1 Background information & depression facts

Quick info:

Scope:
• assessment and management of depression in adults
• covers primary and secondary care management
• gives special consideration to depression in pregnancy, breastfeeding and the perinatal period
• covers pharmacological and psychosocial treatments
• also covers recommendations regarding physical treatments, including electroconvulsive therapy (ECT)
• gives special consideration to depression in those with a chronic physical condition

Out of scope:
• assessment and management in children and adolescents
• seasonal affective disorder

Definition:
• depression is characterised by:
  • depressed mood and/or loss of pleasure in most activities
  • a range of emotional, cognitive, physical, and behavioural symptoms
• can range in severity from a mild disturbance to a severe illness with a risk of suicide
• severity is determined by:
  • number and severity of symptoms
  • degree of functional impairment

Incidence and prevalence of depression:
• Each year 700,000 Australians experience depression.[1 abs]
• Most patients who seek professional help for depression visit a general practitioner, with more Australians receiving clinical care from a GP than all other health professionals combined.[2]
• It is estimated that GPs in Australia deliver more than 3,500,000 services for depression each year.[3]
• mixed anxiety and depression is the most common mental disorder in a community setting [4]
• depression is the fourth leading cause of disability and disease worldwide [5]
• there is a higher incidence of depression in women than men [6]
• on average, the first episode of major depression occurs in the mid-20s [4]

Prognosis of depression:
• the average length of a depressive episode is 6-8 months [5]
• following their first episode of major depression, at least 50% of people will have at least one more episode [4]
• 50% of people diagnosed with depression still have a diagnosis of depression 1 year later [4]
• at least 10% of people have persistent or chronic depression [4]
• after a second episode, the risk of recurrence increases to 70%; after a third episode, the risk increases to 90% [5]

Risk factors for depression:
• co-morbid psychiatric diagnosis, eg:
  • anxiety
  • social phobia
  • panic and various personality disorders
  • post-traumatic stress disorder (PTSD)
  • obsessive compulsive disorder (OCD)
• a previous history of depression in adulthood
• socio-economic factors, including:
  • poverty
  • homelessness
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- unemployment
- chronic physical illness
- chronic pain syndromes
- family history of depression
- catastrophic life event in the previous 6 months [7]
- chronic life difficulty in the absence of adequate social support [7]
- childhood abuse and/or neglect [7]

Postnatal depression:
- definition:
  - postnatal depression is defined as a non-psychotic depressive illness of mild to moderate severity occurring during the first postnatal year
- incidence:
  - approximately 13% of women have an episode of depression during pregnancy [5]

Risk factors for postnatal depression:
- moderate to strong associations with postnatal depression:
  - past history of psychopathology and psychological disturbance during pregnancy
  - low social support
  - poor marital relationship
  - recent life events
- weak associations with postnatal depression:
  - history of abuse
  - low family income
  - lower occupational status
  - preterm infants

References:
[7] Contributors invited by Map of Medicine; 2011

2 Information resources for patients and carers

Quick info:
Information, support and advice phone list
Two page list of local mental health & social supports.

RESOURCES FOR PATIENTS & CARERS:
Black Dog Institute
Daily Mood Chart
Mindfulness in everyday life

Beyond Blue Fact Sheets
Self Care
Reducing Stress
Relaxation techniques
Healthy eating for people with depression, anxiety and related disorders
Keeping active
Sleeping well
Reducing alcohol and other drugs

Depression- age, gender

Depression and anxiety disorders in women
Older adults- opening up about anxiety & depression

Having the conversation with older people about anxiety and depression

Depression and specific health issues

Anxiety & depression in people who are deaf or hard of hearing
Anxiety, depression & breast cancer
Arthritis, anxiety & depression
Asthma, anxiety and depression
Brain tumours, anxiety and depression
Chronic physical illness, anxiety and depression
Coronary heart disease, anxiety and depression
Dementia, anxiety and depression
Diabetes, anxiety and depression
Epilepsy, anxiety and depression
Incontinence, anxiety and depression
Parkinson's disease, anxiety and depression
Serious injury and anxiety, depression and post-traumatic stress disorder
Testicular cancer, anxiety and depression

Depression & Anxiety after Stroke

Perinatal depression

Understanding perinatal depression and anxiety
Perinatal depression & anxiety- A guide for Health Professionals (4 pages)
Perinatal depression & anxiety: Evidence relating to infant cognitive & emotional development- Health Professionals

"Mind the Bump": www.mindthebump.org.au Free mindfulness meditation mobile phone app.

Treatments

Electroconvulsive Therapy (ECT)
Antidepressant Medication

SANE Australia Fact sheets

SANE Australia ‘Healthy Living’ Fact sheet.
Psychological Treatments
Complementary Therapies

Reach Out

Relaxation training

National Prescribing Service (NPS)

Sleep Right Sleep Tight Fact sheet
Sleep Right Sleep Tight- Sleep Diary

CCI (WA Health) Fact Sheets

Breathing exercise/ Calming technique
Problem Solving Strategies

Better Health Channel Fact sheets

Self Esteem
Parenting- Coping with Stress
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Relationships and Communication
CBT Fact sheet

Mental Health Act- Department of Health & Human Services
MHA Advanced Statement Form
MHA Revocation of Advanced Statement Form
Advanced Statement Flowchart

Community Support Frankston leaflets:
Emergency Accomodation services
Homeless in Frankston: hot meals, showers etc.
Financial assistance
Legal assistance
Drug and alcohol problems
Family Violence support for Women
Strategies to manage your anger- women
Anger management support for men
Support for separated men
Abuse and intervention orders- how to apply

Mindhealthconnect
Mental health and wellbeing information, support and services from Australia’s leading health providers, together in one place. Supported by the Australian Government.

