

**Foothills Behavioral Health Clinical Guideline
In Collaboration with MHCBBC and JCMH
Depressive Disorders***

DSM-IV-TR Diagnostic Code: 296.2x; 296.3x; 300.4; 311

Screening/Diagnosing Guidelines:

1. **Substance abuse/dependence** should be evaluated as a possible cause of depression or as a secondary diagnosis. At a minimum, substance use/dependence should be assessed every 6-months.
2. With **adults, particularly older adults**, it is important to consider co-occurring or undiagnosed medical conditions as well as medication interactions or effects in determining the presence of depression.
3. **Screening instruments**, such as the Beck Depression Inventory or the Hamilton Rating Scale may be helpful in the diagnosing process.
4. When diagnosing depression in **youth** remember that, although the core symptoms are the same for children and adolescents, characteristic symptoms may vary with age. For example, somatic complaints, irritability, and social withdrawal are more common in children; psychomotor retardation, hypersomnia, and delusions are more common in adolescents. For all youth, mood may be irritable rather than sad.
5. In **prepubertal children** depressive episodes often occur in conjunction with another disorder, especially disruptive behavior disorders such as ADHD and anxiety disorders. **In adolescents**, depressive episodes commonly co-occur with disruptive behavior disorders such as ADHD, anxiety disorders, substance-related disorders, and eating disorders.
6. Special caution should be used when diagnosing a child with depression. Negativism, behavioral resistance, and impulsive irritability are common symptoms in disruptive behavior disorders while irritability, sadness, or anhedonia are more common in children with depression.
7. In diagnosing depression in the **older adult** special caution should be used to differentiate depressive symptoms from similar symptoms in dementia.

Treatment Guidelines:

1. **Refer for Medication evaluation** for severe melancholic symptoms, suicidal ideation or psychosis or for mild to moderate symptoms if there is no response to therapy in 6-8 weeks.
2. In **medically ill and older adults**, when determining the treatment plan, take into consideration all medications the consumer may be taking and, as appropriate, coordinate with the primary care physician.

3. The following must be **assessed regularly** in consumers with depression: suicidal/homicidal risk and manic symptoms.
4. The attached **medication algorithm** is recommended in prescribing medications for consumers with depression. Clinical rationale for deviations from this algorithm should be documented in the clinical record.
5. **Evidence-based therapies**, including cognitive behavioral or interpersonal therapy, are recommended and family involvement is highly recommended in treating youth. Establish measurable short-term goals with the consumer and family, use homework and encourage behavioral/physical interventions such as exercise, depending upon health status.
6. Consider the **phase of the treatment episode**, i.e. acute, continuation, and maintenance, as well as the severity of the depressive symptoms, in determining an approach. For example, cognitive or interpersonal therapy can be as effective as medication in mild or moderate depression, with medication and case management/support recommended for moderate/severe depression. In addition, cognitive or interpersonal therapy, during the continuation/maintenance phase has been shown to reduce incidents of relapse.
7. **Collaborate** with the consumer and family as partners in their recovery, focusing on their goals. Identify, with the consumer, effective ways they have used to cope with depression and support continued use of these methods. Provide consumer/family education on depression, its treatment, and steps they can take to assist their recovery.
8. Special caution must be exercised in **medication management in children and adolescents**. Most psychoactive medications used in children will be for off-label indications. Dosing must be appropriate to the child's age and weight and consider long-term effects of medication. Polypharmacy should be avoided except when medically necessary based on symptomatology.
9. When prescribing **antidepressant medications for children and adolescents** caution must be exercised with regard to the FDA Black Box Warning and the potential that these medications might increase suicidal thoughts, especially early in the course of treatment.
10. Assist the consumer in maintaining a **regular pattern of daily activities**, including regular sleep-wake cycles, meal times, and physical activity.

*Adopted from American Psychiatric Association (2002). Practice Guidelines for the Treatment of Patients with Major Depressive Disorder. Washington D.C.: Author