Identifying and treating depression in general practice

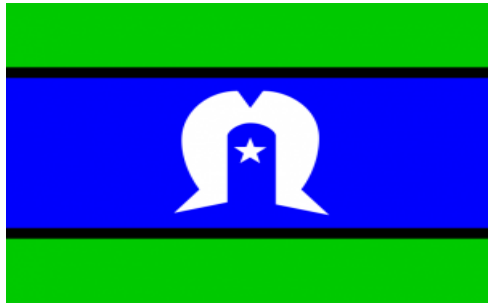
Wednesday 6 March 2024

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



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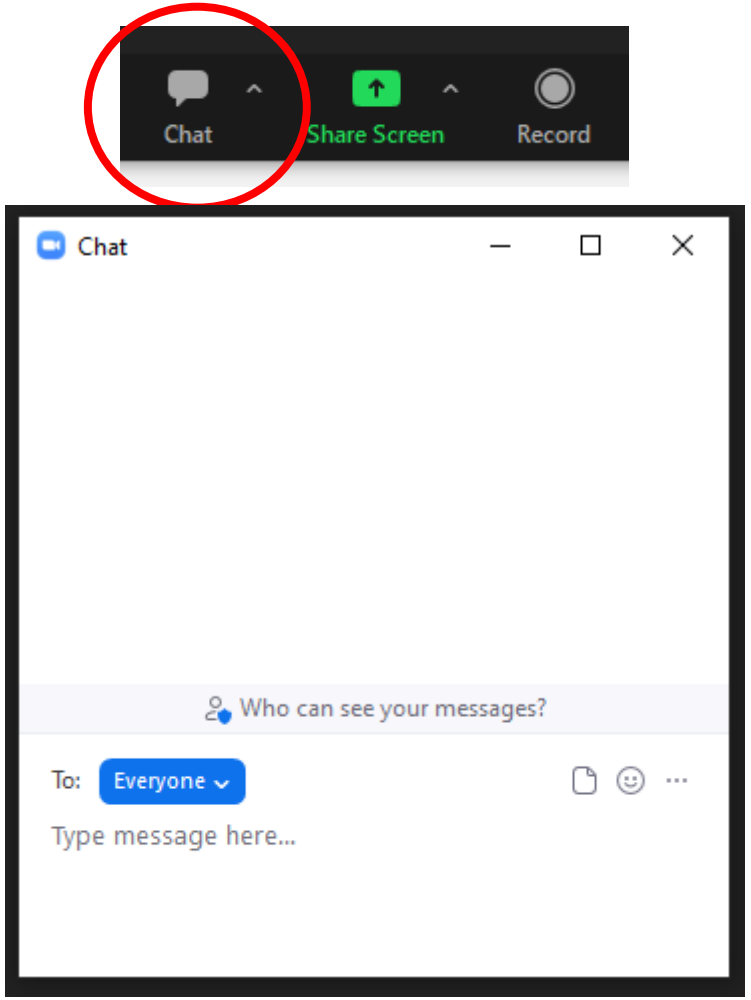

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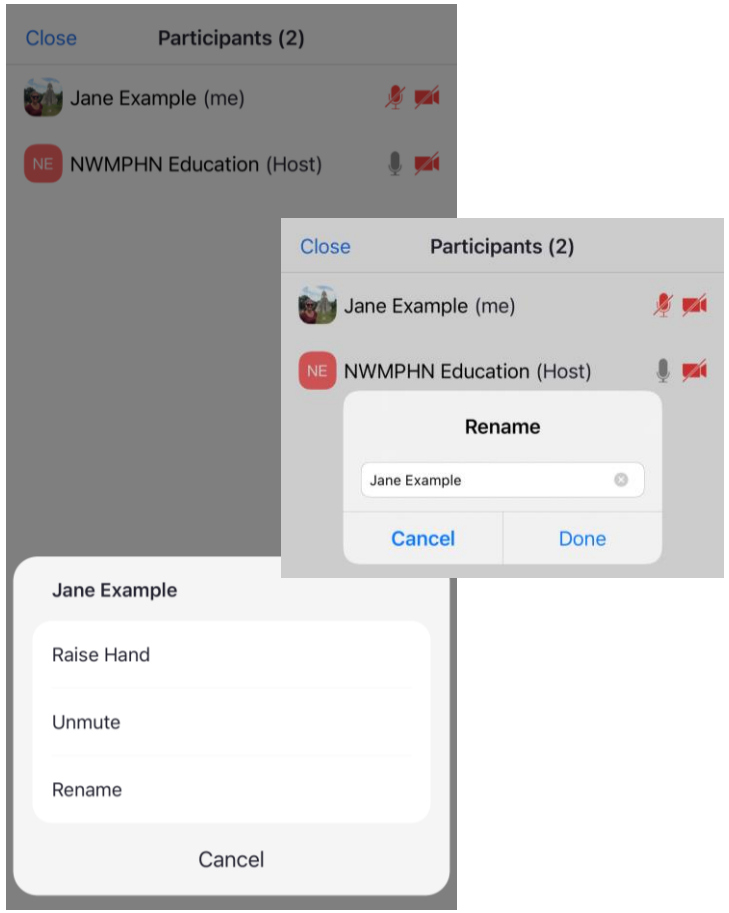

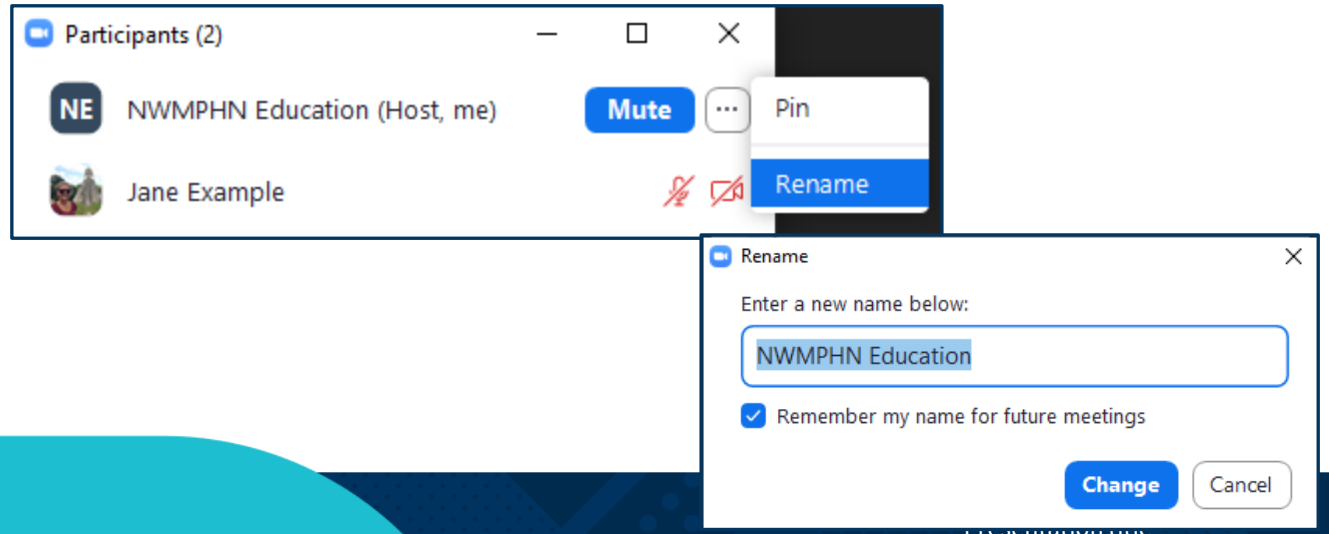

Speakers

Parwana Nawabi, Clinical Director, Senior Psychologist & Family Therapist - Clarity Health Care

- Parwana Nawabi is Clarity Health Care's Clinical Director and a senior psychologist and family therapist.
- She has extensive experience working with individuals and families across the lifespan. She works from an attachment-based and trauma-informed lens and has a special interest in working with a range of mood and anxiety disorders, interpersonal difficulties, grief, life transitions and adverse childhood experiences with a special interest in PTSD and complex PTSD.
- Parwana has held various clinical and leading positions across acute mental health, psychotherapeutic and holistic therapeutic teams.

Dr Matthew Warden, Psychiatrist - Clarity Health Care

- Dr Matthew Warden brings significant experience across public and private mental health services in Australia and the UK.
- His previous roles include Director of Acute Inpatient Services, ECT and MHA governance at St Vincent's Hospital, Melbourne; Consultant Psychiatrist in the Hobart and Southern Districts Community Mental Health Team, Tasmania; and a member of the Mental Health Act Tribunal in Tasmania. Dr Warden has also held academic roles with the University of Melbourne.
- Matthew obtained his MBBS in 1995, his MRC Psych in 2000 and his Diploma of Mental Health Law at Northumbria University, UK, in 2004.

Agenda

Introduction and housekeeping	5 minutes
Education component: Identifying and treating depression in general practice *Dr. Matthew Warden*	30 minutes
Case studies	30 minutes
Reflection on complex cases of depression and Q&A	15 minutes
NWMPHN Referral and Access team	5 minutes
Conclusion	5 minutes

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Identifying and treating depression in general practice

Dr Matthew Warden

ANZJP

Australian & New Zealand Journal of Psychiatry
2021, Vol. 55(1) 7–117
DOI: 10.1177/0004867420979353

The 2020 Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders

Gin S Malhi[1,2,3], Erica Bell[1,2,3], Darryl Bassett[4], Philip Boyce[5,6], Richard Bryant[7], Philip Hazell[6], Malcolm Hopwood[8], Bill Lyndon[1], Roger Mulder[9], Richard Porter[9], Ajeet B Singh[10] and Greg Murray[11]

The Royal Australian & New Zealand College of Psychiatrists

Abstract

Objectives: To provide advice and guidance regarding the management of mood disorders, derived from scientific evidence and supplemented by expert clinical consensus to formulate recommendations that maximise clinical utility.

