DEPRESSIVE DISORDERS

WORKBOOK FOR COMMUNITY HEALTH WORKERS

TEAM UP SCALING AND SUSTAINABILITY CENTER

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Acknowledgements

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TABLE OF CONTENTS

How to Use this Workbook

Goals for this Workbook

- TEAM UP Workbooks are designed to provide a framework for the CHW scope of practice within the TEAM UP Model and emphasize three core areas of work:
  - Engagement
  - Education
  - Care coordination
- Each workbook focuses on a developmental or behavioral concern and aligns with training content available in the TEAM UP CHW Foundational Training and the TEAM UP Virtual Learning Platform.
- CHWs can use this workbook to guide their work with patients and families.
- All tasks and activities outlined in this workbook can be coordinated between the CHW and other members of the integrated care team.
- CHWs should collaborate with others on the integrated care team on work outside of their scope.

Adapting this Workbook

- This workbook is meant as a guide and is intended to be adapted to suit each practice's needs while maintaining the CHW scope of practice as defined within the TEAM UP Model.
- Please maintain all acknowledgements to the TEAM UP Scaling and Sustainability Center as the originator of this workbook's content.

A Family Centered Approach to Healthcare

When communicating with and about people with mental health conditions, it is important to understand how they view themselves and to use inclusive language that respects their self-conceptions. Popularized in the 1970s and codified in the Americans with Disabilities Act, people-first language centers on an individual's personhood when describing their health condition. For example, using a people-first approach, a person diagnosed with autism would be referred to as a *person with autism* rather than an *autistic person*.

However, as social values evolve, so does the language surrounding mental health. Some individuals view their mental health condition as an integral part of their identity and prefer an identity-based approach. This perspective emphasizes the sense of belonging that comes from identifying with a community of people who share the same condition. Using this approach, a person diagnosed with autism might prefer to be called an *autistic person* rather than a *person with autism*.

Given the diversity of perspectives on self-identity and language preferences, it is important to be thoughtful and respectful in communication about mental health conditions. While the TEAM UP Center is committed to using inclusive language that honors people's identities, it does not favor using people-first or identity-based language over the other. To be consistent in its content, this workbook uses people-first language to describe conditions impacting children.

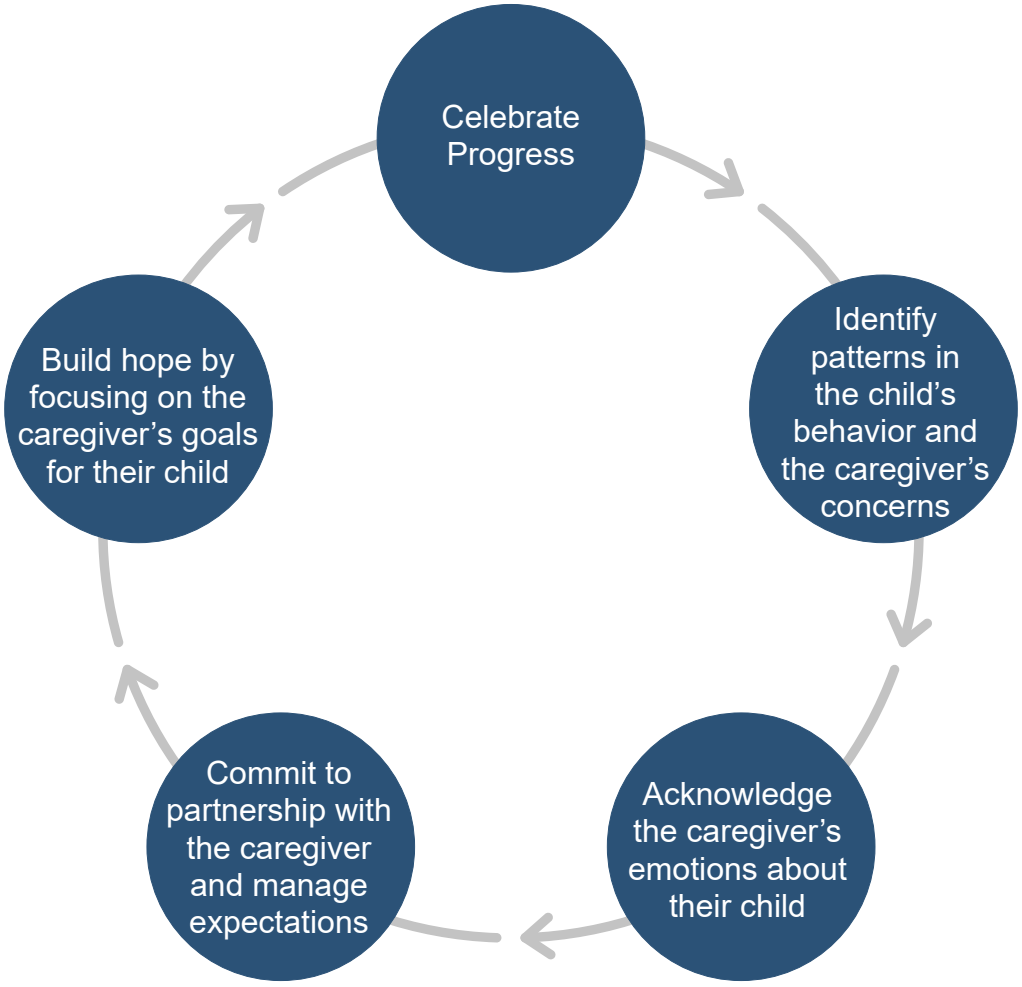
Practitioners should equip themselves with knowledge about the range of ways that people identify, but the most direct way to honor preference is to elicit input from individuals themselves. Using a patient- and family-centered approach involves using the terms preferred by the person or people with whom you are working.

