
Chapter 6

Depression



Key Messages

- Major depression^a is a psychological condition indicated by a persistent (minimum of two weeks) state of sadness or depressed mood and/or lack of interest and pleasure in usual activities. This is in addition to other symptoms, such as significant changes in weight and sleep, a lack of energy, difficulty concentrating, irritability, feelings of worthlessness or guilt, or recurrent thoughts about death or suicide.
- Moderate-to-severe depressive symptoms, an indicator of depression, affect one in three people with insulin-treated type 2 diabetes, one in five people with non-insulin-treated type 2 diabetes, and one in four people with type 1 diabetes; this is two to three times more likely than the general population. Rates of clinical depression affect approximately one in eight people with diabetes.
- Depressive symptoms in people with diabetes are:
 - associated with suboptimal diabetes self-management and A1C, increased diabetes distress, less satisfaction with treatment, and impaired quality of life
 - highly recurrent
 - persistent/long-lasting
 - and different from, yet sometimes confused with, diabetes distress.
- Some depressive symptoms overlap with symptoms of diabetes (e.g., fatigue, sleep disturbance, changes in weight, and altered eating habits).
- A brief questionnaire, such as the Patient Health Questionnaire Nine (PHQ-9), can be used for assessing the severity of depressive symptoms. A clinical interview is needed to confirm major depression.
- Mild and major depression can be treated effectively (e.g., with psychological therapies and medications).



Practice Points

- Assess people with diabetes for depressive symptoms using a brief validated questionnaire; remember that major depression needs to be confirmed by a clinical interview.
- Treatment of depression will depend on severity, context, and the preferences of the individual. Helping people with major depression to access suitable treatment may require a collaborative care approach beginning with the person's PCP.
- Elevated depressive symptoms and mild depression also need attention, as they can develop into major depression.

^a In this chapter, the terms “mild depression” or “major depression” (collectively referred to as “depression”) are used when diagnosis is confirmed by a clinical interview according to DSM-5 or ICD-11 criteria. The term “depressive symptoms” is used where self-report is not yet confirmed by a clinical interview.

How Common Are Symptoms of Depression?



Type 1 diabetes^{b,1}



Type 2 diabetes (insulin)^{b,1}



Type 2 diabetes (no insulin)^{b,1}

WHAT IS Depression?

Depression is “an emotional, physical, and cognitive (thinking) state that is intense, long-lasting, and has negative effects on a person’s day-to-day life.”² In contrast to just “feeling down” or sad, depression is a serious mental health problem.

The diagnostic criteria for depression are described in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5),³ and the *International Statistical Classification of Diseases and Related Health Problems*, 11th revision (ICD-11).⁴ The “gold standard” for diagnosing depression is a standardized clinical diagnostic interview, for example the Structured Clinical Interview for DSM-5 (SCID-5; www.scid5.org).

Major depression (also known as major depressive disorder or clinical depression) is indicated by five or more of the following symptoms being present during a two-week period, representing a change from previous functioning.³

- At least one of the symptoms is persistent depressed mood or loss of interest/pleasure in regular activities.^{3,5}
- Other symptoms include significant weight loss or gain, insomnia or excessive sleeping, lack of energy, inability to concentrate, indecisiveness, feelings of worthlessness, excessive/inappropriate guilt, and recurrent thoughts of death or suicide.³

Mild depression (also known as subthreshold or minor depression) is characterized by the presence of depressive symptoms that do not meet the full diagnostic criteria for major depression.⁶ Although mild depression is less severe than major depression, it still significantly affects the person and deserves attention in clinical practice. Furthermore, if not treated, mild depression can develop into major depression.

Depression in People with Diabetes

There is evidence of a bi-directional association between depression and diabetes. People with depression are more likely to develop type 2 diabetes.⁷

People with diabetes are two to three times more likely than the general population to be affected by symptoms of depression.^{8,9} There is also a bi-directional relationship between depression and diabetes-related complications.¹⁰ As in the general population, depression is highly recurrent in people with diabetes.¹⁰

The causes of depression in people with diabetes are not well understood, but proposed mechanisms include biological, behavioral, social, psychological, and environmental factors.¹¹ Non-diabetes-specific contributors may include stressful life circumstances, substance use, and a personal or family history of depression.¹² Diabetes-specific contributors may include the chronic nature of the condition and complex management regimens.^{8,13} As various factors can contribute, the exact cause will be different for every person.¹²

In people with diabetes, depression or depressive symptoms are associated with adverse medical and psychological outcomes, including:

- suboptimal self-management (e.g., reduced physical activity, less healthy eating, not taking medication as recommended, less frequent self-monitoring of blood glucose, and smoking)^{14–19}
- elevated A1C, hypoglycemia, and hyperglycemia^{14,15,20}
- increased prevalence, and earlier onset, of complications and disability^{21–23}
- increased risk of diabetes distress^{24–27} and elevated anxiety symptoms²⁷
- impaired quality of life and social role/functioning^{27–29}
- increased burden/costs to the individual and the healthcare system^{14,17,30}
- and greater risk of premature mortality.^{31,32}



People with coexisting depressive and anxiety symptoms are likely to experience greater emotional impairment and take longer to recover.^{33,34}

