BEHAVORIAL HEALTH DEPARTMENT – PRIMARY CARE CENTER AND FIREWEED
TREATMENT GUIDELINES FOR

DEPRESSION DISORDERS

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Executive Summary

Introduction and statement of Intent

This treatment guideline is intended to assist clinicians in the Behavioral Health department in treatment planning and service delivery for patients with Post Traumatic Stress Disorder (PTSD). It may also assist clinicians treating patients who have some of the signs and symptoms of PTSD but who do not meet the full criteria of PTSD. The treatment guideline is not intended to cover every aspect of clinical practice, but to focus specifically on the treatment models and modalities that clinicians in our outpatient treatment setting could provide. These guidelines were developed through a process of literature review and discussion amongst clinicians in the Behavioral Health department and represent a consensus recommendation for service provision for this disorder. The guideline is intended to inform both clinical and administrative practices with the explicit goals of outlining treatment that is: effective, efficient, culturally relevant and acceptable to clinicians, program managers, and patients

Definition of disorder

Depression affects approximately 15 – 17 % of the population at large over the course of a lifetime, and is one of the most common complaints in clients seeking treatment at Behavioral Health Services (BHS). BHS tracking data indicates that 27% of adults seen in 2004 were diagnosed and treated for some form of depression. According to the DSM-IV-TR, women are twice as likely to suffer depressive disorders are men, a trend reflected at the PCC-Mental Health and Fireweed clinics. While Major Depressive Disorder is the most studied form of depression, there are several types of depressive disorders ranging in intensity, duration, and, to some extent, cause and symptoms. The table below lists the criteria for a major depressive episode. Several specific mood disorders rely upon the presence of one or more depressive episodes. See the DSM for additional detail.

Table 1: DSM-IV-TR Criteria for Major Depressive Episode

Diagnostic criteria for a Major Depressive Episode

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 due to a general medical condition, or mood-incongruent delusions or hallucinations.

1) Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others
2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
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.
4) Insomnia or hypersomnia nearly every day
5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings 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
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 do not meet criteria for a Mixed Episode

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

General Goals of treatment

As with treatment of other psychiatric illnesses, the goals of treatment for depression are to reduce or eliminate symptoms and to restore function. In studies of depression, remission is usually defined by degree of change in scores on standardized instruments. In the clinic, we are more concerned with patients' subjective sense of recovery and with their ability to function in their families, their work, and their community. The goals are therefore very specific to the individual, but can be generally stated as not the removal of all sadness, but the restoration of an underlying sense of wellbeing and capacity to recover from or adjust to the tragedies and traumas inherent in human life.

Summary of 1st, 2nd and 3rd line treatment

The first line of treatment for depression is psychotherapy, medication, or both. A variety of antidepressant medications and psychotherapies may be used to treat depressive disorders, and the good news is that treatment for depression is effective.

In general, the choice of treatment (group, individual, family therapy, pharmacotherapy) depends on the severity of the depression and the age of the client. For depressive disorders assessed as mild to moderate, medication and psychotherapy appear equally effective in adults. Treatment in children and youth is less well studied. In our clinic, group therapy is indicated for clients ages 3 years and older. (We do not believe attempting group treatment of vary young children is developmentally appropriate or practical, though their parents could be educated in groups.) For very young clients, age 5 years old and younger, the first line of treatment is family therapy, with group or individual therapy for the child done concurrently if needed. For minor clients of any age, it is strongly recommended that parents be educated regarding the depressive disorder, associated parenting issues, and actively involved in their child's treatment. These factors are predictive of a good treatment outcome.

For clients with moderate to severe depression, ages 3 years and older, individual therapy is recommended, as well as evaluation of the potential risks and benefits of medication. Individual therapy is also recommended for clients with concurrent social phobia. The individual treatment may help prepare them for group treatment, or be the primary treatment choice.

The following practice guidelines will advise the reader on indications and contraindications for group and individual treatment for clients with depressive disorders across the lifespan.

