young females has remained static. (Houston K et al, 2001)

Suicide has no single cause but is an individual process in which several risk factors can be identified:

Social status	Low
Educational status	Low
Marital Status	Unmarried, separated, divorced, widowed
Residential status	Living alone, homeless
Employment status	Unemployed, retired, insecure employment

Profession	Vets (3x rate of general population); farmers, doctors, dentists, pharmacists (2x)
Season and time	Spring and autumn, weekend, evening, anniversary.
Life events	Adverse life events such as losses, separations and criminal charges

40 – 50% of those who kill themselves have made previous attempts.

Two thirds of those who commit suicide have seen their GP in the last month.

A quarter of those who commit suicide are psychiatric outpatients at the time of death – half of these have seen a psychiatrist within the previous week.

B3: Methods Used

Men use more "successful" or violent methods of suicide, such as firearms, jumping, hanging or asphyxiation with car fumes, whereas the most common method used by women is self-poisoning with drugs, the effects of which can be unpredictable.

B4: Assessment

Patients should be asked about suicidal thoughts since there is no evidence that doing so might put the idea into their mind. The reasons for such thoughts and the methods being considered should be explored. Feelings that life is pointless or that there is no future should be taken very seriously. Evidence should be sought of loneliness, reduced or absent social contact and the psychiatric or physical illnesses associated with increased suicide risk. Relatives and/or friends should also be interviewed, and information obtained about any losses.

B5: Management

1. Hospital admission in cases of serious risk – compulsorily if necessary.
2. Removal of anything that could be used in a suicide attempt, e.g. sharp objects or a belt / pyjama cord (which may be used as a noose).
3. Regular or continuous observation, depending on the degree of risk.
4. Consider nursing the patient in nightclothes by day, to make it more difficult for them to abscond without being noticed.
5. Appropriate treatment of any psychiatric disorder, particularly ECT for a severe depressive episode.
6. Awareness that patients with psychomotor retardation are at greater risk of suicide once their symptoms begin to improve – when they develop the energy

to carry out the act of suicide.

Appendix C - **Deliberate Self-Harm - Parasuicide**

The term deliberate self-harm (DSH) is generally used to cover all acts of self-harm, self-injury or attempted suicide. Acts of DSH do not necessarily involve the intention to die.

C1: Definition of Parasuicide

"Any act deliberately undertaken by a patient who mimics the act of suicide, but which does not result in a fatal outcome. It is a self-initiated and deliberate act in which the patient injures himself or herself or takes a therapeutic substance in a quantity which exceeds the therapeutic dose (if any) or his or her own habitual level of consumption, and which he or she believes to be pharmacologically active." Thus if a patient takes only a small dose, believing it to be lethal, then this is classed as parasuicide, even though such a dose is not usually lethal.

C2: Methods Used

In the UK, 90% of cases of parasuicide involve deliberate self-poisoning with drugs. Substances used in self-poisoning have changed over the years. There has been a steady increase in the use of paracetamol, and a decrease in minor tranquillisers and sedatives. There has been an increase in overdoses of antidepressants over the period 1985 -1995, which is thought to reflect their wider prescription in the treatment of depression. (Hawton K, et al, 1997) Hence SSRIs are preferred to TCADs for patients at-risk of DSH due to their lower toxicity in overdose.

Paracetamol, which is freely available without prescription, is particularly dangerous since an overdose of as little as 10g, (i.e. 20 x 500mg tablets), can lead to severe hepatocellular necrosis. Patients who had not really wished to die may develop encephalopathy, haemorrhage and cerebral oedema, and then die.

The most common form of self-injury is cutting, but it can also include bruising, scraping, scratching, burning and other self-inflicted wounds.

C3: Epidemiology

DSH is more common in women than men, however a marked increase in DSH in young males has decreased the female:male gender ratio from 1.4 in 1985, to 1.33 in 1990 and 1.23 in 1995.

The highest rates of DSH are seen in the age group 25-34 in women and 15-24 in men.

Different problems precede DCH in men and women. Problems concerning a partner, employment or studies, alcohol, drugs or finances were all more common in men presenting with DSH. Problems with family members other than a partner were more common in women.