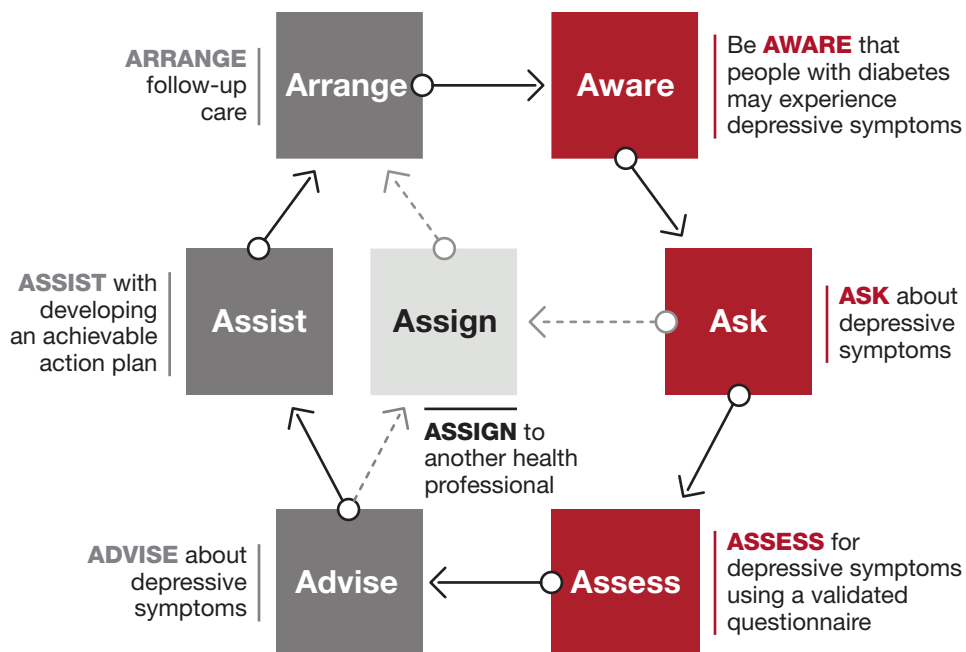
^b 25%, 32%, and 20% respectively have moderate-to-severe depressive symptoms (PHQ-9 total score ≥ 10).

7 A's Model: Depression

This dynamic model describes a seven-step process that can be applied in clinical practice. The model consists of two phases:

- How can I identify depressive symptoms?
- How can I support a person with depression?

Apply the model flexibly as part of a person-centered approach to care.



HOW CAN I IDENTIFY Depressive Symptoms?

■ Be **AWARE**

Depression has physical, cognitive, behavioral, and emotional symptoms. Some common signs to look for include lowered mood (e.g., sadness, hopelessness, or tearfulness), loss of interest or pleasure in usual activities, irritability (e.g., exaggerated sense of frustration over minor matters or persistent anger), difficulties concentrating, lack of energy, weight loss or gain, reduced self-esteem/self-confidence, feelings of worthlessness or excessive/inappropriate guilt,

psychomotor changes (agitation or retardation), social withdrawal, and recurrent thoughts about death or suicide.^{2-4,35} Also, look for signs that the person is not coping adaptively, such as disturbed sleep or substance abuse (e.g., alcohol, sedatives, or other drugs).^{2-4,35} Each person will experience different symptoms of depression.

Two classification systems are commonly used for diagnosing depression: DSM-5³ and ICD-11.⁴ Consult these for a full list of symptoms and specific diagnostic criteria.



Depressive symptoms can overlap with somatic symptoms of diabetes⁸ (see Box 6.1) or with symptoms of diabetes distress (see Box 6.2). As a result, depression may be overlooked in diabetes clinical practice.³⁶

Although depression does not always develop in direct response to diabetes, some common signs include declining motivation to engage in diabetes self-care tasks, more frequent presentations to health professionals with the same symptoms, and missed appointments.

BOX 6.1 Symptoms of Depression or Diabetes

Depression and diabetes share some similar somatic and behavioral characteristics (e.g., fatigue, sleep disturbance, and appetite change). This poses a challenge, as symptoms of depression can be overlooked or mistaken for symptoms of diabetes and vice versa.

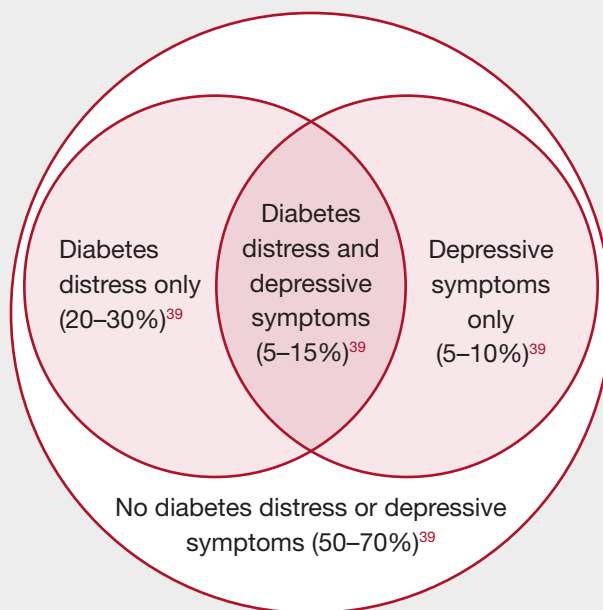
It is important to note that depression questionnaires do not have the capacity to distinguish the underlying cause of the symptoms. For example, a person may feel tired due to disturbed sleep because of depression or because they have had several nighttime episodes of hypoglycemia recently. This can result in elevated scores that do not necessarily indicate depressive disorder. Health professionals need to be mindful of these limitations.