Community Support and Information Centres
Provides limited financial assistance, crisis support, budget support, legal advice, referrals etc.
Southern Peninsula (Rosebud)
Western Port (Hastings)
Frankston Community Support Centre
Mornington Community Support Centre

3 Information resources for health professionals

Quick info:
Information, support and advice phone list
Two page list of local mental health & social supports.

RESOURCES FOR HEALTH PROFESSIONALS
emMHPrac is a DOH funded initiative, providing training to GPs in the use of a suite of e-Mental Health intervention programs, apps and services to support the management of mild to moderate depression and anxiety. Run through th Black Dog Institute.
Depression and E-Mental Health Fact Sheet
New Treatments in Psychiatry: Brain Stimulation (Services run by Alfred Health MAPrc)
Perinatal Psychotropic Medicine Information Service
PPMIS has compiled a range of individual psychotropic medicine profiles, containing specific safety information about pre-pregnancy, during pregnancy and postnatal period. Each psychotropic medicine offers fact sheet to assist health professionals to answer some of the more common questions around psychotropic medicines use during pregnancy and breastfeeding.

4 Updates to this care map

Quick info:
The care map has been updated in line with the following guidelines:
• Medical Journal Australia Open 2012, 1 Suppl 4 Pharmacological treatment approaches to difficult-to-treat depression.
5 Depression - Early detection and clinical presentation

Quick info:

Presenting symptoms of depression include:
- typical presentation at least 2 weeks of:
  - persistent sense of sadness, anxiety or emptiness
  - lack of motivation and interest [1]
  - feelings of hopelessness
  - feelings of worthlessness and/or guilt
  - marked physical slowness or agitation
  - complete lack of reactivity of mood to positive events
  - range of somatic symptoms, such as:
    - appetite and weight loss
    - reduced sleep (pattern of early waking and being unable to get back to sleep)
    - loss of energy or fatigue [1]
  - depression being substantially worse in the morning (diurnal variation)
  - in severe depression, patients may develop psychotic symptoms, eg hallucinations and/or delusions

atypical presentation:
- weight gain
- reactive mood
- increased appetite
- excessive sleepiness

Physical symptoms of depression can include:
- pain
- constant tiredness

The following can accompany or conceal depression:
- anxiety:
  - when depression is accompanied by anxiety, the first priority should be to treat the depression
  - when the person has an anxiety disorder and co-morbid depression or depressive symptoms, consult the relevant guidelines:
    - consider treating the anxiety disorder first (if depression is relatively mild compared to anxiety) [1] – effective treatment of the anxiety disorder will often improve the depression or depressive symptoms
- insomnia
- worries about social problems, eg financial difficulties
- increased irritability and hostility [1]
Depression - assessment and diagnosis

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- increased drug or alcohol use
- in a new mother, constant worries about her infant or fear of harming the baby

**Early warning symptoms of depression in a patient with recurrent depression include:**

- anxiety
- phobias
- milder depressive symptoms
- panic attacks

**Be alert for depression in high-risk groups, such as those with:**

- a history of:
  - depression
  - mania or bipolar disorder [1]
  - suicide attempt
- any significant physical illness, especially those which are [1]:
  - endocrinological
  - neurological
  - life-threatening
  - disabling
  - catastrophic
  - stigmatising
  - painful
  - deforming
- other mental health problems
- family history of depression

**Clinical presentation varies depending on a number of factors, including:**

- age:
  - younger patients show more behavioural symptoms and irritability
  - older adults have:
    - more somatic symptoms
    - fewer complaints of low mood
    - more memory problems [1]
- stage of illness
- severity of illness
- co-morbidities

This information was drawn from the following references:


6 Initial Detection

Quick info:
Assess:
- severity of symptoms and degree of functional impairment
- disability associated with the possible depression
- duration of the episode
- precipitating factors

Sample questions:
- during the last month, have you often been bothered by feeling down, depressed, or hopeless?
- during the last month, have you often been bothered by having little interest or pleasure in doing things?
- during the last month, have you often been bothered by:
  - feeling worthless?
  - poor concentration?
  - thoughts of death?

NB: the World Health Organisation recommends asking about questions relating to low mood, anhedonia and negative thoughts over the past 2 weeks [1].

Review the person's:
- mental state
- biological features
- interpersonal and social functioning

Review management of comorbid conditions.

Consider specialist advice or referral.

References:

7 Assess risk of suicide or harm to self and others

Quick info:
Risk of suicide or harm to self or others is largely independent of severity of depression and is thus assessed separately. Predictors include: history; substance abuse; stressors & loss; guilt & hopelessness. (Australian Family Physician. Mental Health Risk Assessment, A guide for GPs, June 2011)

Try to obtain third party information if in any doubt when making an assessment of clinical risk [1].

