PART TWO – GUIDELINES FOR SUPPORTING CONSUMERS WITH SPECIFIC MENTAL HEALTH DISORDERS

Some Voices from Community

“… sit down and find out their problems, don’t just leave it on their shoulders like that’s your problem you deal with it you know that type of thing. Have someone there to sit down and put it back to them and think of ways to help them, themselves, like you can be there to help but put it back on them - alright what can we do tomorrow, like don’t you suggest it, ask them to do it.”

“Like a long way I thought I was lost by myself um pointless, worthless but now I’m starting to like gain confidence and if no-ones willing to listen, well I’m gonna prove it all by myself and feel like I have the strength to do it.”

“When I was working in health I use to go out with the mental health people who need to find their family but I never had much to say, but being there hopefully they would see me as a support person, just being there with the people that need to help them. And I mean, now I look at, I take a look back and what I reflect on, what use to happen down at, today I see our people, now, who are suffering from mental illness and a lot that has been, there are a few been put away. Like to be in an institution is not the place for them. I reckon to try and untangle their mind and what they’re going through. They should be treated as normal people which they are some of them, and some we’ve lost to mental illness by going in, in an institution. Maybe there’s a way out of that. Ok be on medication, there’s one, but give them something to do.”

"I think [recovery] is very possible cause you can visit counseling, counselors or whatever, and they reckon they can help quite a bit in mental illness. Managing it through probably right diets and exercise, just a good happy family environment I think and no fighting or abusive behaviour round themselves, make it worse I suppose."

“… patient is diagnosed as seeing things such as visions or apparitions or whatever they get classified into certain categories they’re either sane or insane, you know, depending on what science says about them, but in my culture, we have got words for these sorts of things, so therefore, a person who is seeing these things is considered normal because we have a word for spirit of dead people such as [language word], whereas psychology or whatever does not even take that into consideration.”
CHAPTER FIVE - DEPRESSION

Helping the Consumer Manage Depression

Aiming to Achieve the Five Cs

Consumer and Carer
During initial contact and assessment, good communication is essential for the health professional/worker in establishing engagement. An ability to listen actively and to communicate empathy (compassion) and caring are particularly important as the consumer may be very vulnerable at this time.

Developing a therapeutic alliance involves the health professional/worker and the consumer reaching a common understanding of the issues, so that they can set goals and agreed strategies and steps to reach the goals. Respect for the consumer and mutual trust is one of the most important elements in developing a sound relationship. True respect enables providers to let consumers make decisions for themselves and to make, and learn from, their own mistakes. The best way to show that respect is to listen and give the consumer all your attention.

While conducting assessments and organising immediate interventions the health professional/worker must ensure that they explain as much as they can to the consumer on a frequent basis and seek their approval. Using words like, “is this clear to you?”, “do you understand?”, “is this what you want to happen?” are just some examples.

Consumers suffering from depression may require constant reassurance due to low mood, feelings of worthlessness and an inability to cope. These are feelings that should be taken seriously and reassurance should be given. It is important not to inflict judgmental views on the consumer as these may cause feelings of and a reluctance to engage in the future. Being non-judgmental also requires service providers to be uncritical of factors affecting many consumers, over which they have little control.

Carer involvement in consumer treatment programs is very important due to their “lived” experience with the consumer, however we do have to recognise the consumer’s right to confidentiality. Therefore it is vital to obtain consent prior to engaging a carer. Consent can be overridden in situations where a consumer or carer may be placed at significant danger due to risk factors relating to mental impairment. A good example of this in relation to depression may be the presence of suicidal ideation (thoughts) or intent (plans), when a consumer is unwell. This situation requires the carer to be informed if the client cannot be immediately transferred to a place of safety (eg) the local hospital or in-patient mental health facility. There may be an increase in the risk of impulsivity if the client has been consuming large amounts of alcohol. Based on the context of the community, (eg communities in crisis) it may be hard to distinguish a reliable carer/family member and emphasis on the importance of seeking an appropriate (suitable/reliable) other is essential.
Hints for consumer involvement:

- Seek clarification from the consumer about the level and degree of involvement permitted for the carer;
- Determine if you are permitted to engage with the carer privately or only in the presence of the consumer;
- Determine if all treatment information can be disclosed and if long-term liaison is permitted;
- Encourage the consumer to engage carers/family in treatment options;
- Avoid over engagement with carers at the expense of the therapeutic relationship with the consumer. This means that building a positive relationship with the consumer is the most important goal. We have to be careful not to sacrifice this when we seek background history from the carer/family. The aim is to empower the consumer in their care while actively involving the carers;
- Provide regular information to the consumer/carer on their treatment and progress, utilising treatment specific material (eg) brochures, handouts, user friendly materials;
- Provide information on available community resources (eg) mental health nurse/service, life promotions officer, available community services, consumer support group and carer support group; and
- Actively involve the consumer/carer in the development of Care Plans that are specific to their mental health needs and encompasses regular review and updating as the goals change. It is important to regularly review and seek input from the consumer and carer about what the important issues or difficulties are from their perspective.

It is also important to provide emotional and social support to the carer/family.
Hints for support include:

- Offer them time to express their feelings and emotions on what they see as the key issues;
- Give reassurance relating to the consumers illness and level of progress;
- Suggest applying some coping strategies to their routine (eg) taking breaks, relaxing and taking time out; and
- Be available to support them and offer education to them as the principal caregiver.

Context of community

There needs to be continuous and effective consultation and collaboration between consumers, carers, service providers, elected leaders and community members, in order to successfully develop culturally-appropriate healing strategies that directly meet the traditional and spiritual needs of Indigenous people.

When working in Indigenous settings we must aim to listen and learn from the people we are working with in order to understand about local history, issues and living conditions. The consumer may present in such a way that would in other circumstances indicate symptoms of a depressive episode but due to cultural issues could provide a more logical explanation. Some examples are:

- The consumer presenting with perceived low mood. It may be that the consumer is extremely shy or ashamed because they have to see a health worker;
- Certain questions, or the manner in which they are asked by the health professional/worker, may be seen as inappropriate in cultural terms. Direct questioning may be seen as rude; and
• Where it is necessary to address sensitive issues, (eg women’s business) open the discussion by acknowledging that it might be seen as intrusive and explain why it is necessary to ask such a question.

It is important to respect Indigenous consumers’ cultural/health beliefs, knowledge and practices and to recognise that historical and cultural factors affect people’s health and wellbeing. The health professional/worker should appreciate and utilise the expertise of the local people in the community. Emphasis should be placed on working in partnership with the learning community, while appreciating that effective education for mental health needs to be initiated and driven by the community.

The health professional/worker should avoid imposing their own cultural bias on others and should encourage and support local solutions.

**Continuity of care**

It is vitally important that consumers suffering from depression are followed up on a regular basis due to the need for ongoing assessment for severity of symptoms. Examples would be assessment of ongoing self-harming or suicidal ideation, side effects to medication and compliance with it in the community setting. Health professionals/workers should be aware that consumers who have spent time in an in-patient setting with depression and are discharged back into the community still need intensive follow-up.

In-patient admissions for consumers may deal with reducing risk factors and providing a safe environment while establishing the consumer on anti-depressant medication. This does not mean that other symptoms of the illness are not still present on discharge.