This does not mean that depression questionnaires are not useful in clinical practice—it means that a clinical interview is needed to confirm a diagnosis of depression in people with diabetes. It is important to clarify the context and cause of the symptoms.

BOX 6.2 Depression or Diabetes Distress?

Depression is often confused with diabetes distress—both in academic literature and clinical practice. While depression can influence how people feel about living with diabetes, it is broader, affecting how they feel about life in general. Conversely, diabetes distress is the emotional distress arising specifically from living with and managing diabetes and does not necessarily affect how people feel about their life in general.³⁷ Diabetes distress includes problems related to the relentlessness and frustrations of everyday diabetes self-care and worries about future complications (see Chapter 3).

While diabetes distress and depression are separate constructs, they are risk factors for each other.^{23–25} This means that people with depression are more likely to develop diabetes distress, and vice versa. In practice, this means that both depressive symptoms and diabetes distress need to be assessed in clinical practice, to inform the type and intensity of intervention.^{37,38}



■ ASK

You may choose to ask about depressive symptoms:

- › in line with clinical practice guidelines (e.g., on a routine or annual basis; see Introduction, page viii)
- › when the person reports symptoms or you have noted signs (e.g., changes in mood/behaviors)
- › at times when the risk of developing depression is higher, such as:
 - during or after stressful life events (e.g., bereavement, traumatic experience, or diagnosis of life-threatening or long-term illness)
 - periods of significant diabetes-related challenge or adjustment (e.g., following diagnosis of diabetes or complications, hospitalization, or significant changes to the treatment regimen)
- › or if the individual has a history of depression or other mental health problems.⁵



Asking “*How are you doing?*” or, “*How have you been feeling lately?*” may seem like rhetorical questions but the responses can be very revealing and are often the key to what you do next. Take the time to listen to their answers and look for any sign that they may not be doing as well as usual.

Create a supportive and safe environment so the person feels able to be open with you about how they are feeling. People will be more likely to share their innermost thoughts and feelings with you if they are emotionally engaged in the appointment and have confidence that you care and will support them. For more information about having conversations about the emotional aspects of diabetes, see Chapter 1.

There are various ways to ask about depressive symptoms. You may choose to use open-ended questions, a brief structured questionnaire, or a combination of both.

Option 1: Ask Open-Ended Questions

The following open-ended question can be integrated easily into a routine appointment:

- › “*Have you noticed any change in how you have been feeling in the last couple of weeks? What have you noticed?*”

If something during the conversation makes you think that the person may be experiencing depressive symptoms, ask more specific questions, such as:

- › “*I know you as a [very active] person, but you’ve just told me that you haven’t felt motivated to [go running] lately. Do you think this is related to your mood?*”
- › “*Have there been any changes in your [sleeping/ eating] patterns? What have you noticed?*”

If the conversation suggests the person is experiencing depressive symptoms, further investigation is warranted (see **ASSESS**).

Option 2: Use a Brief Questionnaire

Alternatively, you can use a brief questionnaire to ask about depressive symptoms in a systematic way. Collectively, the following two questions are referred to as the Patient Health Questionnaire Two (PHQ-2).⁴⁰ They are the core symptoms required for a diagnosis of depression.

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

PHQ-2: www.phqscreeners.com



Instead of administering this as a questionnaire, you could integrate these questions into your conversation.

Add the responses to the two questions to form a total score. A total score of 3 or more indicates depressive symptoms,⁴⁰ and further assessment for depression is warranted.

At this stage, it is advisable to ask whether they have a current diagnosis of depression and, if so, whether and how it is being treated

If the total score is 3 or more and the person is not currently receiving treatment for depression, you might say something like, “*It seems like you are experiencing depressive symptoms, which can be a normal reaction to [...]. There are several effective treatment options for depression, but first we need to find out more about your symptoms. So, I’d like to ask you some more questions if that’s okay with you.*”

You may then decide to assess for depression using a more comprehensive questionnaire (see **ASSESS**). For information about using questionnaires in clinical practice, see pages 10 and 11.

If the total score is less than 3 but you suspect a problem, consider whether the person may be experiencing diabetes distress (see [Chapter 3](#)), elevated anxiety symptoms (see [Chapter 7](#)), or another mental-health problem.

ASSESS

Validated Questionnaire

The nine-item Patient Health Questionnaire (PHQ-9)⁴¹ is widely used to assess depression. A copy is included on page 105. It mirrors the DSM-5 criteria for depression. It is quick to administer and freely available online (www.phqscreeners.com). Each item is measured on a four-point scale, from 0 (not at all) to 3 (nearly every day). Scores are added to form a total score ranging 0–27. In the general population, PHQ-9 scores are interpreted as follows:⁴²

- 0–4 indicates no depressive symptoms (or a minimal level)
- 5–9 indicates mild depressive symptoms; these people will benefit from watchful waiting
- 10–27 indicates moderate-to-severe depressive symptoms; these people will benefit from a more active method of intervention.



Asking the person to complete the PHQ-9 can be a useful way to start a dialogue about depressive symptoms and the effect they may have on the person's life and/or diabetes management. It can also be useful for systematically monitoring depressive symptoms (e.g., whether the symptoms are constant or changing over a period of time).



A PHQ-9 total score of 10 or more must be followed by a clinical interview using DSM-5³ or ICD-11⁴ criteria to confirm depression.