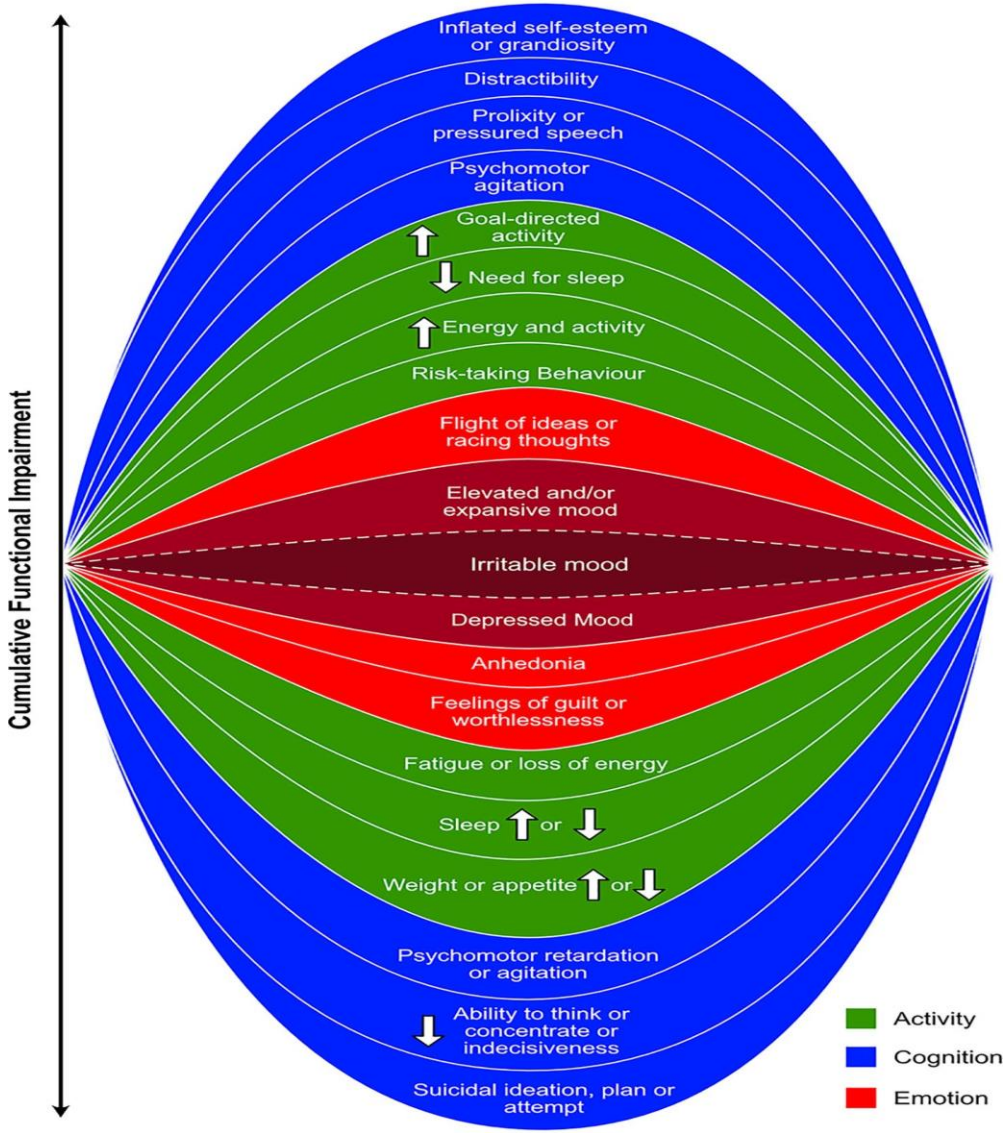
Methods: Articles and information sourced from search engines including PubMed, EMBASE, MEDLINE, PsycINFO and Google Scholar were supplemented by literature known to the mood disorders committee (e.g. books, book chapters and government reports) and from published depression and bipolar disorder guidelines. Relevant information was appraised and discussed in detail by members of the mood disorders committee, with a view to formulating and developing consensus-based recommendations and clinical guidance. The guidelines were subjected to rigorous consultation and external review involving: expert and clinical advisors, key stakeholders, professional bodies and specialist groups with interest in mood disorders.

Results: The Royal Australian and New Zealand College of Psychiatrists mood disorders clinical practice guidelines 2020 (MDcpg^{2020}) provide up-to-date guidance regarding the management of mood disorders that is informed by evidence and clinical experience. The guideline is intended for clinical use by psychiatrists, psychologists, primary care physicians and others with an interest in mental health care.

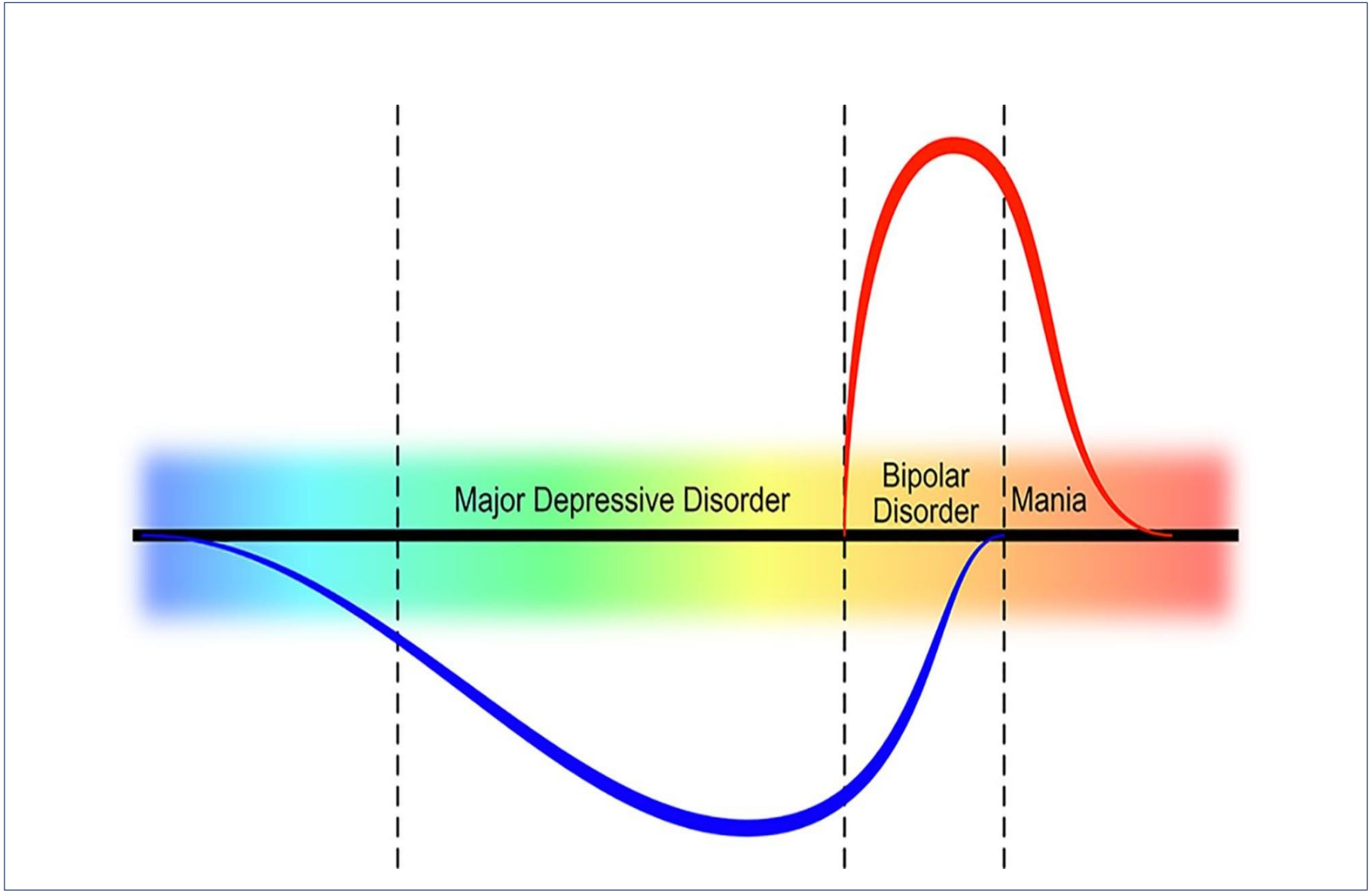
Conclusion: The MDcpg^{2020} builds on the previous 2015 guidelines and maintains its joint focus on both depressive and bipolar disorders. It provides up-to-date recommendations and guidance within an evidence-based framework, supplemented by expert clinical consensus.

Mood disorders committee: Gin S Malhi (Chair), Erica Bell, Darryl Bassett, Philip Boyce, Richard Bryant, Philip Hazell, Malcolm Hopwood, Bill Lyndon, Roger Mulder, Richard Porter, Ajeet B Singh and Greg Murray.

Figure 2. Symptoms of depression and mania according to DSM-5



This schematic shows the symptoms listed within DSM-5 for an episode of both mania and depression. These symptoms have been coloured according to the ACE domains (see 'ACE model', in section 6.1) in which they are predominant (Green = activity; Blue = cognition; Red = emotion). These symptoms, although producing cumulative functional impairment as more are present, are not ranked in any particular order (i.e. inflated self-esteem is not more indicative of mania than elevated and/or expansive mood).


