Depression
Clinical Practice Guideline

Overview of the Condition/Disease

Definition:

- Depression: also known as major depressive disorder; is a common mood disorder that involves persistent feelings of sadness and loss of interest or ability to enjoy things. Depression can affect how an individual perceives, feels, thinks, evaluates, and engages in daily life activities. It can be associated with feeling helpless, hopeless, worthless, and overly pessimistic about the future, that life is not worth living. Depression can also lead to other emotional, physical, and social problems.

Risk Factors:

- Biochemistry: Differences in certain chemicals in the brain may contribute to symptoms of depression
- Genetics: Vulnerability to depression can run in families. For example, an identical twin has a 70% chance of having depression if their twin experiences depression.
- Personality: People with ineffective coping skills, often associated with low self-esteem, being easily overwhelmed by stress or generally pessimistic thinking appear to be more likely to experience depression.
- Environmental factors: Exposure to violence, neglect, abuse, or poverty may contribute to depression.
- Sometimes, depression can be due to multiple causes occurring around the same time

Additional life events that may increase the member's risk for depression:

• Change in routine	• Chronic or new onset pain/discomfort
• Loss of a caregiver	• Financial loss
• Physical, sexual, or emotional trauma	• Divorce/relationship conflict
• Illness or disease that compromise meaningful activities (e.g. stroke, Dementia, sleep apnea)	• Loss of a pet
• Loss or hardship related to housing	• Loss of independence
• Loss of significant other, spouse, family, child, parent, or close friend	• Sensory impairments (hearing, vision)
• Substance abuse (alcohol, stimulants)	• Side effects of some medications
• Nutritional deficiencies	• Other mental health problems

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Best Practice Standards for Prevention and Management

Education: Differentiating between sadness, grief and depression is important in order to identify appropriate or necessary treatment interventions. A depressive episode must last at least two weeks to be diagnosed as major depression in addition to meeting five (or more) of the criteria outlined by the Diagnostic & Statistical Manual of Mental Disorders (DSM-5).

Screening Tools:

- Patient Health Questionnaire (PHQ)-9: A depression screening tool for members of any age who do not have a diagnosis of dementia, intellectual, developmental, or learning disability.
- Glasgow Depression Scale – Self-Report Screening Questionnaire: A depression screening tool for members age 59 and under who are diagnosed with an intellectual, developmental, or learning disability. This screening tool should be administered directly with the member for self-report, and offers italicized supplementary questions, should the primary question not be understood completely. Should the member be unable to participate or reliably provide responses, the Glasgow Depression Scale – Carer Supplement should be utilized for this target population.
- Glasgow Depression Scale – Carer Supplement: A depression screening tool for members age 59 and under who are diagnosed with an intellectual, developmental, or learning disability, and who were unable to reliably answer the questions in the Glasgow Depression Scale Self-Report Questionnaire. The screening tool is administered with a Carer (caregiver) based on observations of the member.
- Cornell Scale for Depression in Dementia (CSDD): A depression screening tool for members of any age, diagnosed with dementia. This tool can also be given in conjunction with a caregiver. Questions should be prompted to describe the individual's behavior observed during the week prior to the interview.
- Informal Depression Screening: A depression screening tool for members age 60 and over who are diagnosed with an intellectual, developmental, or learning disability. This screening can also be used for any member who has refused facilitation of the Patient Health Questionnaire (PHQ-9) or Cornell Scale for Depression in Dementia (CSDD), or when the PHQ-9, CSDD, or Glasgow Depression Scale – Carer Supplement screenings could not be facilitated.

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Anticipating, Recognizing, and Responding to Symptoms

Seek timely medical attention when current interventions and/or medications are not managing symptoms.

Potential symptoms:

- Sleep disturbances (e.g., excessive sleeping or insomnia (difficulty falling or staying asleep at night, or waking too early)
- Change in eating habits (e.g., weight loss or gain, unusual increase or decrease in appetite, binge eating, refusing to eat, food insecurity)
- Frequent crying or tearfulness
- Increase in irritability, angry outbursts
- Loss of interest and/or enjoyment in self (one's well-being) and/or usually enjoyable activities
- Unusual fatigue or loss of energy and/or motivation
- Self-neglect or changes in self-care (e.g., not bathing or changing clothes, not getting dressed, not taking medications as prescribed, or following up with appointments)
- Feeling worthless, hopeless, helpless, shame or guilty
- Difficulty thinking, concentrating or making decisions
- Increase in purposeless physical activity (e.g., agitation, inability to sit still, pacing, handwringing) or slowed movements or speech (these actions must be severe enough to be noticed by others)
- Isolation (i.e., avoiding interaction with others)
- Changes in affect (feeling sad, blue down) or loss of animation (apathy)
- Thoughts or statements of not wanting to wake up in the morning, wishing to be dead or suicide
- Suicide gesture or attempt
- Significant increase in level of anxiety