Approaches for patients who do not respond to initial treatment

Because depression is so well studied, it is beyond the scope of this guideline to review all of the types of treatment that may be helpful for patients who do not respond to the first line treatment. We have not chosen a specific 2nd or 3rd line treatment to be standard in our clinics, however, there are some guiding principles: 1) reassess the diagnosis and any comorbid problems that contribute to symptoms or interfere with treatment, 2) review the treatment to date, it's acceptability to the patient and/or family, and compliance with or participation in the treatment, and 3) include the patient and family in exploring their view of the depression and why treatment is not working. There are several excellent reviews of treatment resistant depression and pathways to guide medication trials in adults. The data for children are more sparse

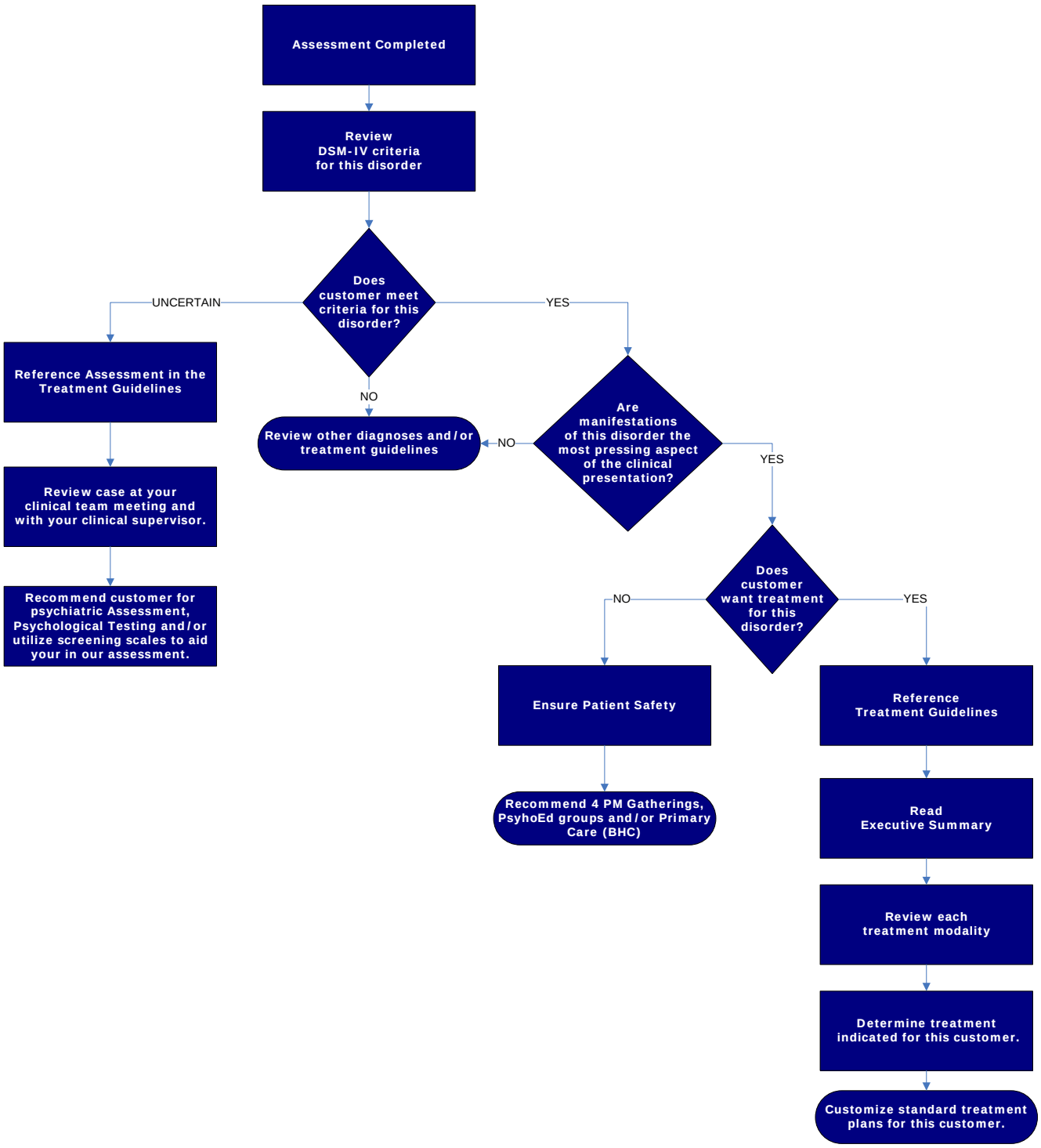
and controversial making algorithms for choice of 2nd or 3rd line medication difficult. Peer consultation is highly recommended.