A high incidence of DSH among offenders supervised by the Probation Service in England and Wales. (Akhurst M, et al 1994)

C4: Psychosocial Assessment

The medical seriousness of self-harming behaviour is unrelated to the psychiatric seriousness. The patient's account of the medication ingested may not be reliable. The presence of any predisposing factors and/or associated psychiatric disorders, as above, should be established. All patients attending hospital A & E Departments following DSH should be fully assessed.

A high degree of suicidal intent before the act of parasuicide is indicated by:

a) *Planning and preparation*, e.g. buying equipment or collecting medication.

b) *Precautions taken to avoid discovery*, e.g. doors locked; the act timed to avoid disturbance or carried out in isolation.

c) *No help sought* after the act.

d) *A violent method attempted*, e.g. hanging, electrocution, shooting, jumping or drowning.

e) *A final act* was performed, e.g. making a will or leaving a suicide note.

f) *Regret* for not having died and *still wanting to die*.

Other factors to assess are:

a) A previous history of suicide attempts.

b) The patient's current problems and the social / financial support available to him.

C5: Management

Following an act of parasuicide, the patient should be treated as necessary and any psychiatric disorder should be treated appropriately.

C6: Prognosis

Repetition is a core feature of suicidal behaviour. Of those who commit suicide, up to 40% have had previous suicide attempts. Of those who deliberately self-harm, 10-15% eventually die because of suicide. The risk of suicide after DSH for males is nearly twice the female risk, the risk being greatest in the first year.

Risk Factors for Suicide following DSH

- High suicidal intent as elicited by the above assessment
- Psychiatric disorder, particularly depressive episodes, alcohol dependence, substance use disorders, schizophrenia and dissocial or anti-social personality disorder
- A history of previous suicide attempt(s)
- Social isolation
- Age > 45 years
- Male
- Unemployed or retired
- Chronic painful illness

Risk Factors for Repetition of DSH

- Previous act of DSH
- Previous psychiatric treatment
- Dissocial or anti-social personality disorder
- Alcohol dependence
- Other psychoactive substance use disorder
- Criminal record
- Low social class
- Unemployment

Appendix D - **Bereavement**

Bereavement can occur after any loss event, e.g. the loss of a relative by death, unemployment, divorce, or even the loss of a family pet.

The effects of bereavement can be modified by:

a) The significance of the loss – death of a spouse, child or (if the bereaved is under 18 years of age) parent.

b) The suddenness - unexpected, untimely and/or multiple deaths.

c) The degree of anticipation.

d) The degree of dependence or interdependence with the deceased.

e) The support available before, during and after the loss.

f) The degree to which appropriate mourning occurs.

g) The material and social consequences of the loss.

The effects of bereavement can be aggravated:

a) If the death involved pain or severe mutilation.

b) If the survivor feels responsible / guilty for the death.

c) By loneliness and social isolation, especially in the immobile elderly.

The loss of a loved person is one of the most severe psychological stresses an individual can undergo. It inevitably causes great distress, and can give rise or contribute to the onset of psychosomatic disorders. Such a loss has profound effects on the autonomic and endocrine systems, and probably on the immune response. Several studies have shown an increase in the mortality rate, (and particularly in deaths from ischaemic heart disease), during the first year of bereavement – especially in widowers over the age of 55 years.

D1: Grief

Grief can be defined as those psychological and emotional processes, expressed both internally and externally, that accompany bereavement.

Three characteristic components of grief, manifested at different phases of bereavement, are:

1. An urge to cry aloud and preoccupation with the deceased, such as: -
   a) Vivid imagery or being drawn towards mementoes and places connected with the lost person.

b) Perceptual disturbances, e.g. transient hallucinations.

c) Mummification, e.g. preservation of possessions and/or the deceased's room.

2. The conflicting urge to inhibit, avoid and minimise these painful antisocial urges – distraction (keeping busy) or avoidance behaviour may achieve this.

3. An urge to discover and confront the implications of the loss, and to revise the thoughts and behaviour that relied on the lost person.