You may have access to other validated questionnaires, such as the Beck Depression Inventory,⁴³ Hospital Anxiety and Depression Scale,⁴⁴ Centre for Epidemiologic Studies Depression Scale,⁴⁵ or Hamilton Depression Scale.⁴⁶ While all of these tools are suitable for assessing depressive symptoms, they each have their own strengths and weaknesses. Summaries of these questionnaires can be accessed elsewhere.^{47,48}

Additional Considerations

Is this individual at risk of suicide? It is essential that you conduct a suicide risk assessment if you identify a person as having depressive symptoms or thoughts about self-harm or ending their life. Most depression questionnaires include an item about self-harm, suicidal ideation, or suicide (e.g., PHQ-9, item 9). If the person with diabetes endorses that item, further investigation and support is necessary (see [Box 6.3](#)), regardless of whether the total score indicates depressive symptoms.

What is the context of the depressive symptoms?

Are there any (temporary or ongoing) life circumstances that may be underlying the depressive symptoms⁴⁹ (e.g., a bereavement, chronic stress, changing/loss of employment, financial concerns, giving birth, or menopause)? What social support do they have? What role do diabetes-specific factors play (e.g., a lack of support for diabetes self-care, severe hypoglycemia, or burdensome complications)?

Are there any factors (physiological, psychological, or behavioral) that are co-existing or may be causing/ contributing to the depressive symptoms? This may involve taking a detailed medical history, for example:

- Do they have a history (or family history) of depression or another psychological problem, such as an anxiety disorder (see [Chapter 7](#)), diabetes distress (see [Box 6.2](#) and [Chapter 3](#)), personality disorder, post-traumatic stress disorder, dementia, or eating disorder (see [Chapter 8](#))? These conditions must also be considered and discussed where applicable (e.g., when and how was it treated, whether they thought this treatment was effective, and how long it took them to recover).⁴⁹
- Do they have any underlying medical conditions that may be contributing to the symptoms?
- What medications (including any complementary therapies) are they currently using?
- How frequently do they use alcohol and/or illicit drugs?

No depressive symptoms—what else might be going on?

If the person's responses to the questionnaire do not indicate the presence of depressive symptoms they may be reluctant to open up or may feel uncomfortable disclosing to you that they are feeling depressed, so consider whether the person may be experiencing diabetes distress (see [Box 6.2](#) and [Chapter 3](#)), elevated anxiety symptoms (see [Chapter 7](#)), or another psychological problem.



If any of these assessments are outside your expertise, you need to refer the person to another health professional (see [ASSIGN](#)).

BOX 6.3 Suicide

Whenever you suspect that a person is experiencing depression, or they appear to be feeling despair, unbearable pain, hopeless, trapped, or like they are a burden on others or don't belong, it is very important that you have a conversation about it and assess their risk of suicide. Making direct enquiries about suicide does not prompt a person to start to think about harming themselves.⁵⁰ Instead, addressing the issue is much more likely to enhance their safety and prevent an attempt.⁵¹

The procedures used to assess risk of suicide or self-harm are no different than those used for medical crises. The key is to know the steps and have the resources in place when the need arises.

Suicidality fluctuates and is influenced by such things as:⁵⁰

- › static risk factors, which are fixed and historical in nature (e.g., family history of depression, a history of self-harm or suicide attempts, or previous experience of abuse)
- › and dynamic risk factors, which fluctuate in duration and intensity (e.g., substance use, psychosocial stress, or suicidal ideation/communication/intent).

Policies and procedures for conducting a suicide risk assessment vary between settings, but this is a general guide:^{50,52}

1. Assess and ensure safety (the person with diabetes, yourself, and others).
2. Establish rapport (non-judgmental, professionally empathetic, compassionate, open body language, and active listening).
3. Assess the suicide risk, including factors such as:
 - any history of suicide attempts
 - any history of mental disorders
 - the existence of a suicide plan
 - access to the means to complete the plan

- duration and intensity of the suicidal ideation
- hopelessness or feeling trapped
- lack of belonging, feeling alone, or alienated
- feeling like a burden on others
- alcohol/substance use
- intention/desire to die
- family history of suicide
- protective factors
- or recent help-seeking behaviors.

There are several questionnaires for assessing suicide risk.⁵³⁻⁵⁵ These can be useful for directing the conversation systematically but there is a lack of evidence for their diagnostic accuracy.⁵¹ **These questionnaires cannot replace clinical interview.**

4. Collect and document relevant information (e.g., the person's medical history, current physical and mental state, and evidence of a suicide risk assessment).
5. Arrange additional psychosocial and psychiatric assessments, or referral to a specialist, if required.
6. Develop a safety plan with the person⁵⁶ (i.e., a written list of coping strategies and support services to which the person can refer when they are having suicidal thoughts).
7. Reassess as necessary and ensure that follow-up care is provided. For people who are at high risk, reassess within 24 hours; for moderate risk, reassess within one week; and low risk, reassess within one month.⁵²

If a person is actively suicidal: provide or arrange continuous supervision.

If a person is in immediate danger: follow your workplace's emergency procedure or contact 911.

Keep in mind that some individuals may decide not to share their suicide plans and deny they have suicidal thoughts.



HOW CAN I SUPPORT A PERSON with Depression?

■ ADVISE

Now that you have identified that the person is experiencing depressive symptoms, you can advise them on the options for next steps and then, together, decide what to do next.

