PEDIATRIC DEPRESSION—IN BRIEF

Assessment and Diagnosis

Assessment Recommendations:

- **Recommendation i:** Evaluate any patient at high risk (i.e., with risk factors such as family history, other psychiatric disorders, substance abuse, trauma, psychosocial adversity, family conflict, or complaints of emotional disturbance, etc.) for the possibility of depression.

- **Recommendation II:** When evaluating a child or teen with possible depression, conduct separate Interviews with the child/adolescent and guardian using DSM 5 criteria. See criteria online at http://psychcentral.com/disorders/depression-major-depressive-disorder-symptoms/

- **Recommendation III:** Assess with validated depression rating sales to help guide the diagnosis and increase diagnostic precision of a depressive disorder

  - The Center for Epidemiological Studies Depression Scale for Children (CES-DC) is an easy-to-use assessment scale for children and adolescents:

  - The PHQ-9-M is a well-validated tool used to assess depression in primary care. For adolescent depression, the PHQ-9-M was modified to better represent adolescent depression and to include questions on suicide attempts and adolescent dysthymia.

  - Both scales can be downloaded at no cost, https://www.cappcny.org/home/clinical-rating-scales/

- **Recommendation IV:** Assess safety/suicide risk

  Red Flags or "High Risk" Considerations to determine suicidal risk:
  - Suicidal ideation, suicidal gestures, and suicide attempts
  - Psychotic symptoms: auditory and/or visual hallucinations
  - Poor parental supervision or family support
  - Multiple areas of poor/impaired functioning (school, social and family)
  - Co-morbid substance abuse
  - Abuse (physical, sexual, emotional, neglect)

Treatment

- Studies have shown that *Cognitive Behavioral Therapy (CBT)* and *Interpersonal Therapy (IPT)* are effective for the treatment of depressive disorders in children and adolescents.
- Medications (*SSRIs)* have been shown to be effective as well for the treatment of depressive disorders in children and adolescents. (March et al, 2004, 2007*)*
- Studies indicate that a *combination* of both medication and therapy (CBT) is more effective in reducing and treating symptoms of depressive disorders.
- 70 to 80 percent of children/adolescents with depression can be effectively treated.

- Without treatment, 40 percent of children and adolescents will have a 2nd episode of depression within 2 years.

Initial Management Recommendations:

- **Recommendation I**: Psychoeducation
  - Clinicians should educate and counsel families and patients about depression and options for the management of the disorder.

- **Recommendation II**: Comprehensive Treatment Planning
  - Clinicians should develop a treatment plan with patients and families and set specific treatment goals in key areas of functioning including home, peer, and school settings.

- **Recommendation III**:
  - Clinicians should establish links with community mental health resources, which may include patients and families who have dealt with child/adolescent depression and are willing to serve as resources to other affected children/adolescents and their family members.

- **Recommendation IV**: Safety Planning
  - Establish a safety plan, which includes restricting access to lethal means, engaging a concerned third-party, and developing an emergency communication mechanism.

Treatment Recommendations:

- **Recommendation I**: ***Mild*** Depression
  - Consider a period of active support and monitoring (6-8 weeks) before starting other evidence-based treatment.
  - If symptoms persist, initiate evidenced-based psychotherapy such as Cognitive Behavioral Therapy (or Interpersonal Therapy)

- **Recommendation II**: ***Moderate*** Depression
  - Initiate evidence-based antidepressant treatment such as selective serotonin reuptake inhibitors (SSRIs, see pharmacotherapy table) for moderate cases; AND
  - Initiate evidence-based psychotherapy.

- **Recommendation III**: ***Severe*** Depression or Co-morbid Conditions Present
  - Consultation with or referral to a mental health specialist should be considered.

Recommendation - Collaborative Care

  - Primary Care clinicians should actively support children and adolescents who are referred to mental health for depressive symptoms. Consider sharing care with mental

health professionals if possible.

- **The free Psych TLC** service is available for:
  - Consultation on psychiatric medication related issues including:
    - Advice on diagnosis and initial management for your patient
    - Titration of psychiatric medications
    - Side effects of psychiatric medications
    - Combination of psychiatric medications with other medications
    - Referral and services consultation regarding children with mental health issues

  - A licensed mental health professional (MHP) and a child and adolescent psychiatrist (CAP) are available via telephone to provide consultation and support to PCPs from 8am-5pm, M-F. Simply call **(844) 547-5688 or (501) 320-7270** to contact the Psych TLC Call Center. One of our expert MHPs will obtain basic information from your about the child and then set up a convenient time for Peter S. Jensen, MD, or another child & adolescent psychiatrist to call you back, usually within 30 minutes to 2 hours.

