Major Depressive Disorder (MDD) in Children under Age 6

Level 0

Comprehensive assessment. Refer to *Principles of Practice* on page 5.

Level 1

Psychotherapeutic intervention (e.g., dyadic therapy) for 6 to 9 months; assessment of parent/guardian depression and referral for treatment if present.

Level 2

If poor response to psychosocial treatment after 6 to 9 months, re-assess diagnosis, primary care giver response to treatment, and/or consider switching to a different or more intensive psychosocial treatment. Consider child psychiatric consultation or second opinion.

Under 3 years, refer to *Principles of Practice* on page 5.

Level 3

If depression is severe, or there is continued poor response to psychosocial treatment alone, consider combination treatment with fluoxetine and concurrent psychosocial treatment.

- Fluoxetine — 4 to 5 years old
  - Maximum dose: 5 mg/day
  - Discontinuation trial after 6 months of any effective medication treatment with gradual downward taper.
  - **Monitor for behavioral disinhibition and suicidality.** Behavioral disinhibition is defined as impulsive, sensation seeking behaviors and lack of self-regulation.

Not Recommended:

- The use of medication without psychosocial treatment.
- Use of tricyclic antidepressants (TCAs) or paroxetine.

Note: In preschool children, MDD is very rare (point prevalence is thought to be 0.5%).

Level 0

Assessment

- Screening using multi-informant, validated rating scales that include depression and screening for comorbidity (other psychiatric and medical conditions):
  - Center for Epidemiological Studies Depression Scale for Children Patient Health Questionnaire (CES-DC)
  - Patient Health Questionnaire-9 (PHQ-9)
  - Pediatric Symptom Checklist (PSC)

  *Note: The above scales are available at **http://medicaidmentalhealth.org/**.*
- Perform risk assessment: Specific screen for harm to self or others and access to firearms, knives/sharps, and other lethal means such as alcohol, prescription and non-prescription medications.
- Evaluate sleep hygiene, diet, and exercise.
- Address environmental stressors such as abuse, bullying, conflict, functioning at school, peer relationships, family dysfunction, and caregiver depression.
- **Establish a safety plan:**
  - Removal of firearms, knives/sharps, and other lethal means such as alcohol, prescription and non-prescription medications.
  - **Develop an emergency action plan:**
    - Provide adolescents with mutually agreeable and available emergency numbers and contacts.
    - Engage a concerned third party familiar with the adolescent.
- Positive screen: DSM-5 based interview evaluation.
- Consider medical reason for depression [e.g., hypothyroidism, B12/folate deficiency, anemia, malnutrition (with or without eating disorder), chronic disorder (diabetes, asthma, inflammatory bowel disease, juvenile rheumatoid disease, infectious mononucleosis, etc.)].
- Rule out iatrogenic etiology of depression (i.e., medication side effects/interactions).
- Evaluate past psychiatric and medical history, previous treatment, family conflict and current depression of family and caregivers, bullying, abuse, peer conflict, school issues, and substance abuse.
- Consider and rule out presence of bipolar depression. Pointers: Prior (hypo) mania, family history of bipolar disorder, atypical depression with reverse neurovegetative signs, seasonal affective component, brief and recurrent episodes, and melancholic depression in prepubertal child.

Level 0 (continued)

- ✦ Track outcomes using empirically validated tools. Refer to DSM-5 Severity Measure for Depression, Child Age 11–17 available and Child Depression Inventory (CDI) available at ***http://www.medicaidmentalhealth.org/***.

  Note: The Child Depression Inventory is not available in the public domain.

Always monitor for:

- ✦ Emergence or exacerbation of suicidality and balance the risk–benefit profile of antidepressants during the acute treatment phase.
- ✦ Behavioral activation (e.g., difficulty falling asleep, increased motor activity, increased talkativeness)
- ✦ Adverse events
- ✦ Treatment adherence
- ✦ Treatment or inherently emergent comorbidity
- ✦ Potential development of (hypo)mania

Level 1

Initial treatment plan

- ✦ Active support: 6 week trial (if mild symptoms).
  - ✧ Components of active support must include psychosocial interventions and psychoeducation and may include: Self-help materials, active listening/relationship building, school involvement, mood monitoring, pleasant activities, cognitive restructuring, family conflict reduction, sleep hygiene, and exercise.

Major Depressive Disorder (MDD) in Children and Adolescents Ages 6 to 17 Years Old *(continued)*

Level 2

Reassess diagnosis first (e.g., bipolar disorder), rule out psychostimulant or substance abuse related psychosis. Targeted treatments if symptoms are moderate to severe, impairment continues, and/or no response to active support. Start with Cognitive Behavioral Therapy (CBT), Interpersonal Therapy (IPT), depression-specific behavioral family therapy.