When a consumer is discharged from an in-patient setting, it is important to make contact at the earliest possible opportunity. There are a number of reasons for this:

• The health professional/worker can offer immediate support and reassurance for the consumer. Many consumers suffering from depression remain vulnerable on discharge thus immediate contact is vitally important.

• The health professional/worker can obtain a true picture of the consumer’s mental state and perform a risk assessment. Some risk factors may alter from in-patient to community settings. For example, the consumer may feel isolated and unsupported in a community setting compared to the in-patient setting thus heightening the recurrence of suicidal ideation.

• An assessment of the overall living environment and the supports in place can be completed. It is a good opportunity to see if the living conditions of the consumer are promoting their mental health and wellbeing.

• Contact with the consumer’s carer/family can be established offering support to carer/family, providing information on illness/diagnosis and determining the issues and concerns that family/carers may have. (For example, are there still risk factors, what does the medication do, what happens if the consumer stops taking medication?)

• It is important to determine the consumer’s degree of insight as this will have a bearing on ongoing care, compliance with treatment and the level of follow-up/intervention. The consumer may decide that because they feel better
following discharge from hospital there is no longer a need to continue taking prescribed medications or that due to side effects (eg over sedation), medications are limiting them in their level of daily functioning.

- Provision of education and monitoring of prescribed medications is important to promote compliance. This is also a good opportunity to observe the client for any side effects relating to the medication. As with most medications there may be side effects with anti-depressants. Some examples are: nausea, difficulty going to sleep, over sedation, headaches and sexual problems. It is important that any side effects are acknowledged immediately to avoid any unnecessary discomfort for the consumer. Some consumers are reluctant to take prescribed medications or are noncompliant with them as a result of experiencing bad side effects.

- Drafting of a community Care Plan must commence at the nearest available opportunity. This should incorporate the consumer's/carer's perspective, primary health care staff, the local mental health team and any local organisations that may be involved in the consumer's care. (Eg ATODs, life promotions officer, sports and recreation officer.) However this will be dependent upon the available resources in the community.

Continuity of Care is essentially an ongoing activity that is performed on a consistent basis for a consumer while there is a need for that consumer to be supported by their Primary Health Care Service relating to their mental health issues. Emphasis should also be placed on continuity of care in relation to preparing and empowering the consumer to aspects of their care. The opportunity for consumers to take control of these aspects of care is vitally important. Sharing responsibility requires a willingness on the part of the health professional/worker to view continuity as a partnership where all parties have shared control.

A Care Planning document is seen as an important part of managing this process and should be completed in consultation with the Multidisciplinary team, the consumer and the family/carer. The Care Plan offers a structured approach for all involved parties and can be updated as goals and treatment issues change.

**What the Care Plan should incorporate for depression**

- Assessment of consumer’s mood and mental state. This can be utilised to determine the stage of treatment/recovery the consumer is at in relation to their illness and can also determine if there are any other underlying symptoms of illness. The presence of depressive symptoms (eg) loss of pleasure or interest, loss of energy, feelings of worthlessness or guilt, insomnia or hypersomnia (oversleeping), agitation, fatigue and the severity of these will be used for determining the immediate focus of care (eg) how distressed they are by the symptoms, how it is impacting on their daily routine, relationships with family members, risk to self and others. (For example, Tanya reports loss of pleasure in her daily activities. She feels worthless and guilty about her lack of motivation. She is also experiencing early morning wakening and reports poor concentration over a four-week period. She declines to answer questions about suicidal thoughts. The immediate focus of care should be to address the existing symptoms. This might suggest commencement on anti-depressant medications but more importantly immediate assessment of the risk factors involved as Tanya declined to answer any questions relating to suicide.)
• It should be developed or altered accordingly relating to risk factors whether that be a consumer’s risk to self, others or risk from others. Is there a risk of self-harm? Is the consumer safe in their home environment? Are there enough support mechanisms in place? Is there a responsible carer/family member around at all times? However it should not focus solely on risk factors. Just because there are no risk factors does not mean that there is not an ongoing underlying problem. In Tanya’s case, she has verbalised her symptoms to staff but has been reluctant to disclose if she has suicidal thoughts or intent. There is an immediate risk to Tanya’s safety if she is feeling suicidal or has intent. Are the carer/family members immediately aware of the risk factors? If not they should be informed.

• The Care Plan should incorporate (avoid negative comments) the consumer’s goals or achievements. It should focus on strengths rather than weaknesses. Portray highlighted problems in a positive manner (Tanya has disclosed that she feels worthless and guilty about her lack of motivation. She has talked about this with staff and is encouraged to keep informing them if she continues to feel like this. She is advised to seek further assistance if she is troubled by these feelings.)

• It should be concise and to the point, using simple language that the consumer and carer can understand. Avoid clinical jargon. Instead of: Tanya will use talking therapies when experiencing dysthymia, try: Tanya will talk to a support person when she is feeling sad and hopeless over the next seven days.

• Emphasise achievable goals. Overloading the consumer with too many goals may be overwhelming for their stage of recovery. Take the treatment phase one step at a time, with the most acute issues being addressed first. Avoid overwhelming the consumer with a long list of issues that may need addressing, even if these issues are important in the consumer’s overall care.

• Use realistic time frames and ensure the Care Plan is regularly updated emphasising the consumer’s achievements (positive reinforcement of these is important so that the consumer is aware of the progress being made). For example, Tanya will aim to be feeling more positive about herself in the next 72 hours. This is not achievable and the consumer is being placed under undue pressure. It is unlikely that these symptoms would disappear or respond so quickly to treatment with medications. Response to anti-depressant medications can take anything up to six weeks and the focus of the Care Plan should centre on strategies to reduce the distress during this period. For example: use of benzodiazepines for agitation and sleep disturbance if necessary, daily contact with the mental health team, coping strategies (relaxation tapes), regular risk assessments and education about the symptoms of the illness.
• Ensure that the consumer/Carer/family view is considered and realistic concerns for all parties are included in the document. For example, the consumer’s auntie states that Tanya’s presentation at interview with the mental health nurse is mainly congruent (similar) with how she is at home. Tanya reports loss of pleasure in her daily activities and she feels worthless and guilty about her lack of motivation. She is also experiencing early morning waking and reports poor concentration. She declines to answer questions relating to suicidal ideation. Tanya’s auntie informs the staff that Tanya has disclosed suicidal thoughts to her; however she has guaranteed that she would never harm herself or act on these. She has disclosed being embarrassed about having these thoughts and finds it very hard to talk about them with others. The auntie informs staff that she has a very close bond with Tanya and that Tanya approaches her when she has a problem. This indicates that the consumer’s reason for non-disclosure of suicidal ideation may have been more to do with personal issues than withholding information due to a firm plan or intent to carry through the act. It also indicates that the level and degree of risk is less than may have been previously believed. However it is still important to continue to perform ongoing risk assessments and to check with family members that the risk factors don’t alter.

• Also ensure the Care Plan is split into sections that emphasise the role of each individual involved in the consumer’s care. This gives all involved parties a sense of ownership in the recovery process and gives the consumer a sense of support and safety. It also reinforces to the consumer that they are not alone. For example, the consumer will participate in regular 1:1 sessions with the mental health nurse; the carer will offer the consumer support with daily activities; the health worker will visit the consumer at home every three days for a chat and to provide further medications or the mental health nurse will follow up with the consumer on a weekly basis.