Working with Caregivers

It is normal for children to experience a wide range of emotions, including sadness, anger, and irritability. However, when a child experiences these emotions for prolonged periods of time, it can negatively affect the child's social or physical functioning and often indicates that the child is experiencing a depressive episode.

When a child experiences a depressive episode or is diagnosed with a depressive disorder, caregivers may experience stress understanding or accepting this diagnosis. They may feel overwhelmed by their child's behaviors and feel like they lack skills to support their child.

CHW should frame the diagnosis as an opportunity for caregivers to learn how to best support their child's unique needs and as a means to get access to more services. As CHWs engage with caregivers, it is important to approach these conversations with empathy and encouragement, keeping the following considerations in mind:



Core Symptoms

Depressive disorders can be broken down into 2 main categories: major depressive disorders and adjustment disorders.

Major depressive disorders are characterized by the child experiencing 5 or more of the following core symptoms for 14 consecutive days, excluding symptoms resulting from drug use or other medical conditions (American Psychiatric Association, 2022):

- Sleeping too much or too little
- Eating too much or too little
- Low energy
- Difficulty concentrating
- Loss of interest in usual activities
- Feeling isolated
- Irritability
- Declining academic performance
- Thoughts of not wanting to be alive
- Lack of motivation
- Somatic symptoms

Adjustment disorders are characterized by emotional or behavioral symptoms that resemble depression but are in response to a significant stressor that the child experienced within the last 3 months. Common symptoms of adjustment disorder include (American Psychiatric Association, 2022):

- Low mood or energy
- Tearfulness
- Feelings of hopelessness

However, adjustment disorder is different from major depressive disorder because the mood of children experiencing adjustment disorder normally resolves within 6 months of the removal of the stressor that induced their symptoms.

Interfering Behaviors and Risk/Protective Factors

There are several factors that can increase the risk of depression in children (American Psychiatric Association, 2022):

- Bullying
- Abuse or neglect
- Traumatic events
- Conflict between caregivers
- Major physical illness
- Family history of depression
- Lack of social support and isolation, relational or social loss
- Barriers to accessing medical care and behavioral health treatment,
- Social or cultural stigma about depression

However, there are several protective factors that can mitigate the risk of depression in children (American Psychiatric Association, 2022):

- Strong connections to family and community
- Medical and behavioral health care
- Strong problem-solving skills and conflict resolution skills
- Cultural and religious beliefs that promote self-esteem
- Consistent school participation
- Coping skills

While depressive disorders can lead to poor academic performance, breakdown in relationships, and problematic behaviors if unaddressed, bolstering protective factors through intervention and consistent support can help improve depressive symptoms and manage associated conditions over the child's lifetime.