Always ask directly about suicidal ideation, plan and intent [2-4,6,7,8] for depression of any severity:
- asking about suicide or self-harm is important and does not increase the risk of suicide or self-harm episodes [1]
- explore their thoughts, development of plans, access to means to undertake these plans, risk and protective factors
• questions to consider include:
  • do you ever think about suicide? [2,6]
  • have you made plans for ending your life? [2,5]
  • have you thought about how you would end your life? [6] If the person with suspected depression answers yes to this question, ask about specific methods considered, eg gun, overdose [6]
  • do you have the means for doing this available to you? [2,5,6]
  • what has kept you from acting on these thoughts? [2,6]
  • do you feel that life is worth living? [6,7]
  • do you wish you were dead? [6]
  • have you ever thought about harming yourself in anyway? [7]

Risk factors for suicide include [2]:
• social characteristics:
  • male gender
  • young age (less than age 30 years)
  • advanced age
  • single or living alone
• history:
  • prior suicide attempt [8]
  • history of impulsive acts and/or violence [9]
  • family history of suicide or mental illness [8]
  • history of substance abuse [8]
  • recently started antidepressants

• clinical features:
  • hopelessness [5]
  • psychosis [8]
  • severe anxiety [8], agitation, panic attacks
  • concurrent physical illness & terminal illness
  • severe depression
  • life stressors [8]
  • lack of protective factors [5,8]
  • males over 45y.o with agitation or who appear to be guarded, are at higher risk of suicide

If there is a risk of self-harm or suicide:
• assess whether the person has adequate and reliable social support [2,3]
• arrange appropriate help [1] - see Adult depression- Referal Options page Information, support and advice phone list
• advise the person to seek further help if the situation deteriorates [2,3]
• consider toxicity in overdose of prescribed medications [2]

Consider earlier referral for specialist care.
Advisse family and carers to be vigilant of [2,10]:
• mood changes
• negativity
• hopelessness
• suicidal ideation and plans
Also assess the patient's level of:
• self-care
• hydration
• nutrition
Consider risk to others – in particular [8]:

- risk to dependants through neglect (mandatory reporting if appropriate)
- risk of violence – enquire about:
  - history of violence
  - homicidal ideas, plans, or intentions

For lower risk patients with suicidal thoughts consider ATAPs - suicide/ self Harm referral (please refer to the referral options pathway box: “Psychological services”.

References:

8 Very Urgent - Emergency Options

Quick info:
Assessed as:
- severe, very urgent and immediate;
- emergency or immediate response required;
- probable or definite risk of danger to life of self or others;
- severe behavioural disturbance, disorder;
- severe agitation or agression

Intensive case management and clinical care required in tertiary service setting.

Immediate risk call 000

Other options include contacting:
- Peninsula Mental Health Triage Service
  ph: 1300 792 977. For clients living in the Frankston/ Mornington Peninsula area.
  Catchment Area Map
- Monash Health Mental Health Triage
  ph: 1300 369 012. For clients living in Langwarrin/ Carrum Downs and beyond areas.
  Catchment Area Map 1
  Catchment Area Map 2
  -Emergency Department
Description: The team provides a 24 hour service within Frankston hospital offering mental health assessment and treatment to patients presenting to the Emergency department at Frankston hospital with acute mental health issues, and facilitates admission to both the adult and aged mental health inpatient units if required, referral to other parts of Peninsula Health Mental Health Service, or referral to external agencies as appropriate. Ph: 9784 7777

Location: Frankston & Rosebud Hospitals
Referral: Ph: 9784 7777
Frankston ED consultant Ph: 9784 7196
Frankston ED: Fax 9784 7284
Frankston Patient Enquiries: Ph 9784 7777
Rosebud ED Consultant Ph: 5986 0624 / 0429 421 850
Rosebud ED Fax: 5986 0728

For lower risk patients with suicidal thoughts consider ATAPs -suicide/ self Harm referal

Access to Allied Psychological Services (ATAPS) - SEMPHN for LOW risk only.

Referral: Fax 9708 8157
Mental Health Care Plan and ATAPS referral form needed. For Suicide or Self harm referrals no MHCP is required however the GP must complete the SPP Risk Assessment Tool for GPs and send with the referral form.

Enquiries: 5973 5655

Description: ATAPS enables GPs to refer patients that meet the ATAPS eligibility criteria to an ATAPs approved Allied Health Professional who delivers focused psychological strategies. ATAPS provides a pathway and referral service for individuals to access short term goal oriented focussed psychological strategies. Up to 10 sessions in a calendar year.

Eligibility: Health care card needed for Standard, ATSI and Perinatal Referrals. No HCC needed for Suicide or Self Harm referrals. ATAPS is specifically to assist individuals who are experiencing a diagnosed mild-moderate mental health disorders such as depression or anxiety, perinatal depression, risk of suicide or self harm, and Aboriginal and Torres Strait Islanders diagnosed with a mental health disorder. Please see the ATAPS Eligibility Matrix for further exclusions criteria.

9 Mental Health Act- Involuntary Assessment Order

Quick info:
Victoria’s new Mental Health Act 2014 commenced on 1 July 2014.

The procedures for initiating compulsory assessment and compulsory mental health treatment have changed. If a person appears to have mental illness and appears to require compulsory mental health treatment, the Act empowers registered medical practitioners, including general practitioners, to make an Assessment Order.

MHA Information Sheet for GP’s
Mental Health Act – Quick Reference Guide
MHA 2014 Handbook
MHA 2014- Assessment Order Form

Assessment Order – role of general practitioners

Under the Act, a registered medical practitioner may make an Assessment Order if they have examined the person and are satisfied that the criteria for an Assessment Order apply.