Interventions to manage symptoms:

- Non-pharmaceutical interventions: Behavioral activation with increases in meaningful physical and social activities (e.g., walking, yoga), increase sunlight exposure, journaling, meditation, socialization, increasing sleep to 7-8 hours per night, avoiding stimulants (e.g., sugar, caffeine, recreational drugs), avoiding alcohol, eating healthier foods, engaging in a preferred activity (e.g., bowling, going for a car ride, coloring, knitting, etc.).
- Pharmacotherapy: anti-depressants and/or mood stabilizers might be prescribed to help modify one's brain chemistry to reduce depression. Some improvement may be seen within the first weeks; however, the full benefits may not be seen for two to three

months. If there is no relief, the dose of medication may be increased, a different medication may be substituted, or other psychotropic medications may be added.

- Therapies: There are several therapeutic modalities that may be evaluated by a mental health professional when treating depression. Psychotherapy is an approach to treating depression which involves talking with a mental health professional and is often referred to as "talk therapy." Cognitive behavioral therapy (CBT) is a type of therapy that is focused on altering the thinking and behavioral patterns that may be reinforcing depression. CBT has been found to be effective in the treatment of depression. Behavior Therapy is a type of therapy that is focused on the modification of harmful or adverse behaviors associated with psychological distress related to symptoms of depression.
- Electroconvulsive Therapy (ECT): a medical treatment reserved for those with severe major depression that have not responded to other treatments, been able to tolerate the side effects of those treatments, at very high suicide risk, such that waiting for other treatments to take effects is impractical, and at risk of death from extremely poor health due to not having taken adequate food or fluids. It involves brief electrical stimulation of the brain while the patient is under anesthesia with muscle relaxants. Typically, a patient receives ECT two to three times per week for six to twelve treatments.

Guidelines and Process for Interdisciplinary Team

- Care teams will complete depression screening upon member's enrollment and at least every six months with care plan reviews. Depression screening may be warranted more often based on risk factors observed during contact with the member.
- Care teams will notify member's primary care provider (PCP) and/or mental health provider(s) (i.e. psychiatrist, psychotherapist, etc.) if the member's depression screening tool indicates they are at risk for or currently experiencing depression for further assessment and treatment interventions.
- Care Teams will consult with the county crisis entity for referral for crisis planning and/or consult with law enforcement for police safety planning or assessment of welfare as applicable based on the member's needs, particularly where there are signs of an increased risk of harm to self or others.
- Based on the member's depression screening results, care teams should consider completing suicide risk screening using the Suicide Risk Screening Tool at an increased frequency outside of the six month and annual assessments. Care Teams will ensure the member's responses to the suicide risk screening tool and the results are entered directly into the CM assessment that is built into MIDAS. If a paper copy was utilized to record member responses, this does not need to be added to the member's record in MIDAS, as the responses/results are entered directly into the CM assessment.
- Care teams will ensure the member's depression screening results are documented in the member's record. Utilize the paper copy of the appropriate depression screening. The

number generated from this screening should then be directly entered into the CM assessment that is built into MIDAS. The paper copy should then be uploaded into Member Attachments in MIDAS under the Mental or Behavioral Health > Depression Screening category/subcategory.

- A member with multiple medical and/or other mental health problems may need modifications to this guideline to be appropriate for their care plan. Please refer the member to their primary care provider for any modifications.

Quality Assurance Monitoring

Internal file reviews are completed by internal staff utilizing an assessment tool developed by the Quality Management Department. These findings are shared with Program Management and staff.

Additional Resources

Care Manager Resource: Depression Screening Tool Selection Reference

Patient Health Questionnaire (PHQ)-9

Glasgow Depression Scale-Self-Report Screening Questionnaire

Glasgow Depression Scale – Carer Supplement

Cornell Scale for Depression in Dementia (CSDD)

Informal Depression Screening

Abnormal Depression Screening Physician Letter

Suicide Risk Screening Tool

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