DEPRESSION

National Standard Treatment Guideline

Ministry of Health
Republic of Maldives

ADB

JFPR
Japan Fund for Prosperous and Resilient Asia and the Pacific

From the People of Japan

World Health Organization
Maldives

National Standard Treatment Guidelines

- Acid Peptic Disease
- Acute Anxiety
- Acute Pancreatitis
- Acute Psychosis
- Acute kidney Injury
- Arrhythmia
- Chronic Liver Disease
- Chronic Pancreatitis
- Chronic kidney disease
- Congenital Heart Diseases
- Dementia
- Depression
- Diabetes Mellitus Type 1
- Diabetes Mellitus Type 2
- Gestational Diabetes
- Epilepsy
- Heart Failure
- Hyponatremia
- Hypernatremia
- Hypokalemia
- Hyperkalemia
- Interstitial Lung Disease
- Liver Failure
- Obesity
- Obstructive Sleep Apnoea
- Osteoarthritis
- Ovarian Cancer
- Pneumonia
- Stroke
- Upper Gastrointestinal bleed
- Unstable Angina

Version No	Version Date	Description of change
1	8 November 2025	Initial release

DOCUMENT NUMBER: MOH-QA/G/25/226-0

Technical Lead and Editor

Dr. Sangeeta Sharma
Professor, Neuropsychopharmacology, Institute of Human Behaviour & Allied Sciences (IHBAS) & President (Honorary), Delhi Society for Promotion of Rational Use of Drugs (DSPRUD), New Delhi, India

Technical Contributors and Reviewers for STGs

Maldivian Contributors

INTERNAL MEDICINE

Dr. Fathimath Nadia
Senior Consultant in Internal Medicine,
Indira Gandhi Memorial Hospital (IGMH), Male', Maldives

Dr. Moosa Murad
Senior Consultant in Internal Medicine,
Indira Gandhi Memorial Hospital (IGMH), Male', Maldives

Dr. Ibrahim Hassan
Senior Specialist Registrar Internal Medicine,
Medical Director of Kulhudhuffushi Regional Hospital.

Dr. Aminath Munaza
Consultant in Internal Medicine, Hulhumale' Hospital

Dr. Mihuna Ibrahim
Consultant in Internal Medicine, Hulhumale' Hospital

Dr. Ahmed Zooshan
Consultant in Internal Medicine, Indhira Gandi Memorial Hospital

Dr. Shivir Sharma Dahal
Consultant in Internal Medicine, ADK Hospital

Dr. Quraisha Haneef
Consultant in Internal Medicine, ADK Hospital.

Dr. Muhammad Asad UR Rehman Khan
Consultant in Internal Medicine, Tree Top Hospital.

ENDOCRINOLOGY

Dr. Ibrahim Faisal
Consultant in Endocrinology, Indhira Gandi Memorial Hospital.

Dr. Mariyam Niyaz
Consultant in sub specialist in Endocrinology,
Indhira Gandi Memorial Hospital.

Dr. Mohamed Shiruhan
Consultant in sub specialist in Endocrinology,
Indhira Gandi Memorial Hospital.

NEPHROLOGY

Dr. Ahmed Abdulla
Consultant Sub specialist in Nephrology,
Indhira Gandi Memorial Hospital.

RHEUMATOLOGY

Dr. Ibrahim Sujau
Consultant Sub specialist in Rheumatology,
Indhira Gandi Memorial Hospital.

Dr. Sariu Ali Didi
Consultant in Rheumatology, ADK Hospital.

PSYCHIATRY

Dr. Shanooha Mansoor
Consultant in Psychiatry, Indhira Gandi Memorial Hospital.

Dr. Shooga Moosa
Consultant in Psychiatry, Indhira Gandi Memorial Hospital.

Dr. Abdulla Nazim
Consultant in Psychiatry, Indhira Gandi Memorial Hospital.

GASTROENTEROLOGY

Dr. Abdullah Isneen Hilmy
Consultant Sub specialist in Gastroenterology,
Indhira Gandi Memorial Hospital.

PULMONOLOGY

Dr. Mohamed Ismail
Consultant in Pulmonology, Indhira Gandi Memorial Hospital

ORTHOPEDICS

Dr. Ahmed Azim Abdul Shukoor
Consultant in Orthopedics, Hulhumale' Hospital

CARDIOLOGY

Dr. Mohamed Shaneez Najmy
Consultant in Cardiology, Indhira Gandi Memorial Hospital

Dr. Migdhaadh Shareef
Consultant in Cardiology, Indhira Gandi Memorial Hospital

Dr. Aishath Eleena
Consultant in Pediatric Cardiology, Indhira Gandi Memorial Hospital

EMERGENCY MEDICINE

Dr. Fahira Ahmed Rasheed
Consultant in Emergency Medicine,
Indhira Gandi Memorial Hospital

ENT

Dr. Ahmed Shifaz
Consultant in Otolaryngology,
Indhira Gandi Memorial Hospital

OBSTETRICS & GYNAECOLOGY

Dr. Hawwa Inaya Abduraheem
Consultant in Obstetrics and Gynaecology,
Hulhumale' Hospital

Dr. Aminath Juhaina Hameed
Consultant in Obstetrics and Gynaecology,
Hulhumale' Hospital

Dr. Nashwa Samir Hussein Abdulla
Consultant in Obstetrics and Gynaecology,
Medica Hospital

Dr. Shirmeen Mohamed
Consultant in Obstetrics and Gynaecology,
Indhira Gandi Memorial Hospital

PAEDIATRICS

Dr. Abbasa Abdul Hamid
Consultant sub specialist in Paediatric Neurology, Hulhumale' Hospital

Dr Ismail Ejaz Ali
Consultant in Paediatrics, ADK Hospital

Dr.Nusaiba Farouk Hassan
Consultant in Paediatrics, Indhira Gandi Memorial Hospital

Dr. Amany Naseer
Consultant in Paediatrics and Medical Director of
Addu Equatorial Hospital

RADIOLOGY

Dr. Basma Ibrahim Sobir
Consultant in Radiology, Indhira Gandi Memorial Hospital

DENTAL

Dr. Nadeema Rasheed
Consultant in Orthodontics,
Indhira Gandi Memorial Hospital.

MEDICAL OFFICERS

Dr. Suha Abdul Shakoor
Medical Officer, B. Atoll Hospital

Dr. Aishath Maurisha
Medical Officer, Gan Regional Hospital

Dr. Mohamed Hishaam
Medical Officer, Shaviyani Atoll Hospital

Dr. Aishath Shurooq Waheed
Medical Officer, Shaviyani Atoll Hospital

DSPRUD contributors

ENDOCRINOLOGY

Dr. SV Madhu
Director Professor, Department of Endocrinology, Center for Diabetes, Endocrinology and Metabolism, UCMS & GTB Hospital, New Delhi

NEPHROLOGY

Dr. Anil Yadav
Additional Medical Superintendent (Admin), Department of Medicine, UCMS & GTB Hospital, New Delhi.

Dr. Likhita V
Senior Resident and Postgraduate Nephrology Trainee, CMC Vellore.

PSYCHIATRY

Dr. R.K. Chadda
Former Professor & Head, Department of Psychiatry, AIIMS, New Delhi; Consultant, Amrita Hospital, Faridabad, Haryana.

Dr. Amit Khanna
Associate Professor, Department of Psychiatry, IHBAS, New Delhi.

NEUROLOGY

Dr. Suman Kushwaha
Professor, Department of Neurology, IHBAS, New Delhi.

Dr. Mridula Rastogi
Assistant Professor, Department of Neurology, IHBAS, New Delhi.

Dr. Manoj Kumar Sharma
Professor, Department of Hepatology, Institute of Liver and Biliary Sciences (ILBS), New Delhi.

Dr. Monika Jain
Head, Gastroenterology, Balaji Action Hospital, New Delhi.

Dr. Ekta Gupta
Professor, Dept of Clinical Virology, Nodal Officer WHO CC, ILBS, New Delhi

PULMONOLOGY

Dr. Anup R Warrier
Senior Consultant, Infectious Disease Specialist, Aster Medicity, Kochi, Kerala, India.

Dr. Amit Mandal
Pulmonologist & ICU Specialist, Senior Director, Paras Hospital, Panchkula, Haryana, India.

Dr. Manvir Bhatia
Founder, Neurology & Sleep Centre; Vice President, Indian Society of Sleep Research

Dr. Ashok Rajput
Chief Consultant & Pulmonologist, Morpheus Lung & Sleep Clinic, CK Birla Hospital, New Delhi.

Dr. Rajendra Prasad
Director Medical Education & Professor, Respiratory Medicine, Era University, Lucknow, Uttar Pradesh, India.

Dr. Nikhil Gupta
Associate Professor, Department of Medicine, Dr. Ram Manohar Lohia Institute of Medical Sciences, Lucknow, Uttar Pradesh, India.

ORTHOPEDICS

Dr. Sumit Sural
Director Professor & Head, Department of Orthopedics, MAMC & LN Hospital, New Delhi.

Dr. N.V. Kamat
Former Director General Health Services, Govt. of NCT Delhi; Executive Vice President, DSPRUD

CARDIOLOGY

Dr. M.S.S. Mukharjee
Senior Interventional Cardiologist, Pulse Heart Center, Hyderabad

Dr. Neeraj Nishchal
Additional Professor, Department of Medicine, AIIMS, New Delhi.

Dr. Prerna Garg
Senior Resident, Cardiology, AIIMS, New Delhi

Dr. R. Krishna Kumar
Pediatric Cardiology, Amrita Hospital, Kochi

Dr. Aashima Dabas
Professor, Pediatrics, LN Hospital, New Delhi

EMERGENCY MEDICINE

Dr. Vanitha Rajagopalan
Assistant Professor, Critical & Intensive Care, Department of Anesthesiology, AIIMS, New Delhi

OBS & GYNAE ONCOLOGY

Dr. Amita Suneja
Former Director Professor, Department of Obstetrics & Gynaecology, UCMS & GTB Hospital, Delhi.

Dr. Poonam Joon
Deputy Medical Superintendent, Head of Department Obstetrics & Gynaecology, Sanjay Gandhi Memorial Hospital; Secretary, DSPRUD, New Delhi

Endorsed by

Uza. Thasleema Usman
Commissioner of Quality Assurance
Ministry of Health, Male', Maldives

Published by

Quality Assurance and Regulations Division
Ministry of Health, Male,
Republic of Maldives

GUIDELINES DEVELOPMENT METHODOLOGY

The development of the Maldives Standard Treatment Guidelines (STGs) followed a structured, evidence-informed, and consensus-driven methodology adapted from internationally accepted guideline-development standards and the Delhi Society for Promotion of Rational Use of Drugs (DSPRUD) model. The process combined systematic evidence retrieval, critical appraisal, contextual adaptation, and multidisciplinary expert review to ensure feasibility, clinical relevance, and national ownership.

1. Determining Scope and Priority Conditions

Priority clinical conditions were identified through consultation with national programme managers, specialty clinicians, and health-system stakeholders. Selection criteria included: (i) major causes of morbidity and mortality, (ii) observed variation in clinical practice or prescribing patterns, (iii) potential to improve patient outcomes, and (iv) the feasibility of implementation across health-facility levels in Maldives. The final list of diseases reflected national epidemiology, service-delivery capacity, and essential-medicine availability.

2. Identification of Existing Evidence and Source Guidelines

A targeted search strategy was used to identify high-quality existing clinical guidelines. Searches were conducted across international guideline repositories (e.g., WHO, NICE, SIGN and other intergovernmental bodies, international and national guideline repositories, specialty societies and professional associations.