• A copy of each Care Plan should be made available to all involved parties and a copy should be kept in the consumer’s file.

The frequency of visits/supportive follow-up for the consumer (eg daily, weekly, fortnightly, monthly etc) may be determined by a whole range of factors. These factors should indicate either increased or lower occasions of service dependant upon the effect they have on a consumer’s mental health. Some of these factors are:

• Level of chronic and acute issues;
• Increase in risk factors;
• Recent or recurrent admissions to hospital;
• Poor compliance with medications;
• Poor compliance with treatment plan;
• Level of insight on the consumer’s behalf into their condition;
• Continual stresses in the consumer’s activities of daily living. For example, a lack of financial income, poor living conditions, lack of community standing or lack of daily structure;
• Lack of adequate support network from family or friends;
• Poor physical health of a consumer;
• Exacerbation of the consumer’s depressive episode due to dual diagnosis factors (eg self medication with either illicit drugs or alcohol);
• Consumer’s vulnerability to exploitation from others in the community (eg physical or sexual assault, financial exploitation, stigma and shame attached to mental illness);
• Lack of access to mental health, health services due to remote isolation;
• Stage of recovery in the consumer’s care;
• Compulsory follow-up under provisions of the Mental Health Act 2000; and
• History of recurring relapse.

Ideally a consumer should have regular follow-up if any or all of the above factors have been identified as prominent issues in their Care Plan. However where intense follow-up is necessary, care and understanding should be given not to alienate the consumer. Emphasis should be placed on rapport building in a non-intimidating environment with awareness of some consumers' beliefs about shame and stigma attached to mental illness. Just because some clinicians believe in the demystification of the stigmas associated with mental health, this does not mean that the consumer accessing the service has the same view. Rapport building is vitally important to the concept of “continuity of care” as a long-term approach.

Checking for change

Utilisation of outcomes measures can be very beneficial in the ongoing care of the consumer and the direction taken based on the outcomes scores. Ideally a set of outcome measures should be used as the basis for determining the course of care and high scoring areas should be addressed in the care-planning document. However it is important that the consumer/carers have an understanding of the principles surrounding the measurements and that these are used when considering cultural issues relating to Indigenous consumers.

It is important to remember that if a health professional/worker is going to use the measurement tools they must first have formal training in the area to ensure that they have a full understanding of the concepts involved. Clarification should be sought at any point where a health professional/worker has difficulty understanding or scoring a particular item. This can be done by:

• Liaising with another worker whom has outcomes training;
• The local mental health clinician/worker; and
• The Zonal Outcomes Coordinator/Educator.

Whenever completing outcomes measures with Indigenous consumers, it is extremely important to be guided by the four principles identified in Chapter Three. Principle one reminds you to involve additional informants in your assessments that lead to outcomes ratings. Remember that carer/family involvement plays a big part in providing you with greater understanding of the consumer’s experience based on the additional information and insight that they can provide. You are also expected to utilise the expertise of the Indigenous health worker or mental health worker when completing assessments.

When using the outcome measures to assess a consumer possibly suffering from depression, it is always important to keep in mind certain specific issues. Some of these are:

• If the consumer’s self-care appears to be very poor, the health professional/worker should determine how long this has been for and whether it is within acceptable standards for that community. Poor self-care might indicate that the consumer has recently stopped caring for themselves and suggests they may be experiencing some of the symptoms of depression.
• When assessing a consumer’s mood, do not confuse shyness or shame with sadness or as evidence of low mood.

• Use simple language and do not assume that everybody's first language is English. A lack of response may be simply because the consumer cannot understand you and rather than evidence of flat affect. Avoid any terminology that might not be fully understood.

• A common belief amongst some Indigenous people is that revealing or showing emotion is a sign of weakness. This also should be considered when assessing flat affect.

• Remember that illicit substances can alter a person’s presentation and it is virtually impossible to obtain a clear picture of a consumer’s mental state when under the influence of these substances. A consumer presenting with a flattened affect may just be "stoned" from THC use. However it is also good to determine that there are no symptoms of depression when the consumer is drug free. The consumer may be self-medicating with illicit substances as a coping strategy for depression and excessive use could precipitate a depressive episode.

• Excessive alcohol consumption can also alter a consumer’s presentation and it is virtually impossible to obtain a clear picture of a consumer’s mental state. Alcohol consumption sometimes causes impulsive behaviours or acts, occasionally manifesting themselves in self-harming behaviour and/or suicidal ideation. Where there may be increased risk for the consumer while intoxicated, this usually (though not always) resolves when the consumer is sober. However it is vitally important to ensure that the consumer remains safe while intoxicated or withdrawing, until further assessment can be performed when they are not under the influence. There is every chance that the consumer's frequent alcohol intoxication may be a self-medicating strategy for depression or the alcohol may have exacerbated or precipitated these depressive symptoms.

Any information/data collected from the outcomes measures relating to the consumer’s care is confidential and it is important to reassure the consumer that all information obtained is not disclosed or used inappropriately.

**Considered clinical care**
With the Fifth “C” it is important that clinicians should consider, but not be limited to the recommendations. The guidelines are not absolute and should not necessarily be interpreted as standards of practice. Mental health professionals' care for patients with depression in many different settings, some of which are isolated and highly challenging, where it may not be feasible to apply all of the recommendations.
Depression

What is Depression?

People who are depressed are people who are feeling very sad inside.

They might:

- Not each much
- Walk round all night
- Cry for no reason
- Feel guilty
- Think of dying
- Sit down alone

Why am I depressed?

These things can cause depression

- Poor physical health
- Loss or bereavement
- Too much stress
- Too much Alcohol or Gunja or other drugs
- Family History (someone else in the family has the illness)
- Stopping usual treatments
- Breaking Law
What change helps if you are depressed or very sad inside?

OUTSIDE CHANGES
Family support
Elders
Traditional Healer
Clinic Mob
Mental Health Mob
Antipsychotic tablets with
dosette or Webster pack
Hunting, fishing, dance
Going to country
Stopping gunja, alcohol or
Other drugs

INSIDE CHANGES
Know about treatment
Remember totems, family, elders
Think with your head not
with your heart

How do you make change?

• Everyone can make change – when they are ready
• There are lots of different ways to change
• Telling people they SHOULD change doesn’t help
• Letting them know you think they CAN change does help
• Everyone changes in his or her own time
• Small steps can lead to big changes

This information sheet is produced by AIMHI NT – 2005. We invite your feedback and comments. (08) 89227943
Depression: a Guide for Primary Care Workers, Consumers and Carers

These guidelines are an adaptation of the “Guide to Treatment for Consumers and Carers” by Suzy Stevens, Don Smith and Pete Ellis for the Royal Australian and New Zealand College of Psychiatrists. It is intended as a general guide only and not as a substitute for clinical advice.

1. What is Depression?
Depression is characterised by significantly lowered mood and loss of pleasure or interest in things that are normally enjoyable. Most people feel miserable or “down in the dumps” at times. Usually these feelings fade over time, especially when people have other good things happening in their lives or found a way to cope with the change or loss.