- Explain that their responses to the PHQ-9 indicate they are experiencing depressive symptoms, and also that:
 - they may have major depression, which will need to be confirmed with a clinical interview
 - and that depressive symptoms fluctuate dependent on life stressors and that it may be necessary to reassess later (e.g., once the stressor has passed or is less intense).
- Elicit feedback from the person about their score (i.e., whether the score represents their current mood).
- Explain what major depression is, and how it might affect their life overall, as well as on their diabetes management.
- Advise that depression is common, and that help and support are available; depression is treatable and can be managed effectively.
- Recognize that identification and advice alone are not enough; explain that treatment will be necessary and can help to improve their life overall, as well as their diabetes management.
- Offer the person opportunities to ask questions.
- Make a joint plan about the “next steps” (e.g., what needs to be achieved to reduce depressive symptoms and the support they may need).



If the depression is clearly related to a particular stressor (e.g., financial or relationship problems), take into account the severity and likely duration of the problem, as this will help to inform the action plan.

■ NEXT STEPS: ASSIST OR ASSIGN?

- The decision about whether you support the person yourself or involve other health professionals will depend on:
 - the severity of the depressive symptoms, and the context of the problem(s)
 - your scope of practice, and whether you have the time and resources to offer an appropriate level of support
 - your qualifications, knowledge, skills, and confidence to address depressive symptoms
 - whether other psychological problems are also present, such as diabetes distress (see [Chapter 3](#)) or an anxiety disorder (see [Chapter 7](#))
 - and the needs and preferences of the person with diabetes.
- If you believe referral to another health professional is needed:
 - explain your reasons for the referral (e.g., what the other health professional can offer that you cannot)
 - ask the person how they feel about your suggestion
 - and discuss what they want to gain from the referral, as this will influence to whom the referral would be made.

■ ASSIST

Neither mild nor major depression is likely to improve spontaneously,⁵⁷ so intervention is important. The stepped care approach provides guidance on how to address depressive symptoms and depression in clinical practice.^{58,59}

Once depression has been confirmed by a clinical interview, and if you believe that you can assist the person:

- Explain the appropriate treatment options (see [Box 6.4](#)), discussing the pros and cons for each option, taking into account:
 - the context and severity of the depression
 - the most recent evidence about effective treatments (e.g., a collaborative and/or a stepped care approach)

BOX 6.4 Treating Depression

It is not within the scope of this guide to recommend specific pharmacological or psychological treatments for depression in people with diabetes. Here are some general considerations based on the evidence available at the time this guide was published:

- › A combination of psychological intervention and pharmacological treatment is recommended for people with recurrent depression and major depression.⁵⁸
- › Psychological intervention and/or pharmacological treatment should be implemented through stepped care and/or collaborative care approaches.^{58,60}
- › Cognitive behavioral therapy (CBT) is the most effective psychological intervention.⁵⁸
- › Antidepressant medications are only effective for people with moderate-to-severe depression, not mild depression.⁶¹
- › Selective serotonin re-uptake inhibitors (SSRIs) are the most effective pharmacological treatment for depression in people with diabetes.⁵⁸
- › When combined with diabetes self-management education, psychotherapy is most effective for reducing depressive symptoms and A1C.⁶²
- › Some antidepressant medications can have adverse side effects (e.g., weight gain and metabolic abnormalities) and are associated with insulin resistance.⁵ Consider the risks and benefits before prescribing these medications, as they may not be appropriate for some people with diabetes.^{5,61}

- and the person's knowledge about, motivation, and preferences for, each option.
- › Offer them opportunities to ask questions.
- › Agree on an action plan together and set achievable goals for managing their depression and their diabetes. This may include adapting the diabetes management plan if the depression has impeded their self-care.
- › Provide support and treatment appropriate to your qualifications, knowledge, skills and confidence. For example, you may be able to prescribe medication but not undertake psychological intervention or vice versa.

- › Make sure the person is comfortable with this approach.
- › At the end of the conversation, consider giving them some information to read at home. At the end of this chapter (see page 107), there are resources that may be helpful for a person with diabetes who is experiencing depression or depressive symptoms. Select one or two of these that are most relevant for the person. It is best not to overwhelm them with too much information.

Some people will not want to proceed with treatment, at first. For these people, provide ongoing support and counselling about depression, to keep it on their agenda. This will reinforce the message that support is available and will allow them to make an informed decision to start treatment in their own time.

ASSIGN

If a decision is made to refer, consider the following health professionals:

- › **A primary care physician (PCP)** to undertake a clinical interview and diagnose major depression, make a referral to an appropriate mental health professional, and prescribe and monitor medications. An extended appointment is recommended.
- › **A psychologist** to undertake a clinical interview and provide psychological therapy (e.g., CBT or interpersonal therapy).
- › **A psychiatrist** to undertake a clinical interview, provide psychological therapy (e.g., CBT), and prescribe and monitor medications. A PCP referral may be required to access a psychiatrist. Referral to a psychiatrist may be necessary for complex presentations (e.g., if you suspect severe psychiatric conditions, such as bipolar disorder or schizophrenia, or complex co-morbid medical conditions).
- › **A mental health social worker** to help the person find ways to effectively manage situations that are contributing to their depression or inhibiting their treatment (e.g., trauma or life stresses), using psychologically based therapies and skills training (e.g., problem solving and stress management).
- › **An occupational therapist specializing in mental health** for therapy to increase independence and functioning (e.g., self-care, work and home roles, socialization, and coping), which may be impaired by depression.

