Title: Protocol for Depression Screening Adults with Stroke	
Manual: Patient Care Policy and Procedure	**Type:** Protocol
Section*:* Stroke	**Additional Sections (if indicated)**:
Developed by: Stroke Quality Committee	**Original Effective Date:** January 2013
Approved by: Clinical Policy and Procedures, January 2013	**Date Revised:**
	Date Reviewed:
Cross references: Acute Stroke Policy, MoCA	
Key Words: stroke, depression screen, PHQ-9	

POLICY STATEMENT

It is Mackenzie Health's policy to screen all adult patients admitted with a stroke for depression.

DEFINITIONS

Mild Depression: Few, if any, symptoms in excess of those required to make the diagnosis of depression and symptoms result in only minor impairment in occupational functioning or in usual social activities or relationships with others (American Psychiatric Association, 2000) (Appendix A).

Moderate Depression: Symptoms or functional impairment between "mild" and "severe" (American Psychiatric Association, 2000).

Severe Depression: Several symptoms in excess of those required to make the diagnosis of depression, and symptoms that markedly interfere with occupational functioning or with usual social activities or relationships with others (American Psychiatric Association, 2000).

PHQ-9 (Patient Health Questionnaire – 9): The PHQ-9 is a brief tool used to screen for depression. Adapted from the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (American Psychiatric Association, 2000).

Depression after stroke affects patient participation in therapy and is associated with decreased outcomes and increased length of stay. Early identification and treatment of post-stroke depression is critical in optimizing patient outcomes.

PROCEDURE

In-patient Screening

1. Patients admitted to Mackenzie Health with a primary diagnosis of stroke (exception aphasia) will be screened for depression within 72 hours of admission using the PHQ- 9 tool (Appendix B).
   - Screening may be conducted by the nurse or other registered health care provider (RHCP).

2. The screener will identify patients with predisposing risk factors for depression:
   - female gender;
   - past history of depression or psychiatric illness;
   - social isolation;
   - functional impairment and;
   - cognitive impairment.

3. Patients should be re-assessed:
   - prior to discharge to the community, or;
   - if there is evidence of depression or change in mood.

4. Patients referred to the Stroke Prevention Clinic for routine follow-up will be re-assessed by the Stroke Prevention Nurse Practitioner.

In-patient Treatment

1. Patients identified with mild depressive symptoms (score of 5 – 9) should be referred to a social worker for counseling (Appendix C). A follow-up PHQ-9 should be administered within one month, with a change in mood, OR prior to transitioning to the community.

2. Patients with moderate depressive symptoms (score of 10 – 14) should be referred to the CNS, Mental Health for further assessment and recommendations. Consideration should be given to pharmacotherapy and/or psychotherapy.

3. Patients with moderately severe (score 15 – 19) OR severe depressive symptoms (score 20 – 27) should be referred to a psychiatrist for recommendations regarding pharmacotherapy and / or psychotherapy.

Treatment – Outpatients in Stroke Prevention Clinic

1. Patients in the community who are identified with mild depressive symptoms (score of 5-9) should be referred for counseling via one of the following options:
   i) To their family physician for follow up and/or community referral
   ii) Family Services York Region (see Appendix D)
   iii) Access to social work through Family Physician's office if part of a Family Health Team
   iv) Private therapy if the patient has additional health care coverage

2. Patients with moderate depressive symptoms (score of 10-14) should be referred to one of the above and consideration given to initiation of pharmacotherapy.

3. Patients with moderately severe depressive symptoms (score of 15-19) or severe depressive symptoms (score of 20-27) should be referred to a psychiatrist or geriatrician for additional assistance regarding treatment options and pharmacotherapy. If patient requires immediate treatment accompany patient to the Emergency Department.

4. Patients will be followed in 1-2 months to reassess PHQ-9 and to monitor patients' response to pharmacological interventions if ordered previously and adjust treatment plan according to patient's current status.

Patient and Family Education

1. Patient and family members should receive education about:
   - Signs and symptoms of depression;
   - Incidence of post-stroke depression;

- Pharmacological treatment for depression, and;
- Non-pharmacological interventions for depression, e.g. exercise

2. Patients and family members should be provided with information regarding community self-management programs and local support groups.