However, when these feelings are intense and persistent, stopping us from doing the things we would usually do over a period of weeks or longer, it is possible that the depressed feeling has become an actual illness. Depressive illness can vary from just interfering with usual activities and relationships (mild to moderate depression), to being very debilitating (severe or “major depression”). Severe depression can make it seem impossible for the person to relate and communicate with others, or to do day-to-day tasks. This can even lead to psychotic experiences, where the person may believe, see or hear things that don’t seem to be real. In these situations, a mental health clinician, working with local family and health worker informants, can assist in understanding the situation and providing helpful assistance to the client and their family.

One very important aspect of depression is that it may cause a person to think about harming or even taking their own life. These thoughts can be distressing and the person may become fearful that they will act on them. Anyone who has thoughts of harming themselves should be urged to talk with trusted family members or friends and seek help at the health centre immediately. Talking with others often helps people to deal with those feelings and seek the help they need to ensure their safety.

There is seldom just one specific cause of depression. Sometimes depression happens without any apparent cause at all; at other times it occurs when people are coping with stressful events or experiencing prolonged stress. Examples of life events that can promote depression include:-
- the loss or death of someone you love
- having a baby
- being under pressure at work or unemployed
- trying to make ends meet on a low income
- feeling lonely
- having a chronic illness that takes away energy and demands major lifestyle change

More than one family member may experience depression. This is related to genetics (the physical make-up we are born with) or environmental factors that surround us, such as an unhappy childhood or relationship. Some factors protect us against depression, such as having supportive and close relationships.
Importance of depression
The prevalence of depression in the general population is 5.8% of adults, or about one in 25 people at any given time[1]. The rate is similar across age groups but reduced in persons 65 years and over. Depression is more common among females (lifetime prevalence of 10-26%) than males (lifetime prevalence of 5-12%). Mental and behavioural conditions (of which depression is a subset) are significantly more common in disadvantaged areas[1].

Depression in Aboriginal and Torres Strait Islander people
Information on levels of depression in Aboriginal and Torres Strait Islander populations is limited; however, it is at least as common, and probably more common, in this group. The terms people use to describe depression varies across cultures. In Aboriginal and Torres Strait Islander communities, people who are depressed may say:
- “I feel depressed”, “I’m sad”, “I’m blue” or
- “I’m slack”, “I feel all washed up”, “I’m no good – all washed up”

Health practitioners need to be attentive to local ways of communicating and be mindful when assessing an Aboriginal and / or Torres Strait Islander person’s mood:
- not to confuse shyness or shame with sadness or as evidence of low mood
- to use simple language and do not assume that English is the first language
- to be aware that a lack of response may be because the person cannot understand you, rather than evidence of flat affect

On the other hand, it is also important:-
- to be aware that a common belief among some Indigenous people is that revealing or showing emotion is a sign of weakness, so they may hide the way they really feel
- that the person may not know that constant sadness can be a sign of illness

Non-Indigenous clinicians are always advised to involve local health workers and family (as appropriate) in assessments when there is some concern that a person may be depressed.

2. Diagnosis
Diagnosis of depression is made by confirmation of symptoms listed which must be present for at least 2 weeks. There is no experience of mania or hypo-mania evident and substance misuse or physical disorders (e.g. hypothyroidism) have been ruled out.

Diagnostic criteria [2] include presence of a minimum number of symptoms:-
• restlessness or slowness observed by others
• inability to make decisions and can’t concentrate
• not sleeping OR sleeping too much
• self blame and feelings of worthlessness
• fatigue or loss of energy nearly every day
• feeling down all day
• thinking about death frequently
• no longer interested in favourite activities, and
• significant changes in weight or appetite.
3. Management Aims
Research (Hubble et al., 1999) has shown that the greatest contributions to positive outcomes in helping a person manage depression come from:-

- maximising the cooperation of the person and building a trusting relationship between client and health professional
- identifying and working on factors that appear to have contributed to the depression
- continuing with treatment for as long as is necessary to allow the person to become stable and then deal with the issues contributing to the depression
- ensuring functional alliances with family/friends, primary care providers, other mental health professionals to enhance the engagement of and support for the consumer in daily activities and health care
- maintaining cultural awareness and sensitivity and accessing cultural and primary language services that meet the traditional and spiritual needs of the client
- establishing local networks, practices and protocols for care of someone with a depressive illness
- identifying and addressing known risk factors for relapse

Management plans will vary with each person however the overall plan will include:-

- mental and physical health assessment
- actions that aim to remove the person's depressed mood such as
  - providing culturally safe and appropriate education and support
  - attention to addressing accompanying problems i.e. sleep, appetite, low activity level, social isolation, unfavourable relationships
  - recognising the signs and taking steps to prevent relapse.
- Actions that aim to enhance wellness and facilitate positive change
  - promoting the person’s ability to see and enhance their strengths
  - assisting the person to identify goals and steps toward achieving them
  - recognise healing and foster realistic hope

4. Relationship with other conditions / diseases
Depression often accompanies other physical health problems (such as diabetes and cardiovascular disease) and substance misuse problems (Burns and Teeson 2002). When other health problems exist together with and compound a mental disorder, this is called co-morbidity.

It is now known that depression can be a cause, a consequence and an aggravating factor in some chronic physical diseases. Most research has focused on depression and cardiovascular disease. For example, men with depression have a 71% increased risk of developing heart disease and are 2.3 times more likely to die of heart disease than non-depressed men [4,5].

History of depression is a common risk factor for self-harm and suicide[3], however it should not be considered a necessary prerequisite for suicidal behaviour. This is especially relevant for young Indigenous people for whom suicide is thought to result from a complex array of risks, including mental health status, alcohol use, impulsivity and the perceived ‘meaning’ of suicide within the social and cultural context (Hunter and Harvey, 2002).

The use of alcohol and other psychoactive drugs in depression is common, as people may turn to these drugs to help them “deal with” depressive feelings. However, this is often harmful, making the depression worse and the combination of alcohol/other drugs and depression increases the chances of self-harming behaviour.
5. Planning Care
When planning client care the following points should be considered:

- assessment of consumer’s mood and mental state to benchmark the client's stage of treatment and recovery
- inclusion of risk factors i.e. risk to self, others or risk from others including ongoing monitoring of suicide risk throughout treatment
- education of the client on what depression is, how they became depressed and the likely length of time their treatment may require
- details of support mechanisms
- incorporate goals or achievements - focusing on strengths. Limit goal setting to small achievable steps
- use realistic time frames and ensure the plan is regularly updated
- ensure that the consumer / carer / family view is considered
- split the care plan into sections that emphasise the role of each person involved
- consider previous experience with medication, physical health, living conditions and history of relapse
- consider ongoing relapse prevention and early intervention in any recurrence
- provision of a copy of the care plan to all involved parties

6. Treatment
Emerging evidence (Hubble et al., 1999; Grossman et al., 2004) shows the equal value of non-pharmacological approaches (cognitive behaviour therapy (CBT), interpersonal psychotherapy (IPT) and mindfulness-based meditation (MM) provided by suitably trained practitioners) to pharmacological treatments for some depression.