- **2a.** Fluoxetine or combination of CBT or IPT psychotherapy with fluoxetine.
- **2b.** May consider use of escitalopram for age 12 and above.

Qualifiers:

- Mild: Psychosocial interventions only.
- Moderate/Severe: Combination of CBT or IPT psychotherapy with fluoxetine.
- Psychosis: SSRIs (fluoxetine, escitalopram) plus consider antipsychotics (adult data only). Careful evaluation of symptoms to determine the degree of psychosis to warrant the use of antipsychotics.
- Comorbidity: Combination of CBT or IPT psychotherapy with fluoxetine; treat comorbidity.
- Suicidality: Intensify surveillance and follow-up; combination therapy with CBT or IPT psychotherapy if on antidepressant only or remove antidepressant if otherwise ineffective; if chronic, consider lithium augmentation.

Level 3

Inadequate response

- If no clinical response to the medication utilized in Level 2, switch to another medication listed above.

Level 4

Poor or non-response

- Refer to mental health specialist.
- Re-assess diagnosis (bipolar disorder, substance use disorder, anxiety disorders, PTSD), rule out medical condition (e.g., hypothyroidism), or medication side effects.
- Increase psychosocial intervention and medication dose if tolerated.
- Augment with alternate psychosocial intervention (either CBT or IPT).
- Consider change in level of care (treatment setting and interventions based on severity of illness).
- For milder form and/or seasonal affective symptoms with light sensitivity, consider bright light therapy.

Level 5

If poor or non-response to Level 4 interventions

- Switch previously used SSRIs to sertraline, citalopram, bupropion or venlafaxine, especially in those who do not have access to psychotherapy or have not responded to non-pharmacological interventions.
- Consider augmentation of SSRI with bupropion, thyroxine, lithium, buspirone, mirtazapine, aripiprazole, quetiapine, or risperidone (adult data only).
- If psychotic/severe: ECT (for adolescents).

Notes:

- Factors favoring maintenance treatment (at any Level):
  - Partial response
  - Prior relapse
  - Suicidality
  - Comorbidity risk for relapse
  - Environmental risk for relapse
  - Family history of relapsing/recurrent major depression
  - Lack of return to full premorbid functioning
- Maintenance treatment: 9 to 12 months.
- After maintenance treatment: If stable, at level of premorbid functioning, and no anticipated increase in stressors, consider discontinuation trial over 3 to 4 months.
- Venlafaxine: Caution due to robust evidence of a significantly increased risk for suicidal behavior or ideation

Note on pharmacogenomic testing: The current evidence does not support pharmacogenomic testing in routine psychiatric clinical practice.

For a full list of references, visit ***http://medicaidmentalhealth.org/***.

Selected Resources

- **Guides for Parents:**
  - If Your Adolescent Has Depression or Bipolar Disorder: An Essential Resource for Parents (Evans, 2005)
  - Adolescent Depression: A Guide for Parents (Mondimore and Kelly, 2015)
  - Depression and Your Child: A Guide for Parents and Caregivers (Serani, 2013)
- **Workbooks for Youth:**
  - Think Good, Feel Good: A Cognitive Behavior Therapy Workbook for Young People (Stallard, 2002)
  - How to Get Unstuck from the Negative Much: A Kid's Guide to Getting Rid of Negative Thinking (Sullivan, 2013)
- **Books for Children:**
  - What to Do When You Grumble Too Much: A Kid's Guide to Overcoming Negativity (Huebner, 2007)
  - The Princess and the Frog: A Story for Children with Depression (Jones, 2015)
- **Relevant Websites:**
  - American Academy of Child and Adolescent Psychiatry (AACAP) Depression Resource Center: *https://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Depression_Resource_Center/Home.aspx*
  - National Institute of Mental Health—Depression in Children and Adolescents: The National Institute of Mental Health Site on Depression in Children and Adolescents *http://www.nimh.nih.gov/health/topics/depression/depression-in-children-and-adolescents.shtml*
  - National Alliance of the Mentally Ill (NAMI): National Alliance of the Mentally Ill (NAMI) *https://www.nami.org/*
  - Depression and Bipolar Support Alliance: Depression and Bipolar Support Alliance *http://www.dbsalliance.org/site/PageServer?pagename=home*
  - Teen Mental Health Website: *http://teenmentalhealth.org/care/parents/*

Note: Above resources and website links were updated at the time of publication.

For a full list of references, visit ***http://medicaidmentalhealth.org/***.