Documentation

Nurse or other Registered Health Care Provider will place completed screen in the patient chart and document in HED:

- Date, time and score
- Any interventions including notifying physician of score and request for consultations as per above
- Any education provided

Most Responsible Physician:

- Assessment of patient with a score indicating depression
- Orders for consults and / or medications

REFERENCES:

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision).* Washington, DC. p. 339-345.

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APPENDIX A: Mood Disorders

Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same two week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

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

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

3) significant weight loss when not dieting or weight gain (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.

4) insomnia or hypersomnia nearly every day

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

6) fatigue or loss of energy nearly every day

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

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

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

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

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

D. The symptoms are dot 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).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than two months or are characterized by market functional impairment , morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Single Episode

A. Presence of a single Major Depressive Episode

B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder not otherwise specified.

C. There has never been a Manic Episode, or a Hypomanic Episode. Note: This exclusion does not apply if all the manic-like, mixed-like or hypomania-like episodes are substance of treatment induced or are due to the direct physiological effects of a general medical condition.

Recurrent

A. Presence of two or more Major Depressive Episodes.
Note: To be considered separate episodes, there must an an interval of a least two consecutive months in which criteria are not met for a Major Depressive Episode.

B. The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder not otherwise specified.

C. There has never been a Manic Episode, or a Hypomanic Episode. Note: This exclusion does not apply if all the manic-like, mixed-like or hypomania-like episodes are substance of treatment induced or are due to the direct physiological effects of a general medical condition.

Patient Sticker

APPENDIX B: PHQ-9

Patient Health Questionnaire – 9
PHQ - 9

Date: _____ **Screener:** _____

Over the **last 2 weeks** how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
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 TV	0	1	2	3
8. Moving or speaking so slowly that other people could have notice? 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

FOR OFFICE CODING 0 + _____ + _____ + _____

= Total Score: _____

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
☐	☐	☐	☐

Bar code

APPENDIX C: PHQ-9 Scores and Proposed Treatment Actions

Proposed Treatment Actions for In-patients with Stroke and Depression		
PHQ-9 Score	**Depression Severity**	**Proposed Treatment Actions**
0 - 4	None - minimal	None. Follow-up PHQ-9 prior to discharge to community
5 – 9	Mild	Refer to Stroke Team Social Worker and/or CNS, Mental Health for counselling. Re-administer PHQ-9 within one month, with change in mood, OR prior to transition to community.
10 - 14	Moderate	Refer to the CNS, Mental Health for further assessment and recommendations.
15 - 19	Moderately severe	Refer to psychiatry for recommendations regarding psychotherapy and pharmacotherapy.
20 - 27	Severe	Refer to psychiatry for recommendations regarding psychotherapy and pharmacotherapy.

APPENDIX D: Outpatient Community Resources

Family Services York Region (FSYR)

FSYR Richmond Hill – Yonge
10909 Yonge Street, Unit 57
Richmond Hill, ON L4C 3E3
Tel: 905-780-9927
Toll Free: 1-866-780-9927
Fax: 905-780-0872

FSYR Richmond Hill - Bayview
10610 Bayview Ave., Unit 18
Richmond Hill, ON L4C 3N8
Tel: 905-883-6572
Toll Free: 1-888-820-9968
Fax: 905-883-6575

FSYR Newmarket
1091 Gorham Street, Suite 202
Newmarket, ON L3Y 8X7
Tel: 905-895-2371
Toll Free: 1-888-223-3999
Fax: 905-895-2389

FSYR Markham
4261 Highway 7, Suite 203
Unionville, ON L3R 1L5
Tel: 905-415-9719
Toll Free: 1-866-415-9732
Fax: 905-415-9706

FSYR Georgina Office
Box 8, 25202 Warden Ave.
Sutton West, ON L0E 1R0
Tel: 905-476-3611
Fax: 905-476-6601

Additional Support Telephone Numbers

York Rainbow support: 1-888-967-5542

Chinese Support: 905-477-5741

Tamil Support: 416-857-6308

Hindi, Punjabi, Urdu, Gujarati support: 416-818-7075

Farsi support: 905-883-6572, ext. 256