While there is increasing evidence that CBT, IPT and MM are as effective as antidepressants in many depressive illnesses, they should only be considered where an experienced practitioner is available. In communities where such expertise is not available the importance of a supportive relationship that encourages service access should not be underestimated. Addressing specific social and interpersonal difficulties should always be an integral part of counselling approaches.

Initiation of treatment will usually be for mild or moderate depressive disorders, which may occur with a physical or substance misuse problem. The level of depression governs the treatment options for the client and can range from mild depression without complications to severe and psychotic depression with the risk of suicide.

More general approaches to assisting people with depression, such as addressing drug and alcohol consumption, improving diet and increasing physical activity, should be universally applied (Hubble et al., 1999; Dunn et al., 2005). However, it is important to help the client set their own goals, make feasible plans to achieve them and gain support from others so there is not a risk of feeling a failure to meet unrealistic expectations.
6.1 Medication treatment for depression

<table>
<thead>
<tr>
<th>Class</th>
<th>Recommended drug</th>
<th>Dose range</th>
<th>Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serotonin Selective Reuptake Inhibitors (SSRI's)</td>
<td>fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram</td>
<td>according to individual and level of depression experienced</td>
<td>• A small number of people feel agitated on SSRI's and clients should be educated to tell their health professional immediately if this happens&lt;br&gt;• Concerns that they may prompt suicidal feelings have not been proven</td>
</tr>
<tr>
<td>Tricyclic anti-depressants (TCA)</td>
<td>imipramine, nortriptyline</td>
<td></td>
<td>• These are more likely to be used if the depression is severe and/or another treatment has not worked sufficiently.&lt;br&gt;• Side effects are more common than SSRI's, especially early in treatment.&lt;br&gt;• Not suitable when some medical conditions are present (such as)&lt;br&gt;• Dangerous in overdose</td>
</tr>
<tr>
<td>Serotonin &amp; Noradrenaline Reuptake Inhibitor (SNRI)</td>
<td>venlafaxine</td>
<td></td>
<td>• Particularly useful when other treatments have been unsuccessful or for severe depression.&lt;br&gt;• Side effects more similar to tricyclic anti-depressants</td>
</tr>
</tbody>
</table>

6.2 Mild and Moderate Depressive Disorders
This section outlines treatment strategies that are usually initiated through primary care settings. Specialist input should always be sought and decisions about community-based care versus hospitalisation must consider factors including existing health and social resources in communities.

6.2.1 Mild depression without any complications
Treatment should be provided within primary care and include:
- education about depression
- discussion and consideration of lifestyle changes
- helping the person develop problem-solving skills
- exploring with the person their relationships with significant others
- offering specific assistance as required
- providing supportive monitoring

There is no evidence supporting the use of pharmacological or psychological treatments for this group unless the symptoms persist beyond 8 weeks – then brief treatment with CBT and IPT or a Selective Serotonin Reuptake Inhibitor (SSRI), in addition to supportive management may assist.
6.2.2 Moderately Severe Depression (including co-morbid anxiety & dysthymia)
- treatment consists of an antidepressant and one of the brief psychological therapies (8–12 sessions of CBT or IPT) is indicated.
- monitoring should be weekly and include:-
  - review of side effects
  - assessing treatment benefits
  - identifying changes in stresses and circumstances
  - encouragement of compliance with treatment

At the end of a reasonable trial period, for example 4 to 6 weeks, treatment should be reviewed and revised as indicated. It is expected that input from specialist services will be limited to the initial phases, with primary service follow-up

6.3 Severe Depressive Disorders
This section discusses severe depressive disorders where specialist input should be obtained and hospitalisation considered. A care coordinator is recommended to manage the clients care in collaboration with other services particularly if substance misuse is also present.

6.3.1 Moderately severe depression with co-morbid substance abuse
Use interventions to reduce alcohol consumption and then treat as if moderate or severe depression. This will require explicit coordination of alcohol and drug, secondary mental health and primary care services.

6.3.2 Moderate to severe depression with physical disorders
Concurrent treatment of the physical disorder and depression in both secondary and primary care services is critical.

6.3.3 Severe depression with melancholia
Generally, initiate an antidepressant and once there has been a response, consider adding a psychological therapy (to either achieve a full response and/or reduce the risk of relapse).

6.3.4 Psychotic depression
Care should be provided by specialist mental health services (usually this will mean hospitalisation) until stabilised, and then continuing consultation/liaison with primary care services. Psychotic depression may require complex medication regimes and, at times, electro convulsive therapy (ECT).

6.3.5 Severe depression with risk of suicide
Assessment suicide risk in an acute presentation is achieved by asking a series of questions as set out in Primary Clinical Care Manual edition 5 – Depression. Care should be provided by specialist mental health services (this often involves hospitalisation) until stabilised, then continuing consultation/liaison with primary care services. In severe depression it is often necessary to proceed to second and third-line treatments at an earlier stage. For example, ECT is an effective treatment in depression that may have a place earlier or later in treatment depending on its nature and severity. In this situation, treatment in a hospital setting will be required.

Treatment away (hospital) from the depressed person’s home may be necessary to ensure greater supervision or specialised treatment is required, eg. ECT. The setting will need to be selected based on the client’s needs, level of expertise and support required. This may include friends/family, respite accommodation or inpatient hospital
care. Good communication between primary and secondary or tertiary services and the family is very important. A care coordinator will assist in this communication.

Summary of non-drug options for treatment of depression

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Considerations &amp; Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behaviour Therapy (CBT). There are several forms of this type of psychological (talking) therapy.</td>
<td>As effective as anti-depressants for mild to moderate depression, may provide skills that reduce risk of relapse. Can be difficult to find an expert therapist. Requires considerable commitment by person with depression.</td>
</tr>
<tr>
<td>Mindfulness Meditation Mood Management for Mindfulness (MMM) workshops or courses</td>
<td>As effective as anti-depressants for mild to moderate depression, may provide skills that reduce risk of relapse. Required experienced teacher or psychologist and commitment from person with depression, but gives long term benefit.</td>
</tr>
<tr>
<td>Interpersonal Psychotherapy (IPT) a particular form of psychotherapy that follows a treatment manual.</td>
<td>As effective as anti-depressants for mild to moderate depression. Can be difficult to find an expert therapist. Requires considerable commitment by person with depression.</td>
</tr>
<tr>
<td>Problem Solving Therapy (PST) is a form of CBT that looks at how you solve problems, not the problem itself.</td>
<td>May be available in general practice as part of the support for mild and moderate depression. Not all doctors are trained in this treatment.</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Levels of physical activity consistent with general public health recommendations is effective in treating major depressive disorder.</td>
</tr>
</tbody>
</table>

6.4 Relapse
Even when treated properly, depression sometimes returns. Sixty per cent of those who have an episode of depressive illness remain well over the next year; others can relapse during this time.