Clinical and demographic issues that influence treatment planning

There is some evidence that Interpersonal Psychotherapy may be more effective than other forms of psychotherapy or medication for women with mild to moderate major depressive disorder. There is some evidence that adults with a history of childhood abuse may respond better to psychotherapy, or psychotherapy and medication than to medication alone. Again, patient preference, severity, and the presence or absence of critical symptoms such as suicidal behavior or comorbid substance abuse probably drive treatment planning more than the literature on efficacy of specific treatments. As more data become available on the effectiveness of different treatments in subpopulations of depressed patients, we may be better able to match patients to treatment.

Although data are not available on the prevalence of depression in the Alaska Native population, clinical experience suggests it is at least as prevalent as in other minority groups with similar socioeconomic status. The unique history of Alaska Native peoples, variation in levels of acculturation, and frequent differences in cultural background and experience between patients and clinicians in our setting create unique challenges to providing effective, efficient, and relevant care. Despite much interest in the notion of “cultural PTSD”, there is a paucity of published trials of treatment in American Indian or Alaska Native populations for depression and conditions known to occur at higher rates in traumatized groups. Although they may lack the formal evaluation and empirical validation of other treatment models, concurrent referral to a talking circle or a traditional healer may be appropriate for some patients.

Flow Diagram



Assessment

The Diagnostic Testing team will be reviewing and commenting on the Psychological Testing column for every disorder.

	Psychiatric Assessment	Psychological Testing	Screening/Scales
Indications	▪ Diagnostic dilemma or clarification of co-morbidity ▪ Unmanageable behavior or other symptoms that have not improved with standard interventions ▪ Patients is already on psychotropic medication and is requesting continuation ▪ Patient or guardian requests a second opinion or wishes to consider pharmacologic intervention ▪ Rule out organic cause and/or contributions to symptoms	▪ Diagnostic clarification following assessment by PCP or ANP. ▪ Question only answerable by psychological testing ▪ Appropriate physical assessment completed	• Establish baseline and/or monitor treatment effectiveness • Clarify symptoms
Contraindications	▪ Diagnosed severe cognitive disorder or developmental delay and collateral source not available ▪ Consent not available (if patient has guardian) ▪ Patient or guardian has forensic rather than therapeutic goal (i.e. compliance with court or parole requirements, disability determination, etc.)	▪ Extremely dangerous to self and/or others ▪ Untreated psychosis ▪ Initial evaluation / assessment is not done ▪ Referral question not answerable and/or not clear ▪ Any physical causes of the disorder have not been ruled out ▪ Attention span inadequate ▪ School or other source has already conducted psychological testing within the last year ▪ Severely depressed	▪ Limited English proficiency. ▪ Attention span inadequate ▪ Lack of cooperation
Structure	In patients with cognitive impairment who cannot give adequate history, parent or guardian with knowledge of the patient's history must be available for assessment.	▪ Depends on the referral question	▪ Self-administered for adults and adolescents ▪ Completed by Parent and/or care giver for children or incompetent adults.

Modalities & Treatment Models

Group Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Customer is 3 years old or older ▪ Mild to moderate severity ▪ Able to tolerate affect without behavior destructive to group ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.	▪ Dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Sexually acting out behaviors ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Severe untreated hyperactivity ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Acute intoxication or withdrawal from alcohol or other substances	• Diagnosis social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services

STRUCTURE

- Groups will be facilitated by a Master's Level Therapist and Case Manager
- For 17 years old and below, some age grouping is recommended
- For 18 years old and above consider adult services

Duration	60 to 90 minutes for 10 to 15 weeks
Frequency	Once a week
Size	▪ 3 to 9 years old 4 customers per provider ▪ 10 years old and over 8 to 10 customers per provider
Open vs. Closed	Open or Closed with windows

TREATMENT MODEL

- CBT
- Supportive Expressive
- Interpersonal
- Solution Focused

See additional details in the individual therapy section and the glossary.