Major Depressive Disorder
Bipolar Disorder
Mania

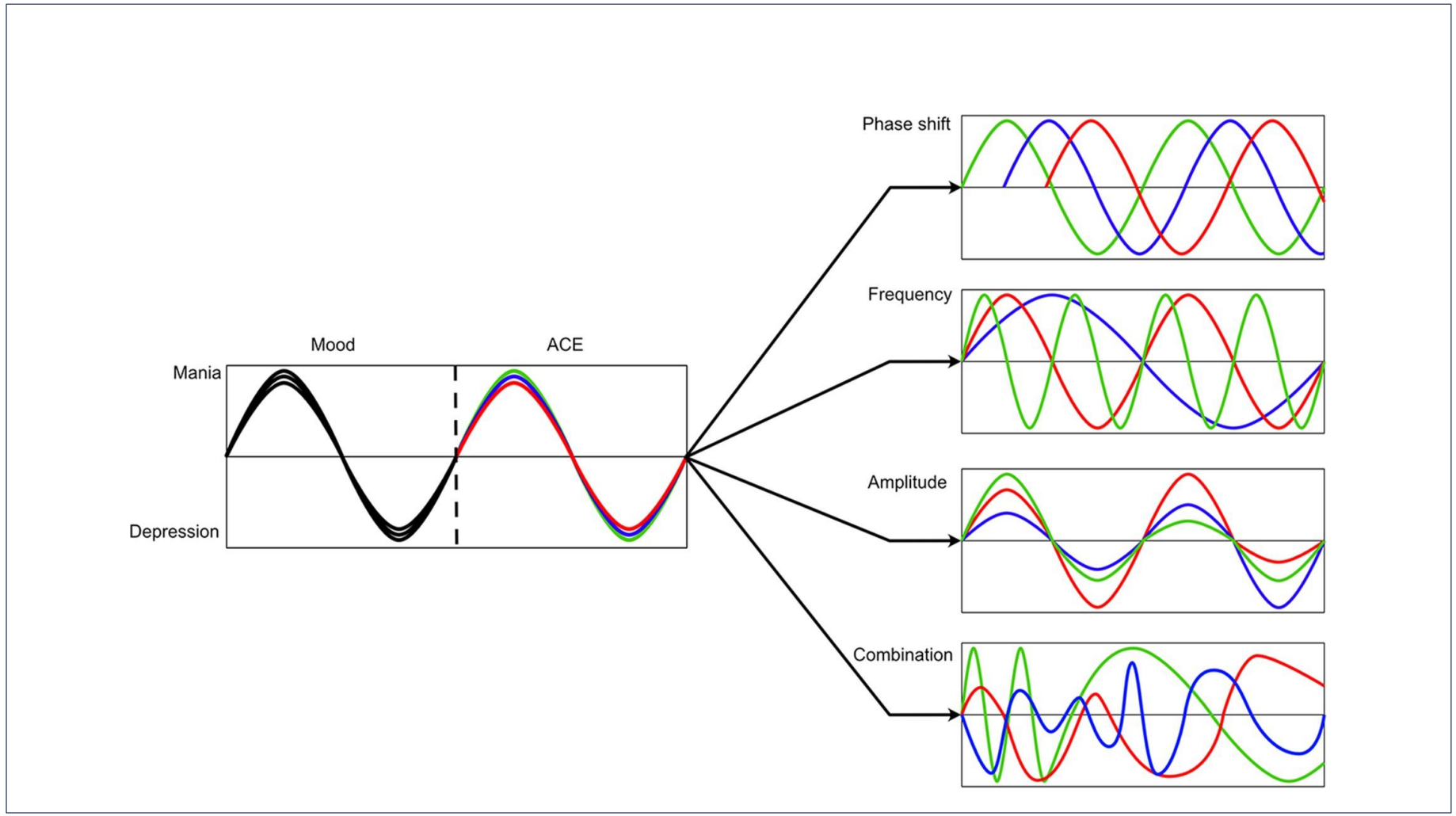
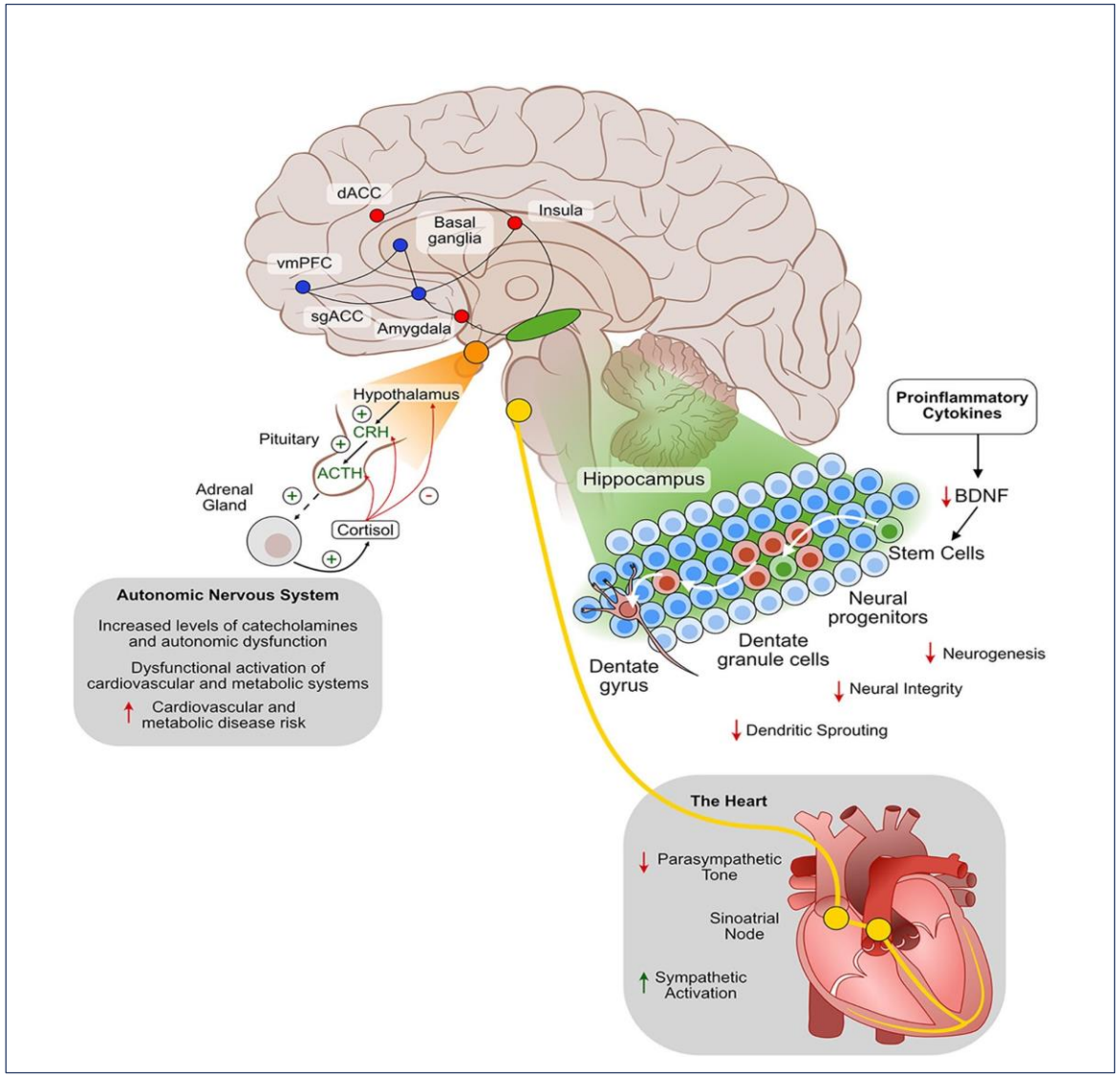
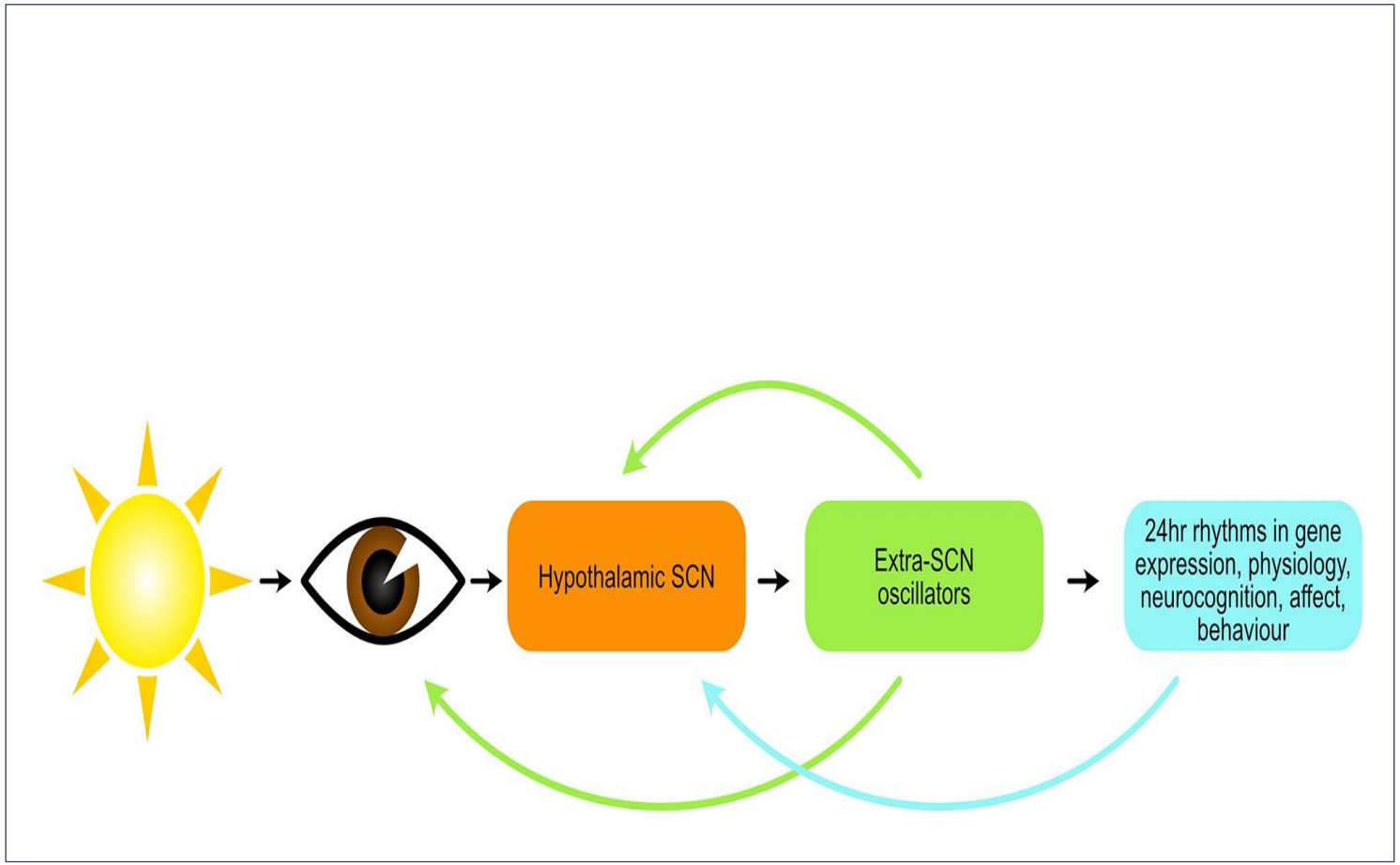