The Assessment Order replaces the previous Request and Recommendation in the Mental Health Act 1986.

The purpose of an Assessment Order is to enable an authorised psychiatrist to examine the person to determine whether they have mental illness and require compulsory mental health treatment.

An Assessment Order is sufficient authority to transport a person to a designated mental health service. Transport arrangements should be appropriate to the person and their circumstances and should use the least restrictive transport option possible. However Ambulance or police assisted transfer may be required.

MHA 2014- Assessment Order Form

The criteria for making an Assessment Order are:

- the person appears to have mental illness, and
- because the person appears to have mental illness, the person appears to need immediate treatment to prevent:
  - serious deterioration in the person’s mental or physical health; or
  - serious harm to the person or to another person, and
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- if the person is made subject to an Assessment Order, the person can be assessed, and
- there is no less restrictive means reasonably available to assess the person (for example, the person cannot be voluntarily assessed).

After completing the MHA 101 Assessment Order form, a general practitioner must:
- tell the person that they have made an Assessment Order
- give the person a copy of the Assessment Order
- explain the purpose and effect of the Assessment Order
- give the person a copy of the Assessment Order - Statement of rights and explain the information. Assessment Order Statement of Rights
- notify the authorised psychiatrist of the relevant designated mental health service and give them a copy of the Order.

10 Mental Health Assessment Tools

Quick info:
There are numerous mental health assessment tools that can assist in assessment, diagnosis and monitoring of clients mental health state. Below is a list of common tools. Each can be printed to complete and placed in patient records.

K10 - Kessler 10 scale - a simple measure of psychological distress. It is not a diagnostic tool, but is an indicator of psychological distress. Research has found a strong association between high scores on the K10 and the diagnosis of Anxiety and Affective disorders.

Depression, Anxiety & Stress Scale (DASS) - The DASS 21 is a 21 item self report Questionnaire designed to measure the severity of a range of symptoms common to both Depression and Anxiety.

Edinburgh postnatal depression scale - a useful tool to screen patients for postpartum depression.

Patient Health Questionnaire (PHQ-9) - is not a screening tool for depression but it is used to monitor the severity of depression and response to treatment.

Risk Assessment - brief tick box suicide risk assessment tool.

Questions to Assess Suicide Risk - prompting questions to discuss and assess suicide risk.

Mental State Examination - a structured way of observing and describing a patient's current state of mind under many domains.

Mini mental State Examination - a brief assessment that can be used to screen for the presence of cognitive impairment.

ASSIST - Alcohol, Smoking & Substance Involvement Screening Tool.

11 History and examination

Quick info:

History:
In your history and assessment, in making a diagnosis of depression, assess diagnostic criteria, consider possible alternative psychiatric diagnosis or organic pathology, undertake a risk assessment and form the basis of a management plan with goals, plan of follow up and service access for patients.

Systemic assessment may include [1]:

- psychiatric history (see below)
- mental state examination
- review of systems
- general medical history
- social history
- family history – ask about:
  - mood disorders
  - suicide
- occupational history
- personal history including:
  - psychological development
  - responses to major life events
Ask about:
- current symptoms of depression, including ideas of suicide
- historical pattern of current illness
- duration of symptoms
- severity of symptoms
- degree of functional impairment
- response to any previous treatment
- quality of interpersonal relationships
- living conditions and social isolation
- alcohol, illicit substance, or prescribed medication use [1]
- recent losses, including bereavement
- psychosocial stressors, eg loss, conflict, financial difficulties, life change, abuse

Psychiatric history [1] including:
- history of self-harm
- history of suicide attempt/s
- past history of mania or hypomania or mixed episodes [1]
- past history of depression
- response to any treatment for depression in the past [1]

Past medical history:
- medication history; the following medications may be associated with major depression:
  - corticosteroids
  - interferon
  - methyldopa
  - isotretinoin
  - varenicline
  - hormonal therapy including Oral and other contraceptives.
- substance misuse/dependence:
  - use of alcohol and hypnotics might mimic and/or induce depression
  - withdrawal from cocaine, anxiolytic, and amphetamines may mimic depression
  - idiosyncratic reactions to illicit substances should be considered

Physical examination must be performed at initial presentation to assess for any physical cause of depression and for co-morbid physical illness [1].

This information was drawn from the following references:

12 Consider differential diagnoses

Quick info:
Before diagnosing depression, consider alternative explanations including:
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• bipolar disorder – people may present with:
  • mania
  • hypomania – ask about symptoms of hypomania when assessing a patient with depression and overactive, disinhibited behaviour
  • depression
  • history of previous episodes of possible:
    • mania or hypomania
    • mixture of both manic and depressive symptoms
  • psychotic symptoms
• other psychiatric conditions:
  • generalised anxiety disorder
  • post-traumatic stress disorder
  • social phobia
  • panic disorder
  • obsessive compulsive disorder
  • personality disorder
  • psychotic disorders
  • adjustment disorder
  • bereavement
  • dementia
• non-psychiatric:
  • alcohol abuse or dependence [1]
  • as a result of illicit substance misuse:
    • anabolic steroids
    • cannabis
    • cocaine
    • narcotics
  • as a result of adverse drug effects:
    • centrally acting antihypertensives
    • beta blockers
    • central nervous system depressants
    • opioid analgesics
    • isotretinoin
    • benzodiazepines
    • corticosteroids
    • H₂-receptor antagonists
    • chemotherapy agents (vincristine, vinblastine, procarbazine, L-asparaginase)
    • levodopa
    • non-steroidal anti-inflammatory drugs (NSAIDs)
    • cholesterol lowering agents
    • oral contraceptives
  • as a result of medical conditions:
    • endocrine disorders, such as:
      • hypothyroidism
      • Cushing’s disease
      • adrenal insufficiency
      • hyperparathyroidism
      • cancer, eg brain tumour [1]
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- diabetes
- cardiac disease
- Parkinson's disease
- cerebrovascular disease, such as:
  - stroke
  - subarachnoid haemorrhage
- myocardial infarction (MI)
- autoimmune diseases
- post-polio syndrome
- HIV [1]

