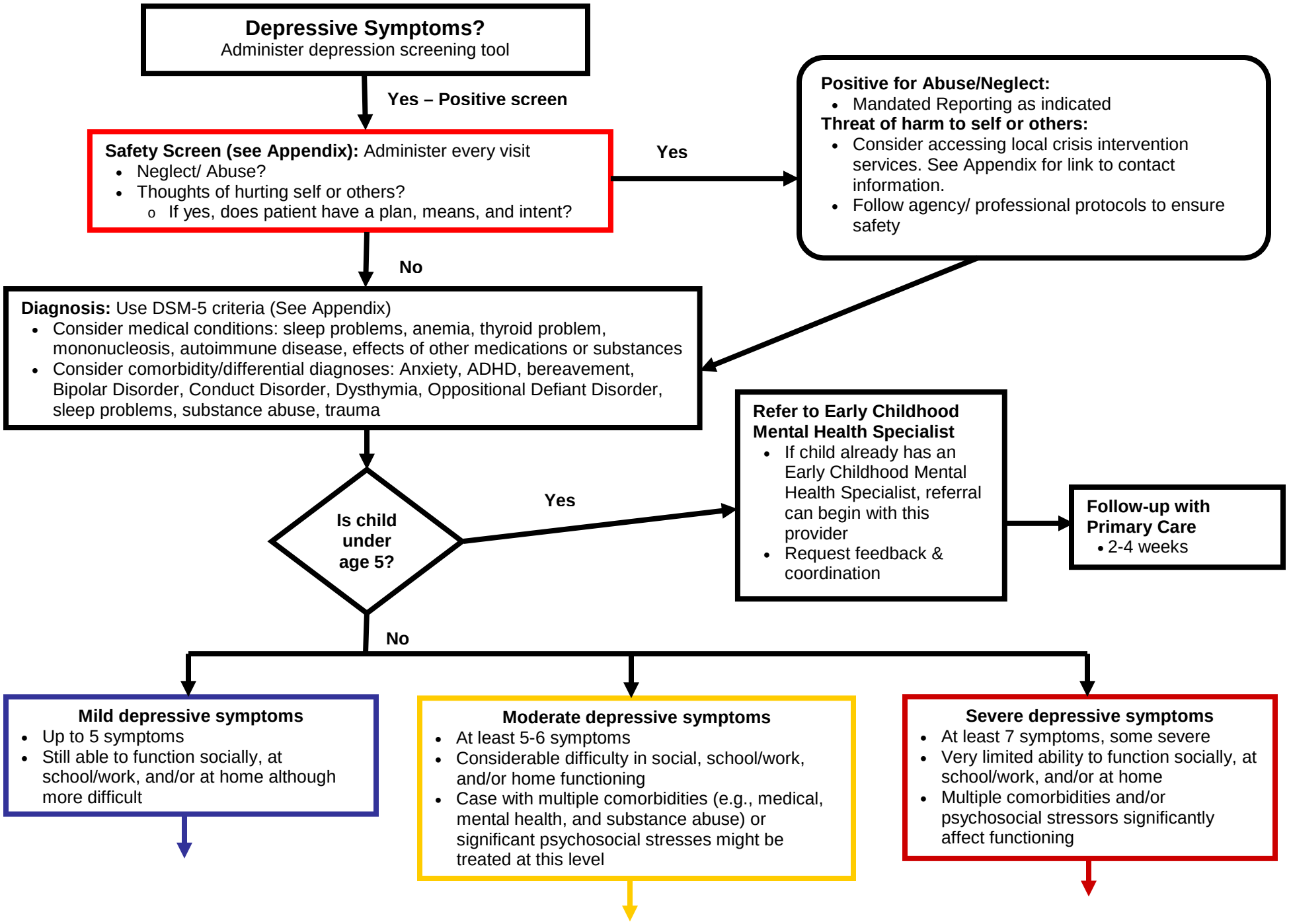
Depression Assessment & Treatment



Depression Assessment & Treatment

Mild depressive symptoms

Educate patient & family:

- Support increased peer interactions
- Encourage good sleep hygiene, activity selection, and exercise
- Reduce stressors
- Secure items that increase risk for harm (e.g., firearms, medications, etc.)
- Offer parent/child further reading resources
- Encourage collaboration with school professionals

Patient or family may opt for immediate referral for mental health specialist (psychologist, social worker, etc.).

Follow-up appt: 4-6 weeks*

- Repeat screening instrument
- If not improving on own, referral to mental health specialist for therapy (as with moderate symptoms on right)

Moderate depressive symptoms

Referral for therapy:

- If child already has a Mental Health Specialist, referral can begin with this provider
- Request information and coordination following referral
- See Appendix for evidence-based treatments and components

Educate patient & family:

- Support increased peer interactions
- Encourage good sleep hygiene, activity selection, and exercise
- Reduce stressors
- Secure items that increase risk for harm (e.g., firearms, medications, etc.)
- Offer parent/child further reading resources
- Encourage collaboration with school professionals

Follow-up appt: 2-4 weeks*

- Review collaborative information
- Repeat screening instrument
- Consider medication (as detailed under severe)

Severe depressive symptoms

Referral for therapy:

- If child already has a Mental Health Specialist, referral can begin with this provider
- Request information and coordination following referral
- See Appendix for evidence-based treatments and components

Educate patient & family:

