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Child & Adolescent Mental Health Service Depression Study

An observation of treatment and change in clinician rated outcome scores in case managed adolescents attending a regional Child and Adolescent Mental Health Service




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Introduction

- Depressive Disorders are common mental problems in adolescents^[1-4]
- Defining what constitutes a case of depression in adolescents has implications for research^[3,5,6]
- Discrepancies exist between available guidelines^[7-9] and contents of actual treatment administered in CAMHS^[10]

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Project Rationale

- Depressive Disorders can cause a significant and sometimes lifetime burden for the adolescent^[1-4]
- Gap in the literature involving what comprises routine treatment of depressed adolescents attending CAMHS^[11]
- Recommendations for more research involving CAMHS^[12]


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Aims


- I. to describe the prevalence of depressive symptoms and depressive disorders present among a cross-section of adolescents being case managed in a regional CAMHS
- II. to describe the treatment of depressive disorders amongst case managed adolescents attending a regional CAMHS
- III. to describe changes in treatment outcome measures amongst adolescents with depressive disorders and depressive symptoms, and whether adolescent factors were associated with the change

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Method – Setting & Participants




- **Latrobe Regional Hospital CAMHS**
 - 5 sites spread across 40,000 sq km
- **CAMHS clinicians**
 - Multidisciplinary teams
- **Adolescents**
 - Age: 12-18 y.o.
 - Case managed
 - Severe biopsychosocial problems

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Method - Instruments


- **Treatment Recording Sheet^[10]**
 - Records treatment for previous month
 - Client details
 - Stage of treatment
 - Treatment interventions
 - Related activities
 - Critical incidents



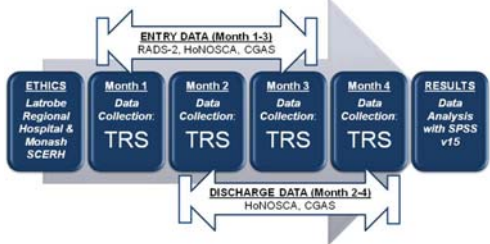
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Method - Instruments

	RADS-2 ⁽¹⁴⁾	HoNOSCA ⁽¹⁵⁾	CGAS ⁽¹⁶⁾
Description	Self-report questionnaire Evaluates 4 domains of depression Categorises into range of depressive symptoms	Global measure of mental health status 15 items rated on a 5-point scale 5 factor subscales	Reflects level of functioning in previous month 1-100 scale ('Needs constant supervision' to 'Superior functioning')
Completed by	Adolescent	Clinician	Clinician
Collected	Entry	Entry and Exit	Entry and Exit
Demonstrated reliability & validity	Yes	Yes	Yes

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Method – Data Collection



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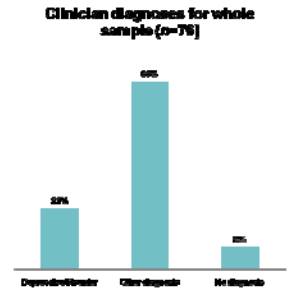
Method - Statistics


	Association	Group comparison
Parametric	Pearson correlation coefficient* Univariate Regression	Independent T-test† Paired T-test‡ ANOVA§
Non parametric	Spearman rho correlation* χ² test	Mann Whitney U test† Wilcoxon Signed Rank Test‡ Kruskal-Wallis Test§
Additional statistics	Fisher's Exact Test Bonferroni correction	

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Results – Aim I

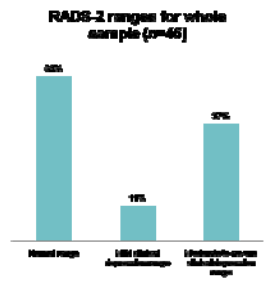
- Depressive Disorders most common diagnosis ($n = 17$)
- Dysthymia was a common comorbid condition ($n = 7$)
- 2 adolescents had 'double depression'




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Results – Aim II


- Depressed adolescent's RADS-2 score was within moderate clinical depression range:
Mean 65.1, 95% CI 59.9, 70.4