This information was drawn from the following references:

13 Investigations

Quick info:

Investigations for depression:
- basic investigations to rule out an organic cause may include [1,2] :
  - biochemistry [1]:
    - blood glucose
    - urea and electrolytes & creatinine
    - liver function tests (LFTs)
    - thyroid function tests (TFTs)
    - calcium levels
  - haematology:
    - full blood count (FBC) [1]
    - erythrocyte sedimentation rate (ESR) [1] or CRP[3]
    - urinary or blood drug screening [1]
  - if indicated clinically or by history, consider HIV and syphilis serology [1]

Consider investigations such as brain imaging (CT or MRI), if the patient presents with:
- unexplained headache [1]
- personality changes [1]
- possible signs of space-occupying lesion [4]
- possible convulsions [4]
- altered state of alertness [4]
- dementia like pattern.
  - Organic/ Dementia screen involves: FBE, ESR, CRP, TFTs, LFT's, U&E's, Cr, B12, Folate, Random Glucose, Treponema antibodies, MSU, CT scan, CXR, ECG.

Investigations are more important where[5]:
- medical review detects symptoms that are rarely encountered in mood or anxiety disorders


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14 Diagnostic criteria

Quick info:

**Diagnosing depression:**

Depression is diagnosed using the DSM-5 or ICD-10 criteria

- **DSM-5:** requires a minimum of 5 symptoms, present during the same 2 week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure [1]:
  - Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful).
  - Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
  - Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
  - Insomnia or hypersomnia nearly every day.
  - Psychomotor agitation or retardation nearly every day.
  - Fatigue or loss of energy nearly every day.
  - Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
  - Diminished ability to think or concentrate, or indecisiveness, nearly every day.
  - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

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

- **C.** The episode is not attributable to the physiological effects of a substance or to another medical condition.

- **Note:** Criteria A-C represent a major depressive episode.

- **Note:** Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered.

- **D.** The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

- **E.** There has never been a manic episode or a hypomanic episode. Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

- **if depression has persisted for more than 2 years, the patient is said to have chronic depression:**
  - 2 year cut off is arbitrary and should be considered in the context of severity and the course of the illness
Consider the use of depression questionnaires to detect and assess severity of depression (do not use to determine the need for treatment), such as:

- **K10- Kessler 10 scale** - a simple measure of psychological distress. It is not a diagnostic tool, but is an indicator of psychological distress. Research has found a strong association between high scores on the K10 and the diagnosis of Anxiety and Affective disorders.

- **Depression, Anxiety & Stress Scale (DASS)** The DASS 21 is a 21 item self report Questionnaire designed to measure the severity of a range of symptoms common to both Depression and Anxiety.

**Special considerations:**

- a meta-analysis of the Geriatric Depression Scale (GDS) recommends the use of GDS(15) but not GDS(30) in the diagnosis of late-life depression in primary care [2]
- for people with significant language or communication problems, consider [3]
  - using the Distress Thermometer 14; and/or
  - asking family or carer about the person's symptoms
- in the postnatal period consider using the Edinburgh Postnatal Depression Scale (EPDS) [8]

**References:**


15 Severity of depression

**Quick info:**

Assessing the severity of depression (as well as complicating symptoms such as the presence of psychotic symptoms) assists in identifying the most appropriate treatment.

**Risk of suicide or harm** to self or others may be independent of severity of depression and is thus assessed separately. Predictors include: history; substance abuse; stressors & loss; guilt & hopelessness. (see “Assess risk of suicide or harm to self and others” node)

In the DSM-5 severity is based on the number of criterion symptoms, the severity of those symptoms, and the degree of functional disability [1].

**The severity of depression can be defined as follows:**

- **subthreshold depression (dysthymia):**
  - significant depressive symptoms below the threshold for DSM-IV depression [2]
- **Mild:** Few, if any, symptoms in excess of those required to make the diagnosis are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational functioning.
- **Moderate:** The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for “mild” and “severe.”
- **Severe:** The number of symptoms is substantially in excess of that required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.

**Reference:**

16 Complex or Specific depressive disorders

Quick info:
Complex depression is defined as depression that [2]:

• shows an inadequate response to multiple treatments; or
• is complicated by psychotic symptoms; or
• is associated with significant psychiatric co-morbidity [1], substance misuse [2], personality disorder [2] eating disorder, or difficult/complex psychosocial factors [1]

Consider specialist referral:

Personality disorders

Spectrum

Referral: through local area Mental health service

Description: a statewide service that supports and works with local Area Mental Health Services to provide treatment for people with personality disorder. Spectrum focuses on those who are at risk from serious self-harm or suicide and who have particularly complex needs. Spectrum provides a range of programs to support AMHS and CAMHS mental health clinicians and their clients, including secondary consultation with clinicians, as well as group treatment and individual treatment with clients. Spectrum treatment is designed to complement AMHS and CAMHS treatment approaches.