Figure 5. Ways in which uncoupling of symptoms from ACE domains leads to mixed presentations.

Figure 13. The neurobiology of mood disorders



This schematic shows some of the key nodes within neural networks thought to underpin emotional mentation. These brain regions and neural networks have individual functions and also serve collective functions and are impacted by their connections with each other and by influences and inputs from other parts of the body. Examples of these include connections with the neuroendocrine axis, in particular, the hypothalamic pituitary adrenal axis (HPA) that subserves responses to stress, and which in addition to being modulated by hormonal processes, is subject to autonomic nervous system control. Changes in the latter, and more specifically cardiac changes related to parasympathetic and sympathetic tone, can also modify inputs to the brain. A key region that is important to emotional processing and subject to many of these inputs, and itself provides outputs to many networks within the brain, is the hippocampus. The schematic shows the emergence of cells that begin as stem cells under the influence of brain-derived neurotrophic factor (BDNF). The generation of new cells and the many steps involved are all subject to influences such as those from proinflammatory cytokines that can diminish neurogenesis, neural integrity and reduce dendritic sprouting, thereby diminishing the functional capacity of the hippocampus. These types of changes within the brain that are driven by stress are thought to underpin the emergence of emotional disorders, such as depression and bipolar disorder. In addition, neural networks involved in emotional regulation and processing of emotion play a significant role, as do intrinsic biological factors that contribute to the development of necessary neural structures. Psychosocial and environmental factors are thus able to impact these complex systems and their sophisticated interactions, and it is disruptions within these that ultimately lead to changes that are reflected as clinical symptomatology of mood disorders.


Hypothalamic SCN
Extra-SCN oscillators
24hr rhythms in gene expression, physiology, neurocognition, affect, behaviour

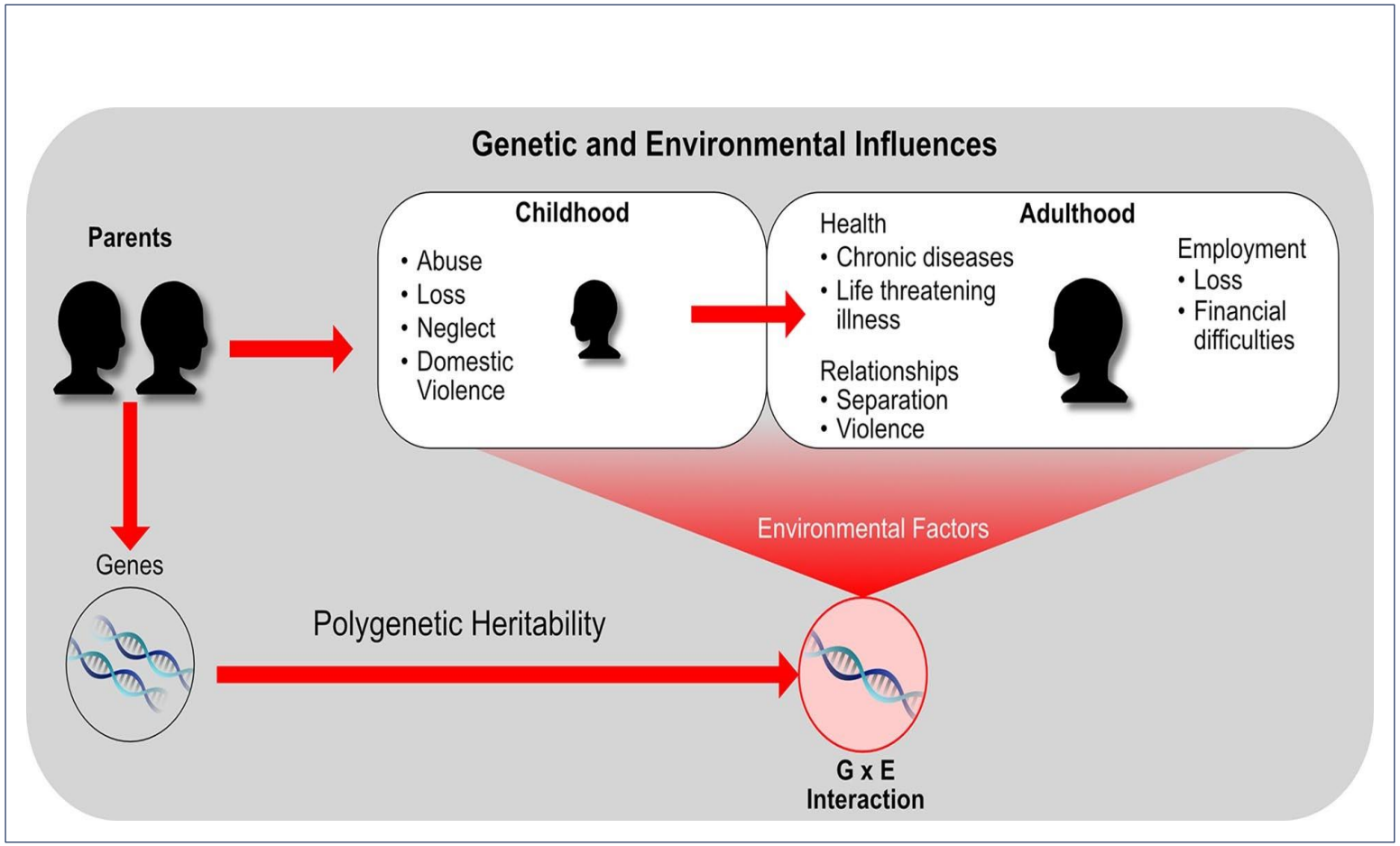
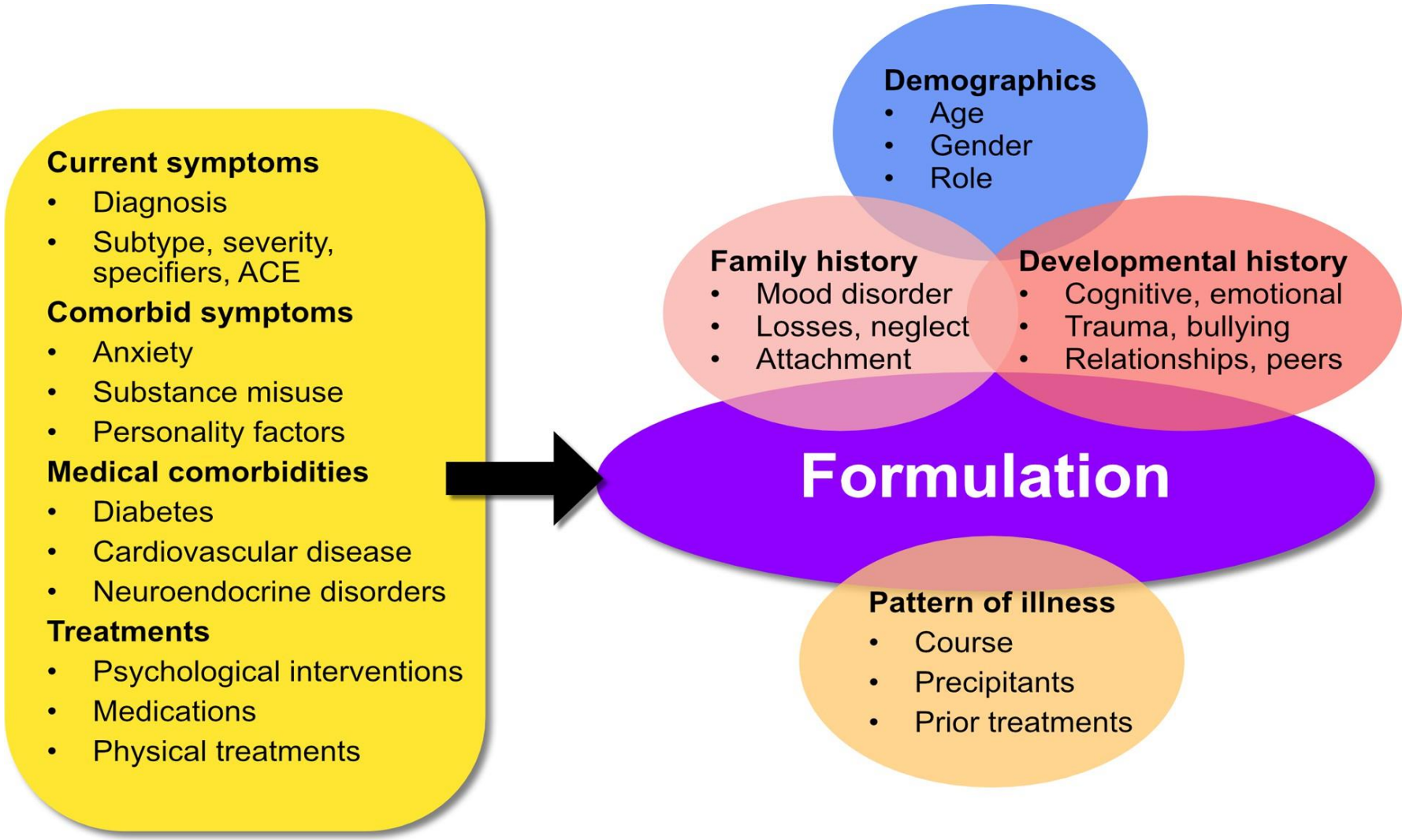
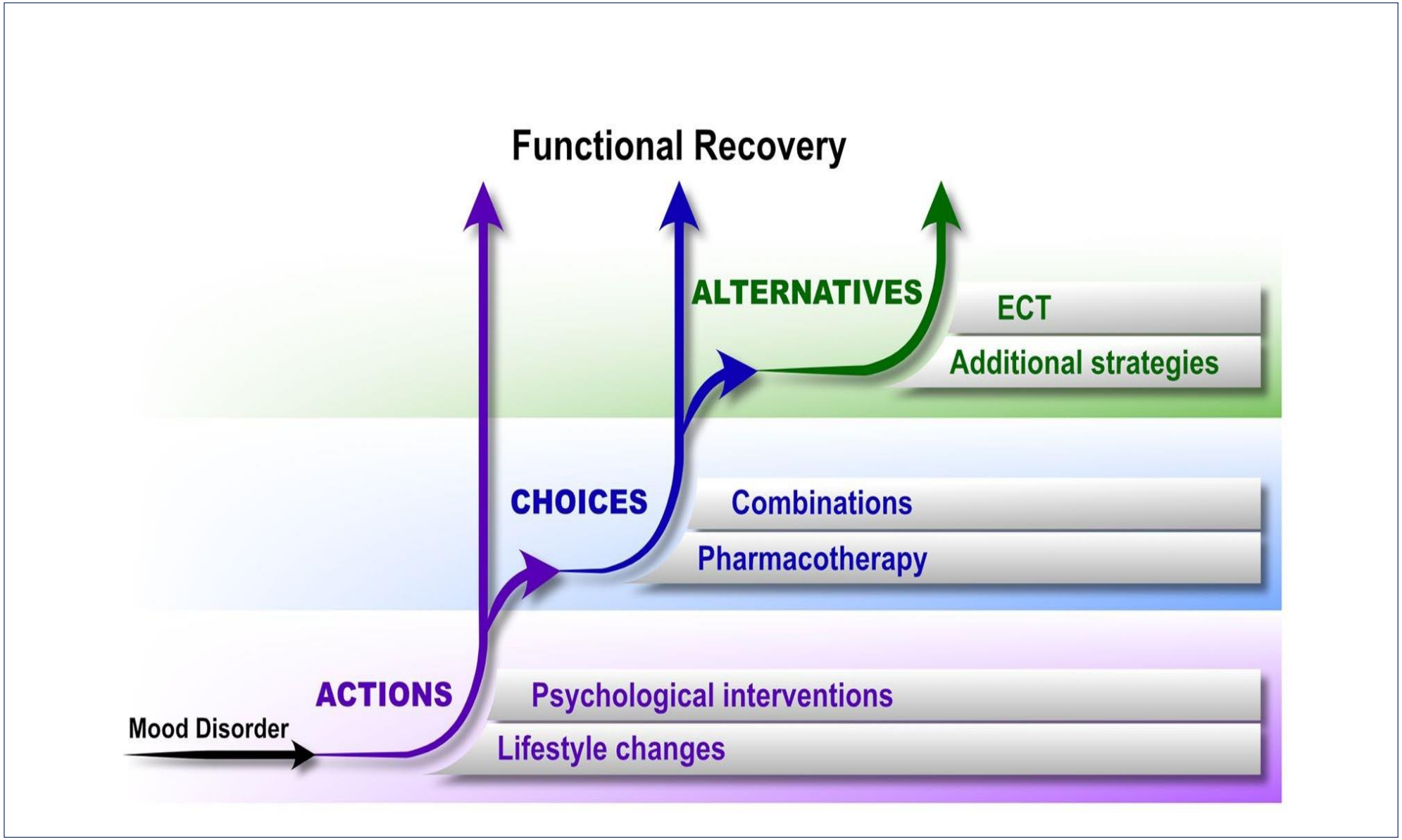