See **Chapter 9** for guidance about preparing mental health referrals and what to say to the person with diabetes about why you are making the referral.



If possible, consider referring the person to health professionals who have knowledge about, or experience in, diabetes. For example, if their diabetes management is affected by their depression, they may need a new diabetes management plan that is better suited to their needs and circumstances at the time. This might require collaboration with a PCP or diabetes specialist (e.g., an endocrinologist, diabetes educator, and/or dietitian).



If you refer the person to another health professional, it is important:

- that you continue to see them after they have been referred so they are assured that you remain interested in their ongoing care
- and to maintain ongoing communication with the health professional to ensure a coordinated approach.

■ ARRANGE

If there is need and scope, consider including more frequent follow-up visits or extended appointments in the action plan. Encourage the person to book a follow-up appointment with you within an agreed timeframe to monitor progress and address any issues arising. Telephone/ video conferencing may be a practical and useful way to provide support in addition to face-to-face appointments.

Mental health is important in its own right, but it is also likely to affect the person's diabetes self-management and their physical health. Therefore, it is important to follow up to check that they have engaged with the agreed treatment.

At the follow-up appointment, revisit the plan and discuss any progress that has been made. For example, you might say something like, *“When I saw you last, you were feeling depressed. We made a plan together to help you with that and agreed that [you would make an appointment to see Shirley, a psychologist, and I wrote a referral to her]. Have you had an opportunity to [see her]? How has this worked out for you?”*



CASE STUDY

Julie

65-year-old woman living alone

Type 2 diabetes, managed with diet and exercise;
history of depression

Health professional: Dr. Robert Stevens (PCP)

■ Be AWARE

When Julie arrives for her routine check-up, Dr. Stevens notices signs that she isn't her usual self—she is not wearing make-up, has dark circles under her eyes, and she doesn't greet him with her usual cheerfulness. He asks her how she has been, and she shrugs her shoulders replying, *"You know how it is, just a bit tired. I need a vacation I think."* As the discussion moves on to her general physical health and diabetes management, Dr. Stevens notes that Julie mentions again that she is tired, which has prevented her from exercising, and as a result her blood glucose has been a bit higher than usual and she has gained 10 lbs.

■ ASK

When Dr. Stevens enquires further using open-ended questions, Julie confides that in the past she had enjoyed exercising with a friend, but over the past month she has found herself making excuses not to leave the house. *"I just can't get motivated to exercise at the moment. I feel awful when I cancel my walks with Fran, but I'm just too tired these days—it feels like a chore. And I tell myself, 'just do it, it's not that hard, you'll enjoy it once you're outside.' But then I can't bring myself to leave the house."* Julie says she feels guilty for not exercising and has begun eating late at night, which she is ashamed about. She worries about her weight but when she feels down, she eats more. She feels unsure about how to break herself out of this cycle.

Dr. Stevens is concerned about Julie's struggles with motivation and about the impact her recent changes

in behavior and thought patterns will have on her diabetes if they continue in the longer term.

■ ASSESS

Dr. Stevens knows that Julie has a history of depression and wonders whether her negative thoughts about herself, her low mood, the changes in her eating and exercise patterns, and her tiredness might be linked. He invites Julie to complete the PHQ-9. Julie's score of 18 suggests she is experiencing moderately severe depressive symptoms. Because of her high PHQ-9 score, he also conducts a suicide risk assessment, and finds Julie to be at low risk of suicide.

■ ADVISE

Dr. Stevens explains the PHQ-9 score to Julie and asks her if this fits with how she has been feeling lately. Julie says that she recognizes the symptoms she has been experiencing from a couple of years ago when she was depressed after separating from her husband. Dr. Stevens asks Julie whether she had sought help for the depression at the time and whether she had needed antidepressants. Julie says she had consulted a psychologist who had been able to help her without antidepressants. He asks Julie whether this would be a good option for her this time. They agree that it will be the best course of action for Julie to return to the same psychologist, as they have a previously established rapport. The psychologist will conduct a formal assessment and discuss a treatment plan with Julie.

■ ASSIGN

Dr. Stevens encourages Julie to make an appointment with the psychologist. Dr. Stevens makes a comment in his EHR note to follow-up with Julie at her next visit to inquire about her status with her psychologist and her level of satisfaction with that portion of her care.

■ ARRANGE

Dr. Stevens encourages Julie to make another appointment to see him after she has met the psychologist to update him on her progress and assess whether there is a need for antidepressants at that stage. He also invites her to see him sooner if she needs to.



CASE STUDY

Luke

24-year-old man living with his older brother

Type 1 diabetes (diagnosed 23 years ago)

Health professionals: Dr. Glenn Jin (endocrinologist) and Thomas Mitchell (diabetes nurse)

■ Be AWARE

Dr. Jin is aware that people with diabetes are at a higher risk of emotional problems. He has decided to add a mental health questionnaire to the annual review process at his diabetes clinic. The questionnaire includes the Diabetes Distress Scale-17 (DDS-17; see page 46) to assess diabetes distress and the PHQ-2.

Thomas is a diabetes nurse working at the clinic who assists with some of the physical health checks. He has been given the task of explaining the purpose of the questionnaire and encouraging people to complete it on a tablet computer in the waiting room while awaiting their appointment. The person's questionnaire responses are automatically saved in their chart, for discussion during the appointment.

