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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

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. Psychomotor agitation or retardation
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.

- 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 himself; 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, s/he needs to be seen by an outpatient behavioral health clinician within 7 days of discharge.

TREATMENT

- Education, support, and case management appear to be sufficient for treatment of uncomplicated or brief depression.
- For children and adolescents who do not respond to the above or have more complicated depression, a trial of CBT and/or medication is indicated.
- Treatment with medication should always include acute and continuation phases. Some children may require maintenance treatment.
- May be seen more frequently during the first month and subsequent two months based on the needs of the child and the family.
- Each phase of treatment should include psychoeducation, supportive management, family and school involvement.
- Kennard, et. al. (2009) found that adolescents treated with a combination of an anti-depressant and CBT will remit earlier than those who receive either treatment alone and improvement is superior to that of both monotherapies.
- To consolidate the response to acute treatment and avoid relapse, treatment should always be continued for 6–12 months.
- Treatment should include the management of comorbid conditions.
- Progress in treatment should be monitored with rating scales such as the Beck Depression Inventory, Children's Depression Inventory or Reynolds Adolescent Depression Inventory.
- Abrupt discontinuation of anti-depressants is not recommended.

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

REFERENCES

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition TR (2013) American Psychiatric Association.

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