Figure 14. Genetic and environmental influences in the development of mood disorders.

Figure 16. Clinical assessment and formulation of mood disorders.



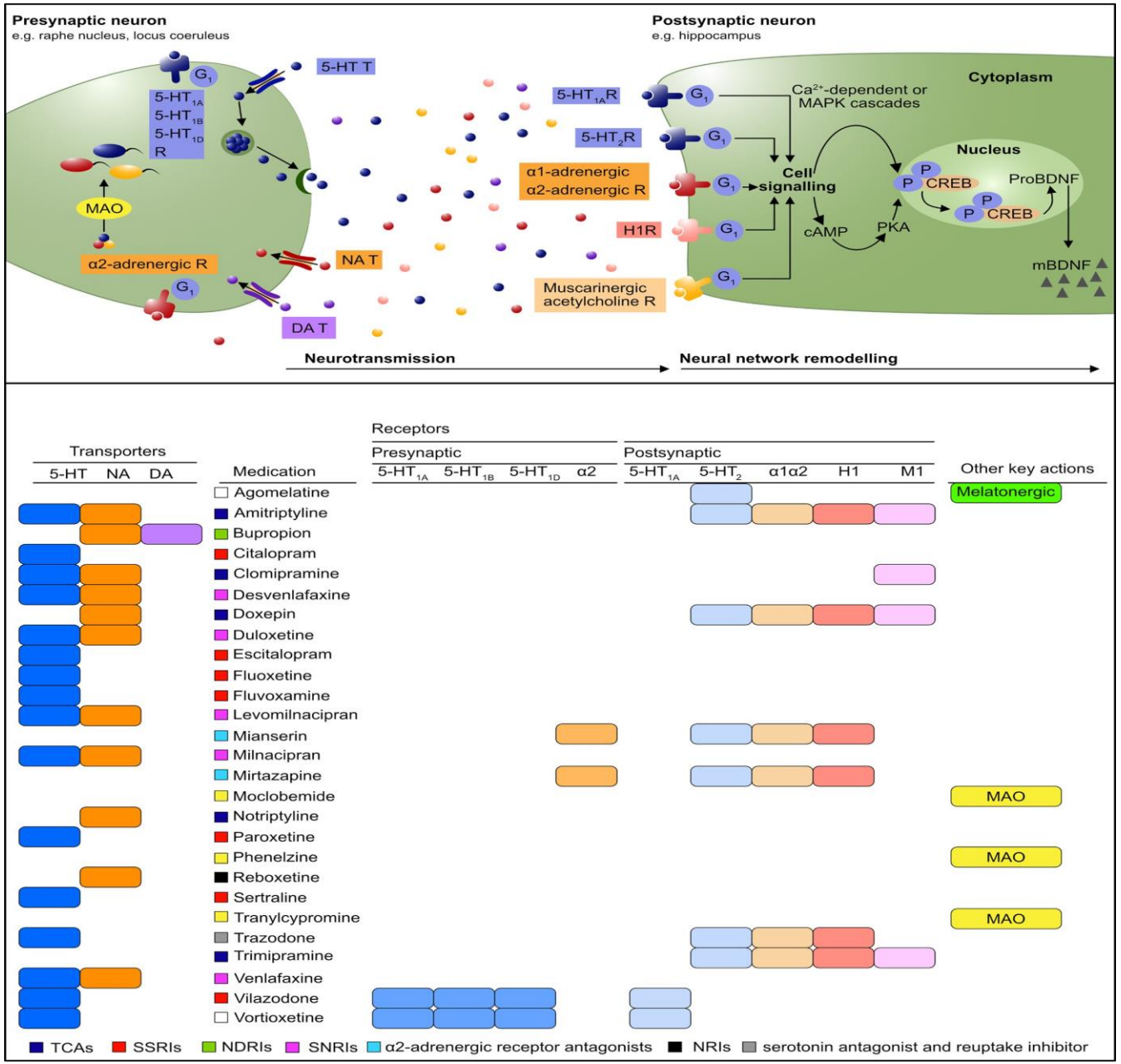
Level	Context	Diagnosis	Treatment
1	Self-care: general population - e.g. self-diagnosis via online questionnaire	Depressive symptoms and non-specific distress	Self-help approaches, internet or digital interventions
2	Outpatient care: GP, community services	Mild-moderate depression	Stepped care approach
3	Specialist service diagnosis	Bipolar disorder Severe major depression with: • Marked impairment • Psychosis • Melancholia • Treatment resistance	Later options in stepped care approach
4	Inpatient care: voluntary admission	Admission to hospital indicated • Severe depression with suicidal intent or • Agitated melancholia or • Psychotic depression or • Treatment-refractory depression or • Mania	Higher-level observation Complex pharmacotherapy ECT
5	Inpatient care: involuntary admission	As for level 4, patient at risk and not competent to make decisions (e.g. severe mania, catatonia)	As for level 4