Individual Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
• Group therapy contraindicated • Sufficient verbal and/or cognitive ability to benefit from treatment • Moderate to Severe severity • Unable to tolerate affect without behavior destructive to group ▪ Customer is 3 years old or older • Recent sexual, physical, abuse and/or neglect • For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Untreated Psychosis or mania ▪ Acute intoxication or withdrawal from alcohol or other substances	

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

- CBT
- Supportive Expressive
- Interpersonal
- Solution Focused

Several short term therapies are effective in treating depression, and the number grows each year as more psychotherapies for depression are empirically tested against treatment as usual, against no treatment, and against each other. We recommend focusing more on two, Interpersonal Therapy and Cognitive Behavioral Therapy, because training in these is readily available, and they can be effectively delivered in an outpatient setting such as ours with an emphasis on brief, individual and group treatments. With interpersonal therapy, the focus is on the client's problematic personal relationships, with the assumption that the disturbed relationships both cause and contribute to the depression. In cognitive behavioral therapy, the therapeutic goal is to help clients change negative patterns of thinking and behaving often associated with depression. There is some suggestion that Interpersonal Therapy may be more effective than other psychotherapies in depressed women. Depression in children and youth is increasingly recognized, but there are fewer clinical trials of psychotherapy in children to suggest which types are most effective. In general, the goals of treatment are similar to treatment of adults, but the specific interventions are tailored to the developmental age of the child and the capacity of the family and community to support the child's recovery and development.

Family Therapy / Couples Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ First line of treatment for 0 to 5 year old ▪ Disorder is impacting the family and/or relationship ▪ Family dynamic exacerbating or triggering symptoms ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ No buy-in to group and/or individual therapy ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible. ▪ Concurrent with group and/or individual treatment for children or adults with severe mental illness	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Current Domestic violence or abuse of child ▪ Custody dispute ▪ Untreated Psychosis ▪ Acute intoxication or withdrawal from alcohol or other substances	

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

Treatment shold include a psycho educational component, safety planning if appropriate, and skills building to help customers express their needs.

Individual Medication Management

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Parent and/or legal guardian consent ▪ Current biopsychosocial intake or psychiatric assessment is available. ▪ Recommended concurrent with psychotherapy and/or psychoeducation	▪ Refuses Medication Management ▪ Acute intoxication or withdrawal from alcohol or other substances	▪ Documented history of medication non-compliance ▪ Disorder is caused by an untreated physiological disorder.

STRUCTURE

Duration	30 minutes
Frequency	Monthly, may be more frequent during exacerbations of symptoms or side effects and less frequent during periods of stability. Minimum frequency is every 3 months.

TREATMENT OPTIONS

The literature to date does not provide evidence that a particular antidepressant medication or class of antidepressant medications is more effective than another in controlled trials. In the absence of clear evidence of superiority of one medication over another, side effects, risk in overdose, potential treatment of comorbid conditions or symptoms, cost, patient preference, and previous response to treatment guide the choice of antidepressants. The table below shows the list of antidepressants currently on formulary at ANMC and their cost at this time. Contact the ANMC pharmacy for more up to date information.

Group Medication Management

Need for parent and/or guardian presence makes group medication management impractical for customers 0 to 18 years old. For adults, it may be possible to provide medication management and some supportive therapy in a group.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ If symptoms stable and patient cannot return to primary care for maintenance treatment, group medication management should be considered. ▪ History of non-compliance ▪ Able to tolerate affect without behavior destructive to group ▪ Frequently misses scheduled appointments	▪ Acute dangerousness to self or others ▪ Untreated psychosis ▪ Sexually acting out behaviors ▪ No child care available ▪ Severe untreated hyperactivity	• Diagnosed social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services

STRUCTURE

Duration	▪ 90 minutes ▪ 8 to 12 weeks for customer over 17 years old
Frequency	Once a week
Size	8 to 10 customers per clinician
Open vs. Closed	Open

TREATMENT OPTIONS

See Individual Medication Management for medication recommendations.