Depressive disorders can often be associated with the following (American Psychiatric Association, 2022):

- Conduct disorders and ODD
- Anxiety issues
- Difficult peer relationships
- Trauma
- Substance use

Screening

Children are often first screened through general developmental screening tools like the Survey of Well-Being for Young Children (SWYC), which asks about child behavior, child development, and family questions, Ages and Stages Questionnaire (ASQ), or the Parents' Evaluation of Developmental Status (PEDS) (American Academy of Pediatrics, 2024).

Depression can be diagnosed with the Beck Depression Inventory (BDI) or the Patient Health Questionnaire (PHQ-9).

- The PHQ-9 is a 9-item questionnaire given to the patient to complete. It asks questions about all symptoms of depression. The clinician then scores the child's responses to determine the severity of the depressive symptoms.
- BDI is a 21-item self-reporting questionnaire that measures the severity of depression symptoms. Like the PHQ-9, the questionnaire is completed by the child and scored by the clinician.

Of note, depression screening tools were originally developed primarily using white, middle-class samples, which can result in misclassification for people with identities outside of those groups. When screening children for depression, it is important to take the cultural context of a patient into consideration and how it can influence the situation because families across many cultures appraise symptoms of depression differently. The following cultural factors are important to consider for screening:

- The role of religion in the child's and family's life
- Perception of mental illness within the specific culture
- Symptoms may be reported as physical complaints within certain cultures, rather than typical symptoms of hopelessness
- Irritability or anger may be the predominant mood symptom of depressive symptoms in certain cultures

Interventions

Interventions for children commonly involve caregiver active participation, psychoeducation, developmental education and emotion regulation skills, behavioral management and coping strategies, and, when appropriate, directly addressing behavioral and mental health concerns in a safe therapeutic setting. For young children, play-based interventions are most typically used to support a child's developmental capacity for expression and interpretation of their experiences. Below are examples of commonly used interventions for children and families.

Outpatient (OP) Therapy

- OP therapy is a common and effective treatment approach for supporting children and families with behavioral health concerns. It is flexible and centered around the patient's and family's needs. Therapists are able to support the development of essential skills, such as coping, caregiving strategies, and behavioral plans, to increase and stabilize the patient's ability to function and succeed in the home and other settings. OP therapy can be delivered in an individual, family, play, or group setting. Therapists provide follow-up and ongoing monitoring.

Children's Behavioral Health Initiative (CBHI)

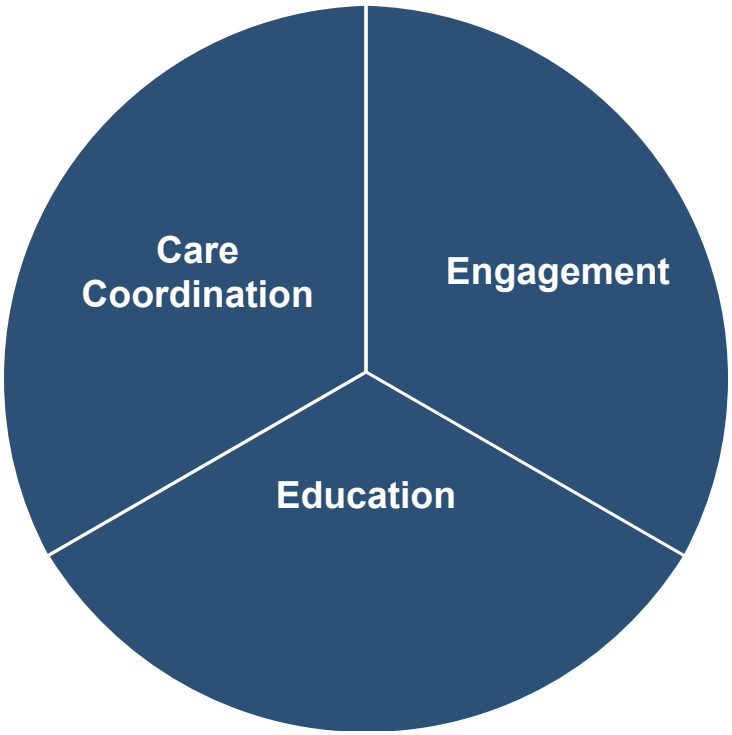
- CBHI provides children and their families with integrated behavioral health services and a comprehensive, community-based system of care. Services under CBHI include, but are not limited to, intensive care coordination (ICC), in-home therapy (IHT), therapeutic mentors (TM), and in-home behavioral services (IHBS) (Children's Behavioral Health Initiative, 2015).
- While all the CBHI services provide support for children and their families, IHBS may be particularly helpful for children with anxiety. IHBS is similar to ABA in that a team works with the child and family to create a behavior plan that targets specific behavior challenges to change behaviors that interfere with everyday life (Children's Behavioral Health Initiative, 2015).