■ ASK

During Luke's annual visit, the check-in staff at the clinic ask Luke, *"We've added something new to our annual assessments. Dr. Jin has put together a brief set of questions about how living with diabetes affects your life and well-being. The questionnaire takes about 10 minutes, there's no writing—you just have to tick the boxes. You can do it now while you're waiting to see Dr. Jin. Will you fill in the questionnaire?"* Luke agrees. When Thomas meets with Luke, he asks him some general questions about his health and well-being, but Luke does not seem to be in the mood for talking.

■ ASSESS

At the appointment, Dr. Jin quickly looks over the questionnaire responses. Luke's DDS-17 score does not indicate a problem that needs immediate attention and he confirms this with Luke. However, Luke's PHQ-2 score indicates that he is likely to be experiencing depression.

Dr. Jin asks Luke about how he felt completing the questionnaire, and Luke replies, *"It was OK, y'know, a bit different, but OK."* Dr. Jin says to Luke, *"Looking at your responses, it looks like you've been feeling down over the past two weeks and not very interested in things. What's going on Luke?"* Luke tells him that he lost his job about six months ago, and he couldn't find work, which has affected his moods and relationships. *"I can't do anything right y'know; can't find a job... then my girlfriend left me... and I'm sleeping on my brother's couch because I couldn't pay the rent... I can't catch a break. I'm such a loser, I'm nothing."*

Dr. Jin acknowledges that Luke seems to have had a tough time lately, and that it is understandable that he has been feeling down. He explains to Luke that he may be experiencing depression and that help is available. Dr. Jin asks Luke whether he has been diagnosed with depression before; Luke has not. Dr. Jin then asks Luke to complete a few more questions to help him to be sure. Luke agrees, so Dr. Jin gives him a copy of the PHQ-9. Luke's PHQ-9 score is 23, indicating severe depressive symptoms. As Luke's score on item 9—"Thoughts that you would be better off dead or of hurting yourself in some way"—was 2 ("More than half the days"), Dr. Jin also conducts a suicide risk assessment and finds Luke to be at moderate risk.

■ ADVISE

Dr. Jin explains the scores to Luke and gives him some information about depression, including the phone number for the National Suicide Prevention Lifeline: (800) 273-8255. Dr. Jin tells Luke that depression is treatable and explains the various options available. He advises Luke to visit a PCP and the reasons for this—the PCP will help him to access the most appropriate treatment. He invites Luke to ask questions.

■ ASSIST

Dr. Jin checks whether Luke has a PCP that he would be comfortable to speak with, and whether he is OK to do so. Luke agrees to both queries. Dr. Jin also asks Luke if there is someone in his life (e.g., a friend or family member) that he can talk to if he has thoughts about ending his life. Luke says that he has a good relationship with his brother who is very understanding and supportive. He will talk with him or call the Lifeline about how he is feeling if things get too much. Dr. Jin discusses other suicide risk mitigation strategies with Luke; together they develop a safety plan.

■ ASSIGN

Dr. Jin writes a letter of referral to a mental health professional and sends a note to Luke's PCP. In the referral, Dr. Jin includes a copy of his PHQ-9 score and interpretation with the letter.

Luke's situation also prompts Dr. Jin to refer Luke to an onsite social worker who can assess any potential food insecurity issues and help Luke identify community resources and benefits he may need while unemployed.

■ ARRANGE

Dr. Jin asks Luke to come back to see him next month, so he can see how he is getting on with his PCP. They will also continue with his annual diabetes visit and consider whether any changes are needed to his diabetes management plan while Luke is receiving support for the depressive symptoms.

Questionnaire: Patient Health Questionnaire Nine (PHQ-9)

Instructions: For each statement, please tick the box below that best corresponds to your experience in the last two weeks.

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 every day
1 Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2 Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3 Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4 Feeling tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5 Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6 Feeling bad about yourself—or that you are a failure or have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7 Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8 Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9 Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

(Office use only) Total score =

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
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?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer, Inc. No permission is required to reproduce, translate, display, or distribute. See: www.phqscreeners.com

Background

The PHQ-9 is a nine-item questionnaire for assessing depressive symptoms and their severity.^{41,63} It has been validated for use with people with diabetes.⁶⁴ Each of the nine items corresponds with a DSM-5³ criterion for depression.

It is freely available online in more than 40 languages, quick to administer, and easy to score and interpret. Many of the translations are linguistically valid, but not all have been psychometrically validated against a diagnostic interview for depression⁶³ and few have been validated in people with diabetes.⁴⁷

How to Use the PHQ-9 in Clinical Practice

Respondents are asked to indicate how frequently they are bothered by each of the nine items (each describing a different symptom of depression).^{41,65} Items are scored on a scale from 0 (not at all) to 3 (nearly every day).⁶⁵

An additional supplementary item (which does not contribute to the total score) can also be asked to evaluate the level of social or occupational difficulty caused by the depressive symptoms. This question appears in the version on the website,⁶³ and has been included in the questionnaire.



For tips about using questionnaires, see “Using Questionnaires to Inform Appointments” (pages 10 and 11).

Interpretation of Scores

The scores for each item are summed to generate a total score (range: 0–27).⁶⁵ Depressive symptom severity is indicated by the PHQ-9 total score.⁴² Generally, a PHQ-9 total score of 10 or more is an indicator of likely depression,⁴¹ and needs to be followed up with a clinical interview.