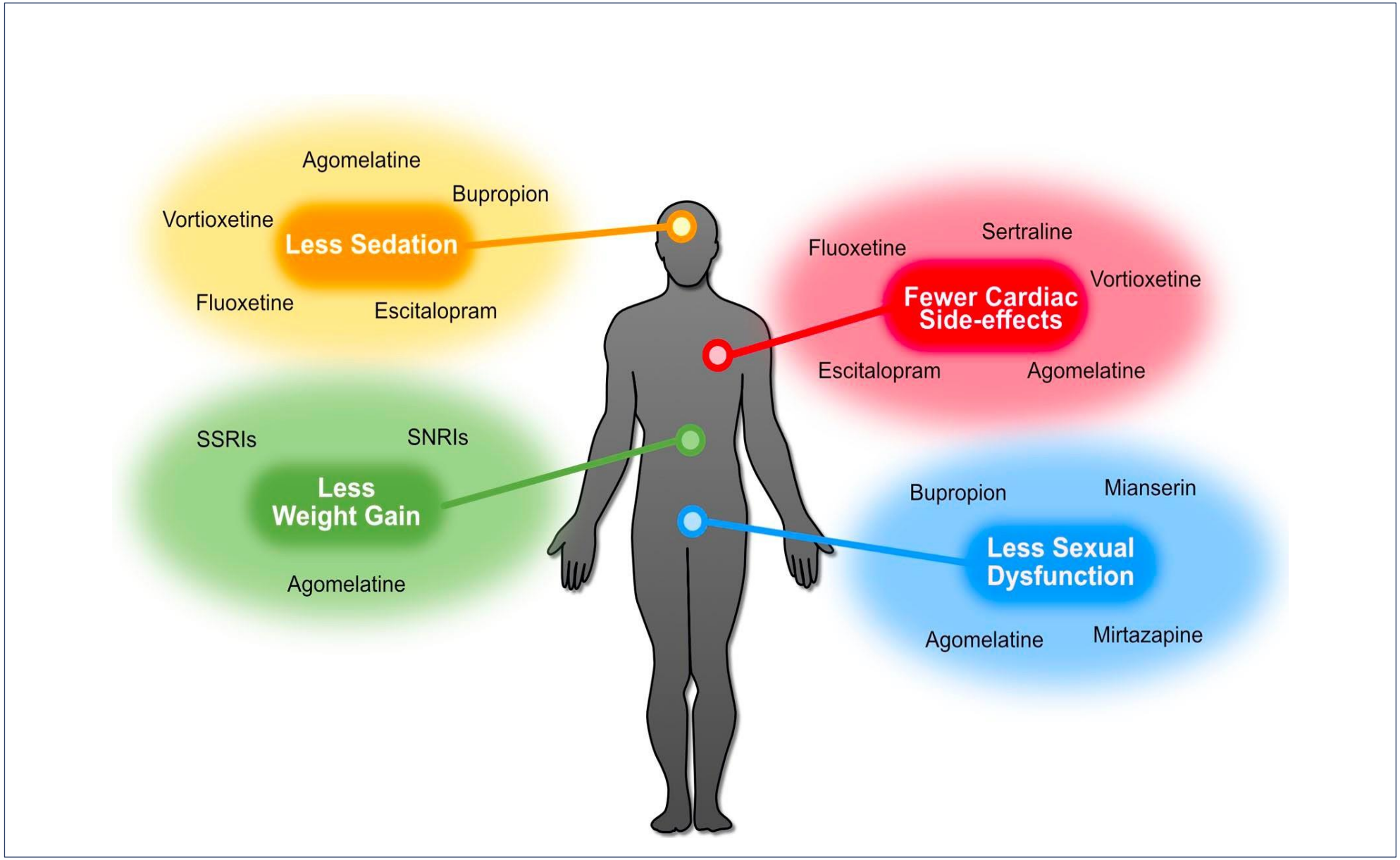

Functional Recovery
ALTERNATIVES
ECT
Additional strategies
CHOICES
Combinations
Pharmacotherapy
ACTIONS
Psychological interventions
Lifestyle changes
Mood Disorder

- Evidence for the efficacy of psychological treatment is derived from studies in which the intervention is delivered by trained therapists, under supervision, in a manualised form with high fidelity to a particular treatment brand. The evidence base therefore does not generalise to eclectic selection of elements from existing evidence-based treatments.
- CBT is by far the most commonly employed intervention and the most widely tested.
- Therapies with very different assumptions have indistinguishable effects, and the perennial 'common versus specific factors' debate remains open (Mulder et al., 2017).
- Clinical trials of psychological interventions have significant limitations, including the impossibility of patient blinding and the lack of long-term follow-up (see MDcpg[2015])
- Demonstrated effect sizes depend partly on the chosen control group (waiting list is probably a 'nocebo', generating the largest effect sizes).
- Publication bias has overestimated treatment effects, just as it has for antidepressant medication (Driessen et al., 2015b).

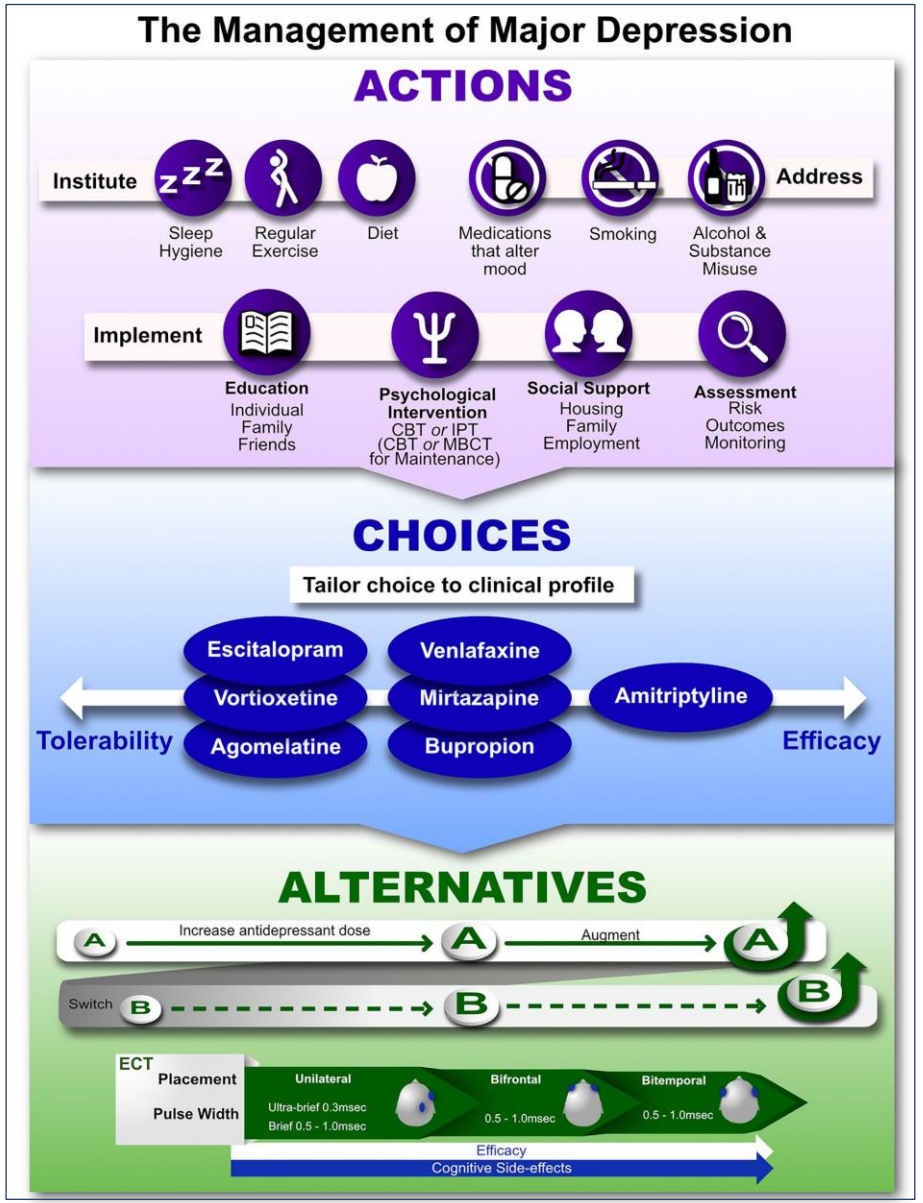
Site	Description
Head to Health	Government website to assist consumers identify digital resources and programs for a range of problems including depression
MindSpot	Online clinic, offering free evidence-based iCBT programs with therapist assistance for a range of problems including depression
This Way Up	Online clinic, offering low-cost therapist-assisted and self-guided evidence- based versions of iCBT-based programs; also contains useful supporting materials for clinicians
Mental Health Online	Online clinic, offering free self-guided and therapist-assisted evidence-based iCBT-based programs for anxiety syndromes (a behavioural activation approach to depression is forthcoming on this site)
MoodGYM	Evidence-based self-help program for depression
Mental Health Foundation of New Zealand	Web site introducing apps, e-therapy and guided self-help programs, including an online CBT-based depression program (GP referral required)
depression.org.nz	New Zealand National Depression Initiative culturally-sensitive site, including an online depression self-management program