Psycho Educational Groups

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ Able to tolerate affect without behavior destructive to group ▪ Could benefit from skills development	▪ Dangerousness to self or others ▪ Sexually acting out behaviors ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Severe untreated hyperactivity	

STRUCTURE

Groups will be facilitated by 1 to 2 Case Managers.

Duration	60 to 90 minutes for up to 8 weeks
Frequency	Once a week
Open vs. Closed	Open

Case Management

All Ages	
Assessment	▪ Collect psychosocial history ▪ Collect collateral history and/or past treatment records ▪ Obtain patient and/or guardian consent ▪ Liaison with outside agencies and/or link to community resources ▪ Administer standardized scales ▪ Lead orientation to services ▪ Review and/or conduct client initial screening and triage
Treatment	▪ Psychosocial education ▪ Maintain supportive contact ▪ Triage current clients in crisis ▪ Crisis management (e.g. triage, risk assessment, skills coaching, referrals when needed) ▪ Community liaison work and coordination of care ▪ Manage charts ▪ Provide aspects of treatment ▪ Assist with group preparation ▪ Draft treatment plans ▪ Follow-up when customer fails to keep appointments. ▪ Encourage medication and treatment compliance
Follow-up	▪ Liaison with outside agencies ▪ Link to community resources ▪ Gather and disseminate information from external referral sources

Referral

INDICATIONS

- Services needed are not available within the Behavioral Health department.
- Meets CMI criteria and not receiving rehab services
- Legal custody or other issues predominate
- Needed treatment is available elsewhere.

CONTRAINDICATIONS

Meets criteria for treatment within the Behavioral Health department system

Primary Care

INDICATIONS

- Refuses specialty mental health care
- Specialty Mental Health care not available
- Uncomplicated Medication Management
- Maintenance Medication Management

CONTRAINDICATIONS

Higher intensity services needed to ensure safety to patient or others

Appendix A: Glossary

Term or Acronym	Term Definition
Acute Intoxication	A reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. Clinically significant maladaptive behavior or psychological changes that are due to the effect of the substance on the central nervous system and develop during or shortly after use of the substance. (Adapted from DSM-IV)
Acute Withdrawal	A substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged. (Adapted from DSM-IV)
CBT	Cognitive Behavioral Therapy
Closed Group	Customers may enter only at initial formation of group.
Closed Group with Windows	Customer enrollment available intermittently
Eclipse	Overshadow, for example, when the symptoms and dysfunction related to one disorder overshadow another making treatment of one more pressing.
Exposure Therapy	Exposure therapy (Haug et al, 2003) with or without response inhibition is most cited as effective for specific phobia, obsessive compulsive disorder and PTSD. Generally, these run 10 -12 sessions with each session targeting a specific skill, exposure level and cognitive reframing. Manuals are available to guide clinical work.
Intervention	Any thoughtful action taken by a clinician or customer with the purpose of addressing a perceived problem or therapeutic goal
IPT	Interpersonal Therapy
NOS	Not Otherwise Specified
Open Group	Participants can enter at any time.
PDD	Pervasive Developmental Disorder
Play Therapy	Play therapy is a form of psychotherapy for children who have been traumatized. It encourages children to explore their emotions and conflicts through play, rather than verbal expression.
Psychiatric Assessment	Formal assessment by a psychiatrist or ANP
Psychoeducation	teaching and training about the disease or problem for which the customer or family member is seeking treatment. Psychoeducation is frequently presumed to be part of all forms of assessment and treatment, yet additional interventions that emphasize education about an illness are often shown to improve outcomes over treatment as usual. Psychoeducation can be incorporated into many treatments, but can be viewed as an intervention in its own right and can be delivered by non-professional staff such as case managers or health educators.
Psychological Testing	Formal psychological assessment which includes clinical interview and appropriate tests conducted by a psychologist and/or psychometrician. This testing is standardized and normed.
Screening/Scales	Brief, easily administered screening and scales which do not require advance training to interpret.
Social Rhythm Therapy	A structured psychotherapy combining elements of behavioral therapy and psychoeducation and shown to reduce rates of relapse and rehospitalization in bipolar disorder

