



Interpreting a MAP Report

The MAP is a computerised assessment based entirely on patient self-report and as such it may be necessary to clarify detail in the clinical setting. The MAP Report recommendations should always be used in conjunction with clinical assessment.

A guide to the content of a MAP Report:

Page 1: The first page of the report is a page of general information containing an overview of the MAP and explanation of the terms used in the report. It is not patient specific.

Page 2: Here the report becomes patient specific with demographic information about your patient and some general information about the patient's current episode and history under the headings:

- Depression severity
- Overall functioning
- Depression history
- Background factors (family history , lifestyle factors and medical issues)

Explanatory notes in each section provide additional information to help you interpret the scores.

DMI-10 Score	30
Functioning Score (out of 24)	2
<6	- No or minimal impairment
6 to 12	- Moderately impaired functioning
Above 12	- Severely impaired functioning
Age at first episode of depression	10
Duration of current episode	2 weeks

Page 3: This describes the most characteristic symptoms of your patient's depression. This algorithm provides insight into whether the depression is most likely *melancholic* or *non-melancholic*.

**Diagnostic algorithm of prototypic symptom profile
favours a sub-typing diagnosis of**

Probable non-melancholic depression

Page 4: There are 3 sections here which answer the following questions:

- Is this illness likely to be part of a Bipolar Disorder?
- Are there any psychotic features?

The sample MAP report data in this document are fictitious

- Is there evidence of an underlying anxiety disorder?

Unipolar or bipolar lifetime course	Probable unipolar
Duration of longest 'high'	N/A
Ever hospitalised for a 'high'	N/A
Ever experienced delusions and/or hallucinations during a 'high'	N/A

Lifetime Occurrence, Age of Onset and Impairment Severity

Social Phobia	Yes +	20	(Moderate)
Generalised Anxiety Disorder	No		
Obsessive Compulsive Disorder	No		
Panic Disorder	Yes +	50	(Not Impaired)
Agoraphobia	Yes +	14	(Not impaired)
Post Traumatic Stress Disorder	Yes	99	(Moderate)

(+ indicates condition also present during current episode, with self-reported impairment severity indicated in brackets)

Page 5 records past and current medical conditions and stressful events in the last 12 months as well as across the patient's lifetime.

Stressful Events over Lifetime and their impact on depressive episode(s).

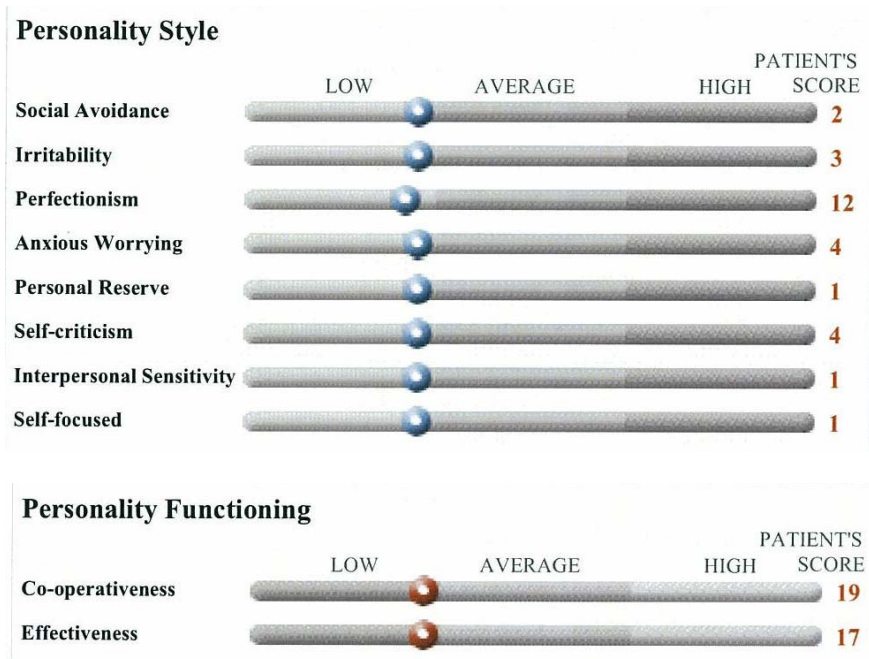
No Impact	Some Impact	Significant Impact	
			Had problems in close relationship

Page 6 is a summary of past and current treatments.

Antidepressant Medication Adherence (during the past week)	High
Current Psychological Therapies	None recorded
Current Herbal Therapies	Vitamin

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Page 7 displays the results of personality testing identifying aspects of personality that may have made this patient vulnerable to depression. This information will be helpful in guiding non-pharmacological interventions.



The final page of the MAP report provides generalised treatment guidelines according to depression sub-type, including recommendations in general terms to guide appropriate prescribing.

It should be remembered that the report is only intended as a tool to guide treatment planning. It is based entirely on patient self-reporting and it may be necessary to clarify detail in the clinical setting. The MAP Report recommendations should always be used in conjunction with clinical assessment.

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