

## BHP CLINICAL ACTIVITIES GUIDELINE

### Depression Assessment Guideline

This guideline is intended to encourage all practitioners to use a comprehensive method when diagnosing depression. It is a general guideline for assessment only. While it should be used as a starting point, we do expect all BHP practitioners to **address and document all of the elements in this guideline** when diagnosing depression in adults age 18 and up within the diagnostic assessment.

- I. A complete history of symptoms including onset and functional impairment. Include severity of symptoms as well, which may be aided by the use of a standardized assessment tool such as the PHQ-9 or HAM-D. Assess for all symptoms the patient may be experiencing in order to make the most appropriate diagnosis.
- II. A family history of mental illness, substance abuse, suicide and treatment patterns.
- III. A thorough medical history and current medical conditions, including medications. Some medical conditions or medications may be associated with symptoms of depression. It's important to distinguish if the symptoms are due to a general medical condition or diagnosable as major depression.
- IV. Gather information on current and past drug and/or alcohol use. Carefully assess whether symptoms of depression could relate to substance use.
- V. A complete psychosocial history. Gather information on life events such as trauma or abuse, educational history, occupational history, psychological development and relationships (past and present).
- VI. A mental status exam analyzing at a minimum: Appearance, speech and thought patterns, memory, mood, affect, psychosis, orientation and suicidality.
- VII. Obtain information related to behavioral health treatment history, including psychiatric hospitalizations and chemical health treatments. Include information related to response to treatment and history of commitment.
- VIII. Complete a risk assessment to evaluate safety of the patient. Gather information related to history of previous suicide attempts and self-injurious behaviors. A thorough assessment of risk should include information related to suicidal ideation and behaviors, plans or preparations, availability and lethality of means, and intent. Also assess for history of violence, homicidal ideation and plans.
- IX. Application of DSM criteria and diagnosis. Consider a differential diagnosis of bipolar disorder, this may be aided by the use of a screening tool such as the MDQ.
- X. Documentation of a **physical/medical examination**, or a referral for one, to rule out all possible medical explanations for depression-like symptoms.
- XI. Documentation of a **psychiatric assessment**, a referral for one, or a clinical rationale for not having a medication component for this patient. If patient is currently taking psychotropic medications, include information related to medication compliance.
- XII. Recommend an effective psychotherapy to produce the best therapeutic outcome and determine the least restrictive treatment setting that will promote improvement in the patient's symptoms.

If a practitioner determines that an element of the diagnostic assessment is not appropriate for the patient being treated, the practitioner must clearly document this in writing. Include reason(s) why the element is not being assessed and plans to collect this information in the future if possible.

If the mental health status of the patient has changed and may warrant an additional or alternate diagnosis, a new diagnostic assessment should be completed. Please review DHS standards regarding the types of diagnostic assessments and when review/updates should occur.

**Regulatory/External Resources:** NCQA QI 10, Minnesota Statute 245.467,

**References:**

American Psychiatric Association. (2010). Practice guideline for the treatment of patients with major depressive disorder.

**Source:** BHP Quality

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