3. Quality Appraisal of Source Guidelines

Retrieved guidelines were screened for transparency of development, methodological rigour, clarity of recommendations, applicability to health-system reality, editorial independence. Guidelines were included if they met the Institute of Medicine (IOM) definition of a clinical guideline and addressed treatment or management of priority conditions. Guidelines that did not meet minimum quality standards, review articles, diagnostic criteria, or technical standards were excluded.

4. Adoption, Adaptation, and Contextualization

The guideline-development team employed an adopt–adapt–contextualize model:

- **Adoption**: High-quality recommendations that aligned with Maldivian health-system realities were retained without modification.
- **Adaptation**: Recommendations were modified when local considerations such as diagnostic capacity, medicine availability, workforce skills, referral pathways, or cost constraints affected feasibility.

- **Contextualization**: Where evidence was absent or inconclusive, conditional recommendations were formulated based on expert consensus, with explicit consideration of pragmatism, safety, and local workflows.
  Medicines were selected in alignment with the Maldives National Essential Medicines List (NEML), based on suitability, efficacy, safety, and availability.

5. Expert Consensus and Multidisciplinary Input

Draft recommendations were initially prepared by experts from the DSPRUD, India, providing a strong methodological foundation for the process. Building on this, a collaborative and participatory process brought together clinicians from internal medicine, paediatrics, obstetrics-gynaecology, surgery, emergency medicine, endocrinology, cardiology, general practitioners, and public health representing different levels of healthcare. Consensus was achieved through moderated discussions, iterative revisions, and resolution of divergent views. For topics lacking strong evidence, recommendations were derived from expert clinical judgment grounded in extensive practice experience.

6. Drafting, Peer Review, and Validation

Each guideline section was organized in a standard format including key clinical features, essential investigations, non-pharmacological management, pharmacological therapy (with step-up/step-down options where relevant), referral criteria, paediatric considerations, and follow-up requirements. Drafts were peer-reviewed by senior clinicians and national experts. Reviewer comments were systematically integrated to strengthen clarity, accuracy, and applicability.

7. Addressing Conflicts of Interest

All contributors declared the absence of conflicts of interest. Individuals with potential or perceived conflicts were excluded from authorship or decision-making roles.

8. Updating and Future Revisions

The STGs were conceptualized as a living document. Future updates will incorporate new scientific evidence, changes in essential-medicine availability, national programme priorities, and user feedback from clinicians. Periodic review cycles will ensure the continued relevance and reliability of recommendations.

9. Distinctive Features of the Guidelines

Developed through a collaborative process involving a large group of multidisciplinary experts from different levels of healthcare, the guidelines incorporate the following distinctive features:

- **Diagnostic Assumption and Confirmation**: While assuming that an initial diagnosis has been established by the healthcare provider, the guidelines provide essential information for confirming diagnoses. This includes a comprehensive overview of major signs and symptoms, descriptions of confirmatory tests, and clear guidance on practices that are prohibited, discouraged, or unreliable—promoting evidence-based medicine supported by relevant references.
- **Comprehensive Treatment Approach**: The guidelines offer a systematic, up-to-date framework for managing medical conditions across the continuum of care. They begin at the primary care level and extend to secondary and tertiary care, incorporating protocols for treatment response assessment and referral criteria as integral components.
- **Diverse Treatment Modalities**: Recommendations encompass both non-pharmacological and pharmacological interventions and surgical intervention where applicable, providing flexibility for individualized treatment plans. Cautionary notes are included where necessary to ensure safe and effective use of therapies.
- **Assessment and Referral Criteria**: Clear criteria and goals for evaluating patient response to treatment are provided, along with guidance on when referral to higher levels of care is warranted ensuring continuity and comprehensiveness in patient management.

ACKNOWLEDGEMENTS

The Government of the Republic of Maldives is committed to ensuring universal access to quality health services for all citizens. The Constitution of Maldives mandates the progressive realization of rights, including the right to good standards of health care for the population. In line with this national commitment, standardized quality health services are regarded as the foundation of a strong and equitable healthcare system.

This important work would not have been possible without the cooperation and support of many individuals and institutions. We express our sincere appreciation to the Honourable Minister of Health, Abdullah Nazim Ibrahim, for his leadership, commitment, and continuous guidance throughout the development process. We are grateful to WHO and ADB for their significant contribution, support, and technical assistance.

Our heartfelt gratitude is extended to the technical lead and editor, Dr. Sangeeta Sharma, Professor, Neuropsychopharmacology, IHBAS and President, Delhi Society for Promotion of Rational Use of Drugs (DSPRUD), and her team. We express our deepest appreciation to the Maldivian and DSPRUD experts and contributors who played a pivotal role in this process. Their technical expertise and dedication to adapt the standards to the Maldivian context have been instrumental in the development and finalization of these guidelines. The time, experience, generous sharing of knowledge and insights contributed by all parties have not only enriched the work but also have been invaluable in making these standards practical, locally acceptable, and aligned with the needs of the resident population.

It is important to acknowledge the immense efforts, involvement, timely coordination, collaboration, and dedication of the Quality Assurance and Regulation Division team who made it possible for these Clinical Treatment Guidelines to come into existence.

Uza. Thasleema Usman

Commissioner of Quality Assurance
Ministry of Health, Male', Maldives

DEPRESSION

DEPRESSION

QUICK REFERENCE GUIDE

Depression occurs across all ages, but its onset is most frequent in late adolescence to early adulthood. Children and adolescents have a point prevalence of 3–8%, and by late teens, 15-20% have had at least one episode. In older adults, depression often presents with more somatic complaints and cognitive symptoms (sometimes called "pseudodementia").

Definitions & different types

- Depression (Major Depressive Disorder): persistent low mood and/or loss of interest with cognitive, physical, and behavioral symptoms causing impairment.
- Subtypes: melancholic, atypical, psychotic depression, seasonal pattern, Persistent Depressive Disorder (dysthymia).
- Diagnostic standards: International Classification of Diseases, 11th Revision (ICD-11) and Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR).

Causes, Risk factors & Precipitating factors

- Biological: family history, endocrine illness (thyroid), neurological disease, postpartum period.
- Psychological: prior depression/anxiety, trauma, maladaptive coping.
- Social: loss, conflict, isolation, unemployment, poverty.
- Precipitating factors: medical illness, medications (steroids, isotretinoin, interferon, beta-blockers), alcohol/drugs.

Evaluation for Diagnosis

- History: core symptoms, duration ≥2 weeks, course, suicidality, functional impact, mania screens (to exclude bipolar), substance use.
- Physical exam: vitals, weight/BMI, thyroid, cardiopulmonary, focused neuro exam.
- Mental status exam: mood/affect, thought content (suicide/psychosis), psychomotor change, cognition, insight/judgment.
- Laboratory (as indicated): full blood count, electrolytes, renal/liver function, fasting glucose/HbA1c, thyroid tests, vitamin B12/folate; electrocardiogram (ECG) if cardiac risk or TCA use.
- Screening/severity tools: Patient Health Questionnaire-9 (PHQ-9), Hospital Anxiety and Depression Scale (HADS), Beck Depression Inventory (BDI).
- Confirm diagnosis with DSM-5-TR/ ICD-11 criteria; exclude bipolar disorder, substances, and medical causes.

Classification / severity assessment criteria

- Severity: mild / moderate / severe (psychotic features), based on symptom count, intensity, and functional impairment (work/school/self-care).
- Course: single vs recurrent; with anxious distress; with seasonal pattern.

Differential Diagnosis

- Bipolar depression, bereavement, adjustment disorder, grief reactions.
- Medical: hypothyroidism/hyperthyroidism, anemia, Parkinson's disease, stroke, sleep apnea.
- Substance/medication-induced mood disorder.
- Primary psychotic disorders, dementia (late life).

Management Goals & principles

- Goals: full remission, functional recovery, relapse prevention, suicide risk reduction, minimal adverse effects.
- Principles: patient-centered, stepped care, combine psychotherapy and pharmacotherapy when indicated, treat comorbidities, safety-plan, shared decision-making.

Approach to management

- Mild: psychoeducation, cognitive behavioral therapy (CBT) or interpersonal therapy (IPT), activity... scheduling; consider medication if preference, prior severe episodes, or poor response.
- Moderate–severe or psychotic: antidepressant ± psychotherapy; urgent safety plan; electroconvulsive therapy (ECT) for severe/psychotic or high-risk cases.
- Treatment-resistant: optimize dose/duration, switch class, augmentation (see below), consider transcranial magnetic stimulation (TMS) or ECT.

Non-Pharmacological interventions

- Psychotherapies: CBT, IPT, problem-solving therapy (PST), mindfulness-based cognitive therapy (MBCT) (relapse prevention).
- Lifestyle: structured routine, sleep hygiene, ≥150 min/week moderate activity, reduce alcohol/drugs, balanced diet.
- Low-resource: brief/manualized CBT/PST, group formats, task-sharing with trained nurses/community health workers, tele-follow-ups, simple symptom trackers (PHQ-9).

Pharmacological therapy

Start low, review at 2–4 weeks, reach therapeutic dose by 4–6 weeks if tolerated. Continue 6–12 months after remission (longer for recurrent/chronic). All antidepressants: monitor for suicidality (especially 18–24 years), serotonin syndrome with serotonergic combinations, and withdrawal if stopped abruptly (taper).

Drug (class)	Indication	Start → Titrate	Usual/Max daily dose	Route	Duration guidance	Key cautions (brief)
Fluoxetine (SSRI)	First-line; adherence issues	10–20 mg → ↑ by 10–20 mg q2–4 wks	20–60 mg	PO OD (AM)	Long half-life aids adherence	Activating/insomnia; strong CYP2D6 inhibitor; fewer withdrawal issues
Sertraline (SSRI – selective serotonin reuptake inhibitor)		25–50 mg → ↑ by 25–50 mg q1–2 wks	50–200 mg (max 200)	PO OD	Continue 6–12 mo after remission	GI upset, activation/ insomnia; sexual dysfunction; taper
Escitalopram (SSRI)	First-line	5–10 mg → ↑ by 5–10 mg q2 wks	10–20 mg (max 20)	PO OD	As above	QT caution at higher dose/ cardiac disease; sexual dysfunction
Venlafaxine XR (SNRI – serotonin-norepinephrine reuptake inhibitor)	anxious features	37.5–75 mg → ↑ by 37.5–75 mg q1–2 wks	75–225 mg (max 225)	PO OD	As above	BP rise at higher doses; significant discontinuation symptoms if abrupt stop
Mirtazapine (NaSSA – noradrenergic & specific serotonergic antidepressant)	Depression with insomnia/ weight loss/ anxiety	7.5–15 mg HS → ↑ by 7.5–15 mg q1–2 wks	15–45 mg HS	PO OD	As above	Sedation (more at lower dose), weight gain, dry mouth; rare neutropenia (seek care if fever/sore throat)
Bupropion XL (NDRI – norepinephrine/ dopamine reuptake inhibitor)	Low energy, hypersomnia, sexual side-effects on SSRIs	150 mg AM → 300 mg after 3–7 d	300 mg (max 450*)	PO OD	As above	*Seizure risk dose-related; avoid in eating disorders, seizure disorder; may increase insomnia/anxiety
Amitriptyline (TCA – tricyclic antidepressant)	Second-line; pain/ migraine comorbidity	10–25 mg HS → ↑ by 10–25 mg q3–7 d	75–150 mg (max 300)	PO	As above	Anticholinergic, orthostasis, weight gain; QT prolongation/overdose toxicity—ECG if cardiac risk; lethal in overdose
Nortriptyline (TCA)	Second-line; better tolerated than amitriptyline	25 mg HS → ↑ by 25 mg q3–7 d	50–150 mg	PO	As above	Similar TCA risks; consider level monitoring; ECG in cardiac risk
Olanzapine (Second generation antipsychotic-SGA) augmentation	Inadequate response to antidepressant; consider **olanzapine–fluoxetine** combo (OFC)	2.5–5 mg HS → ↑ by 2.5–5 mg q1–2 wks	5–20 mg (augment typically 5–10)	PO HS	Use as augmentation; review need regularly	High metabolic risk (weight, lipids, glucose), sedation, orthostasis; avoid in uncontrolled diabetes; monitor metabolic profile

Note:

1. Antidepressant + olanzapine: reassess at 2–4 weeks. If mood still depressed, add Lithium (or T3 if Lithium not suitable). Lithium augmentation is used for refractory or recurrent depression and for suicide prevention.
2. Modified ECT for severe or treatment-resistant cases.
3. Specialist agents (monoamine oxidase inhibitors, ECT, Transcranial Magnetic Stimulation (TMS) reserved for resistant/psychotic/severe cases.