Some Spectrum programs can be provided at the site of an AMHS or CAMHS community clinic. Other programs take place at premises in East Ringwood.

Women’s health

Women’s Mental Health Clinic

Referral: Ph 9076 6924. Fax: 03 9076 8545.

GP referral necessary

Description: State wide service run by MAPrc at the Alfred Hospital. The women’s mental health clinic provides tertiary consultation in the form of second opinions by expert psychiatrists and psychologists for women with a variety of psychiatric disorders. In particular the impact of hormonal changes and other reproductive factors are carefully considered in the management of mental illnesses.

Women’s Mental Health Clinic Leaflet

Acquired brain injury

Arbias

Referral: Ph 1800 272 424

GP referral not necessary

Description: Arbias provides specialist services for people with acquired brain injury. Staffed by employees in the areas of neuropsychology, case management, accommodation, professional training, community development, and individualised support.

Disability

Primary Care Psychiatric Consultancy Clinic for Adults with Intellectual Disabilities. Centre for Development Disability Health Victoria (CDDHV).

Referral: Complete referral form must have GP section completed

Description: The CDDHV operates a number of consultancy and research clinics, as well as clinical services for people with developmental disability. This includes a psychiatrist assessment and opinion if required. The CDDHV does not provide ongoing medical or psychiatric management to the patients it assesses.

Enquiries: Ph 9902 4467

Victorian Dual Disability Service

Referral: Ph 9288 2950, by Community Mental Health Team only

Description: State-wide mental health service for adults with developmental disabilities (intellectual disability or autism spectrum disorders). To achieve this we work with specialist mental health services in Victoria to help them treat people with a dual disability. Provides Specialist assessments and opinion.

17  Severe depression

Quick info:
Severe depression:
 DSM-5: The number of symptoms is substantially in excess of that required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning [1]. May be with or without psychotic symptoms [2]

See "Diagnostic criteria" node above for more detail.

Admission to mental health services may be indicated for severely ill patients who:
• lack adequate support outside of a hospital setting [3]
• have complicated psychiatric or general medical conditions [3]
• carry significant risk to themselves or others but cannot be managed safely outside a hospital setting [4]

References:

18  Moderate depression

Quick info:
Moderate depression:
 DSM-5: The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for “mild” and “severe” [1].

• more than the minimum number of symptoms are present; and
• there is moderate functional impairment

See "Diagnostic criteria" node above for more detail.

References:

19  Mild depression

Quick info:
Mild depression:
 DSM-5: Few, if any, symptoms in excess of those required to make the diagnosis are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational functioning [1].

References:
20 Subthreshold depression & dysthymia

Quick info:

**Subthreshold depression**:  
- is defined as fewer than five depressive symptoms [1,2]  
- does not meet the DSM-V criteria for depression [2]

**Dysthymia** is defined as persistent subthreshold symptoms - normally for at least 2 years [2]:

See "Diagnostic criteria" node above for more detail.

References:

21 Indications for referral to specialist mental health services

Quick info:

**Consider immediate referral to specialist mental health services if the person with depression:**  
- is considered to be an immediate risk to themselves or others [1,2,3,4,5]  
- is actively suicidal, has a current suicide plan, is at risk of self-harm [1,6]  
- has psychotic symptoms [1,6], eg hallucinations, delusions [1]  
- has severe agitation accompanying severe symptoms [1]  
- presents with severe self-neglect [6]  
- has deteriorating personal circumstances exacerbating their mental illness [1]  
- is at risk to other people [8]

If the person needs to be admitted to hospital, every attempt should be made to persuade them to go voluntarily where possible and when risk allows [8].  
If the person refuses to go to hospital, compulsory assessment may be necessary [8,5]:

See information box above - Mental Health Act- Involuntary Assessment Order

In some situations police and or ambulance may be required to transport the client to hospital for further assessment.

The criteria for making an Assessment Order are (see information box above -Mental Health Act- Involuntary Assessment Order - for further details):
- the person appears to have mental illness, and
- because the person appears to have mental illness, the person appears to need immediate treatment to prevent:
  - serious deterioration in the person’s mental or physical health; or
  - serious harm to the person or to another person, and
- requires assessment and/or treatment in a hospital, and
- needs to be admitted in the interests of their own health or safety, and/or for the protection of other people

Admission to mental health services may also be indicated for severely ill patients who [5]:
- lack adequate support outside of a hospital setting
- have complicated psychiatric or general medical conditions
22 Depression in the Intellectually Disabled

Quick info:
Prevalence rates of depression in intellectual disability are between 1.3% & 3.7%, with symptoms of depression (reported by carers) limiting activity, participation & independance in up to 50% [1].

Patients with an intellectual disability present with concerning behaviours, usually described by their family or carers. These might include self-injurious behaviours, unexplained irritability or aggression, excessive or unusual vocalisations, etc., and may be a manifestation of an underlying medical condition or psychiatric disorder. Communication difficulties can make diagnosis difficult. [2]

Diagnosis should include:
- History of the behaviour of concern: triggers, exacerbating and relieving factors
- Physical assessment of the patient.