Cognitive Behavioral Therapy (CBT)

- CBT helps the child to identify automatic and negative thoughts that are fueling their depressive symptoms and to develop various coping skills to enhance their problem-solving abilities, relationships with others while encouraging them to engage in pleasurable activities. See Appendix for more information.
- CBT is often administered in combination with FDA approved medications such as fluoxetine and escitalopram to reduce some of the more physically distressing symptoms of depression.

Overview of the CHW Role in Depressive Disorders

CHWs within the TEAM UP Model specialize within 3 core areas described below to support the developmental and behavioral health needs of pediatric patients at their practice:



Engagement

Engage families in understanding healthy child development, navigating diagnostic processes and pathways, accessing appropriate formal supportive services, and seeking support for parenting stress. This includes outreach to families lost to care or experiencing gaps in care and informal counseling and coaching to promote healthy development, increase access to care and services, reduce stigma, and improve informed decision making for patients, caregivers, and families. Outlined below are some of the ways CHWs can effectively engage with families and caregivers.

Communication Style

- Listening actively
  - Offer encouragement
  - Paraphrase patients' and caregivers' thoughts
  - Observe non-verbal cues and identify emotions
- Asking open-ended questions to allow for more sharing and closed questions to obtain specific details

Motivational Interviewing

- MI is a directive, client-centered approach for eliciting changes in behavior by helping patients and caregivers to explore and resolve ambivalence; this approach focuses on:
  - Collaboration with the patient or caregiver
  - Evoking responses
  - Corroborating the patient or caregiver's autonomy
  - Offering compassion
- MI uses a four-pronged approach to engage with patients and caregivers, called OARS:
  - (O)pen questions: invite others to tell their story without leading in a specific direction
  - (A)ffirmations: recognize patient and caregiver strengths and acknowledge behavior that leads in the direction of positive change
  - (R)eflective listening: is a pathway for engaging others in relationships, building trust, and fostering motivation to change
  - (S)ummaries: apply reflective listening to summarize back what the patient or caregiver shared; can be used throughout conversation

Problem Solving

- Problem solving is an approach to engagement that seeks to:
  - Increase understanding of the link between current problems, stress, and depression risk
  - Define problems and set concrete, realistic goals
  - Teach a systematic problem-solving strategy
  - Promote behavioral activation with concrete tasks including pleasant social and physical activities
- Problem Solving Education (PSE) is a 7-step method for applying problem solving skills to decrease caregivers' stress, improve functioning, and promote wellbeing; PSE steps include:
  - Exploring the problem
  - Setting realistic goals
  - Brainstorming solutions based on set goals
  - Examining pros and cons of the proposed solutions
  - Choosing a solution
  - Making an action plan to execute solution
  - Reviewing tasks, effectiveness of chosen solution for problem, and reinforcing success reinforcing success