- Support increased peer interactions
- Encourage good sleep hygiene, activity selection, and exercise
- Reduce stressors
- Secure items that increase risk for harm (e.g., firearms, medications, etc.)
- Offer parent/child further reading resources
- Encourage collaboration with school professionals

Consider medication:

- Wait 4 weeks between dose increase and monitor side effects
- Stop SSRI if agitation, anxiety, or suicidal thoughts
- Communicate and coordinate with mental health specialist

Follow-up appt: 1-3 weeks*

- Repeat screening instrument
- Review collaborative information
- Monitor safety, medication compliance, and side effects

***Note:** Follow-up may be completed by mental health specialist if no medications have been prescribed.

Depression Assessment & Treatment

Ongoing Care: <u>Mild to moderate</u> depressive symptoms

<u>At every visit:</u>
- Repeat screening instrument
- Review collaborative information
- Monitor safety and side effects
- Inform other providers of changes

No medication prescribed:
- Severe Risk – see "Safety Screen" (Appendix)
- Moderate Risk – appointment in 2-6 weeks
- Low Risk –
  - 7-12 weeks: therapy needed, but not accessed
  - 13-24 weeks: therapy resources in place

New medication or medication change:
Follow-up appointment in 2-4 weeks

Continued medication – no change:
Follow-up appointment frequency
- 4-6 weeks: 1) therapy needed, but not accessed; 2) concerns about medication effects; or 3) medication change in past 3 months
- 7-12 weeks: therapy resources in place, but medication change in past 4 months
- 13-24 weeks: therapy resources in place and stable medication dose over past 4 months

Ongoing Care: <u>Severe</u> depressive symptoms

<u>At every visit:</u>
- Repeat screening instrument
- Review collaborative information
- Monitor safety and side effects
- Inform other providers of changes

No medication prescribed:
Follow-up frequency based on safety risk
- Severe Risk – see "Safety Screen" (Appendix)
- Moderate Risk – appointment in 2-6 weeks
- Low Risk – see mild/moderate
- If no medication, visit frequency can be shared with mental health specialist

New medication or medication change:
Follow-up appointment in 2-4 weeks

Continued medication – no changes:
Follow-up appointment frequency
- 1-3 weeks: therapy needed, but not accessed
- 4-6 weeks: therapy resources in place
- Visit frequency can be shared with mental health specialist if medication monitoring is not included in appointment agenda

Depression Assessment & Treatment

Primary References:

American Academy of Child and Adolescent Psychiatry Official Action (2007) – Practice Parameter for the Assessment and Treatment of Children and Adolescents With Depressive Disorder. http://www.jaacap.com/article/S0890-8567(09)62053-0/pdf

American Academy of Child and Adolescent Psychiatry Official Action (2009) – Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents. http://www.jaacap.com/article/S0890-8567(09)60156-8/pdf

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (5th ed.).* Washington, DC: Author.

Jellinek M, Patel BP, Froehle MC, eds. (2002): Bright Futures in Practice: Mental Health –Volume I. Practice Guide. Arlington, VA: National Center for Education in Maternal and Child Health. http://www.brightfutures.org/mentalhealth/pdf/

PracticeWise (2015). Evidence-Based Youth Mental Health Services Literature Database.

Appendix

List of Recommended Screening Tools:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&dDocName=dhs16_178591

Resources:

American Academy of Child & Adolescent Psychiatry – Depression Resource Center
https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Depression_Resource_Center/Home.aspx

Safety Screen:

Some questions to assess potential threat of harm to self: Children and adolescents may be asked the following diagnostic questions (Jacobsen et al., 1994).

- "Did you ever feel so upset that you wished you were not alive or wanted to die?"
- "Did you ever do something that you knew was so dangerous that you could get hurt or killed by doing it?"
- "Did you ever hurt yourself or try to hurt yourself?"
- "Did you ever try to kill yourself?"

*If the threat assessment (i.e., Safety Screen) indicates risk of harm to self or others, educate families on the appropriate care options and safety precautions including removal of firearms from the home and securing all medications, both prescription and over-the-counter.

Depression Assessment & Treatment

Warning Signs of Suicide: (Developed by the U.S. Department of Health and Human Services – Substance Abuse and Mental Health Services Administration (SAMHSA; 2011).

These signs may mean someone is at risk for suicide. The risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Threatening to hurt or kill oneself or talking about wanting to die or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting recklessly or engaging in risky activities – seemingly without thinking
- Feeling trapped – like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

Minnesota Mental Health Crisis Contact Numbers: http://mn.gov/dhs/people-we-serve/people-with-disabilities/health-care/childrens-mental-health/resources/crisis-contacts.jsp

Current Evidence-Based Depression Treatments include: Cognitive Behavior Therapy (CBT), CBT with Medication, CBT with Parents, and Family Therapy

Elements of effective depression treatment include: cognitive processing, psychoeducation, activity selection, maintenance/relapse prevention, problem solving, self-monitoring, goal setting, self-reward/self-praise, communication skills, relaxation, social skills training, guided imagery, talent or skills building, behavioral contracting, modeling, stimulus control or antecedent management, therapist praise/rewards, relationship/rapport building, and assertiveness training.

DSM-5 Major Depressive Disorder Criteria:

A) 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 attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**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 by either subjective account or observation).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feeling 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.

B) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The episode is not attributable to the physiological effects of a substance or to another medical condition.

C) The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
Note: Criteria A-C represent a major depressive episode.
Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

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

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