Management should consider:
- Underlying medical diagnoses: pain, constipation, UTI, itch, GORD, etc
- Psychiatric diagnosis: anxiety, depression, psychosis, etc
- Environmental or other triggers?
- Does the behaviour constitute a serious risk to the client or to others?
- Is medication required? The use of medications primarily to manage difficult behaviours should only occur after the exclusion of underlying diagnoses and consideration of environmental and other triggers or in situations where the behaviour presents a significant danger to the person or others.
- Review all medications
- Are there other interventions that might be effective?
- Consider specialist review

Note that Victorian Legislation defines chemical restraint as the use of a chemical substance to control or subdue a patient for the primary purpose of behavioural control. It does NOT include the use of a drug prescribed by a medical practitioner for the treatment of mental or physical illness.

The Management Guidelines: Developmental Disability provides GPs with further advice on the assessment and management of these behaviours.[2]

The RACGP website www.gplearning.com.au has 6 modules aimed at supporting GPs managing patients with intellectual disability. These include a category 1 active learning module "Comprehensive Care for People with Intellectual Disability" and category 2 learning activities.

References:
23 Depression in the perinatal period

Quick info:
Consider early specialist referral.
The Peninsula Health GP Liaison Perinatal Mental Health details referral and management options, and resources.

Medicare Item #291- One off Mental Health Assessment & Management by Private Psychiatrist
Medicare Item #293- Post Mental Health Assessment & Management review by Psychiatrist. (see Referal Options Page for details-link is below)

Suicide causes more death in women during pregnancy and the postpartum period, than childbirth or its complications. Thus although effort should be made to minimise drug doses, it is equally important not to under treat the psychiatric illness.[1]

Women taking psychotropic medication & of childbearing age require discussion of: [2]:
• contraception; and
• the risks of pregnancy (including relapse, risks associated with stopping or changing medication, and risk to the fetus)
• pregnancy plans (see node below)

At antenatal and postnatal appointments ask about:
• past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period, and severe depression [2]
• previous treatment by a psychiatrist/mental health specialist [2]
• previous postnatal depression [3]
• a family history of perinatal mental illness [2]

Sample questions to identify possible depression [2]:
• during the past month, have you often been bothered by feeling down, depressed or hopeless?
• during the past month, have you often been bothered by having little interest or pleasure in doing things?
If the woman answers yes to the previous 2 questions, ask [4]:
• is this something you feel you need or want help with?

If there are specific concerns, the woman should be referred to a specialist service for assessment [2].

Specialist mother and baby units are best practice for Inpatient care for a mental disorder within 12 months of childbirth [2].

Monash Hospital Mother & Baby Unit:
246 Clayton Road Clayton Vic. Referral: Health professional to call: 03) 9594 1414.

Edinburgh postnatal depression scale - a useful tool to screen patients for postpartum depression. It is used to screen women in the FMP area at antenatal and Maternal Child Health visits.
• a score of 13 or more can be used to detect possible depression in women during the postnatal period

Routine screening using the EPDS is also done at Frankston & Mornington Peninsula Maternal and Child Health Services. Further information including the following is found on The Peninsula Health GP Liaison Perinatal Mental Health page.

GP Resources
• Perinatal Mental Health Assessment and Care Options Aug 2013 Contains local and statewide clinical and service information including Perinatal Medication Advice, Assessment & Management Advice, public and private Specialist Services & Sleep/Settling Clinics, enhanced Maternal & Child Health Nurse Services, self-referral and patient information for women.
• GP Perinatal Mental Health Guide 2013 Describes the perinatal screening program for depression and anxiety and antenatal care for pregnant women with a mental illness at Peninsula Health.
Depression - assessment and diagnosis
A-Z Frankston-Mornington Peninsula local pathways > Depression > Depression in adults

Perinatal ATAPs Information on access to allied psychological services for women in the perinatal period at Frankston Mornington Peninsula Medicare Local can be found here.
- BeyondBlue CPG- Perinatal mental health Clinical Guidelines from Beyond Blue about depression, anxiety and other conditions such as bipolar disorder and puerperal psychosis in the perinatal period.

References:

24 REFERRAL to specific Intellectual Disability Services

Quick info:

**Disability**

**Primary Care Psychiatric Consultancy Clinic for Adults with Intellectual Disabilities.** Centre for Development Disability Health Victoria (CDDHV).

**Referral:** Complete referral form must have GP section completed

**Description:** The CDDHV operates a number of consultancy and research clinics, as well as clinical services for people with developmental disability. This includes a psychiatrist assessment and opinion if required. The CDDHV does not provide ongoing medical or psychiatric management to the patients it assesses.

**Enquiries:** Ph 9902 4467

**Victorian Dual Disability Service**

**Referral:** Ph 9288 2950, by Community Mental Health Team only

**Description:** State-wide mental health service for adults with developmental disabilities (intellectual disability or autism spectrum disorders). To achieve this we work with specialist mental health services in Victoria to help them treat people with a dual disability. Provides Specialist assessments and opinion.

25 Antidepressants in Pregnancy & Breastfeeding

Quick info:

**Suicide** causes more death in women during pregnancy and the postpartum period, than childbirth or its complications. Thus although effort should be made to minimise drug doses, it is equally important not to under treat the psychiatric illness.

Do not routinely use antidepressants to treat persistent subthreshold depressive symptoms or mild depression. Choose therapy according to clinical factors, including previous efficacy, tolerability and patient preference. Selective serotonin reuptake inhibitors (SSRIs) are recommended first line if medication is used.