Caregiver Coaching and Support

- Recognize the impact of sociocultural differences on mental health awareness and caregivers' subsequent feelings of frustration, grief, shame, and stress
- Help caregivers work on parenting strategies, structure, reinforcement mechanisms, coping skills, and advocacy for appropriate services
- Emphasize that caregivers' emotions affect children's emotions by:
  - Modeling coping strategies
  - Validating children's struggles
  - Maintaining consistency in disciplinary measures
  - Making themselves accessible to their child
- Empower caregivers to communicate effectively:
  - Describe their child's behavior in specific terms
  - Identify triggers for their child's behavior
  - Provide insight into patterns of behavior (stimulus and reaction)

Supports and Services

- Early Intervention for children under the age of three
- School-based assessments beginning at 2.9 years of age
- Developmental screeners and assessments
- Outpatient services, such as outpatient individual or family therapy based on child's symptoms and family's needs
- School-based services, such as ABA, speech, PT, OT, special education instruction, paraprofessional, and other services based on child's symptoms and needs to support functioning and access to school curriculum
- In-home services, such as IHBS and ABA

Education

Educate and offer support to caregivers regarding child growth and development as appropriate including information about symptoms, diagnosis, management, services available for caregivers, family members, and youth, and other resources to promote informed decision-making related to care and to manage parenting stress. This also includes education to support caregiver self-management skills that anticipate and address barriers to accessing services and treatment. CHWs should provide education about:

- Child growth and development
- Common symptoms for developmental delays and appropriate screeners
- EI referral process
- Diagnostic process
- Local options for services

Care Coordination

Coordinate care and assist families in connecting to and maintaining treatment, services, and resources through ongoing collaboration with patients, caregivers, primary care providers (PCP), behavioral health clinicians (BHC), and other care team members.

- Assist with navigation pathways, including pre-diagnosis, diagnostic, and post-diagnosis stages
- Assist with initiating CORE evaluation for school-based services (see Appendix)
- Assist with additional outpatient or in-home services, such as outpatient therapy, IHBS, and ICC

Resources

Depression

- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Families for Depression Awareness
- National Institute of Mental Health Teen Depression
- MA Behavioral Health Help Line 833-773-2445

Suicide

- American Foundation for Suicide Prevention
- MA Suicide Helpline: 877-870-4673 (Call or Text 24/7)
- National Suicide Prevention Lifeline: 1-800-273-8255
- Crisis Text Line: Text HOME, HELLO or START to 741-741

Caregiver Resources

- Center for Disease Control (CDC) Positive Parenting Tips Handouts
- Zero-to-Three Parenting Resources
- Parent/Professional Advocacy League
- Parenting Stress Line (1-800-632-8188)

Citations

American Academy of Pediatrics. (2024). Developmental screening and surveillance. In Bright Futures Tool and Resource Kit (2nd ed.). https://publications.aap.org/toolkits/resources/15625.