Term or Acronym	Term Definition
Structural Family Therapy (SFT)	Structural Family Therapy is model of treatment in which a family is viewed as a system with interdependent parts. In this treatment model, the family system is understood in terms of the repetitive patterns of interaction between the parts. From such a perspective, the goal of structural family therapy is to identify maladaptive or ineffective patterns of interactions, then alter them to improve functioning of the subparts and the whole.
TBI	Traumatic Brain Injury
Treatment Modality	For purposes of this guideline, we have defined "modality" as the structure in which the customer receives treatment, for example, individual psychotherapy, group psychotherapy, or psychoeducation.
Treatment Model	For purposes of this guideline, we have defined the "model" of care as the underlying theoretical approach to clinical intervention, for example, Cognitive Behavioral Therapy, Insight Oriented Therapy, Interpersonal Therapy.
Untreated Psychosis	For the purposes of this treatment guideline, we define untreated psychosis as psychotic symptoms that are prominent, disruptive in some way, and for which the customer is not accepting or engaging in care that would mitigate such symptoms. The diagnosis of a psychotic disorder or the presence of psychotic symptoms at some point in the course of illness or treatment should not be a barrier to participation in treatment that might be helpful. However, nor should a customer with a significant psychotic disorder be treated with some forms of psychotherapy from which they are not likely to benefit. Clinical judgment will be needed in selecting appropriate treatment for each customer.
Untreated Substance Dependence	Because "dual diagnosis" is the norm, rather than the exception in behavioral health settings, customers with substance abuse problems should not be excluded, a priori, from participation in treatment for other mental health conditions. However, the impact of their substance use on their capacity to participate in treatment must be assessed on an ongoing basis. Customers with current substance dependence may not be appropriate candidates for some forms of treatment.

Appendix B: Literature Summary

Evidence Based Clinical Guidelines
Southcentral Foundation Research Project
Summary Sheet
MOOD DISORDERS

Diagnosis: Depression 296.__: 5 of 9 symptoms experienced over two consecutive weeks: depressed mood; diminished interest/pleasure; significant weight change; sleep disturbance; psychomotor changes; fatigue; guilt; diminished concentration; thoughts of dying.

With Psychotic Features: Above symptoms with either mood congruent hallucinations (transient voices berating person) or delusions of causality around depressive related themes.

Dysthymia: Persistent depressed mood for a period of two years with or without acute depressive episodes. Symptoms of irritability, anhedonia or low motivation are cardinal.

General Information: The literature is large and diverse on the subject of depression and treatment. For this project, the major conclusions are that efficacy studies indicate 1) a lack of superiority between the different major therapy theories (interpersonal, psychodynamic and cognitive/behavioral), non-significant differences between psychotherapy and psychopharmacological interventions although the combination is cited as more effective, 3) depression is treatable in group therapy; 4) brief therapies are equally effective; 5) manualized or structured specific foci of treatment are essential to best practice; 6) strong supervision, model fidelity and accountability are primary elements in best outcomes; 7) common factors such as therapist qualities, alliance bonds, client participation and external activities contribute more than theories or techniques.

Group Therapy and Depression: McDermut, W., writing in *Clinical Psychology: Science and Practice 2001*, concluded from 48 studies on depression and group therapy that group is as effective as individual therapy and more effective than control groups. The conclusions lend more support to a structure psycho-educational model versus a process model. There is some limitation to the severity of client finding success in this model. This meta-analysis supports previous studies around group therapy models and depression. McClure (2002) cite the empirical evidence on all types of interventions for children mood disorders.