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Results – Aim II

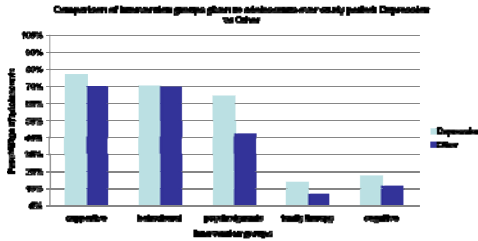
Treatment Recording Sheet Collection



Reasons for missing TRS were:

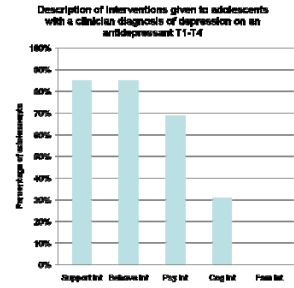
- adolescent not yet enrolled
- adolescent had been discharged from CAMHS
- case manager on leave
- TRS not returned

Results – Aim II



Results – Aim II

- 13 adolescents (17%) were on an antidepressant (AD)
- 5 of the 13 had a clinician diagnosis of a Depressive Disorder
- Being on an AD didn't appear to influence psychological treatment



Results – Aim III

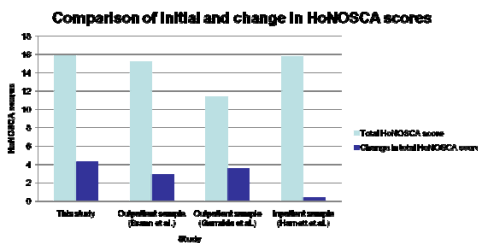
- Strong negative correlation between Δ HoNOSCA and Δ CGAS for whole study sample

Change in score (n = 31)	
HoNOSCA	Mean -4.3 [†] (95% CI -6.1, -2.4)
Depressed	Mean -4.7 [†] (95% CI -8.6, -0.8)
Other	Mean -4.2 [†] (95% CI -6.4, -1.9)
CGAS	Mean 9.1 [‡] (95% CI 6.5, 11.8)
Depressed	Mean 10.5 [‡] (95% CI 2.9, 18.1)
Other	Mean 8.8 [‡] (95% CI 5.7, 11.9)

Discussion - Context

- Higher prevalence of depression than underlying population^[17]
- RADS-2 scores similar to NZ study involving highschool children^[20]
- Use of multiple forms of therapeutic interventions common^[21]
- Similar change in HoNOSCA and CGAS scores^[19]
- Similarities and differences in Δ HoNOSCA associations^[18]

Discussion – Context continued



Discussion – Strengths and Limitations

- Strengths
 - Clinicians able to incorporate TRS into practice
 - Adds to limited knowledge
 - First experience participating in research
 - Adolescents not excluded based on severity of disease
- Limitations
 - Small sample size
 - Missing & outlying data
 - TRS not standardised
 - Selection bias
 - Measurement error
 - TRS interventions coded by one clinician

Discussion – Explanation of findings

	Explanation
High prevalence of Depressive Disorders	Primary mental health service Selective bias
RADS-2 scores similar to NZ study & higher in Depression	No standardised approach to diagnosis Severely depressed adolescent missing Depressed adolescents experience more depressive symptoms
No difference in treatment	No difference in treatment Sample size too small to detect difference Depression present but unidentified TRS not able to detect difference
Improvement in outcome measures	Usual care is effective in improving global mental health status Missing data resulted in overestimate of treatment response

Conclusion – Implications

- Practice Implications
 - Other factors rather than diagnosis influence what treatment is given to case managed adolescents within this CAMHS
- Research Implications
 - Provide an insight into the prevalence of depressive disorders and management of adolescents within a regional CAMHS
 - Methodological limitations informative

Summary

- Depressive Disorders were the most common diagnosis
- No statistically significant difference in treatment
- Adolescents experienced a statistically significant 11% improvement in HoNOSCA and 33% improvement in CGAS scores.
- No statistically significant association between client factors and change in HoNOSCA or CGAS scores

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APPENDICES

Clinician diagnoses