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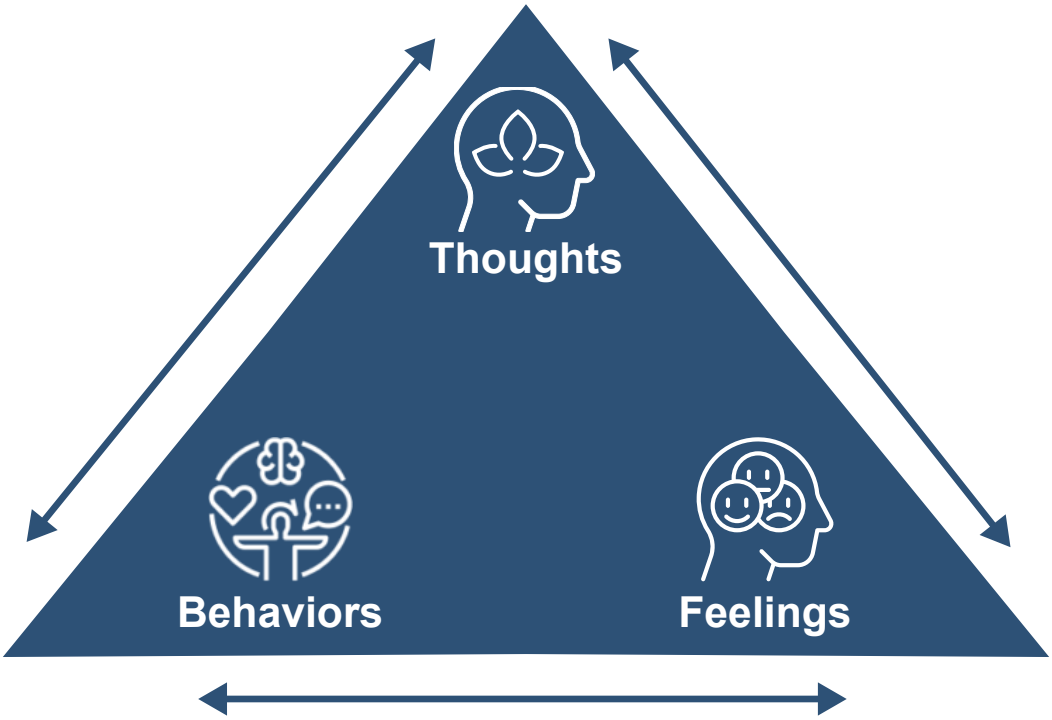
Appendix

Cognitive Behavioral Therapy (CBT)



CBT interventions typically consist of the following 8 steps (American Psychological Association, 2024):

Intervention Stage	Description
Cognitive Reframing	• **Identifying and Challenging Negative Thoughts:** CBT helps individuals recognize distorted or unhelpful thought patterns that exacerbate anxiety. These can include catastrophic thinking (assuming the worst will happen) or overgeneralization (thinking one bad outcome means all future outcomes will be bad). • **Reframing Thoughts:** The goal is to challenge these automatic thoughts and replace them with more balanced, realistic, and evidence-based ones.
Exposure Therapy	• **Facing Fears Gradually:** A key CBT technique for anxiety disorders is exposure therapy, where individuals are gradually and repeatedly exposed to the source of their anxiety in a controlled and safe environment. This process helps desensitize the person to the feared object, situation, or thought. • **In-vivo exposure:** Directly facing feared object/place/situation in real life. • Imaginal exposure: Vividly imagining the feared object/place/situation. • Systematic Desensitization: This involves gradual exposure paired with relaxation techniques to reduce anxiety responses.

Intervention Stage	Description
Behavioral Activation	• **Encouraging Positive Activities:** For people with anxiety, avoiding situations that cause stress can be common, but this avoidance can reinforce the anxiety. Behavioral Activation helps patients engage in meaningful activities that they may have been avoiding- improving mood and reducing anxiety.
Problem Solving	• **Developing Effective Coping Skills:** This involves learning to break down overwhelming problems into smaller, manageable parts and finding practical solutions, which can reduce anxiety related to feeling out of control or overwhelmed.
Relaxation Techniques	• **Breathing Exercises and Progressive Muscle Relaxation:** CBT often incorporates relaxation strategies like deep breathing, mindfulness, and progressive muscle relaxation to help manage the physiological symptoms of anxiety.
Psychoeducation	• **Teaching About Anxiety and CBT:** CBT includes education about how anxiety works and how thoughts, feelings, and behaviors interact to maintain the anxiety. Recognizing these links helps individuals take an active role in their treatment.
Mindfulness and Acceptance	• **Focusing on the Present Moment:** Mindfulness is sometimes integrated into CBT, encouraging individuals to observe and accept their thoughts and feelings without judgment, rather than reacting to them emotionally. • Mindfulness techniques help individuals to recognize the connection between mind and body.
Goal Setting	• **Setting Specific, Measurable Goals:** CBT focuses on concrete goals related to reducing anxiety, and therapy is structured around working toward these goals. Tracking progress helps maintain motivation and gives a clear sense of accomplishment.

