Hospitalization for Depression At A Glance

Major depressive disorder includes symptoms of low mood, anhedonia, and other neurovegetative symptoms (e.g., insomnia, decreased concentration, low energy). Hospitalization of persons with major depressive disorder or other forms of depression aims to stabilize the person served and reduce the risks of suicide.

Depressed people have a lifetime risk of attempted suicide of 50%. While women are 3 times more likely than men to attempt suicide, men are 3 times more likely to be successful. The lifetime risk of completed suicide in persons hospitalized with depressive disorders depends on the reason for admission and is as high as 8.6% in those hospitalized for suicidality.

Depression is often a chronic, relapsing, remitting condition. From half to more than three-quarters of persons suffering from depression will have more than one episode. About one third will have an episode within 1 year of following the cessation of therapy. The risk of recurrence increases with number of previous major depressive episodes and the persistence and severity of symptoms.

Admission Criteria

Inpatient admission may be considered when the following conditions are present:

- Suicidal and/or homicidal ideation or behavior;
- Psychosis, substance dependence, severe unremitting depression
- Agitation, inability to adhere to treatment,
- Severe impairment in occupational functioning and interpersonal relationships.

Hospitalization

It is imperative to evaluate for:

- Presence of suicidal or homicidal ideation, intent, or plans
- Access to means for suicide and the lethality of those means
- Presence of ongoing or past exposure to negative events, the environment in which depression is developing, support, and family psychiatric history
- Presence of alcohol or substance use
- History and seriousness of previous attempts
- Family history of or recent exposure to suicide

Because suicide rates in persons with depression are high, assessment of suicide risk is critical. The treatment of depressive disorders should always include acute and continuation phases. Both phases of treatment should include psychoeducation, supportive management; and for children and adolescents in particular, family and school involvement.

Pharmacotherapy

Fluoxetine is the only medication to be approved by FDA for the treatment of child and adolescent depression, and it shows a larger difference between medication and placebo than do trials with other antidepressants. It is not clear whether this is due to actual differences in the effect of the medication, to other related properties of the medication (long half-life may improve adherence to treatment), or the studies involving fluoxetine enrolled more severely depressed patients.

SSRIs and other novel antidepressants are generally well tolerated by both children and adolescents, with few short-term side effects. The side effects of the SSRIs and other serotonergic and/or adrenergic reuptake inhibitors novel antidepressants appear to be similar and dose dependent and may subside over time

Effective treatment also includes management of co-occurring disorders, psychotherapy especially CBT, education about the illness, and continuous treatment for 6-12 months to prevent relapse.

Hospitalization

Order laboratory tests: blood and urine drug screen tests, testing for substance intoxication and EEG for persons served age 40 and older who are started on lithium.
Consider medications to reduce mania and manage out-of-control behavior.

Complete medical, psychosocial and psychiatric evaluation for medications.

It is imperative that treatment planning emphasizes discharge planning and relapse prevention including supportive therapy, education, family intervention and medication monitoring. Initiate and continue individual psychotherapy, family psychotherapy, group therapy and other milieu therapies as depression symptoms subside.

Educational programs should be reinforce that adherence to treatment, especially medications, is vital.

Discharge should be to the least restrictive environment. Consider day treatment or return home.

Follow-up includes adherence to medications and individual and family psychotherapy as indicated.