Phases of uncomplicated grief

1. Shock and disbelief - often described as a feeling of numbness.

2. a) Increasing awareness of loss with painful pangs of grief (yearning) accompanying emotions of sadness and anger – the anger felt may be denied, especially if there is conflict or ambivalence concerning the deceased.

   b) Increased irritability may be intensified by the denial.

3. a) Disorganisation and despair as the full reality of the bereavement is accepted.

   b) Other symptoms, indistinguishable from those seen in depression, may include:

   - Sleep disturbance, with early morning wakening.
   - Loss of appetite, weight and libido.
   - Reduced performance, energy, drive and interest in everyday activities.
   - Social avoidance, emotional numbness, depressive ideation and tearfulness.
   - Constipation.
   - Somatic symptoms of pain or discomfort.

4. Reorganisation as the appetites for food, sex and other human needs return, and a new identity is discovered.

Mourning

Mourning refers to the necessarily lengthy period of culture-bound social and cognitive processes through which one must pass in order to return to more normal functioning. Feelings may be hidden because of social pressures not to share grief. Regressions are likely at times of anniversaries and other reminders of loss, which cause pain that occurs less frequently but remains just as intense.

Pathological grief

Pathological (or morbid) grief occurs when there is disruption of the normal

mourning process. The expression of grief may be delayed or prolonged. Such disruption may occur in the following situations:

1. Children are particularly vulnerable, because grieving parents or carers may miss the grief of the children and thus fail to provide an appropriate environment for the children to grieve. Children may be sensitive to the adults' distress and so hide their own grief. Uncharacteristic behaviour may be the expression of a child's grief and be misinterpreted by observers.
2. Conversely, caring for children or other dependants, or dealing with the practical consequences of the loss, may take precedence over individual concerns, providing a barrier to proper mourning and disrupting the grieving process.
3. Social or family disapproval of the expression or sharing of emotion may inhibit mourning. Such disapproval may be associated with inadequate mourning of previous losses and the consequent avoidance of the reawakening of painful memories and emotions.
4. Separation from the reality of loss may interfere with adequate mourning. Involvement of Western-style hospitals may separate a large proportion of the population from contact with the reality of death. Over-reliance on psychoactive medication by the bereaved may similarly separate them from the bereavement experience.
5. Mental or physical illness and alcohol or substance abuse may delay grief.
6. If the loss is due to traumatic circumstances, then post-traumatic stress disorder is likely to interfere with normal mourning – characterised by recurrent memories or images, which are so painful that people go to considerable lengths to avoid any trigger situation. Social withdrawal may persist, together with a continued fantasy relationship with the dead person.

Facilitation of normal grieving

The bereaved need reassurance that the normal physical and mental features of grief will pass. They need permission and time to grieve and, later, permission and encouragement to stop grieving and face the new challenges and opportunities that confront them. Normal grieving may be facilitated by the extended family, the primary health care team, religious organisations and specialist voluntary sector organisations such as CRUSE and the Stillbirths and Neonatal Deaths Society (SANDS). True depression may occur in the context of normal grieving and needs appropriate treatment.

Treatment of pathological grief

Only when grief becomes pathological in its intensity or length do mental health services need to be involved. Specialist treatments include bereavement counselling and guided mourning. Medication may be used if mental illness supervenes, but care must be taken that this does not interfere with the grieving process. SSRIs are preferable to TCADs because of the increased risk of suicide during bereavement. β-blockers may reduce the otherwise increased risk of death from IHD in bereaved people with known coronary impairment; they also reduce the

palpitations, which are a common accompaniment of anxiety during the early phases of grief.

Disabling effects

"Bereavement" is not an acceptable diagnosis for the certification of incapacity for work. However, if a true mental illness supervenes, then this can properly be recorded as the reason for incapacity, and the expected length of disability will be related to the nature of this condition.