MEDICATIONS FOR DEPRESSION AND ANXIETY

	Generic Name	Trade Name	Available Forms	Dosing	Duration	Peak Effect	FDA Indication	Side Effects	Comments
SSRI	citalopram	CELEXA	Tablets: 10, 20, 40 mg Solution: 10 mg/5ml	Start with 10 mg given every morning Dose range: 10-40 mg daily	24 hours	4-6 weeks	MDD (A)	Common: nausea, dry mouth, somnolence, insomnia, tremor, ejaculatory dysfunction, dyspepsia, decreased libido Serious: serotonin syndrome, increased suicidality/worsening depression, mania,	profile. Does not usually cause insomnia
SSRI	escitalopram	LEXAPRO	Tablets: 5, 10, 20 mg Solution: 5 mg/5ml	Start with 5 mg (or less) given every morning Dose range 5-20 mg daily	24 hours	4-6 weeks	MDD (12 - 17 yo) & GAD (A)		S-isomer of citalopram
SSRI	fluvoxamine	LUVOX	Tablets: 25, 50, 100 mg	Start with 25 mg given at bedtime; doses above 50 mg should be divided Dose Range: 50-300 mg daily	24 hours	4-6 weeks	OCD (Child & Adolescents)		Luvox brand discontinued in US
SSRI	paroxetine	PAXIL / PAXIL CR	Tablets: 10, 20, 30, 40 mg Solution: 10 mg/5ml CR Tablets: 12.5, 25, 37.5 mg ER	Start with 10 (12.5 if CR) mg daily (may be given at night) Dose range: 10-50 (12.5-37.5 if CR) mg daily	24 hours	4-6 weeks	Paxil: MDD, OCD, Panic, SAD, GAD, PTSD (A) Paxil CR: MDD, panic, PMDD (premenstrual), SAD (A)		Increased risk of withdrawal symptoms if discontinued aburptly
SSRI	fluoxetine	PROZAC	Tablets: 10, 20, 40 mg Solution: 20 mg/5ml	8-11 yo: Start 5-10 mg given every morning 12 and older: Start 10 mg given every morning Dose range: 5-20 mg in children under 12 y/o and 5-40 (to 80 in some cases) mg in children over 12 y/o	24-72 hours	4-6 weeks	MDD, OCD, Bulimia Nervosa, Panic, PMDD (A) MDD (8-17 y/o), OCD (7-17 y/o)		Weekly form available. Long half life prevents withdrawal symptoms if dose is missed
SSRI	sertraline	ZOLOFT	Tablets: 25, 50, 100 mg Solution: 20 mg/ml	Start 12.5 mg per day Dose range: 50-200 mg daily	24 hours	4-6 weeks	MDD, OCD, Panic, PTSD, PMDD, SAD (A) OCD (6-17 y/o)		
SSRI	venlafaxine	EFFEXOR / EFFEXOR XR	Tablets: 25, 37.5, 50, 75, 100 mg XR Capsules (Extended release): 37.5, 75, 150 mg	Start 75 mg/day in divided doses; XR form can be used once daily Dose Range: 75-225 mg (225 mg max per FDA indication; however, in adults max frequently up to 375 mg)	8-12 hours XR: 24 hours	4-6 weeks	MDD (A) XR: MDD, GAD, Panic, SAD (A)	Common: nausea, dry mouth, somnolence, insomnia, tremor, ejaculatory dysfunction, dyspepsia, decreased libido Serious: serotonin syndrome, increased suicidality/worsening depression, mania, HTN, seizures	Monitor BP closely
OTHER	duloxetine	CYMBALTA	Capsules: 20, 30, 60 mg	Starting dose: 30 mg / day for 2 weeks before considering an increase to 60 mg Dose range: 30 to 120 mg / day 7 - 17 y/o Adults: 40-60 mg/ day for MDD, up to 120 for GAD	24 hours	4-6 weeks	MDD, diabetic neuropathy, GAD	Common: nausea, dry mouth, somnolence, insomnia, tremor, ejaculatory dysfunction, dyspepsia, decreased libido, HTN Serious: serotonin syndrome, increased suicidality/worsening depression, mania, hepatotoxicity, Stevens-Johnson syndrome, seizures	
OTHER	bupropion	WELLBUTRIN	Tablets: 75, 100 mg	Start with 75 mg given twice per day Dose range: 37.5 to 450 mg/day in 2-3 divided doses	12 hours	4-6 weeks	MDD (A)		
OTHER	bupropion	WELLBUTRIN SR	Tablets: 100, 150 mg	Start: 100 mg PO qam, incr. 100 mg/day qwk, divide dose bid Max: 400 mg/day Info: avoid/minimize alcohol use; do not cut/crush/chew	12-24 hours	4-6 weeks	MDD (A)	Common: insomnia, irritability, dry mouth, headaches, stomach upset, agitation, muscle aches, appetite suppression and weight loss, constipation or diarrhea. Less common: Stevens-Johnson syndrome, erythema multiforme, seizures, mania, psychosis, increased heart rate, liver failure, severe hypertension, migraines, worsened depression, suicidal thoughts	
OTHER	bupropion	WELLBUTRIN XL	Tablets: 150, 300 mg	Start: 150 mg PO qam, incr. after 7 days to 300 mg/day Max: 450 mg/day Info: avoid/minimize alcohol use; do not cut/crush/chew	24 hours	4-6 weeks	MDD & SAD (A)		

NOTE: ALL INFORMATION SHOULD BE CHECKED AGAINST CURRENT PDR