Some important points to keep in mind:
- those who have had three episodes of depression have a higher rate of recurrence
- of this group, 20% remain free of depression over three years
- the pattern of relapse varies between different people
- for some people, depression is more common at a particular time of year, for instance during the wet season, or at the time of the year when a significant event occurred in the past, such as the death of a loved one

6.4.1 Recurrent depression / failure to respond to first-line treatment
- check whether the client is taking prescribed medication regularly, discuss any problems they are having and possible solutions
- check adequacy of dose and adequacy of treatment period
- check diagnosis: consider second opinion and
- consider second line treatments

If first-line treatment was an SSRI or a psychological therapy, consider a switch to Venlafaxine or another antidepressant; or combine a course of one of the brief psychological therapies and an antidepressant.
The most important factor in the management of depression is to maintain the clients understanding of and their participation in their treatment regime for at least one year for a first episode and three years duration for a recurrent depression. Addition of a psychological therapy, such as CBT, MM or IPT, to the continuing and maintenance phases has been associated with lower relapse rates after 2-3 years. (Teasdale et al., 2000).

However, since depression is often recurrent, most presentations, even to primary care providers, will be for a second or subsequent episode of depression. The key intervention should be continuing with effective, acceptable treatment.

### 6.5 What to do at a depression check –up

<table>
<thead>
<tr>
<th>Goals</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical cause of depression is ruled out</td>
<td>Perform full physical examination – blood pressure, weight, respiratory rate, at initial visit including – pathology for thyroid function test (TFT), ? what other pathology (eg FBP, LFTs etc)</td>
</tr>
<tr>
<td>Identify current or past life problems or social stressors which may have contributed to depression</td>
<td>MSE is conducted to assist in gathering baseline assessment and benchmarking the client’s progress. It assists the client, family and clinician to understand how these problems and stressors have led to illness and to discuss ways to develop skills and strategies to deal with future challenges. Obtain a history or past depressive episodes and rule out psychosis</td>
</tr>
<tr>
<td>The client understands what depression is, treatment options available and what steps they can take to improve wellbeing</td>
<td>Education occurs on what depression is – see above. It also needs to be explained that it may have taken many years for them to get to this stage and that it may take a long time to deal with the depression.</td>
</tr>
<tr>
<td>Clients understand their medication</td>
<td>Consumer medication information is given about the clients medication and an explanation is given on how long they maybe required to take the medication. Side effects are explained (need to spell these out) Interaction with other medications and alcohol and other drugs such as beta-blockers, anti-hypertensives, oral contraceptives and corticosteroids</td>
</tr>
<tr>
<td>There is a trusting relationship between client and health professional</td>
<td>Counselling is offered to the client, and they participate in their care planning. They have one person who they can contact at the health centre who coordinates their care.</td>
</tr>
<tr>
<td>The client knows who and where to seek help if they feel suicidal</td>
<td>The client is assessed for suicidal risk by asking questions such as Do they have any ideas about suicide? Have they thought about death or dying? Do they have a plan about suicide? Also ask about risk to others and if they have access to weapons. Clients are given contact name and details for support services such as Life Promotion Officers, Crisis Counselling</td>
</tr>
<tr>
<td>The client has a short term plan on activities which may improve their enjoyment in life</td>
<td>The client is assisted to problem solve stressors in their life as they present which adversely affect their mental health. They are encouraged to resist negative thoughts and replace them with more realistic thoughts, resist pessimism and self-criticism</td>
</tr>
<tr>
<td>The client is able to sleep at night</td>
<td>Education is given on “sleep hygiene” practices which assist in getting a good night’s sleep. Such as cutting down alcohol or caffeine drinks before bedtime, personal hygiene practices, lack of interruptions and disruptive noise (if possible) during the night, comfortable bedding</td>
</tr>
<tr>
<td>The client knows about lifestyle choices that can help improve their health</td>
<td>Education is given about safe drinking levels, healthy nutrition, physical activity levels (exercise, where possible, is very important) and cessation of smoking</td>
</tr>
<tr>
<td>Steps are in place to address substance misuse (if appropriate)</td>
<td>Referral to alcohol, tobacco and other substance (ATODS) services occur to help client if dual diagnosis of substance misuse exists. Care coordinator is given feedback about consultations.</td>
</tr>
</tbody>
</table>
### 7. Care plan summary

<table>
<thead>
<tr>
<th>Action</th>
<th>Frequency</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dx</strong> Full physical health check</td>
<td>6 weeks</td>
<td>RN / HW / MO</td>
</tr>
<tr>
<td><strong>Dx</strong> TFT, what other pathology?</td>
<td>monthly</td>
<td></td>
</tr>
<tr>
<td><strong>Dx</strong> MST at 6 weeks</td>
<td>6 mthly</td>
<td>Specialist MH HW, RN / MO AND family</td>
</tr>
<tr>
<td><strong>Dx</strong> Medication review</td>
<td>6 mthly</td>
<td>MO AND family</td>
</tr>
<tr>
<td><strong>Dx</strong> Education on physical symptoms</td>
<td>6 mthly</td>
<td>Specialist MH HW, RN / MO AND family</td>
</tr>
<tr>
<td><strong>Dx</strong> Support systems</td>
<td>6 mthly</td>
<td></td>
</tr>
<tr>
<td><strong>Dx</strong> Feeding safe and secure – having worries</td>
<td>6 mthly</td>
<td></td>
</tr>
<tr>
<td><strong>Dx</strong> Coping strategies</td>
<td>6 mthly</td>
<td></td>
</tr>
<tr>
<td><strong>Dx</strong> Depression</td>
<td>6 mthly</td>
<td></td>
</tr>
<tr>
<td><strong>Dx</strong> Lifestyle issues</td>
<td>6 mthly</td>
<td></td>
</tr>
<tr>
<td><strong>ATODS service Review</strong></td>
<td>As needed</td>
<td>ATODS staff AND family if appropriate</td>
</tr>
<tr>
<td><strong>Education on nutrition, physical activity, smoking cessation and alcohol</strong></td>
<td>At 6 weeks</td>
<td>All staff</td>
</tr>
<tr>
<td><strong>Dx</strong> Weight</td>
<td>6 mthly</td>
<td>All staff</td>
</tr>
<tr>
<td><strong>Dx</strong> Blood pressure</td>
<td>6 mthly</td>
<td>All staff</td>
</tr>
<tr>
<td><strong>MO Review</strong></td>
<td>6 mthly</td>
<td>All staff</td>
</tr>
</tbody>
</table>

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**Further Information and Support**

Useful websites for depression include:
- [www.bluepages.anu.edu.au](http://www.bluepages.anu.edu.au)
- [www.beyondblue.org.au](http://www.beyondblue.org.au)
- [www.blackdoginstitute.org.au](http://www.blackdoginstitute.org.au)

Information about the location of mental health services is available through the local primary care centre or hospital.

Information is also in the Emergency Health and Help section of the local White Pages. Alternatively Lifeline’s “Just Ask” information line can be accessed on 1300 131 114.

Urgent telephone assistance is also available through: Lifeline 1300 131 114 (local call)

Kids Helpline 1800 55 1800 (free call)
Treatment for Depression: a Guide for Clinicians

These guidelines are an adaptation of the “Summary Australian and New Zealand Clinical Practice Guidelines for the Treatment of Depression” published in Australasian Psychiatry by Pete Ellis, Ian Hickie and Don Smith for the RANZCP Clinical Practice Guideline Team for Depression (Ellis, Hickie et al 2003) which are themselves based on the RANZCP full guidelines (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression 2004). NH&MRC-defined levels of evidence for each suggestion are recorded in the text and information regarding these is published elsewhere (Boyce, Ellis et al 2003; Boyce, Ellis et al 2003) and includes a description of the guideline development process. Consumer guidelines have also been developed. While the levels of evidence are retained in this document the reader is referred to the original documents for full referencing.