Structure of Groups: Clients need to have similar needs and generally similar acuity. Women seem to do better in groups and all male groups might be more engaging for men (Davis, 2004). Average group size is 6 with sizes up to 12 for therapy, larger for family sessions and specific psychoeducational groups. The consensus is that the smaller the group the more effective (Bright, 2001). Cohesion is also very important and essential to any positive outcome (Burlingame et al, 2001). Age is not a limiting factor to use of groups. Clarke et al (2001) noted group success working with at risk adolescents. Schaefer (1999) outlines empirically supported group work for children on specific problems including depression and depressive like problems.

Professional Status and Effectiveness in Groups: There is no significantly different outcome in client rated depressive symptoms based on professional or paraprofessional status in either cognitive-behavioral therapy or mutual support group therapies (Bright, 1999). There is a moderate difference in clinician-based symptom relief based on two factors 1) professionally lead CBT groups and 2) adherence to a manual based format of group. This review also concluded that group is as effective as individual therapy regardless of clinician orientation.

Brief Therapy Models and Depression: Generally, brief therapy was considered a robust model regardless of clinical orientation. There is considerable confusion in the term “brief” psychotherapy. Generally it is held as less than 20 sessions. New research and practitioner guides provide appropriate limits on the different models. Dewan, M., Steenbarger, B., and Greenberg, R., in The Art and Science of Brief Psychotherapies (2004) outline the guidelines for various theoretical orientations. An overarching principle is

the mind set shift from time-unlimited to brief therapy. The practitioner is more focused on mutually established issues, spends less time dealing with resistance and history and pushes for more extensive extra-sessional work by the client. The average number of contacts is based on severity, complexity and level of improvement sought. Some research strongly suggests that in the first eight sessions the bulk of change is conducted.

Professional Status in Brief Therapy: Although no specific research was found, brief therapy mechanics can be taught. There is no evidence that I found, that paraprofessionals could not be taught to execute the foci of treatment. There are obviously some advantages to experience and education in that the theoretical underpinnings are understood, ability to draw on numerous models, and diagnostic abilities are more honed. Some of the common factors supporting all good therapy though are not the exclusive domain of professionally trained practitioners.

Structure of most Brief Therapy: There was stronger support for structured skills-based interventions in brief therapy. Homework is essential. Each session has a set of well defined tasks to address and limited foci for the allocation of resources. Following manuals that outline a basic structure in combination with ongoing supervision and model fidelity have produced the best researched outcomes. Manualized treatment is generally not supported by clinical staff due to the fear of loss of autonomy, heterogeneity of clients, appearance of diminished judgment and intra-sessional decision making. While these issues apply to most therapies, evidence based therapy outcome studies demand some fidelity. But the above mentioned concerns are adequately dispelled by Conner-Smith and Weisz, 2003. They state, "…at this point, it appears that specific wording and specific exercises are not likely to be essential, but that adaptations do need to convey the core concepts and skills of the intervention (p.5)." Therapist satisfaction following training and implementation of Manualized treatments is generally high (Najavit et al, 2004).

Average number of sessions is 10 with the range from 3-20. Age is not a consideration although very young children lack the capacity for most cognitive therapies. These clients are usually involved with their parent in behavioral modification. Compton et al (2002) outline the power of psychosocial interventions with children with internalizing disorders.

Multi-Cultural Considerations: The literature on multi-cultural adaptation of evidence based treatments was less than complimentary. Nagayama Hall, 2001, reviewing the empirically supported literature plainly states: "there is not adequate empirical evidence that any of these empirically support therapies is effective with ethnic minority populations" (p.502). Bernal and Scharron-Del-Rio, (2001) earlier noted the same conclusion and called for a more "pluralistic" methodology in developing evidence based and culturally sensitive treatments. The overall consensus is that, even lacking specific cultural treatments, the application of evidence supported interventions is better than using non-supported techniques.

Pharmacological Interventions: JAMA just released a meta-study of adolescent treatment for depression. The conclusion is that Prozac and therapy (CBT) is best with medications being the single best intervention. This is not the results of other researchers and studies that strongly suggest that psychotherapy and pharmacological treatments are equally powerful. For the client and agency model that supports primary pharmacological interventions, the Texas Algorithm Project prescribing decision tree for depression is very helpful. The physician's manual outlines decision points where changes in medications, additions and augmentations are called for. The general belief is that the newer SSRIs are superior although there is research that suggests otherwise. For psychotic symptoms, medications are the preferred method of intervention although the application of group CBT for schizophrenia could be adapted.