Assessment of response, Review; follow-up and adjustment of treatment

- Frequency: every 2–4 weeks during titration; 4–8 weeks to stabilization; 3–6 months in maintenance.
- Track: symptoms (PHQ-9), function (work/school/self-care), side-effects, adherence, suicidality, comorbidities, substances.
- Before change: confirm diagnosis, check dose/duration adequacy, adherence, medical contributors, psychosocial stressors.

Step-up (intensify)

- Inadequate improvement after 6–8 weeks at therapeutic dose, or worsening function/suicidality.
- Actions: optimize to upper therapeutic range; switch class; augment (lithium, aripiprazole, quetiapine XR, mirtazapine/bupropion combinations); add/expand psychotherapy; address sleep, pain, substances.

Step-down (de-escalate)

- Remission sustained 6–12 months (longer if recurrent/severe). Taper slowly over weeks–months; continue psychotherapy and lifestyle measures; monitor for relapse/withdrawal.

Referral (tiered: primary → secondary → tertiary)

- Primary → Secondary/Tertiary: diagnostic uncertainty; bipolar/psychosis suspicion; suicidality/self-harm; severe symptoms; failure of two adequate trials; complex comorbidity; pregnancy/postpartum with moderate–severe depression.
- Secondary → Tertiary: treatment-resistant depression, need for ECT/TMS or complex augmentation; psychotic depression; high-risk medical comorbidity.
- Handoff: concise summary (timeline, doses/durations, responses, adverse effects, comorbidities, current meds/allergies, safety plan).

Complications

- Suicide/self-harm, substance misuse, social/occupational decline, cardiovascular risk elevation, poor adherence, medication adverse effects (e.g., TCA cardiotoxicity, metabolic effects of SGAs).

Patient education & Instructions to the patient/caregiver

- Depression is treatable; recovery is the goal.

- Adherence: take medicines exactly as prescribed; don't stop abruptly; report side-effects early.
- Expect delay: improvement may take 2–4 weeks; full response by 6–8 weeks.
- Lifestyle: regular sleep, activity, routine; limit alcohol/drugs; balanced diet.
- Warning signs: return of low mood/ anhedonia, sleep/appetite change, hopelessness—seek review early.
- Urgent help: suicidal thoughts—seek immediate care (emergency services/ helpline/trusted person).
- Caregivers: support routines/ adherence; watch early relapse signs; be patient—recovery can be stepwise.

INTRODUCTION

Depression is a common, disabling illness marked by persistent low mood, loss of interest, sleep/appetite changes, low energy, and poor concentration, often impairing daily life and sometimes leading to self-harm or suicide. About 280 million people are affected worldwide; lifetime risk is ~10–20%, with women nearly twice as affected. In South-East Asia, care is limited by stigma and scarce services, especially in rural and island areas. Depression occurs across all ages and raises the risk of other illnesses and early death, while also hurting school, work, and relationships. It is highly treatable with psychological therapies, medication, and psychosocial support; early detection and sustained care can lead to full recovery.

Harm arises both from under-correction—such as missed diagnosis, early treatment discontinuation, or reliance on non-evidence-based remedies—and over-correction, including unnecessary antidepressant use, polypharmacy, and neglect of psychosocial care. Inconsistent recognition, diagnosis, and treatment between urban centres and remote areas may result in variable outcomes. Standard treatment guidelines are needed to ensure consistent, evidence-based care across all levels, support early detection, reduce treatment delays, integrate mental health into primary care, and establish effective referral pathways to secondary and tertiary care.

SCOPE OF THE GUIDELINES

These guidelines provide practical, evidence-based recommendations for early detection, diagnosis, treatment, follow-up, referral, and prevention of depression in adults, adaptable to adolescents with specialist input. They cover primary-care screening with PHQ-9 or WHO-5, severity assessment, first- and second-line psychological and pharmacological treatments, management with medical comorbidities, urgent care for suicidal patients, and special considerations in pregnancy, postpartum, and older adults. Modified electroconvulsive therapy is included only as a referral-based intervention.

Intended users:

Primary care (medical officers, family physicians, nurses, community health workers); secondary care (GPs, internists, psychiatrists, mental-health–trained nurses); tertiary specialists (psychiatry, psychology, neurology, multidisciplinary teams); allied health (clinical psychologists, counsellors, social workers, occupational therapists); and public health/program managers integrating mental health services.

- **Primary care:** Screen (PHQ-9, WHO-5), give psychoeducation/supportive counselling, start first-line meds when appropriate, monitor, refer moderate–severe/complex cases.

- **Secondary care:** Confirm diagnosis, manage comorbidities, adjust/initiate treatment, handle moderate–severe (incl. stable suicidality), coordinate follow-up with primary care.
- **Tertiary care:** Treat resistant depression/complex comorbidity; provide modified ECT, TMS, structured psychotherapies; support lower tiers via outreach/telepsychiatry.
- **System enablers:** Standardized protocols and simple algorithms, clear referral triggers, telehealth for remote areas, task-sharing with nurses/CHWs for psychoeducation, adherence support, basic counselling.

DEFINITIONS

Depression is a common mental disorder marked by persistent sadness, loss of interest, and emotional, cognitive, physical, and behavioural symptoms. Per the International Classification of Diseases, 11th Revision (ICD-11) and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), diagnosis requires symptoms most of the day, nearly every day, for at least two weeks, with significant distress or functional impairment.

Major Depressive Episode (MDE)

A period of at least two weeks during which there is either depressed mood or loss of interest/pleasure, accompanied by at least four additional symptoms such as:

- Significant weight/appetite change
- Sleep disturbance (insomnia or hypersomnia)
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive guilt
- Impaired concentration or indecisiveness
- Recurrent thoughts of death or suicidal ideation

Major Depressive Disorder (MDD)

One or more major depressive episodes without a history of manic or hypomanic episodes. Can be:

- Single episode – Only one MDE in a lifetime.
- Recurrent – Two or more MDEs separated by at least two months without significant symptoms.

Persistent Depressive Disorder (Dysthymia)

A chronic form of depression lasting for at least two years (one year in adolescents), with depressed mood most of the day, more days than not, and at least two other depressive symptoms. Symptoms are less severe than MDD but more persistent.

Subthreshold/Minor Depression

Depressive symptoms that do not meet the full criteria for MDD but still cause significant distress and functional impairment. Common in primary care and important to identify for early intervention.

Atypical Depression

Characterized by mood reactivity (mood brightens in response to positive events) plus two or more of:

- Increased appetite or weight gain
- Hypersomnia
- Leaden paralysis (heavy, leaden feelings in limbs)

Psychotic Depression

Severe depression accompanied by delusions and/or hallucinations, typically mood-congruent (themes of guilt, poverty, illness). Requires urgent psychiatric referral.

Seasonal Affective Disorder (SAD)

Depressive episodes occurring in a seasonal pattern, most commonly in winter months, linked to reduced light exposure.

Depression in Special Contexts

- Perinatal depression – Occurs during pregnancy or within 12 months postpartum.
- Depression in older adults – May present with more somatic complaints and cognitive impairment ("pseudodementia"). Vascular depression (A late-onset depression (≥65 years) linked to vascular risk factors like hypertension, marked by executive dysfunction, poor treatment response, and higher risk of cognitive decline).
- Depression with comorbid medical illness – Common in chronic diseases such as diabetes, cardiovascular disease, thyroid disease, autoimmune diseases, obesity and metabolic syndrome, cancer, COPD and asthma, CKD, HIV/AIDs, neurological disorders and chronic pain conditions.

CAUSES, RISK FACTORS & PRECIPITATING FACTORS

Depression arises from a multifactorial interaction of biological, psychological, and social determinants. The impact of isolation, climate vulnerability, and cultural stigma towards mental illness adds to the global risk profile.

Table: Factors, Risks, and Precipitating factors for Depression

Category	Key Elements
Biological Factors	■ Genetic predisposition (family history ↑ risk 2–3 fold) ■ Neurotransmitter dysregulation (serotonin, norepinephrine, dopamine) ■ Neuroendocrine changes (HPA axis overactivity, high cortisol) ■ Inflammation (elevated markers linked to symptoms) ■ Medical conditions (hypothyroidism, Cushing's, diabetes, CVD, stroke, chronic pain) ■ Neurological disorders (Parkinson's, MS, epilepsy, post-stroke)
Psychological Factors	■ Personality traits (high neuroticism, low self-esteem, perfectionism) ■ Cognitive patterns (negative thinking, hopelessness, guilt) ■ History of mental illness (depression, anxiety, substance use) ■ History of trauma (childhood abuse, neglect)
Social & Environmental Factors	■ Life stressors (bereavement, divorce, financial hardship, unemployment) ■ Social isolation ■ Stigma & discrimination (delays care, ↑ chronicity) ■ Climate change–related stress (displacement, storm damage) ■ Cultural barriers (supernatural attributions)
Risk Factors	■ Limited access to specialists (esp. outside Malé) ■ Reliance on informal care due to stigma/lack of access ■ Vulnerable livelihoods (tourism, fishing) ■ Youth unemployment & few higher education options
Common Precipitating factors	■ Acute life events (loss, illness, relationship breakdown) ■ Chronic stress (financial/occupational strain) ■ Substance misuse (alcohol, drugs) ■ Medication-induced (interferon, corticosteroids, some antihypertensives, hormones) ■ Postpartum period (hormonal shifts, sleep disruption, role changes)

EVALUATION FOR DIAGNOSIS

A structured, stepwise evaluation is essential to confirm depression, rule out secondary causes, assess severity, and identify comorbidities. This ensures appropriate treatment initiation and timely referral when necessary.

