

Clinical Care Guidelines for:
Major Depression in Children and Adolescents

OBJECTIVE

To guide the appropriate diagnosis and treatment of Major Depression in children and adolescents.

DIAGNOSIS & ASSESSMENT

DSM-5 Criteria

Five (5) or more symptoms present during a 2 week period; (1) depressed or irritable, cranky mood (outside being frustrated) or (2) loss of interest or pleasure and any three of the following:

1. Significant weight loss or decrease in appetite (more than 5 percent of body weight in a month or failure to meet expected weight gains.)
2. Insomnia or hypersomnia
3. Nearly every day and observable by others
4. Fatigue or lack of energy
5. Feelings of worthlessness or guilt
6. Decreased concentration or indecisiveness
7. Recurrent thoughts of death or suicide

In addition to the above DSM-5 criteria, children and adolescents may also have some of the following symptoms:

- Persistent sad or irritable mood
- Frequent vague, non-specific physical complaints
- Frequent absences from school or poor performance in school
- Being bored
- Alcohol or substance abuse
- Increased irritability, anger or hostility
- Reckless behavior

Symptoms cause significant distress or impairment in functioning.

Depression Scales such as the Beck Depression Inventory, Children's Depression Inventory or the Reynolds Adolescent Depression Inventory can be used to establish severity, baseline functioning and to monitor the progress of treatment.

Screening and Evaluation

Clinicians should screen all children for key depressive symptoms including sadness, irritability and a loss of pleasure in previously enjoyed activities. If these symptoms are present most of the time, affect psychosocial functioning and are not developmentally appropriate, refer for a full evaluation.

A thorough evaluation for depression should include determining the presence of other co-morbid psychiatric and medical disorders, interviews with the child and parents/caregivers, and if an adolescent, try to meet with him/her alone. Additionally, collect information from teachers, primary care physician and other social service professionals. Assessing for depression is an ongoing process and should be done continuously.

- Assess for Suicidal Ideation/Crisis
 1. If the patient has a plan, the means or has recently attempted, hospitalize.
 2. If the situation is unclear, refer to a behavioral health practitioner.
 3. Evaluate level of impulsivity and if patient can commit to not harming themselves; seek help if the ideation becomes overwhelming.
 4. Refer to a psychiatrist or behavioral health professional if symptoms are severe, there are co-morbid conditions, there are significant psychosocial stressors, and/or substance abuse.
- Assess for presence of on-going or past exposure to negative events such as abuse, neglect, family psychopathology, family dysfunction, and exposure to violence.
- If a child or adolescent is discharged from an inpatient hospitalization, they need to be seen by an outpatient behavioral health clinician within seven days of discharge.

TREATMENT

MEDICATION MANAGEMENT

Initial Treatment Selection:

Preferred Antidepressants: SSRIs are the medication of choice. Fluoxetine and escitalopram are the only SSRIs approved for use in adolescents with depression.

Antidepressants are considered in the presence of moderate depression for which psychotherapy is not feasible, severe depression with or without psychotic symptoms, and depression that fails to respond to an adequate trial of psychotherapy

Antidepressants should be initiated concurrently with psychotherapy if severe symptoms and/or functional impairment are present or the patient is at risk for suicide.

When antidepressants are to be used, i.e., SSRIs, especially fluoxetine should be considered as the first choice in children aged ≥ 8 years

- When used, antidepressants should be started in low doses (half the starting dose of adults) and gradually titrated up to a level where a balance between symptom control and avoidance of side effects is established
- Once antidepressants are started patients should be treated for at least 4-6 weeks. If no response is seen by 4 weeks, the dose can be increased
- Rapid and early dose adjustment should be avoided as adequate time should be allowed for clinical response

Maintenance Phase:

It is recommended that children and adolescents with two (if episodes are characterized by psychotic symptoms) or three episodes of depression, especially when associated with severe suicidality, severe dysfunction during the episodes, family history of affective disorders, and history of treatment resistance should receive maintenance treatment.

The pharmacologic treatments which were effective during the acute and continuation phase of treatment should be used for maintenance therapy.

Continue medication for 6-12 months following cessation of symptoms.

PSYCHOTHERAPY

Initial Treatment Selection:

For mild-to-moderate depression, psychotherapy is the preferred initial modality of treatment

- After initial diagnosis, clinicians should consider a period of 6-8 weeks of active support and monitoring before starting evidence-based treatment in those with mild depression

CBT (cognitive behavioral therapy) is preferred in children and adolescents with cognitive distortions and comorbid anxiety disorders

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Changing Medication:

- When to use a different SSRI: A different SSRI should be used when the maximum dose is reached and maintained for 4-6 weeks without response or there are major side effects
- When to use a second-line medication: Consider using a second-line medication for depression if a child fails two (2) SSRIs and a course of psychotherapy. A mental health specialist should be consulted regarding second-line medications. A doctor should also re-evaluate the diagnosis and consider a combination of medications if a child fails three (3) medication trials.

Disclaimer: Recommendation of treatment does not guarantee coverage of services.

Adolescent Antidepressants

	Medication	Starting Dose* (once daily dosing), mg	Increments, mg	Effective Dose, mg	Maximum Dosage, mg	Contraindicated
First Line	Flouxetine	10	10-20	20	40-8 to 11 y.o; 60-12 to 17 y.o.	MAOIs (Pimozide, Thioridazine) x
Second Line	Citalopram**	10	10	20	60	MAOIs
	Fluvoxamine	50	50	150	200 – 8 to 11 y.o. 300 – 12 to 17 y.o	MAOIs
	Sertraline	25	12.5-25	50	200	MAOIs
	Escitalopram (1st line for 12 and older)	10	5	10	20	MAOIs

*Young adolescents should be started on lower doses

**Clinicians should consider an EKG given the warning of cardiac side effects

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