If the person scores 1 or more on item 9 (referring to suicidal ideation), further assessment for risk of suicide or self-harm is required, irrespective of the total score.⁴¹

PHQ-9 total score	Depressive symptom severity	Proposed treatment actions
0–4	None – minimal	None
5–9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10–14	Moderate	Treatment plan, consider counselling, follow-up, and/or pharmacotherapy
15–19	Moderately severe	Active treatment with pharmacotherapy and/or psychotherapy
20–27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or limited response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

Additional Information

Alternative cut-off values: For people with diabetes in specialty clinics (usually those with severe complications), a cut-off value of 12 or more has been recommended due to the overlap between symptoms of depression and diabetes.⁶⁶ For older people with diabetes in general practice, a cut-off of 7 or more has been recommended.⁶⁷

Short Form—PHQ-2

- › The PHQ-2⁶⁸ consists of two items from the PHQ-9: item 1, “Little interest or pleasure in doing things,” and item 2, “Feeling down, depressed, or hopeless.”
- › The timeframe and response options are the same as for the PHQ-9.
- › The two item scores are summed to form a total score. Total scores of 3 or more warrant further assessment for depression.⁶⁵

Resources

For Health Professionals

Peer-Reviewed Literature

- › **Depression and diabetes: treatment and health-care delivery**

Description: This paper makes recommendations for clinical practice for addressing depression and diabetes.

Source: Petrak F, Baumeister H, et al. *The Lancet Diabetes & Endocrinology*. 2015;3:472-485.
- › **The confusing tale of depression and distress in patients with diabetes**

Description: A commentary on diabetes distress and depression, and recommendations for clinical practice.

Source: Fisher L, Gonzalez JS, et al. *Diabetic Medicine*. 2014;31:764-772.
- › **Depression in diabetes mellitus: to screen or not to screen? A patient-centred approach**

Description: A review article discussing methods for routinely screening for depression in people with diabetes.

Source: Van der Feltz-Cornelis CM. *British Journal of Diabetes & Vascular Disease*. 2011;11:276-281.
- › **Safety planning intervention: a brief intervention to mitigate suicide risk**

Description: This paper describes how to develop a safety plan to mitigate suicide risk.

Source: Stanley B, Brown GK. *Cognitive and Behavioral Practice*. 2012;19(2):256-264.

Additional information: Information about safety planning from the same authors can also be accessed at www.suicidesafetyplan.com

Guidelines and Recommendations

- › **American Psychological Association Clinical Practice Guidelines for the Treatment of Depressions**

Description: Developed for psychiatrists, psychologists, physicians, and other health professionals with an interest in mental health, these evidence-based guidelines cover the management of depressive disorders.

Source: Gelenberg AJ, Freeman MP, et al. American Psychiatric Association practice guidelines for the

treatment of patients with major depressive disorder. *Am J Psychiatry*, 167(Suppl 10), 9-118.

URL: www.apa.org/depression-guideline/guideline.pdf

Books

- › **Treatments that Work (Series)**

The *Treatments that Work* book series describes evidence-based psychological interventions for a variety of mental health conditions. They have a wide array of therapist guides with accompanying patient workbooks.

Source: Oxford University Press

URL: www.oxfordclinicalpsych.com/page/ttwseries/treatments-that-work-series
- › **Management of Mental Disorders, 5th edition**

Description: A book that provides practical guidance for clinicians in recognizing and treating mental health problems, including depression. The book also includes worksheets and information pamphlets for people experiencing these problems and their families.

Source: Andrews G, Dean K, et al. Clinical Research Unit for Anxiety and Depression (CRUFAD). 2014.

Additional information: Sections of this book (e.g., treatment manuals and worksheets) are freely available to download from the “Support for clinicians” section on the CRUFAD website at www.crufad.org

Websites

- › **American Diabetes Association (ADA)**

Description: ADA and the American Psychological Association partnered to create an educational program for mental health professionals interested in emotional issues specific to people with type 1 and type 2 diabetes. Clinicians who have completed this training can be found on the ADA website in their Mental Health Provider Directory Listing.

URL: professional.diabetes.org/mhp_listing

For People with Diabetes



Select **one** or **two** resources that are most relevant and appropriate for the person. Providing the full list is more likely to overwhelm than to help.

Support

› National Suicide Prevention Lifeline

Description: Confidential telephone and online crisis support service for people experiencing a personal crisis or thinking about suicide.

Phone: 800-273-8255 (24 hours a day, seven days a week)

URL: www.suicidpreventionlifeline.org online crisis support chat 24/7

› Mental Health America

Description: A good resource for finding peer support. Also includes access to screeners for anxiety and depression, which can then help connect patients with an appropriate referral. Individuals who indicate they have diabetes will also be routed through to the ADA Mental Health Provider Directory.

URL: <https://mhanational.org/finding-help>

› Local State Psychological Associations

Description: Most states have a local directory for mental health professionals, and many have a phone number for more information.

Information

› Diabetes and Depression

Description: A handout for people with diabetes about depression designed along with this practical guide.

Source: National Diabetes Services Scheme and the American Diabetes Association, 2021.

URL: <https://professional.diabetes.org/meetings/mentalhealthworkbook>

› Breaking Free from Depression and Diabetes

Description: An information leaflet for people with diabetes about depression from the Behavioral Diabetes Institute that covers a broad range of topics related to depression and diabetes, including ways to get support.

Source: Behavioral Diabetes Institute, 2014.

URL: <https://behavioraldiabetes.org/xwp/wp-content/uploads/2015/12/BDIDepressionBookletFINAL.pdf>

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