Domain	Focus	What to ask/examine/test	Key criteria / pearls
History taking	Presenting symptoms	Persistent sadness/irritability, anhedonia, fatigue/low energy, poor concentration/indecisiveness, sleep change (insomnia/ hypersomnia), appetite/weight change, worthlessness/guilt, thoughts of death/suicidality	Cluster symptoms; include somatic complaints
		Children/adolescents: Irritability, school refusal, somatic complaints	
		Elderly: Cognitive impairment ("pseudodementia"), medical comorbidity	
	Symptom duration & course	Onset, first vs recurrent episode, bipolar spectrum features	Rule out delirium/dementia
	Functional impairment	Impact on social, occupational/ educational, daily living	Document subjective distress and objective limitations
	Risk assessment	Suicide: ideation/intent/plan/past attempts. Self-neglect: poor self-care, malnutrition, inability in ADLs	Safety plan if any risk; urgent referral when indicated
	Comorbid/past psychiatry	Prior depression, bipolar disorder, anxiety, psychosis, substance use	Screens guide treatment and referral
	Medical history	Thyroid disease, diabetes, CVD, stroke, chronic pain, neuro disorders; recent infections (post-viral)	Medical contributors common and treatable
	Medications/substances	Rx/OTC/herbals; alcohol/ recreational drugs	Many agents can precipitate/ worsen depression
	Psychosocial	Supports, stressors, relationships, trauma history	Guides therapy focus and risk
Physical exam	General	Vitals (BP, pulse, temp), weight/ BMI, grooming, psychomotor agitation/retardation	Baseline for meds and severity
	Systemic	Thyroid exam; brief neuro exam (tone, reflexes, coordination); CV/ resp/abdomen	Rule out systemic illness mimicking depression

Mental status exam (MSE)	Appearance/behaviour	Eye contact, posture, psychomotor change	
	Speech	Rate, tone, volume	Psychomotor correlates
	Mood & affect	Self-reported mood vs observed affect	Note congruence
	Thought content	Suicidal/homicidal ideation, delusions, preoccupations	Immediate safety actions if positive
	Thought process	Coherence, logic, relevance	Disorganization suggests other pathology
	Perceptions	Hallucinations (psychotic depression)	
	Cognition	Orientation, attention, memory	Screen for cognitive disorder if indicated
	Insight & judgment	Illness awareness, decision capacity	Impacts adherence and risk
Laboratory investigations	Basic (primary/ secondary care)	Full blood count (FBC), thyroid function (TSH, free T4), fasting glucose/HbA1c, renal & liver function, electrolytes, vitamin B12/ folate (when indicated)	Identify anemia, thyroid, metabolic or organ disease; guide dosing
	Additional (as indicated)	ESR/CRP; HIV/syphilis serology; urine toxicology; neuroimaging (MRI/CT) for late onset >50, neuro signs, atypical features	Targeted tests—avoid routine over-investigation

Use of Screening and Assessment Tools

Screening tools should not replace clinical judgment but can aid diagnosis and monitor treatment response.

- Patient Health Questionnaire-9 (PHQ-9): Widely used; scores ≥10 suggest moderate depression.
- Hospital Anxiety and Depression Scale (HADS): Useful in medically ill patients.
- Beck Depression Inventory-II (BDI-II): Common in research and specialist practice.
- WHO-5 Well-being Index: Short tool for primary care and health promotion.

CONFIRMATION OF DIAGNOSIS

The diagnosis of depression should be based on formal diagnostic criteria (ICD-11 or DSM-5-TR), corroborated by a thorough history, mental status examination, and exclusion of secondary causes.

ICD-11 Criteria for Depressive Episode: A depressive episode is diagnosed when the following are present:

Symptoms	Criteria / Requirement	Details / Thresholds
Core symptoms	≥ 2 required	1) Persistent depressed mood 2) Markedly diminished interest/pleasure 3) Reduced energy/increased fatigability
Additional symptoms	Add to core to grade severity	Need ≥2 more for mild; 3–4 for moderate; ≥4 for severe: reduced concentration/attention; low self-confidence; guilt/self-blame; pessimistic future; thoughts of self-harm/suicide; sleep disturbance; appetite/weight change
Duration	Time criterion	≥2 weeks, most of the day, nearly every day
Functional impact	Distress/impairment	Significant impairment in social/occupational/ educational/daily living
Exclusion	Rule-outs	Not better explained by another medical/psychiatric condition, substances, or bereavement (unless prolonged/severe)
DSM-5-TR: Major Depressive Episode (MDE)	Symptom count	≥5 symptoms in the same 2-week period, a change from baseline; at least one is depressed mood or loss of interest/pleasure
	9 DSM-5-TR symptoms	Depressed mood; diminished interest/pleasure; significant weight/appetite change; insomnia/ hypersomnia; psychomotor agitation/retardation; fatigue/low energy; worthlessness/excessive guilt; poor concentration/indecisiveness; recurrent thoughts of death/suicidal ideation/attempt
	Additional DSM-5-TR requirements	Causes clinically significant distress/impairment; not due to substances/medical condition; no manic/ hypomanic episode (unless substance/med-induced)

Context / Setting	What to do	Remarks
Primary care (remote/low-resource)	Clinical confirmation using ICD-11; PHQ-9 for WHO- 5 for documentation	Manage first episode/uncomplicated cases; safety-net and arrange regular follow up
Secondary care	Rule out reversible causes with basic labs (CBC, TSH, glucose, electrolytes, etc.	Titrate/adjust antidepressants; manage comorbidity, initiate psychotherapy if available, refer if poor response
Tertiary referral	Complex or treatment-resistant cases	Full psychiatric assessment (e.g., Indira Gandhi Memorial Hospital, Malé), access to advanced treatments (ECT, augmentation strategies, inpatient care)

Exclude secondary causes before confirming primary depression

Secondary causes	Examples
Autoimmune/inflammatory	SLE, RA, IBD, other connective tissue disorders
Endocrine	Thyroid, adrenal, pituitary disorders
Cancer	Pancreatic, lung, haemotological malignancies
Neurological	Stroke, Parkinson's disease, multiple sclerosis
Chronic infections	HIV, syphilis, hepatitis
Medications	Corticosteroids, beta-blockers, isotretinoin, interferon-alfa, varencline, some anticonsulvants (leveracetam, topiratam), some hormonal therapies (GnHR agonists, tamoxifen)
Substance-induced	Alcohol, opioids, sedatives, cannabis, stimulants (cocaine, amphetamine), withdrawal from benzodiazepine, nicotine

CLASSIFICATION / SEVERITY ASSESSMENT CRITERIA

Classifying depression by severity guides treatment intensity, follow-up frequency, and referral needs. This can be done clinically and supported by validated scales (e.g., PHQ-9, Hamilton Depression Rating Scale).

ICD-11 Severity Criteria

Severity	Symptom Profile	Functional Impact
Mild	At least 2 core symptoms + ≥2 additional symptoms.	Distress and some difficulty in work/social activities, but can still function with effort.
Moderate	2–3 core symptoms + ≥3–4 additional symptoms.	Significant difficulty in daily functioning; requires support or treatment adjustments.
Severe	All 3 core symptoms + ≥4 additional symptoms, often including suicidal thoughts or psychotic symptoms.	Marked inability to function; may require hospitalization.

PHQ-9 Severity Cut-offs (Primary Care Utility)

PHQ-9 Score	Severity	Suggested Action
0–4	None/minimal	Monitor; no active treatment required.
5–9	Mild	Psychoeducation, lifestyle changes, close follow-up.
10–14	Moderate	Active treatment (psychotherapy ± medication).
15–19	Moderately severe	Combined therapy; consider specialist input.
20–27	Severe	Urgent specialist referral; assess suicide risk.

DIFFERENTIAL DIAGNOSIS

Accurate diagnosis of depression requires ruling out other psychiatric, medical, and substance-related conditions that can mimic or contribute to depressive symptoms. Misclassification can lead to inappropriate or harmful treatment.

Category	Conditions & Key Features	Red Flags (Suggests Non-Primary Depression)
Psychiatric Conditions	■ Bipolar disorder (depressive phase): Depression alternating with mania/ hypomania. ■ Adjustment disorder: Symptoms within 3 months of stressor, resolve within 6 months. ■ Persistent depressive disorder: Chronic ≥2 yrs (adults). ■ Schizoaffective disorder, depressive type: Depression + schizophrenia symptoms. ■ Bereavement: Grief, fluctuating intensity, self-esteem intact.	■ History of elevated mood, ↓ sleep, ↑ activity (bipolar). ■ Psychotic symptoms (delusions, hallucinations). ■ Rapid improvement once stressor removed (adjustment). ■ Preservation of self-esteem (bereavement).
Medical Conditions	■ Endocrine/metabolic: Hypothyroidism, hyperthyroidism, Cushing's, Addison's, diabetes. ■ Neurological: Stroke (esp. left frontal), Parkinson's, dementia, MS, epilepsy. ■ Infectious: HIV, syphilis, hepatitis B/C, TB. ■ Nutritional: Vitamin B12/folate deficiency. ■ Chronic pain syndromes: Fibromyalgia, migraine.	■ Recent stroke or neuro deficits. ■ Endocrine features: weight changes, heat/cold intolerance, skin changes. ■ Cognitive decline (suggesting dementia). ■ Neurological symptoms (tremor, seizures, focal deficits). ■ Chronic pain not explained by mood alone.
Substance- & Medication-Induced Mood Disorders	■ Substances: Alcohol, opioids, sedatives, stimulant withdrawal. ■ Medications: Corticosteroids, beta-blockers, isotretinoin, antiepileptics, interferon, hormonal agents.	■ Symptoms begin after starting/stopping a drug. ■ Improvement after withdrawal of offending agent. ■ History of substance use or intoxication/ withdrawal timeline.
When to Refer to Psychiatry Immediately	■ Any depressive presentation with suicidal intent or recent attempt. ■ Suspected bipolar disorder before antidepressant initiation. ■ Psychotic features (hallucinations, delusions). ■ Severe functional impairment or inability to self-care. ■ Depression with catatonia or severe psychomotor retardation. ■ Diagnostic uncertainty where medical vs psychiatric overlap is unclear.	■ High suicide risk or safety concerns. ■ Acute behavioural disturbance posing danger to self/others. ■ Non-response to two adequate antidepressant trials (treatment-resistant). ■ Need for specialized interventions (ECT, TMS, inpatient care).

Key Distinguishing Features

- Bipolar disorder: Past manic/hypomanic episode; family history; mood lability.
- Hypothyroidism: Fatigue, cold intolerance, constipation, dry skin; elevated TSH.
- Cushing's syndrome: Truncal obesity, moon facies, striae, hypertension; abnormal cortisol tests.
- Bereavement: Symptoms triggered by loss, intermittent intensity, preserved self-worth.
- Medication-induced: Clear temporal association with starting/stopping a drug.

MANAGEMENT GOALS

- Achieve remission: resolve core symptoms (low mood, anhedonia, fatigue, sleep/appetite/cognition) and associated anxiety/irritability/somatic complaints.
- Restore function: return to work/school/caregiving, improve self-care and relationships.
- Prevent suicide/self-harm: routine risk checks, safety plan, rapid crisis response.
- Prevent relapse/recurrence: continue therapy through continuation/maintenance phases; address precipitating factors; support adherence.
- Minimize side effects: choose well-tolerated options; monitor and manage adverse effects.
- Promote long-term wellness: exercise, nutrition, sleep hygiene, stress management, skills for resilience.
- Manage comorbidities & adherence: treat coexisting medical/psychiatric conditions; reinforce medication and therapy adherence.

MANAGEMENT PRINCIPLES

- Patient-centred & personalized: align to preferences, goals, and context.
- Stepped care: match treatment intensity to severity; escalate/de-escalate promptly.
- Holistic: address psychological, physical, and social needs.
- Evidence-based & consistent: standardized protocols across primary, secondary, tertiary care.
- Systems focus: ensure continuity, use available resources, and close workforce/infrastructure gaps.