**SSRIs-currently** insufficient evidence to choose one over another, although caution is recommended:
- paroxetine may cause heart defects if taken during the first trimester [1]
- fluoxetine (due to its longer half-life).
- taking SSRI after 20 weeks' gestation may cause persistent pulmonary hypertension in the neonate [1]

Venlafaxine at high doses can cause high blood pressure (BP) [1]

All antidepressants can cause withdrawal or toxicity in the neonate (usually mild or self-limiting) [1]

If prescribing medication:
- start at the lowest effective dose and slowly increase [1]
- use monotherapy in preference to combination treatment [1]
- take additional caution when prescribing antidepressants to mothers who are breastfeeding, with preterm, low birthweight, or sick infants [1]
Depression - assessment and diagnosis
A-Z Frankston-Mornington Peninsula local pathways > Depression > Depression in adults

- acknowledge uncertainty risks of taking antidepressants [1] – but there are also risks to the mother and fetus of not treating severe depression, eg severe neglect [2]
- explain the background risk of fetal malformations for pregnant women without a mental disorder (between 2-4 in 100 in the general population) [1]

Mood stabilisers [3]:
- women taking antiepileptic medication should be prescribed a daily dose of 5mg folic acid (500mcg for all other pregnant women) from 3 months pre-conception until the end of the first trimester [3]
- valproate is best avoided [3] because of high rates of fetal abnormality [2]

Antidepressants & breastfeeding: [1]:
  - low levels with imipramine, nortriptyline & sertraline
  - high levels in citalopram & fluoxetine
- monitor the infant for side effects
- there is no clinical evidence that women treated with TCAs (other than doxepin), paroxetine, sertraline, or fluoxetine should be recommended to stop breastfeeding [3]
- breast feed immediately before the dose and avoid for 1-2 hours after any dose of medication [3]
- mothers taking lithium should be encouraged to avoid breast feeding [3]:
  - if breast feeding, monitor the infant (including serum lithium levels)

When stopping a medication take into account [1]:
- the risk to the fetus or infant during the withdrawal period
- the risk from not treating the disorder (see above text)

Medication and Preconception, & General Advice:
- RWH Perinatal Psychotropic Medicines Information Service comprehensive advice with references
- Monash Medical Centre - Phone 9594 2361 - to speak to a Pharmacist
- Royal Women’s Hospital - Phone 8345 3190 – to page a Psychiatric Registrar for consultation
- NICE(UK) Antenatal and postnatal mental health- Clinical Management and service guidance pages 12-17.
- Beyond Blue for clinical practice guidelines re medication
- Perinatal Psychotropic Medicine Information Service PPMIS has compiled a range of individual psychotropic medicine profiles, containing specific safety information about pre-pregnancy, during pregnancy and postnatal period. Each psychotropic medicine offers fact sheet to assist health professionals to answer some of the more common questions around psychotropic medicines use during pregnancy and breastfeeding.

St John’s Wort and other alternative medicines should not be used during pregnancy and lactation [3]
Hormonal therapies are not advised for routine management of postnatal depression [4]

References:

26 REFERRAL Mental Health Triage
Quick info:

**Peninsula Mental Health Triage Service ph: 1300 792 977.**
For clients living in the Frankston/Mornington Peninsula area.
Catchment Map

**Monash Health Mental Health Triage ph: 1300 369 012.**
For clients living in Langwarrin/Carrum Downs area.
Catchment Area Map 1
Catchment Area Map 2
Depression

Mental health/mood disorders

Provenance certificate

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Overview

This document describes the provenance of the Depression pathway.

This pathway was last updated in June 2015.

The Map of Medicine Program aims to improve the continuity of patient care between primary, community and hospital care settings in the Frankston-Mornington Peninsula region. Work groups comprising of experienced health professionals (GPs, specialists, nurses, allied health professionals) were established to review and localise pathways.

The objective of this pathway is to improve outcomes for patients with depression.

To cite this pathway, use the following format:


Editorial methodology

This pathway is currently the first version localised to Frankston Mornington Peninsula.

This pathway has been developed according to the Map of Medicine editorial methodology. The content of this care map was developed with reference to current evidence-based guidelines and practice-based knowledge provided by local practitioners with front-line clinical experience (see contributors section of this document).

Editors

Dr Sue Boucher | General Practitioner
Meagan Lindorff | Mental Health Nurse

Contributors

The following were clinical contributors to the pathway:
Depression

Mental health/mood disorders

- Assoc Prof Sean Jesperson | Mental Health Clinical Director, Peninsula Health
- Dr Sanil Rege | Psychiatrist
- Dr Bray Gray | General Practitioner
- Dr Priscilla Yardley | Head of Psychology, Peninsula Health
- Jennifer McGowan | Psychologist
- Yolande Maltman | Mental Health Nurse

The following were contributors through the GP review committee and wider consultation process:

- Dr Martin Coffey | General Practitioner
- Dr Emma Donovan | General Practitioner
- Dr Damian Flanagan | General Practitioner
- Dr Glenn Mathieson | General Practitioner
- Dr Peter Meggyesy | General Practitioner
- Dr Jo Newton | General Practitioner

Disclaimer

It is not the function of the Pathways Program, Frankston-Mornington Peninsula Medicare Local to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care. Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.