CLASS	ANTIDEPRESSANTS
Selective serotonin reuptake inhibitors (SSRIs)	Escitalopram, citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline
Serotonin-noradrenaline reuptake inhibitors (SNRIs)	Venlafaxine, duloxetine, desvenlafaxine, levomilnacipran, milnacipran
Selective noradrenergic reuptake inhibitors (NRIs)	Reboxetine, atomoxetine, teniloxazine
Noradrenaline-dopamine reuptake inhibitor (NDRI)	Bupropion[c]
Noradrenergic and specific serotonergic antagonist (NASSA)	Mirtazapine[c], mianserin[c]
Serotonin partial agonist and serotonin reuptake inhibitor (SPARI)	Vilazodone
Serotonin receptor antagonist and serotonin reuptake inhibitor (SARI)	Vortioxetine,[a] nefazodone, trazodone
Serotonin-noradrenaline reuptake inhibitor and serotonin receptor antagonist (SNRISA)	Amoxapine[c]
Noradrenaline reuptake inhibitor with serotonin receptor antagonism (NRISA)	Maprotiline[c]
Tricyclic antidepressants (TCAs)	Amitriptyline, clomipramine, dosulepin, doxepin, imipramine, nortriptyline
Monoamine oxidase inhibitor (MAOIs)	Moclobemide,[b] phenelzine, tranylcypromine
NMDA-glutaminergic receptor blockers	Esketamine, ketamine
Melatonergic agonist and selective serotonergic antagonism	Agomelatine
Atypical antipsychotics with potent $5HT_{2A/2C}$ receptor blockade	Aripiprazole, brexpiprazole, lurasidone, quetiapine, olanzapine, risperidone
Neurosteroid progesterone analogue and gamma aminobutyric acid (GABA) receptor modulator	Brexanolone


Presynaptic neuron
e.g. raphe nucleus, locus coeruleus
Postsynaptic neuron
e.g. hippocampus
Cytoplasm
Nucleus
5-HT T
5-HT1A
5-HT1B
5-HT1D
R
MAO
α2-adrenergic R
NA T
DA T
5-HT1AR
5-HT2R
α1-adrenergic
α2-adrenergic R
H1R
Muscarinergic
acetylcholine R
Ca2+-dependent or
MAPK cascades
Cell
signalling
cAMP
PKA
P
CREB
ProBDNF
mBDNF
Neurotransmission
Neural network remodelling
Transporters
5-HT NA DA
Medication
Receptors
Presynaptic
5-HT1A 5-HT1B 5-HT1D α2
Postsynaptic
5-HT1A 5-HT2 α1α2 H1 M1
Other key actions
Agomelatine
Amitriptyline
Bupropion
Citalopram
Clomipramine
Desvenlafaxine
Doxepin
Duloxetine
Escitalopram
Fluoxetine
Fluvoxamine
Levomilnacipran
Mianserin
Milnacipran
Mirtazapine
Moclobemide
Notriptyline
Paroxetine
Phenelzine
Reboxetine
Sertraline
Tranylcypromine
Trazodone
Trimipramine
Venlafaxine
Vilazodone
Vortioxetine
Melatonergic
MAO
MAO
MAO
TCAs
SSRIs
NDRIs
SNRIs
α2-adrenergic receptor antagonists
NRIs
serotonin antagonist and reuptake inhibitor


Agomelatine
Bupropion
Vortioxetine
Less Sedation
Fluoxetine
Escitalopram
Fluoxetine
Sertraline
Vortioxetine
Fewer Cardiac Side-effects
Escitalopram
Agomelatine
SSRIs
SNRIs
Less Weight Gain
Agomelatine
Bupropion
Mianserin
Less Sexual Dysfunction
Agomelatine
Mirtazapine

Supplement	Comments	Level
Methylfolate	Methylfolate supplements are valuable in managing depression when specific polymorphisms of MTHFR gene are present.	II
Omega-3 fatty acids	EPA rich (>60%) omega-3 fatty acid supplements may be helpful in managing depression, but quality and EPA composition of supplements is an impediment.	II
Hypericum perforatum	*Hypericum perforatum* (St John's Wort) does appear to be helpful in some patients with depressive disorders but there are risks with some medication combinations; mania may be precipitated, and the dose is difficult to define. SSRI pharmaceutical agents are recommended instead.	III
S-adenosylmethionine	There is insufficient evidence to recommend the use of S-adenosylmethionine (SAM-e) in the management of depression.	IV
Cannabidiol	There is insufficient evidence to recommend the use of cannabinoids in the management of mood disorders.	IV


The Management of Major Depression
ACTIONS
Institute
Address
Sleep Hygiene
Regular Exercise
Diet
Medications that alter mood
Smoking
Alcohol & Substance Misuse
Implement
Education
Individual
Family
Friends
Psychological Intervention
CBT or IPT
(CBT or MBCT for Maintenance)
Social Support
Housing
Family
Employment
Assessment
Risk
Outcomes
Monitoring
CHOICES
Tailor choice to clinical profile
Escitalopram
Vortioxetine
Agomelatine
Venlafaxine
Mirtazapine
Bupropion
Amitriptyline
Tolerability
Efficacy
ALTERNATIVES
A
Increase antidepressant dose
A
Augment
A
Switch
B
B
B
ECT
Placement
Pulse Width
Unilateral
Ultra-brief 0.3msec
Brief 0.5 - 1.0msec
Bifrontal
0.5 - 1.0msec
Bitemporal
0.5 - 1.0msec
Efficacy
Cognitive Side-effects

General	Chills, malaise, flu-like symptoms, diaphoresis
Sensory	Paraesthesia, numbness, 'electric-shock-like' sensations, rushing noise 'in head', blurred vision, palinopsia
Disequilibrium	Light-headedness, dizziness, vertigo
General Somatic Symptoms	Lethargy, fatigue, headache, tremor, sweating, anorexia
Affective symptoms	Irritability, anxiety/agitation, low mood, tearfulness
Gastrointestinal symptoms	Nausea, vomiting, diarrhoea
Sleep disturbance	Insomnia, nightmares, excessive dreaming

Recommendation Box 4. Withdrawal of antidepressants		Grade
4.1	Inform patients when starting on an antidepressant that they may experience discontinuation and withdrawal symptoms and should not stop antidepressants abruptly and should discuss stopping their antidepressant with their treating physician	CBR
2.	The dose of AD should be tapered down with the dose lowered generally in at least weekly steps, and the rate of stepping down the dose needs to be tailored to the individual patient	EBR IV
	(a) Initially, titrate down to the recommended minimum effective dose of the antidepressant	CBR
	(b) Once minimum effective dose is achieved, reduce the dose by no more than 50% weekly	CBR
3.	For patients with one or more risk factors for withdrawal and discontinuation symptoms (treatment at higher than usual dose, long-term period on antidepressant, previous discontinuation and withdrawal symptoms or symptoms emerging with missed dose(s)), a slower taper is recommended.	EBR IV
	(a) Initially, drop to the recommended minimum effective dose of the antidepressant	EBR IV
	(b) Reduce the dose by small decrements (dependent on how the tablets can be cut up) every 2 weeks	EBR IV
4.4	For patients stopping their medication in order to switch to another antidepressant because of lack of efficacy or intolerable side-effects, a more rapid dose reduction can be used (over days) while the new antidepressant is introduced at a low dose and then the dose increased (provided there are no contraindications for this, such as switching to and from an MAOI).	CBR
	(a) Discontinuation/withdrawal symptoms from the first antidepressant (after careful review of the symptoms the patient reports) need to be distinguished from treatment emergent side-effects from the newly introduced antidepressant.	CBR

2

Case Studies

Dr Matthew Warden

Parwana Nawabi

Treating Depression with Pharmacology

Long standing depression

No significant trauma

Mild secondary anxiety

Check Diagnosis of Depression

Anhedonia

Persistent low mood

Biological symptoms

Previous Treatments

SSRI x4

SNRI X2

Benzodiazepines

Treatment Plan

Continue current SSRI (escitalopram)

Increase dose if side effects allow

Add brexpiprazole 0.5mg

Review in 3 Weeks

Mood significantly improved

Noted at day 2

Need to work to resolution of all symptoms

This is remission

Keep in remission for 6 to 12 months

Options to cease medication

Treating Depression with Psychotherapy

Major depressive disorder in DSM-5

At least 5 of the following symptoms have been present during the same **2-week period** and represent a change from previous functioning; **1 of the symptoms is either (1) or (2)**:

1. **Depressed mood, most of the day, nearly every day.**
2. **Diminished interest/pleasure (anhedonia), most of the day, nearly every day:**
3. Weight changes.
4. Sleep disturbances.
5. Psychomotor agitation (e.g. inability to sit still, pacing, hand-wringing etc.)/retardation (e.g. slowed speech, thinking, movement etc.).
6. Fatigue/loss of energy.
7. Feelings of worthlessness or excessive or inappropriate guilt.
8. Diminished ability to think or concentrate, or indecisiveness.
9. Recurrent thoughts of death/suicidal ideation.

The symptoms cause **clinically significant distress or impairment in** social, occupational, or other important areas of **functioning**.[3]

Interpersonal Psychotherapy (IPT) stands as the gold standard evidence-based treatment for Mood Disorders. In this case review, the focus will be on a client treated with IPT for Major Depressive Disorder.

Client Demographics:

Sarah is a 32-year-old woman who works as a marketing executive.. She presented with a history of recurrent depressive episodes, with her current episode lasting for six months. Sarah reported experiencing low mood, fatigue, sleep disturbances, decreased motivation and passive suicidal ideation. She described feeling disconnected from her friends and family, which further exacerbated her feelings of loneliness and worthlessness.

Presenting Problems:

Sarah's depressive symptoms significantly impacted her work performance, leading to frequent absences and decreased productivity. She struggled with maintaining relationships, often avoiding social interactions and isolating herself from others. Sarah expressed feelings of guilt and self-blame, believing that she was a burden to her loved ones. Despite previous attempts at therapy and medication, Sarah's symptoms persisted, she reported an overreliance on her GP for mental health support.

Comprehensive Psychological Assessment, Depression Scale and Questionnaire

BDI score	Level of depression	Category
1-10	Normal	1
11-16	Mild mood disturbance	2
17-20	Borderline clinical depression	3
21-30	Moderate depression	4
31-40	Severe depression	5
>40	Extreme depression	6

The Beck Depression Inventory (BDI)

The BDI is a 21-item, self-rated scale that evaluates key symptoms of depression including mood, pessimism, sense of failure, self-dissatisfaction, guilt, punishment, self-dislike, self-accusation, suicidal ideas, crying, irritability, social withdrawal, indecisiveness, body image change, work difficulty, insomnia, fatigability, loss of appetite, weight loss, somatic preoccupation, and loss of libido. Individual scale items are scored on a 4-point continuum (0=least, 3=most), with a total summed score range of 0–63. Higher scores indicate greater depressive severity.