APPROACH TO MANAGEMENT OF DIFFERENT TYPES OF DEPRESSION

Management must be tailored to severity, subtype, comorbidities, and patient-specific factors such as age, pregnancy status, medical illness, and treatment preferences. A stepped-care model ensures that interventions are proportional to clinical need while optimizing resource use.

Mild Depression

1. Psychoeducation about depression, treatment options, and recovery expectations.
2. Lifestyle interventions: Regular exercise, healthy diet, adequate sleep, avoidance of alcohol and drugs.
3. Structured self-help (e.g., guided CBT workbooks, digital tools where available).
4. Problem-solving therapy or brief counselling sessions at primary care level.
5. Pharmacotherapy is usually not indicated unless symptoms persist >6–8 weeks, worsen, or there is a history of recurrent depression.

Moderate Depression

1. Structured psychotherapy (Cognitive Behavioural Therapy [CBT], Interpersonal Therapy [IPT]) if available.
2. Antidepressants (SSRIs preferred: e.g., sertraline, fluoxetine, escitalopram) when psychotherapy is not available or patient prefers medication (see below Pharmacological therapy)
3. Combination Therapy is recommended if psychosocial stressors are significant or partial response with monotherapy.
4. Initial review within 2 weeks of starting medication to monitor response and side effects.

Severe Depression (Without Psychosis)

1. First-line: Combination of antidepressant medication and psychotherapy. Intensive follow-up and safety monitoring.
2. Inpatient Care: Consider if high suicide risk, severe functional impairment, or inability to self-care. Treat using Modified ECT for high-risk suicide cases.

Severe Depression (With Psychotic Features)

1. Combination of an antidepressant and an antipsychotic (e.g., SSRI + olanzapine) or Modified ECT if urgent response required.
2. Urgent transfer to tertiary care with psychiatric facilities.

Atypical Depression

(Hypersomnia, increased appetite, mood reactivity)

1. SSRIs (if specialist available).
2. Emphasize behavioural activation.

Persistent Depressive Disorder (Dysthymia)

1. Long-term psychotherapy (CBT, IPT) often combined with antidepressants.
2. Focus on gradual functional improvement.

Depression in Special Populations

a. Children & Adolescents :

- Use of play techniques for younger children is recommended.
- Prefer psychotherapy first-line; SSRIs (fluoxetine) only if severe or unresponsive, with close monitoring for suicidality.
- Comorbidity is common, especially with anxiety disorders, ADHD, conduct disorders, and others.

b. Pregnancy & Postpartum

- Mild: Psychotherapy preferred.
- Moderate–Severe: SSRIs (sertraline preferred for pregnancy/lactation). Avoid paroxetine during pregnancy due to teratogenic risk.

b. Older Adults

- Start with lower medication doses; avoid tricyclic antidepressants where possible due to cardiac and anticholinergic risks.
- Consider comorbid cognitive impairment in treatment planning.

DEPRESSION MANAGEMENT

Type	Key Actions
Mild	■ Psychoeducation. ■ Lifestyle changes (exercise, diet, sleep, avoid alcohol/drugs). ■ Self-help or brief counselling. ■ Consider SSRIs only if persistent/worsening >6–8 weeks, history of recurrence, or patient preference
Moderate	■ Psychotherapy (CBT/IPT). ■ SSRIs if therapy unavailable/preferred. ■ Review at 2 weeks.
Severe (No Psychosis)	■ Antidepressant + psychotherapy. ■ Inpatient if suicide risk or poor self-care. ■ Modified ECT for acute suicidality or treatment resistant. .
Severe (With Psychosis)	■ Antidepressant + antipsychotic (olanzapine, risperidone, quetiapine). ■ ECT if urgent. ■ Refer to tertiary care.
Atypical (hypersomnia, increased appetite, mood reactivity)	■ SSRI (if specialist available). ■ Focus on behavioural activation.
Persistent (Dysthymia)	■ Long-term psychotherapy + antidepressants (if needed). ■ Gradual functional improvement.
Children & Adolescents	■ Psychotherapy first-line. ■ Fluoxetine if severe or unresponsive, with close monitoring. ■ Sertraline if fluoxetine is not tolerated. ■ Close monitoring for suicide risk. ■ Common comorbidities include anxiety, ADHD, conduct disorders.
Pregnancy & Postpartum	■ Mild: Psychotherapy. ■ Moderate–severe: Sertraline preferred. ■ Avoid paroxetine (teratogenic risk). ■ Monitor mother and infant, consider lactation safety.
Older Adults	■ Start with low doses, titrate slowly. ■ Prefer SSIs (sertraline, citalopram, escitalopram), avoid TCAs. ■ Screen for cognitive impairment. ■ Monitor for hyponatremia, cardiac issues (QT prolongation), polypharmacy

PHARMACOLOGICAL THERAPY

Pharmacological treatment is indicated for moderate-to-severe depression, depression with significant functional impairment, high relapse risk, or when non-drug measures fail in mild cases. Choice of drug depends on patient profile, side-effect tolerance, comorbidities, drug availability, and cost.

Indications for pharmacological therapy include:

- Moderate or severe depressive episode (with or without psychotic features).
- Recurrent depression.
- Chronic depression (persistent depressive disorder).
- Depression in high-risk patients (postpartum depression, comorbid chronic illness).
- Depression associated with suicidal risk where rapid improvement is required (may combine with other measures).

Antidepressants and their dose, and cautions

Domain	Drug Name	Starting Dose	Usual Dose Range	Route	Key criteria / pearls
First line					
SSRIs	Sertraline	25–50 mg/day	50–200 mg/day	Oral	Preferred for most patients; safe in cardiac disease and pregnancy; GI upset common initially.
	Fluoxetine	10–20 mg/day	20–60 mg/day	Oral	Long half-life; useful in poor adherence; may cause activation or insomnia, minimal withdrawal issues .
	Escitalopram	5–10 mg/day	10–20 mg/day	Oral	Well-tolerated; monitor QT interval in cardiac patients, lower risk of drug interaction.
SNRIs	Venlafaxine XR	37.5–75 mg/day	75–225 mg/day	Oral	Useful in depression with neuropathic pain; monitor BP; withdrawal symptoms if abrupt stop.
Second line (Specialist -initiated options					
NaSSA (noradrenergic & specific serotonergic antidepressant)	Mirtazapine	7.5–15 mg at night	15–45 mg at night	Oral	Sedating (more at lower doses); good for insomnia, anxiety, poor appetite/weight loss. Low sexual side-effects. Weight gain/increased appetite, dry mouth, dizziness; rare neutropenia (seek care if fever/sore throat). Use caution in obesity, diabetes, hyperlipidemia; avoid with MAOIs; taper when stopping.

Tricyclic Antidepressants (TCAs)	Amitriptyline,	10–25 mg at night	75–150 mg/day (max 300)		Sedation, anticholinergic effects, orthostasis; QT prolongation/cardiotoxic in overdose—avoid in recent MI/arrhythmias, glaucoma, urinary retention; ECG if cardiac risk; lethal in overdose—limit quantity. Useful for neuropathic pain/migraine prophylaxis.
	Nortriptyline	25 mg at night	50–150 mg/day		Less anticholinergic than amitriptyline but same class risks (arrhythmia/QT, overdose toxicity); monitor levels/CYP2D6 interactions if available; consider ECG with cardiac risk. Useful for neuropathic pain.

Duration of Treatment

- First episode: Continue for at least 6–12 months after full remission.
- Recurrent depression: Consider maintenance for ≥2 years; longer if high relapse risk.
- Taper gradually over 2–4 weeks to avoid withdrawal.

Cautions & Monitoring

- Assess for bipolar disorder before starting (antidepressants alone can trigger mania).
- Monitor for emergence of suicidal thoughts, especially in first 2–4 weeks.
- Regularly check BP (SNRIs), weight, and metabolic profile if on long-term therapy.
- In pregnancy, avoid paroxetine; in lactation, sertraline preferred.

PSYCHOTIC DEPRESSION

In case of persistent psychosis or inadequate response after 2–4 weeks on antidepressant

1. Antidepressant + antipsychotic combination (e.g., Fluoxetine + Olanzapine; sertraline + Olanzapine 2.5-5 mg; Aripipazole 2–5 mg once daily (morning if activating); increase by 2–5 mg every 3–7 days based on response/tolerability; Usual effective range: 5–10 mg/day and ceiling for augmentation: 15 mg/day (higher doses rarely help mood and raise akathisia risk). Caution: Elderly / sensitive patients: start 1–2 mg/day.

   Reassess: by **2–4 weeks;** if no clear benefit by 6 weeks at 10–15 mg, rethink plan.During therapy watch for weight, waist, fasting glucose, lipids (baseline, 3 months, then 6–12 monthly), somnolence, anticholinergic effects; Extrapyramidal symptoms (EPS) at higher doses.

Cautions: diabetes risk, metabolic syndrome; avoid in uncontrolled metabolic disease; consider prolactin if symptomatic. Taper after remission of psychosis (typically maintain 4–6 months), taper slowly while maintaining antidepressant.

2. If no response, mood still depressed, **add lithium** (or T3 if lithium not suitable).

   Lithium augmentation is used for refractory or recurrent depression and for suicide prevention. Start 300 mg at bedtime (HS) and titrate using serum levels to a trough of 0.6–0.8 mmol/L; give by mouth (PO) and consider long-term use in selected patients. Monitor renal and thyroid function regularly, check levels 5–7 days after dose changes, and counsel on hydration and consistent salt intake. Target serum 0.6–0.8 mmol/L for augmentation (check 5–7 days after dose change, 12-hour trough). Watch for toxicity (tremor, diarrhea, ataxia, confusion). Important drug interactions include nonsteroidal anti-inflammatory drugs (NSAIDs) and angiotensin-converting enzyme inhibitors (ACE inhibitors/ACEi), which can raise lithium levels; review other nephrotoxic or sodium-depleting agents before prescribing.

   Thyroid hormone (T3, liothyronine) augmentation in case of incomplete response to antidepressant ± antipsychotic, especially low-normal thyroid function or prior good response to T3. **Dose:** start 12.5–25 mcg daily; usual dose 25–50 mcg/day; give in morning. It can speed response and enhance energy/drive. **Monitor** baseline and 4–6 week TSH and free T4; watch for palpitations, anxiety, sweating, weight loss.

   Cautions: ischemic heart disease, arrhythmias, osteoporosis risk (use lowest effective dose, add calcium/vitamin D if needed).

   If TSH suppresses: reduce dose or stop.