Overview
Depression is common, serious and treatable. The Australian and New Zealand Clinical Practice Guideline provides evidence-based treatment guidance across the spectrum of depressive disorders and delineates where specialist treatment and primary care management are indicated. This version covers the key contents of the guideline. It includes assessment, treatment and general management issues by category type and severity of depressive disorder. In Indigenous primary care settings initiation of treatment will usually be for mild or moderate depressive disorders which may be complicated by comorbid physical or substance misuse problems. These include:

- Mild depression without complications;
- Moderately severe depression (including with comorbid anxiety) and dysthymia;
- Uncomplicated, melancholic or atypical depression;
- Moderately severe depression with comorbid substance abuse; and
- Moderate to severe depression with physical disorders.

More severe depressive disorders will usually require prompt specialist assessment and intervention, at times hospitalisation. These include:

- Severe depression with melancholia;
- Recurrent depression or failure to respond to a preferred first-line treatment; and
- Psychotic depression, and severe depression with risk of suicide.

Continuing and maintenance treatments for recurrent depression are discussed. Emerging evidence of the equal value of cognitive behaviour therapy (CBT) and interpersonal psychotherapy (IPT) to pharmacological treatments for some depression is discussed, and the need to ensure that they are provided by suitably trained practitioners. Indications for hospitalisation and electroconvulsive therapy (ECT) are also provided.
Introduction

The diagnosis of depression
Two diagnostic frameworks are commonly used by mental health professionals, the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-IV) and the Mental Health Manual (10th Revision) of the International Statistical Classification of Diseases and Related Health Problems (ICD-10AM). The latter is now standard in Queensland Health. A comparison of the diagnostic guidelines for depression are presented in Appendix 1.

The prevalence of depression
Depression is common, serious and treatable. It affects 1 in 25 people in any one month. Information on levels of depression in Indigenous populations is limited. However, data from the Australian Institute of Health and Welfare reveal (AIHW) that for 1998-1999, the Indigenous:non-Indigenous standardised morbidity ratio for mood and neurotic disorders was 1.3 for Indigenous males and 1.2 for Indigenous females. For 2002 to 2003 the AIHW databases show that only 5.4% of Indigenous psychiatric hospital care days were attributed to depressive disorders (ICD-10). The real burden of depressive disorders is clearly much greater than these figures suggest and likely to be particularly so in remote and rural settings where access to community-based and hospital care is limited. This is supported by the much higher rates of completed suicide, particularly in the young adult Indigenous population.

Assessment
In addition to establishing rapport, assessment should include full evaluation and formulation, take into account social and cultural issues and include particularly:

• Risk assessment;
• Subtype, severity and duration of depression;
• Comorbidity (with medical and or other psychiatric and or alcohol and drug problems);
• Current stresses, strengths and supports; and
• Relevant personal and family history and past history of any mental illness.

Summary of treatment evidence
The evidence supports the following treatments provided as part of an overall clinical management plan. Every person with depression is an individual facing uniquely different circumstances. Their treating clinician should consider the extent to which the available evidence is pertinent to the treatment of this individual.

Components of an effective treatment plan include:

• A therapeutic relationship, which is essential to maximise benefits of treatment;
• Treatment alliances with patient, family/friends, primary care providers, other mental health professionals; and
• Access to cultural and primary language services.

The greatest contribution to a positive treatment outcome comes from:

• Maximising cooperation of the person with the selected treatment;
• Identifying and addressing known risk factors for relapse; and
• Maintaining a treatment regime for as long as is necessary to allow the person to stabilise (ie at least 1 year, and where there is a history or significant risk of recurrence at least monitor and treat proactively for three years).
These considerations considerably outweigh the limited advantages of one treatment over another. Figures 1 and 2 outline the stages generally indicated in the process of assessment and treatment. The research evidence on which these recommendations are involves carefully selected subjects in controlled clinical trials. The extent to which this reflects the complex circumstances of Indigenous settings and patients needs to be considered carefully in terms of considered clinical care.

**For all depressed people**
Provide education about depression and lifestyle changes that will assist recovery, mindful of identified stresses and supports. This should be ongoing to maintain changes achieved, and repeated if life circumstances change. Suicide risk needs to be monitored throughout treatment.

**Mild and moderate depressive disorders**
The following sections outline treatment strategies for depressive disorders that will usually be initiated and monitored through primary care settings. Specialist input should always be sought and decisions about community-based care vs hospitalisation often must take into account a range of other factors including existing health and social resources in Indigenous communities.

**Mild depression without any complications**
Treatment should be provided within primary care. It should include education about depression; examine the need for lifestyle changes; consider teaching problem-solving techniques; consider relationships with significant others and offer specific assistance as required; and provide supportive monitoring. There is no evidence for the use of pharmacological or psychological treatments for this group unless the symptoms persist beyond 8 weeks – then brief treatment with Cognitive Behaviour Therapy (CBT) or Interpersonal Psychotherapy (IPT) or a Selective Serotonin Reuptake Inhibitor (SSRI) in addition to supportive management may assist.

**Moderately severe depression (including with comorbid anxiety) and dysthymia**
Either an antidepressant and if possible, one of the brief psychological therapies (8–12 sessions of CBT or IPT) is indicated. Monitoring should be regular and include review of side effects, treatment benefits, changes in stresses and circumstances and encourage compliance. Monitoring should be at a frequency appropriate to the severity of the illness (at least weekly is suggested). At the end of a reasonable trial period, for example 4 to 6 weeks, treatment should be reviewed and changed/revised as indicated. It is expected that input from specialist services will be limited to the initial phases and thereafter will be consultative to primary services, which will manage long-term care.

**Severe depressive disorders**
The following sections deal with severe depressive disorders where specialist input should be obtained as soon as possible and where hospitalisation should be considered.

**Moderately severe depression with comorbid substance abuse**
Use interventions to reduce alcohol consumption and then treat as if moderate or severe depression. This will require explicit coordination of alcohol and drug, secondary mental health and primary care services.
Moderate to severe depression with physical disorders
Concurrent treatment of the physical disorder and depression in both secondary and primary care services is critical.

Severe depression with melancholia
Generally, initiate an antidepressant and once there has been a response, consider adding a psychological therapy (to either achieve a full response and/or reduce the risk of relapse).

Psychotic depression
Care should be provided by specialist mental health services (usually this will mean hospitalisation) until stabilised, and then continuing consultation/liaison with primary care services. Psychotic depression may require complex medication regimes and, at times, ECT.

Severe depression with risk of suicide
Care should be provided by specialist mental health services (as above, this will usually involve hospitalisation) until stabilised, and then continuing consultation/liaison with primary care services.

Recurrent depression or failure to respond to a preferred first-line treatment
- Check compliance;
- Check adequacy of dose and adequacy of treatment period;
- Check diagnosis: consider second opinion; and
- Consider second line treatments: if first-line treatment was an SSRI or a psychological therapy, consider a switch to Venlafaxine or another antidepressant; or combine a course of one of the brief psychological therapies and an antidepressant.