The Patient Health Questionnaire (PHQ-9)

The PHQ-9 is an instrument for the identification of mild, moderate, moderately severe, and severe depression, with questions asked for a reference period of the last two weeks

Table 1 Interpretation of PHQ 9 total score

Total Score	Depression Severity
0-4	No depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

The BDI & PHQ-9 were administered at monthly intervals throughout the course of treatment.

Interventions

Grief: Sarah struggled with unresolved grief following the loss of her father several years ago. The clinician facilitated discussions to help Sarah process her feelings of loss and sadness, enabling her to work through her unresolved grief.

Role Transitions: Sarah recently experienced a significant role transition at work, which exacerbated her feelings of inadequacy and self-doubt. The clinician supported Sarah in adjusting to her new role, exploring coping strategies, and building confidence in her abilities.

Interpersonal Disputes: Sarah harboured unresolved conflicts with her mother, stemming from childhood resentments and unmet expectations. The clinician strategies for assertiveness and healthy communication.

Interpersonal Deficits: Sarah struggled with assertiveness and expressing her needs in relationships. The clinician utilised role-playing exercises and communication skills training to enhance Sarah's interpersonal effectiveness and assertiveness.

Conclusion

This case study highlights the effectiveness of Interpersonal Psychotherapy (IPT) in treating Major Depressive Disorder (MDD) by addressing interpersonal issues. Through targeted interventions, Sarah experienced significant symptom relief and improved interpersonal functioning. IPT offers a structured and evidence-based approach to treating depression, emphasising the importance of interpersonal relationships and the role of community in mental health recovery.

Interpersonal Psychotherapy (IPT)
What is it?

IPT is a time-limited psychotherapy that focuses on interpersonal issues, which are understood to be a factor in the genesis and maintenance of psychological distress. IPT is considered a form of Cognitive Behaviour Therapy, however the model is more effective in treating depression as is takes steps from psychoanalytic theories to focus on the underlying issue of the problem and not just the presenting problem

The Interpersonal Triad

IPT is explicitly based on a Biopsychosocial/Cultural/Spiritual Model. IPT works from the premise that interpersonal distress is connected with psychological symptoms

HealthPathways-Depression

Disclaimer: For presentation purposes only

Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts

- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available to my patients

Depression in General Practice related and relevant pages

Related Pathways

Depression in Children and Adolescents

Depression in Adults

Depression in Older Adults

Child and Youth Mental Health

Medications for Depression and Anxiety (Pregnancy and Breastfeeding)

Medications for Depression in Adults

Medications for Depression in Older Adults

LGBTIQA+ Mental Health

Pregnancy and Postpartum Mental Health

Psychosis

Self-harm

Suicide Prevention

Relevant Pathways

Alcohol and Other Drugs

Anxiety in Adults

Anxiety in Children and Adolescents

Bipolar Disorder

Practical Prescribing Guide

Safe Script

Depression in General Practice referral pages and related services

Referrals

Adult Mental Health Service Referrals

- Acute Adult Psychiatry Referral (Same-day)
- Non-acute Adult Psychiatry Referral (> 24 hours)
- Adult Psychological Therapy and Counselling Referral

Acute Child and Adolescent Psychiatry Referral or Admission

Transgender Health and Gender Diversity Referral

Perinatal Mental Health Referrals

Related Services

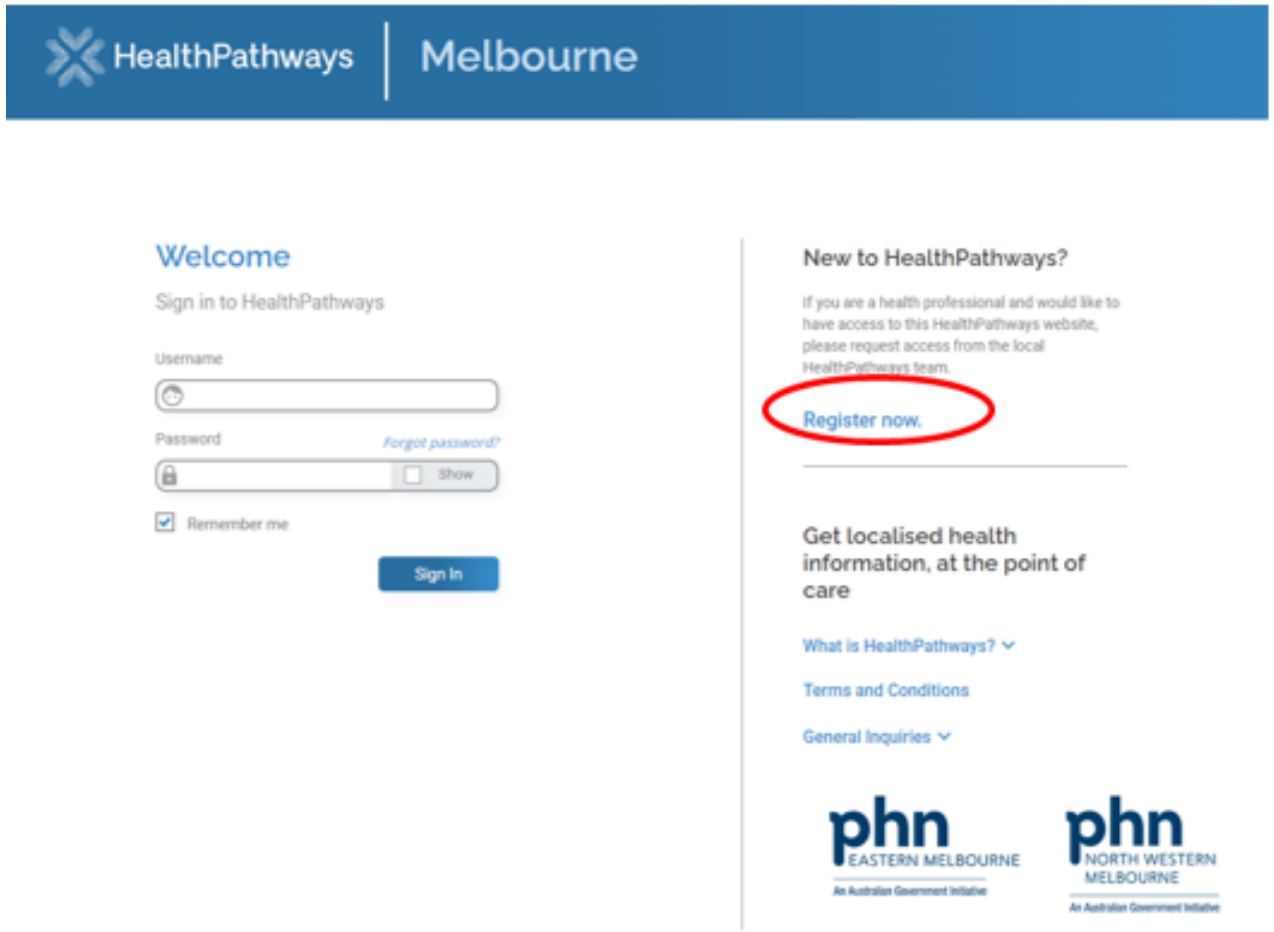
Carer Support - Mental Health

E-Mental Health Services

GP Mental Health Treatment Plan

Mental Health Community Support Services

Accessing HealthPathways: Go to melbourne.healthpathways.org.au



Register via QR code

info@healthpathwaysmelbourne.org.au

Disclaimer: For presentation purposes only

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Reflection on complex cases of depression

Dr Matthew Warden

Parwana Nawabi

This is the space to engage in a large group discussion regarding your experiences in identifying and treating depression in general practice.

Do you have any questions for Matthew & Parwana?

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NWMPHN Referral and Access team

Paulette Belcastro

Referral and Access Team for Head to Health and CAREinMIND Services

Our response promotes a person-centred approach, matching people with available supports according to their specific mental Health needs.
Service navigation is undertaken through our Referral and Access team, that consists of experienced Mental Health Clinicians. The team can assist to link people in with mental health services within the NWMPHN catchment.
Services range from suicide prevention (not crisis care), targeted therapeutic intervention and even care co-ordination for people who are experiencing chronic and complex mental illness who can be managed in the community.
PLEASE NOTE: We are not equipped to manage patients in crisis. Referrals should be made to Psych Triage in these instances.

NWMPHN mental health services are designed to improve access to mental health support for people who cannot easily access services due to financial constraints and for people from priority populations.

You can refer using the Referral Form which can be found on the PHN website and can be downloaded in a variety of formats and into your systems.
The more information you provide about a patient's current presentation and reason for referral, the faster and more accurate the navigation into services.
Information can include the history of mental illness, potential triggers, current stressors as well as any Dx.
These forms have been designed so that you can bill Medicare for Mental Health Care Plan.

If your patient is not ready to talk or engage in therapy, then they can be given the Head to Health number – 1800 595 212. The patient can then call when they are ready. At this time, they will then undertake an Intake Assessment and linked in with appropriate mental health services.

Session Conclusion

We value your feedback, let us know your thoughts.

Scan this QR code

You will receive a post session email within a week which will include slides and resources discussed during this session.

Attendance certificate will be received within 4-6 weeks.

RACGP CPD hours will be uploaded within 30 days.

To attend further education sessions, visit,

https://nwmphn.org.au/resources-events/events/

This session was recorded, and you will be able to view the recording at this link within the next week.

https://nwmphn.org.au/resources-events/resources/