Manuals: There are numerous sources of manuals or structured programs. For Depressions are the Burns "Feeling Good Workbook", Adolescent Coping with Depression (www.kpchr.org), or FRIENDS (Barrett 1998). Other resources for manual is NIH, NIMH and APA Division 12.

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Appendix C: Sample Treatment Plans

Treatment plan for Adults – Sample #1

PROBLEM #1: Depression (7 on a 10 point scale with 10 as the worst, and 0 as normal mood)

As evidenced by: Low mood, loss of motivation to seek employment, feelings of failure and futility, passive suicidal ideation, no longer participating in previously enjoyable activities

"Everything is a chore", "I don't know why I bother, there's no point"

Goal: The Patient will report improved mood (3 or below on 10 point scale) and restored function including seeking employment, reengaging in social activities, and no suicidal ideation.

Objectives:

1. Begin medication, take each day as prescribed, track and report effects and potential side effects to behavioral health staff at agreed frequency by keeping appointments, using phone contact within clinic guidelines, etc.
2. Engage in "talk therapy" by attending "managing your moods" group weekly for 6 weeks, participating in group and completing recommended activities at home.
3. Develop and commit to a plan for regular, enjoyable physical exercise 3+X week

PROBLEM #2: Inadequate Social supports

As evidenced by: Joblessness, estrangement from family

Goal: Increased social interaction w/family & friends and renewed interest in enjoyable activities, achieve employment

Objectives:

1. Refer to case manager to facilitate linkage to education and vocational opportunities
2. Review important familial and social relationships (additional assessment)
3. Identify and engage in one activity each week with others
4. Slowly build goal directed activities from an hour a day to multiple hours a day to support capacity for employment and education.

PROBLEM #3: Overuse of alcohol and MJ

As evidenced by: Time and money spent on these activities to the exclusion of other activities. Clients report that it no longer improves mood, but is only social contact at this point

Goal: Reduce use and reliance on substances as link to others

Objectives:

1. Additional assessment, consider referral to specialized treatment
2. Monitor use on a calendar daily and bring to future appointments
3. Build alternative socialization routes and activities as identified above

Treatment plan for Adults – Sample #2

PROBLEM #1: Diminished interest in or enjoyment of activities

Objectives:

4. Participate in social contacts and initiate communication of needs and desires 1-3X/week
5. Engage in physical and recreational activities that reflect increased energy and activities 1-3X week
6. Develop and commit to a plan for regular, enjoyable physical exercise 3+X week

PROBLEM #2: Depressed Affect

Goal: Increased social interaction w/family & friends and renewed interest in enjoyable activities

Objectives:

5. Identify cognitive self-talk that is engaged in that supports feelings of sadness and tearfulness
6. Replace negative self-talk w/verbalization of realistic and positive cognitive messages on a daily basis 2-6+X
7. Make positive statements regarding ability to cope w/life stressors and set min. of 1-4 positive goals for the future

PROBLEM #3: Low sense of self-worth

As evidenced by: Negative self-talk, negative statements regarding life and ability to cope w/daily functioning

Goal: Replace negative thoughts and statements w/realistic, positive self-talk and verbalizations that reflect optimism

Objectives:

1. Keep a daily journal of dysfunctional thinking that includes situations associated w/negative thoughts & feelings
2. Replace negative thoughts and self-talk w/verbalizations of realistic & positive messages 1-5+ X min. daily
3. Read books on overcoming a low sense of self-worth

PROBLEM #4: Unresolved grief issues

As evidenced by: Client self-report of losses about which he/she is unable to resolve feelings of grief

Goal: Appropriately grieve the loss in order to normalize mood and return to previous adaptive level of functioning

Objectives:

Multiple modalities of expression beyond verbalization.)

1. Verbalize any unresolved grief issues that may be contributing to depression
2. Explore history of losses that trigger feelings of grief
3. Identify and resolve losses that have contributed to feelings of grief