Continuing treatment
The most important factor in the management of depression is to maintain compliance with an effective treatment for at least one year for a first episode and three years duration for a recurrent depression. Addition of a psychological therapy to continuing and maintenance phases has been associated with lower relapse rates.

Maintenance treatment for recurrent depression
Depression is often a relapsing condition, so once the person has responded to treatment, ongoing relapse prevention and early intervention in any recurrence is essential. Indeed, most presentations, even to primary care providers, will be for a second or subsequent episode of depression and the treatments offered should acknowledge this. In this respect depression is similar to many medical conditions such as congestive heart failure or basal cell carcinoma, where risk of relapse is significant and ongoing monitoring is indicated. The key intervention should be continuing with an effective and acceptable treatment. The uses of CBT or IPT where there are residual symptoms or inadequate response have been associated with lower rates of relapse after 2 or 3 years.

Maintenance and relapse prevention should include:
- Arrangement of social support;
- Educate to recognise symptoms and reduce risk factors for relapse; and
- Proactive follow-up.
General management issues
Severe depression
In severe depression it is often necessary to proceed to second- and third-line treatments at an earlier stage. For example, ECT is an effective treatment in depression, which may have a place earlier or later in treatment depending on the nature and severity of depression. In this situation, treatment in a hospital setting that provides this treatment will be required.

While there is increasing evidence that CBT and IPT are as effective as antidepressants in many depressive illnesses, not all therapists are equally experienced or effective. Research studies of these therapies adhere strictly to versions of these therapies that follow treatment manuals and may not reflect usual practice. CBT and IPT should be considered where an experienced practitioner is available. In Indigenous communities where such expertise is often not available the importance of a supportive relationship that encourages service access should not be underestimated. Addressing specific social and interpersonal difficulties should always be an integral part of counselling approaches.

Hospitalisation
Treatment away from the depressed person’s usual home may be necessary to ensure greater supervision if they are:
- Suicidal;
- Unable to look after themselves;
- In a setting that is considered to be exacerbating their illness;
- In need of otherwise unavailable psychological support in severe distress; and
- If further specialised treatment is required eg. Electroconvulsive Therapy (ECT).

The setting for this will need to be selected on the basis of the depressed person’s needs, the extent and level of expertise or support required and the range of options available. This may include friends and family, respite accommodation, or inpatient hospital care.
Figure 1: Assessment and treatment of depression in specialist care

Establish rapport and then assessment of:
- Cultural issues
- Suicidality
- Comorbidity (ie: anxiety, substance abuse)
- Determine: duration, severity, melancholic/atypical/psychotic features

Ensure appropriate access to cultural and primary language services or support for the whole course of using available resources

Assess risk, implement management plan and treat depression

If co-morbidity:
- Alcohol and drug: treat first then depression
- Anxiety, treat in parallel or concurrent with depression

Ensure appropriate access to cultural and primary language services or support for the whole course of using available resources

Assess risk, implement management plan and treat depression

If co-morbidity:
- Alcohol and drug: treat first then depression
- Anxiety, treat in parallel or concurrent with depression

Mild Moderate Severe and/or melancholic Atypical Psychotic

Refer back to GP - ongoing treatment (see figure 2 for treatment) if:
- Inadequate response by 12 weeks
- More severe or psychotic
- Suicidal or likely to harm others then refer for further specialist assessment, treatment and/or support

First line treatments (as per algorithms)

- Check compliance and adequacy of dose
- Consider obtaining a second opinion
- Consider Second line treatments

Response

Inadequate response

Worse/suicidal

Continuation of an effective treatment (for at least 1 year for first episode and 3 years for recurrent)

Remission

Relapse

Maintenance and relapse prevention:
- Treat residual psychological issues
- Arrange social support
- Education to recognise symptoms and reduce risk factors for relapse
- Proactive follow-up for recurrent depression

Response

Inadequate response

Consider a second opinion
- Implement second/third/fourth line treatments (as per algorithms)

Recurrence
**Figure 2: Selection of evidence-based treatment for uncomplicated, melancholic or atypical depression**

**First Line: Mono-therapy:**
- Adjustment disorder of Mild - lifestyle, problem solving and monitor
- Dyathymia or Moderate - CBT/IPT or SSRI
- Severe uncomplicated - TCA, Venlafaxine, Nefazadone, SSRI or CBT/IPT
- Sever with melancholic - TCA or Venlafaxine
- Atypical (not necessarily severe) - Phenelzine or CBT/IPT

**Second Line:**
- If monitoring only add CBT/IPT or SSRI
- If TCA or Venlafaxine, review and increase dose
- If SSRI or Nefazadone switch to TCA or Venlafaxine (mild/mod add CBT)
- If TCA or Venlafaxine consider adding CBT/IPT
- If CBT/IPT then add TCA or Venlafaxine (mild/mod add SSRI)
- If atypical: Add other therapy (CBT/IPT or Phenelzine)

**Augmented or Combined:**
- Add lithium
- Consider high dose Venlafaxine

**Right unilateral ECT and an effective antidepressant (preferably during, certainly following, ECT)**

**Notes:**
1. If at any stage suicidal or otherwise at serious risk and not responding to current treatment, then consider ECT.
2. CBT or IPT should only be used if a practitioner of similar competence to that used in the research studies is available.

**Legend**
Levels of Evidence (NHMRC):
- Level I: Systematic Review of RCTS
- Level II: At least one adequate RCT
- Level III: Non-RCT study
- Level IV: Case series
- Level V: Expert opinion
**Figure 3. ICD 10 and DSM IV Criteria**

<table>
<thead>
<tr>
<th>ICD10 Criteria for Depressive Episode</th>
<th>DSM IV Criteria for Depressive Episode</th>
</tr>
</thead>
</table>
| In typical mild, moderate, or severe depressive episodes, the patient suffers from lowering of the mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimal effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt or worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by so called “somatic” symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of the symptoms, a depressive episode may be specific as mild, moderate, or severe. Includes single episodes of
  - depressive reaction
  - psychogenic depression
  - reactive depression
| Five (or more) of the following symptoms have been 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. Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.
  1. Depression mood most of the day, nearly every day, as indicated by either subjective report (eg, feels sad or empty) or observation made by others (eg, appears tearful). Note: in children and adolescents, can be irritable mood.
  2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation made by others)
  3. Significant weight loss when not dieting or weight gain (eg, a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: in children, consider failure to make expected weight gains.
  4. Insomnia or hypersomnia nearly every day
  5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
  6. Fatigue or loss of energy nearly every day
  7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
  8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
  9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
| Excludes:
  - adjustment disorder (F43.2)
  - Recurrent depressive disorder (F33.- )
When associated with conduct disorders in F91.- (F92.0)
The following fifth-character subdivision is for use with category F32:  
  0 = not specified as arising in the postnatal period
  1 = arising in the postnatal period
| B. The symptoms do not meet criteria for a mixed episode.
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not due to the direct physiological effects of a substance (eg, a drug of abuse, a medication) or a general medical condition (eg, hypothyroidism).
E. The symptoms are not better accounted for by bereavement, ie, after the loss of a loved one, the symptoms persist for longer than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.