3. Modified ECT for severe, suicidal or treatment-resistant cases.

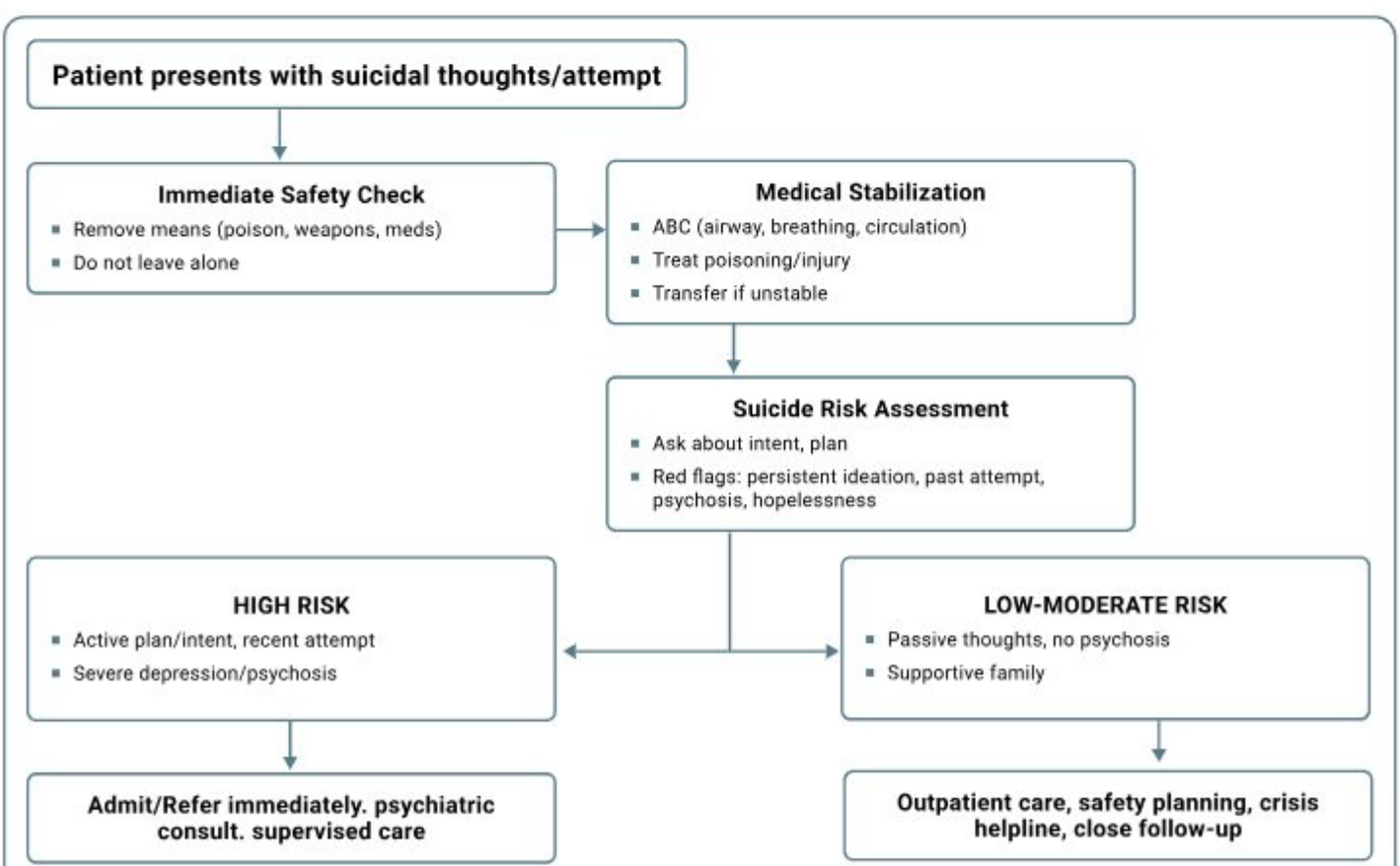
Follow-up

- Review every 1–2 weeks during titration; track PHQ-9 (or equivalent), psychosis rating, sleep, weight/BMI, labs as above.
- Maintain remission for at least 6–12 months before cautious de-escalation; relapse risk is high—step down one agent at a time with close monitoring.

Step	Intervention	Typical Doses / Notes	Monitoring & Cautions
1. Antidepressant + Antipsychotic	• SSRI + antipsychotic (e.g., Fluoxetine + Olanzapine; Sertraline + Olanzapine 2.5–5 mg; Aripiprazole 2–5 mg/day)	• Titrate antipsychotic 2–5 mg every 3–7 days • Usual effective range: 5–10 mg/day • Ceiling: 15 mg/day; start 1–2 mg/day in elderly / sensitive patients	• Weight, waist circumference, fasting glucose, lipids (baseline, 3 months, then 6–12 monthly) • EPS, sedation, anticholinergic effects • Metabolic syndrome, diabetes risk • Consider prolactin if symptomatic

2. Augmentation if partial / no response	Lithium	• Start 300 mg HS; titrate to trough 0.6–0.8 mmol/L • Long-term use possible in selected patients	• Serum levels 5–7 days after dose change • Renal and thyroid function • Watch for tremor, diarrhea, ataxia, confusion • Interactions: NSAIDs, ACEi, nephrotoxic drugs
	Thyroid hormone (T3 / liothyronine)	• Start 12.5–25 mcg AM; usual 25–50 mcg/day	• Baseline and 4–6 week TSH / free T4 • Watch for palpitations, anxiety, sweating, weight loss • Caution in ischemic heart disease, arrhythmias, osteoporosis
3. Modified ECT	For severe, suicidal, or treatment-resistant psychotic depression	• Specialist-administered; frequency and sessions individualized	• Cardiac monitoring, anesthesia risk assessment; usually inpatient; effective in urgent/high-risk cases
Follow-up	• Review every 1–2 weeks during titration	• Track PHQ-9 or equivalent, psychosis rating, sleep, weight/BMI, labs	• Maintain remission ≥6–12 months before taper • Step down one agent at a time due to high relapse risk

HANDLING SUICIDAL PATIENTS



Risk Level	Clinical Features	Action
Low Risk	Passive suicidal thoughts, no plan, intact judgment, supportive family	Outpatient management; safety planning; crisis helpline numbers; close follow-up within 1 week
Moderate Risk	Thoughts of death, vague plans, no immediate intent, mild functional impairment	Psychiatric referral within days; safety plan with family; initiate/adjust antidepressants; schedule follow-up in ≤3 days
High Risk	Active suicidal intent, specific plan, recent attempt, severe depression/psychosis, social isolation	**Immediate psychiatric referral/ admission**; constant supervision; restrict means; initiate treatment under specialist
Emergency	Imminent intent, violent attempt, refusal of food/fluids, catatonia, severe agitation	**Stabilize in ER/PICU/ICU**; airway/ABC; treat poisoning/injury; urgent transfer to facility with psychiatric emergency care

Essential Reminders

- Always ask directly about suicide → it reduces risk, not increases it.
- Never leave a high-risk patient unattended.
- Document risk assessment, actions taken, and family counselling.
- Provide helpline/crisis numbers on the back of the card.

MODIFIED ELECTROCONVULSIVE THERAPY (ECT)

Modified Electroconvulsive Therapy (ECT)

Indications

- Severe depression with suicidality or psychotic features not responding to pharmacotherapy
- Treatment-resistant depression (≥2 failed adequate antidepressant trials)

- Catatonia of any cause
- Severe mania or schizophrenia with poor response to medications
- Urgent, life-threatening states (refusal to eat/drink, very high suicide risk, malignant catatonia)

Procedure

- Pre-assessment: Detailed psychiatric evaluation, medical history, physical exam, ECG, labs (including electrolytes), and anesthesia clearance.
- Conducted under general anesthesia with muscle relaxation (modified ECT).
- Induction: Short-acting anesthetic (e.g., methohexital, propofol) and succinylcholine (muscle relaxant).
- Electrode placement: Bilateral (more effective, higher cognitive risk) or unilateral (fewer cognitive effects).
- Seizure induction with brief-pulse current; monitored using EEG and observation.
- Sessions: Requires 6–12 sessions, 2–3 times per week, individualized per response.
- Post-procedure: Monitor vitals, airway, orientation, and mental status until full recovery.

Cautions

- Use with caution in patients with cardiovascular disease (recent MI, uncontrolled hypertension, arrhythmia), raised intracranial pressure, cerebrovascular disease, pulmonary disease, or high anesthetic risk.
- Avoid unnecessary CNS depressants that raise seizure threshold.
- Monitor cognitive side effects (confusion, memory impairment) and adjust frequency/technique as needed.
- Informed consent is essential; if capacity is lacking, follow legal/guardian protocols.

Facilities Where modified ECT Should Be Undertaken

- Secondary and Tertiary Care Hospitals equipped with:
  - Operating theatre or designated ECT suite
  - Anesthesia support and resuscitation facilities
  - EEG monitoring capability (desirable but not mandatory)
  - Recovery area with trained nursing staff
- Should **NOT** be administered in primary care or facilities without anesthesia backup and emergency care.

By Whom

- **Psychiatrist**: Responsible for indication, consent, electrode placement, and monitoring response.
- **Anesthesiologist**: Administers anesthesia, muscle relaxants, manages airway, monitors vital signs.
- **Nursing staff**: Support during procedure, maintain IV line, monitor recovery, provide post-ECT care.
- **Multidisciplinary Team**: Includes psychiatrist, anesthetist, trained nurses, and where available, psychologist for post-ECT support.

NON-PHARMACOLOGICAL INTERVENTIONS

Non-drug approaches form the foundation of depression management across all severity levels, either as standalone treatments in mild cases or in combination with pharmacotherapy for moderate-to-severe depression. In the areas where access to specialist psychiatric care is limited, these interventions are vital for early recovery and relapse prevention.

Category	Intervention	Purpose / core elements	Practical notes
Psychotherapy	Cognitive behavioral therapy (CBT)/ If CBT is not available, practical psychotherapy options can be exercised (see anxiety disorders).	Structured, goal-oriented therapy to challenge negative thoughts, build coping skills, problem-solve.	Works across severities; in-person or telehealth; set homework and exposure where relevant

	Interpersonal therapy (IPT)	Targets role transitions, interpersonal disputes, and grief	Useful in postpartum depression; time-limited with clear focal areas
	Problem-solving therapy	Teaches a stepwise approach to manage real-life stressors	Short-term; well suited to primary care
Counselling & psychoeducation	Patient/family sessions	Explain depression, recovery timelines, and treatment options; tackle myths and stigma; involve family (with consent)	Improves adherence; give written plans and crisis contacts
Lifestyle interventions	Physical activity	≥150 minutes/week moderate activity to improve mood and sleep	Start gradual; track minutes/steps
	Sleep hygiene	Regular schedule; limit screens before bed; avoid evening caffeine	Pair with relaxation routines
	Nutrition	Balanced diet; more fruits/ vegetables/omega-3; less processed sugar	Consider local, affordable options
	Avoid alcohol/drugs	Prevent symptom worsening and drug interactions	Screen and offer brief intervention/ referral if misuse present
Mind–body approaches	Mindfulness-based cognitive therapy (MBCT)	Prevent relapse in recurrent depression	Group formats feasible; 8-week programs common
	Meditation, yoga, deep breathing	Reduce arousal and rumination	Adapt to cultural context; teach brief daily practices
Social & occupational rehabilitation	Return to work/school	Gradual graded re-entry with accommodations	Coordinate with employer/school
	Skills/vocational support	Build routines, skills, and confidence in long-standing illness	Link to local training and placement services
	Peer support groups	Ongoing motivation and social reintegration	Use community-based groups or moderated online options

CBT COMPONENTS

If specialist mental health professionals are scarce, then train primary care providers, nurses, and community health workers in basic CBT principles

Core CBT Components for Depression

- Behavioral Activation – scheduling rewarding activities to counteract withdrawal.
- Cognitive Restructuring – identifying and challenging unhelpful thoughts.
- Problem-Solving Skills – structured approaches to practical difficulties.

Relapse Prevention – building coping plans and recognizing early warning signs.

Conditional Recommendations for CBT in Depression

1. Task-Shifting and Stepped-Care Delivery

- If specialist mental health professionals are scarce, train primary care providers, nurses, and community health workers in basic CBT principles using structured, manualized protocols.
- If session time is constrained, use brief CBT formats (4–6 structured sessions) on behavioral activation and cognitive restructuring.
- If ongoing supervision is needed, establish tele-mentoring links with regional or international CBT experts for case discussions and skill reinforcement.