Summary

Grief can be difficult to distinguish from depression. Characteristics that help to distinguish a grief reaction from depression are outlined in below (Block and Snyder, 2000]

Characteristics of grief	Characteristics of depression
Biological symptoms of loss of sleep, appetite, and concentration	Biological symptoms plus psychological symptoms of hopelessness, worthlessness, and guilt
Distress relates to a particular loss	Distress is usually generalized to all facets of life
The person retains the capacity for pleasure	The person enjoys nothing
Grief comes in waves	Depression is constant and unremitting
The person may express a passive wish for life to end	The person may express suicidal ideation
The person is able to look forward to the future	The person has no sense of a positive future
Most people cope without medical intervention	Medical or psychological intervention is usually necessary

Appendix E - **Simplified Version of the Criteria for a Depressive Episode**

Based on the criteria given in the International Classification of Diseases version 10, World Health Organisation.

E1: Major Depressive Episode

A to **D** must all apply:

A. At least 5 of the following have been present for at least 2 weeks, representing a change from previous functioning; one of the five symptoms must be symptom 1 or 2:

1. Depressed mood nearly every day for most of the day.
2. Markedly diminished interest or pleasure in all, or nearly all, activities nearly every day for most of the day.
3. Significant weight loss or weight gain when not dieting, or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Agitation or retardation nearly every day.
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
9. Recurrent thoughts of death or suicide.

B. **1.** No organic cause.

2. Not caused by bereavement.

C. No delusions or hallucinations in the absence of mood symptoms for as long as 2 weeks during the course of the illness.

D. Not superimposed on schizophrenia or other psychosis.

E2: Minor Depressive Episode

Minor depression is defined as depressed mood **or** anhedonia, **and** one other of the 9 depression symptoms – **B**, **C** and **D** must also apply.

Appendix F - **Differential Diagnosis between Generalised Anxiety and Depressive Disorders**

Generalised Anxiety Disorder	Depressive Disorder
Common in early adult life	Commoner in later adult life
Onset age 20–40 years	Onset age 20-60+ years
More frequent in those of premorbid anxious personality	More frequent in those of previous stable personality
Previous episodes of anxiety	Previous episodes of depression or even mania
Panic attacks frequent	Panic attacks uncommon
Lack of concentration	Loss of interest (anhedonia)
Minor loss of appetite	Major loss of appetite (or increased appetite)
Sexual performance reduced	Reduced libido
No diurnal variation of mood	Marked diurnal variation of mood
Initial insomnia	Early morning wakening
Somatic symptoms common	Ideas of reference, guilt and hopelessness common
More related to external precipitants	Less often related to external precipitants
Chronic course	Episodic course

N.B. (1) Diagnostic category of neurosis often changes over time and in different medical records.

(2) 90% of individuals with neurosis are labelled as having neurotic depression.

Appendix G - **Assessment Scales for Depression**

Please note that, although all of the tools discussed below can be easily found by an internet search, all three scales are licensed tools and as such are subject to copyright.

G.1.2 Mini Mental State Examination

The mini mental state examination uses a brief 30 point questionnaire format to attempt to quantify an individual's cognitive functioning capabilities in five fields: orientation; registration; attention; calculation; and language. This examination was initially documented by Folstein et al in 1975. The original version was widely available without cost, however subsequently copyright has been rigidly enforced and is only available through the publishers - Psychological Assessment Resources - as a licensed tool. This can be accessed at www.minimental.com/.

The enforcement of copyright issues has lead to researches looking for alternative scales for assessments (Holsinger et al, 2007)

Despite copyright issues versions of this scale are reproduced widely on the internet for example:

http://www.gp-training.net/protocol/psychiatry/mini_mental_state.htm.

http://www.depression-guide.com/mini-mental-state-examination.htm

G.1.3 Hamilton Rating Scale for Depression

This scale is a 21 point questionnaire that was first developed in the 1960s (Hamilton, 1960, 1966, 1967, 1969) and long thought to be standard assessment tool for assessing severity of depression.

This is also a licensed tool and as such cannot be reproduced due to copyright reasons.

The content of this scale can be accessed from a variety of internet resources.

G.1.4 Hospital Anxiety and Depression Scale

This scale is a 14 point self administered questionnaire that was first developed for use within a psychiatric outpatient setting but is commonly used in primary care.

Again, although versions of this scale are widely available from internet resources, this tool is licensed – see www.gl-assessment.co.uk/health_and_psychology/resources/hospital_anxiety_scale/hospital_anxiety_scale.asp

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