Individualized Education Plan Checklist

Individualized Education Plan (IEP) Checklist			
	KEY TASKS	**DATE COMPLETED/ TEAM MEMBER**	**TIMEFRAME**
REFERRAL STAGE			
	Engage family to confirm consent to refer		
	Provide education on school district and referral process		
	Support caregivers with writing “letter” requesting school assessment		Within 5 days district notifies caregivers and provides consent form for testing
	Get release signed		
	If child in EI, coordinate with EI provider		
	Support caregivers with gathering records, e.g., DBP assessment, IFSP, etc.		
	Place follow up call within a week to confirm caregiver signed and returned consent form		
ASSESSMENT STAGE			
	Provide education on evaluation process and remind caregivers to provide IEP Team with important documents, e.g., DBP assessment, IFSP, etc.		Must be completed within 30 days of district receiving signed consent
	Ensure caregiver understands when and where assessment will take place (note that assessments usually occur in the child’s school or if not already attending school, a school within the district)		
	Address anticipated logistical barriers for completing assessment		
	Help reschedule assessment if necessary (note that waiting periods for next available dates may be long)		
	Ensure that child will be tested in all areas of suspected disability, e.g., speech, physical, cognitive, etc.		
	Follow up with family and EI provider 3 days before scheduled assessment to review questions, concerns, and important documents have been given to the district		

Individualized Education Plan (IEP) Checklist		
ELIGIBILITY DETERMINATION		
	IEP Team eligibility meeting was or will be scheduled after completion of assessment. A completed evaluation report can be requested 2 days before the scheduled meeting.	Must occur within 45 school days of receiving signed consent
	Schedule follow up visit to review evaluation report together. Asist caregivers in understanding assessment results and preparing questions for determination meeting. Determine if it would be beneficial for CHW to accompany caregiver at the meeting.	
	At the meeting, the IEP team will discuss findings from assessments and determine disability and how it negatively impacts access to educational programming.	
	If eligible, the Team will recommend services, goals, and delivery options for proposed IEP. Caregivers will receive a hard copy in the mail.	IEP must be developed and sent to caregivers within 30 days of determination meeting
	If not eligible, caregivers may request a 504 plan or informal support plan	
ACCEPTING PROPOSED IEP		
	Assist caregivers in reviewing proposed IEP	
	Ensure services are clear and goals are defined with measurable outcomes and time components.	
	Provide education on caregiver's options (accepting in full, accepting in part, or rejecting in full). It is recommended that caregivers accept at least parts of the IEP they agree with to avoid delays in child receiving services.	
	Obtain copy of IEP and document in EMR	
IEP REVIEWS		
	Provide caregivers with education on review schedules and options	
	IEPs are reviewed once every year	
	Re-evaluations occur every 3 years, or sooner if there are other concerns, needs, or information	
	Caregivers may request the team convene at any time if there are concerns	

Individualized Education Plan (IEP) Checklist

COMMON CHALLENGES IN SUPPORTING FAMILIES WITH SCHOOL SERVICES

Initial Connection:

- It is crucial to ensure caregivers are aware of educational rights and the school navigation process.
- It may also be helpful to explain the difference between medical and educational diagnoses, as well as the most commonly identified disabilities in school settings. It's important for caregivers to understand that having a diagnosis does not automatically mean a child will qualify for an IEP. The IEP Team must determine whether the disability impacts the child's academic access and performance.
- If a child is found not eligible, this is an opportunity to collaborate with school and families to find creative solutions that would best serve the child. It may also be helpful to address caregivers' concerns through other lenses, such as cultural factors that may influence their decision-making process.

Special Circumstances:

- Manifestation determination – if a child with an IEP or 504 plans has been suspended for more than 10 days, from school, transportation, or other programming, for misbehavior there should be a meeting to determine if it is due to the child's disability.
- At the manifestation determination meeting, the Team must answer 2 questions:
  - Is the conduct a direct result of the district's failure to implement the IEP?
  - Does the conduct have a direct and substantial relationship to the disability?

If the team answers yes to either of these questions, then it is a manifestation of the disability. The Team must answer no to both of these questions for a determination of the behavior not being a manifestation of the disability.