---

2. Group-Based CBT

- If individual sessions cannot meet demand, deliver group CBT for patients with mild-to-moderate depression.
- Group work can help reduce stigma, build peer support, and improve cost-effectiveness.
- Use culturally adapted group exercises and maintain confidentiality agreements.

---

3. Digital and Remote CBT

- If in-person services are not feasible (remote islands, transport barriers), offer:
  - Tele-CBT via video or phone
  - Mobile app–based guided CBT and mindfulness programs
  - Printed CBT workbooks with periodic phone or SMS check-ins
- If connectivity is poor, prioritize low-bandwidth or offline solutions.

---

4. Cultural and Linguistic Adaptation

- If standard CBT materials feel unfamiliar, translate into Dhivehi and replace abstract metaphors with locally relevant examples.
- If family involvement is culturally valued, integrate supportive family members in psychoeducation or homework activities.
- Align therapy content with local beliefs, religion, and daily realities.

5. Integration into Primary Care

- If stigma prevents patients from seeking mental health care directly, embed screening (e.g., PHQ-9) and brief CBT-based interventions into general outpatient visits.
- Provide psychoeducation alongside CBT to improve understanding and adherence.

---

6. Prioritization Based on Severity. If resources are extremely limited, prioritize:

- Mild to moderate depression without high suicide risk for primary care–level CBT
- Severe or treatment-resistant depression for specialist or telepsychiatry referral
- Combine CBT with medication in moderate-to-severe cases when possible.

---

7. Core Psychotherapy Modalities to Include

- CBT (12–20 sessions where possible) — restructuring distorted thinking, reducing avoidance, building coping skills.
- Exposure therapy — gradual, safe exposure to feared situations (especially for phobias, panic disorder, and social anxiety).
- Mindfulness-based therapy — meditation, body awareness, reducing rumination.
- ACT (Acceptance and Commitment Therapy) acceptance of anxiety and focus on values-driven living.

8. Telehealth and Digital Support

- If remote supervision or patient support is needed, use:
  - Telepsychiatry networks
  - Regional mental health hubs
  - Digital mood-tracking and guided self-help tools

Depression in children/adolescents (Salient features)

Point prevalence 3–8% in children/adolescents; by late teens 15–20% have had at least one episode. Higher in girls after puberty. Under-recognition is common.

Clinical features

- Core syndrome as in adults: low mood or irritability, anhedonia, sleep/appetite change, fatigue, poor concentration, guilt, suicidality.
- Child/teen specifics: more somatic complaints (headache, stomachache), school refusal, withdrawal, irritability > sadness, decline in grades, risk behaviors or self-harm (teens), family conflict.
- Comorbidities: ADHD, anxiety, autism spectrum, learning disorders; screen for bullying and substance use (adolescents).
- Relies on multi-informant input (child, caregivers, school) and developmental norms; use youth tools (SCARED/RCADS, PHQ-A) in addition to clinician interview.

Management (first line)

- Psychotherapy first for mild–moderate: family-based cognitive behavioral therapy (CBT) or interpersonal therapy for adolescents (IPT-A), plus psychoeducation, sleep and activity routines, and a school plan.
- Medication for moderate–severe, high risk, or CBT non-response: start selective serotonin reuptake inhibitor (SSRI) at low dose and titrate slowly—fluoxetine 10→20–40 mg/day, sertraline 25→50–200 mg/day, or escitalopram 5→10–20 mg/day. Continue 6–12 months after remission, then taper.

- Safety: monitor suicidality at every visit (highest in first 2 months and after dose changes); avoid benzodiazepines; involve caregivers; create a safety plan.
- Treatment emphasis: greater role for family involvement and school accommodations; SSRI use is more cautious (lower starting doses, closer monitoring for activation/suicidality).
- Comorbidity mix: neurodevelopmental disorders and bullying more prominent than in adults.

ASSESSMENT OF RESPONSE

Regular evaluation of treatment response is essential to ensure that depression management is effective, timely adjustments are made, and relapse or deterioration is prevented. Structured follow-up helps overcome challenges of limited specialist availability and ensures continuity across different levels of care.

Domain	Key Points	Red Flag / Warning Signs
Follow-up Schedule	■ First visit within 2 weeks of starting treatment (earlier if high suicide risk). ■ Every 2–4 weeks until remission. ■ Every 1–3 months during maintenance. ■ Remote check-ins possible via teleconsultation or community health workers.	Missed follow-ups, refusal to attend reviews, or worsening symptoms between scheduled visits.
Symptom Severity	Track using PHQ-9 or HAM-D; compare with baseline.	Rapid symptom worsening, severe hopelessness, or inability to carry out daily activities.
Functional Status	Monitor work ability, daily activities, and social engagement.	Sudden collapse in functioning (e.g., inability to self-care, neglect of hygiene, withdrawal from all social contact).
Suicide Risk	Reassess at every visit.	New or escalating suicidal thoughts/attempts, self-harm behaviors, giving away belongings, or expressing intent.
Medication Adherence	Ask about missed doses, side effects, barriers.	Stopping medicines abruptly, misuse/overdose, or refusing all treatment.
Side Effects & Tolerability	Watch for adverse drug reactions.	Severe adverse effects – serotonin syndrome, liver toxicity, allergic rash, or excessive weight/metabolic change.
Comorbidities	Screen for diabetes, thyroid disorders, other chronic diseases.	New-onset psychotic symptoms (hallucinations, delusions), severe agitation, aggression, or violence risk.
Step-Up Criteria	<25% improvement after 4–6 weeks, persistent functional decline, intolerable side effects.	Non-response to 2 adequate treatment trials; needs urgent specialist review.
Step-Down Criteria	Remission ≥6 months, functional recovery, stable environment.	Relapse during taper or rapid deterioration after dose adjustment.

Note: In resource limited settings where psychiatric review is not immediately available, primary care providers should use standardized treatment protocols and escalate via referral pathways. Patient-held treatment cards can bridge information gaps during transfers between islands or facilities.

PROGNOSIS AND PROGRESSION

Depression is a treatable condition, and with timely, evidence-based management, most individuals can achieve full remission and return to their previous level of functioning. Prognosis is influenced by the severity at presentation, adherence to treatment, presence of comorbidities, availability of psychosocial support, and timely access to appropriate care.

Aspect	Key Points
Treatment Response	■ Mild–moderate depression: Most recover in 3–6 months with treatment. ■ Severe depression: Often needs prolonged therapy, combination approaches, and closer follow-up due to high relapse risk.
Recurrent Depression	■ Higher likelihood of future episodes with each recurrence. ■ Risk increases if treatment is delayed or inadequate.
Predictors of Recovery	■ **Positive**: Early diagnosis, strong social support, treatment adherence, no major comorbidities. ■ **Negative**: Delayed treatment, diabetes, cardiovascular disease, ongoing psychosocial stressors, poor adherence, substance misuse.
Chronicity & Relapse	■ Without treatment, up to 20% become chronic.• Relapse: ~50% within 5 years after first episode, 80–90% after ≥3 episodes if no maintenance therapy. ■ Subthreshold symptoms increase relapse risk.
Functional & Health Impact	■ Leads to functional decline, low productivity, strained relationships, social withdrawal, suicide risk. ■ Worsens comorbidities such as cardiovascular and metabolic disorders.
Health System Factors	■ Limited specialist access prolongs untreated episodes and increases chronicity risk. ■ Tiered care pathways, training primary care workers, telepsychiatry, and community-based initiatives improve outcomes.

Note: Limited access to mental health professionals can prolong untreated episodes and raise the risk of chronicity. Implementing tiered care pathways, training primary care workers in early detection and follow-up, and integrating telepsychiatry. With community-based mental health initiatives, it can significantly improve long-term outcomes.

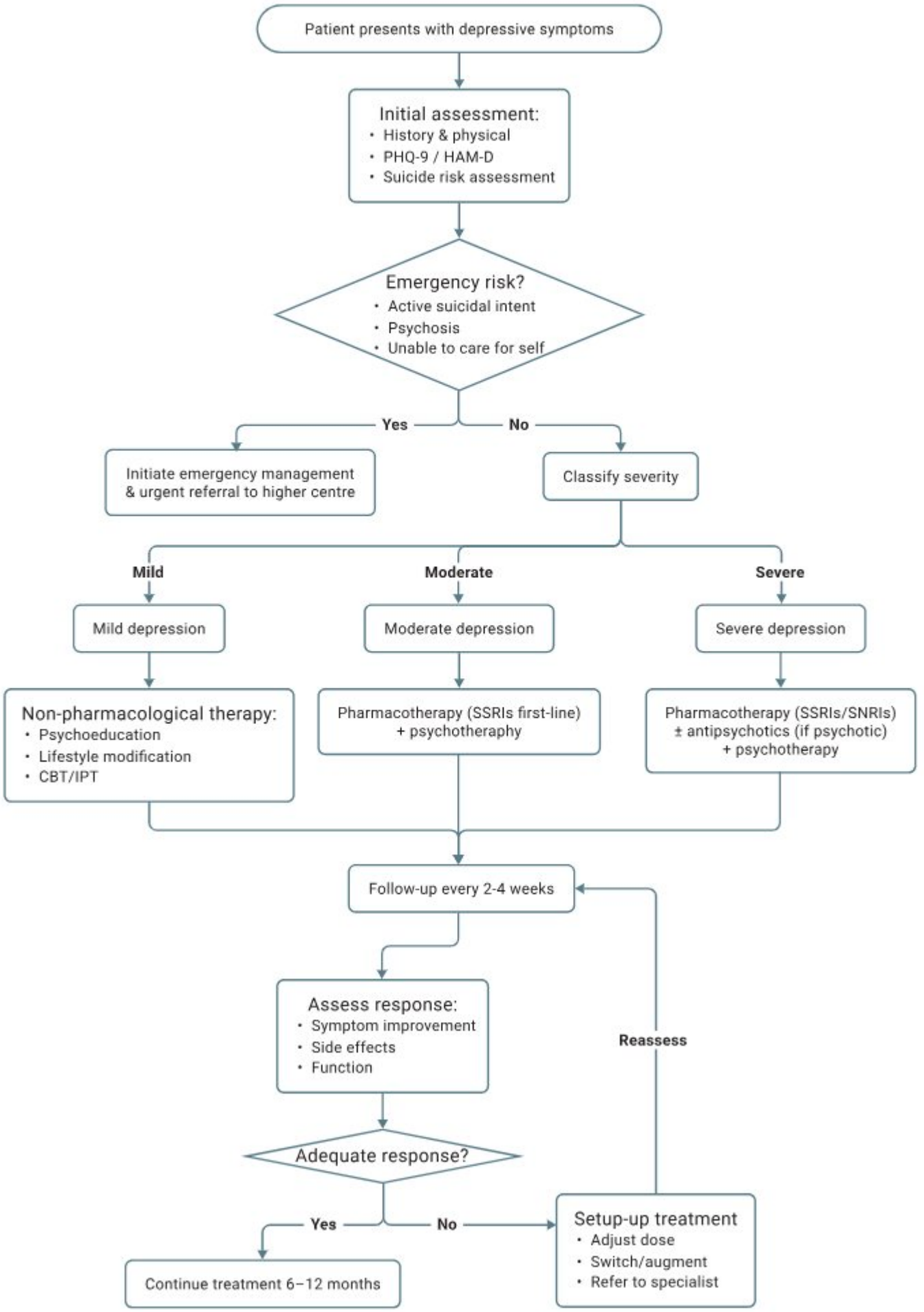
REFERRAL FOR SPECIALIST CONSULTATION OR TO TERTIARY CARE

A tiered referral approach ensures that patients with depression receive the right level of care while optimizing the use of limited specialist resources. Referral decisions should consider severity, complexity, comorbidities, and available infrastructure at each healthcare level.

Referral Pathway for Depression: Primary → Secondary → Tertiary Care

Level of Referral	Indications
From Primary to Secondary Care	■ Moderate–severe depression not improving after 4–6 weeks of primary care management. ■ Suicidal ideation or recent suicide attempt needing close monitoring. ■ Complex comorbidities complicating pharmacological care (e.g., diabetes, cardiac disease, epilepsy). ■ New-onset depression in pregnancy or postpartum with functional impairment. ■ Presence of psychotic features (delusions, hallucinations).
From Secondary to Tertiary Care	■ Treatment-resistant depression (≥2 failed adequate antidepressant trials with/without psychotherapy). ■ Severe depression with persistent suicidal intent or high-risk behaviours requiring inpatient admission. ■ Catatonia or severe psychomotor retardation. ■ Need for advanced therapies not available at lower levels (modified ECT, TMS). ■ Severe psychiatric comorbidity (bipolar disorder, schizophrenia) requiring multidisciplinary input. ■ Forensic psychiatry evaluation.
Emergency Referral (to nearest psychiatric-capable facility)	■ Imminent suicide risk. ■ Severe or rapidly worsening psychotic depression. ■ Inability to maintain hydration/nutrition due to depressive symptoms. ■ Acute behavioural disturbance posing risk to self/others. ■ Immediate stabilization and urgent transfer required.
Infrastructure & Process Considerations	■ Geographic isolation and transport delays: prioritize interim safety (suicide risk monitoring, crisis intervention, medication initiation). ■ Use standardized referral forms including diagnosis & severity, medications tried and response, medical history & investigations, suicide risk assessment. ■ Encourage patient-held records for continuity across facilities.

Management algorithm for depression



COMPLICATIONS

Untreated or inadequately managed depression can lead to a wide range of medical, psychiatric, and social consequences, many of which have lasting impacts on quality of life, productivity, and overall health.

Complication	Management and Prevention Strategies
Psychiatric	
Suicide & Self-Harm	Screen for suicidal ideation routinely, initiate urgent psychiatric intervention, restrict access to means, involve family/caregivers, ensure crisis helpline access. Prevention: early treatment of depression, continuous follow-up, adherence monitoring.
Chronic Depression	Early, adequate treatment of first episode, maintenance therapy in high-risk cases, psychotherapy for relapse prevention, lifestyle modification.
Treatment Resistance	Optimize dosage/duration, switch or combine antidepressants, add psychotherapy (CBT, IPT), consider ECT or newer options (TMS, ketamine in select cases). Prevention: early aggressive treatment in severe cases, avoid undertreatment.
Substance Misuse	Screen for alcohol/drug use, provide de-addiction support, integrate dual-diagnosis management. Prevention: psychoeducation on risks, healthy coping strategies.
Medical	
Cardiovascular Disease	Screen for risk factors, encourage exercise, smoking cessation, manage hypertension/diabetes. Prevention: lifestyle modification, adherence to cardiac medications.
Metabolic Disorders	Monitor glucose, lipids, weight; encourage diet control, physical activity. Prevention: regular health check-ups, early treatment of metabolic syndrome.
Impaired Immunity	Vaccinations (influenza, pneumococcal), infection control, stress management techniques. Prevention: optimize nutrition, reduce chronic stress burden.
Poor Adherence to Medical Treatment	Simplify regimens, use reminders, involve caregivers, provide counseling. Prevention: strengthen doctor-patient communication, address depression early.
Psychosocial & Functional	
Occupational Impact	Workplace accommodations, stress management programs, early return-to-work interventions. Prevention: timely treatment, vocational rehab.
Relationship Strain	Couple/family therapy, caregiver support groups, open communication. Prevention: early recognition of irritability and withdrawal.
Educational Disruption	School counseling, academic support, flexible schedules. Prevention: early school-based mental health screening and support.
Reduced Quality of Life	Psychotherapy, community engagement, focus on hobbies and physical activity. Prevention: early treatment and psychosocial rehabilitation.
Context-Specific	
Geographic Isolation	Telepsychiatry, mobile health clinics, community health workers. Prevention: strengthen rural mental health programs.
Stigma	Public awareness campaigns, peer support networks, integration of mental health into primary care. Prevention: normalize mental health conversations.
Economic Impact	Health insurance coverage, government schemes, community-based rehabilitation. Prevention: policy-level support for mental health care.

PREVENTION AND HEALTH PROMOTION

Depression prevention requires a combination of population-level strategies and targeted interventions for high-risk groups, with the aim of reducing incidence, delaying onset, and minimizing severity through mental health promotion, early detection, and timely intervention in line with the WHO *Mental Health Gap Action Programme (mhGAP) Implementation Guide*.

Level of Prevention	Key Strategies
Primary Prevention	■ School- and community-based awareness to reduce stigma, promote emotional regulation, and normalize help-seeking. ■ Encourage healthy lifestyles: physical activity, balanced diet, adequate sleep, reduced alcohol/ substance use. ■ Build resilience via coping skills, stress management, and problem-solving training, especially in youth. ■ Workplace mental health policies: flexible schedules, anti-bullying measures, employee assistance programmes. ■ Public education campaigns (print, electronic, online) to raise awareness, reduce stigma, and promote early help-seeking.
Secondary Prevention	■ Early detection with validated tools (e.g., PHQ-9) in primary care, maternal clinics, and chronic disease management. ■ Monitor high-risk groups (chronic illness, perinatal women, family history, prior episodes). ■ Rapid referral pathways for specialist care.
Tertiary Prevention	■ Prevent recurrence with adherence to pharmacotherapy or psychotherapy. ■ Rehabilitation services for reintegration into work, education, and community. ■ Peer support and self-help groups to reduce isolation and maintain wellness.
Cross-cutting / System-level Strategies	■ Use telepsychiatry to extend specialist services to remote areas. ■ Engage community health workers and trained nurses in education, screening, and follow-up. ■ Integrate mental health promotion within NCD programmes under the Maldives National Mental Health Policy.

PATIENT EDUCATION

Patient education in depression aims to empower individuals and their caregivers with the knowledge, skills, and confidence to actively participate in recovery, prevent relapse, and maintain long-term mental well-being.

- Explain that depression is a medical illness, not a personal weakness. Describe common symptoms and how they may affect mood, behaviour, and physical health. Clarify the chronic and relapsing nature of depression, stressing the importance of ongoing management.

- Explain the role of medications (e.g., antidepressants) and psychotherapy in recovery. Emphasize the importance of taking medications as prescribed and not stopping abruptly. Highlight possible side effects, what to expect, and when to seek medical advice.
- Teach stress management techniques (deep breathing, relaxation, mindfulness). Encourage regular exercise, healthy diet, and adequate sleep. Guide on recognizing early warning signs of relapse and seeking timely help.
- Encourage open communication with family and friends. Promote participation in support groups and community activities. Involve caregivers in monitoring progress and medication adherence.
- Provide culturally appropriate information to reduce stigma in communities. Counter myths that depression is solely due to "weak willpower" or "laziness".

Instructions to the Patient/Caregiver

Do	Don't
Understand that depression is treatable; recovery is possible with support.	Treat depression as a personal weakness or failure.
Give treatment time—symptoms may improve after several weeks.	Expect instant results or stop early if you don't feel better right away.
Take medicines exactly as prescribed; report side effects early.	Skip doses, stop suddenly, or self-adjust doses.
Attend all follow-ups so treatment can be adjusted.	Miss appointments or avoid lab/monitoring checks.
Keep a regular sleep schedule (aim 7–8 hours).	Stay up late, oversleep, or keep irregular sleep patterns.
Be active daily (walk, swim, light exercise).	Be sedentary or avoid activity entirely.
Eat a balanced diet; hydrate well.	Rely on processed foods or extreme diets.
Avoid alcohol and drugs; they worsen depression and interact with meds.	Use alcohol/drugs to cope with symptoms.
Watch for relapse signs (low mood, loss of interest, sleep/appetite change).	Ignore early warning signs or isolate from others.
Seek immediate help for suicidal thoughts (helpline/ER/trusted person).	Keep suicidal thoughts secret or delay seeking help.
Caregivers: support adherence, provide structure, and encourage routine.	Nag/blame or take over all responsibility—work with the patient.
Caregivers: learn early relapse signs; act promptly.	Delay help or dismiss concerns; allow unsafe environments.

REFERENCES

1. World Health Organization. *Depression and other common mental disorders: global health estimates*. Geneva: WHO; 2017. Available from: https://apps.who.int/iris/handle/10665/254610

2. World Health Organization, Regional Office for South-East Asia. *Regional mental health action plan 2023–2030*. New Delhi: WHO SEARO; 2023. Available from: https://www.who.int/india/publications/i/item/9789290229893

3. Ministry of Health, Republic of Maldives. *National Mental Health Strategic Action Plan 2025–2029*. Malé: Ministry of Health; 2022. Available from: https://health.gov.mv/storage/uploads/7wzEkvoW/bwjwjfot.pdf

4. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 5th ed, text revision (DSM-5-TR). Washington (DC): American Psychiatric Association; 2022.

5. National Institute for Health and Care Excellence. *Depression in adults: treatment and management*. NICE guideline NG222. London: NICE; 2022. Available from: https://www.nice.org.uk/guidance/ng222

6. World Health Organization. *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings*. Version 2.0. Geneva: WHO; 2016. Available from: https://www.who.int/publications/i/item/9789241549790

7. Ministry of Health, Republic of Maldives. *National noncommunicable disease (NCD) action plan 2023–2031*. Malé: Ministry of Health; 2023. Available from: https://health.gov.mv

8. Cuijpers P, Karyotaki E, Weitz E, Andersson G, Hollon SD, van Straten A. *The effects of psychotherapies for major depression in adults on remission, recovery, and improvement: a meta-analysis*. *J Affect Disord*. 2014;159:118–126. doi:10.1016/j.jad.2014.02.026

9. Malhi GS, Bell E, Bassett D, Boyce P, Bryant R, Hazell P, et al. T*he 2023 Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders*. Aust N Z J Psychiatry. 2023;57(2):142–244. doi:10.1177/00048674231157523

10. Patel V, Chatterjee S, Chowdhary N, Rahman A, Verdeli H, Kirkwood BR, et al. *Efficacy of a lay health worker-led intervention for depressive and anxiety disorders in primary care: a cluster randomized controlled trial in Goa, India. Lancet. 2010*;376(9758):2086–2095. doi:10.1016/S0140-6736(10)61508-5

11. Grover S, Avasthi *A. Clinical practice guidelines for the management of depression in children and adolescents*. Indian J Psychiatry. 2019;61:226–240.

12. Gautam S, Jain A, Gautam M, Vahia VN, Grover S. *Clinical practice guidelines for the management of depression*. Indian J Psychiatry. 2017;59:34–50.

13. Grover S, Avasthi A. Clinical practice guidelines for the management of depression in children and adolescents. Indian J Psychiatry 2019; 61:226-40.

14. Gautam S, Jain A, Gautam M, Vahia VN, Grover S. Clinical Practice Guidelines for the management of Depression. Indian J Psychiatry 2017; 59:34-50.

15. Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders. Geneva: World Health Organization; 2023, https://iris.who.int/bitstream/handle/10665/374250/9789240084278-eng.pdf?sequence=1