### Major Depression in Children under Age 6

#### Level 0
Comprehensive assessment *(see Principles of Practice)*.

#### 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.

Under 3 years, *(see Principles of Practice)*

#### Level 3
Consider child psychiatric consultation or second opinion.

#### Level 4
If continued poor response to psychosocial treatment alone, consider combination treatment with fluoxetine and concurrent psychosocial treatment.

**Fluoxetine – 4 to 5 years old**
- Starting dose: 1 mg/day
- Maximum dose: 5 mg/day
- Discontinuation trial after 6 months of any effective medication treatment with gradual downward taper.

---

**Not Recommended:**
- Use of tricyclic antidepressants (TCAs) or paroxetine.
- The use of medication without psychosocial treatment.

*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 (CES-DC)
  - Pediatric Symptom Checklist (PSC)
  The above scales are available at [http://medicaidmentalhealth.org](http://medicaidmentalhealth.org).
- Specific screen for harm to self or others and access to firearms.
- 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 1
#### Initial treatment plan
- Address environmental stressors such as abuse, bullying, conflict, and caregiver depression.
- Establish a safety plan:
  - Removal of firearms, knives/sharps, and other lethal means such as alcohol, prescription and non-prescription medications.
  - Providing adolescents with mutually agreeable and available emergency numbers and contacts.
  - Engaging a concerned third party familiar with the adolescent.
- 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.
Level 2
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.
- Fluoxetine or combination of CBT or IPT psychotherapy with fluoxetine (COMB).
- May consider use of escitalopram or citalopram for age 12 and above.

Qualifiers:

- Mild: Psychosocial interventions only.
- Moderate/Severe: COMB.
- Psychosis: SSRI (fluoxetine, escitalopram, citalopram) plus antipsychotic*.
- Comorbidity: COMB, treat comorbidity.
- Suicidality: intensify surveillance and follow-up; COMB if on antidepressant only or remove antidepressant if otherwise ineffective; if chronic, consider lithium augmentation.

Always Consider:

- Abuse/conflict/bullying
- School functioning
- Peer relationships
- Sleep hygiene/exercise/diet
- Medical conditions (e.g., hypothyroidism, B12/folate deficiency, anemia, malnutrition (with or without eating disorder) and chronic disorders (diabetes, asthma, inflammatory bowel disease, juvenile rheumatoid disease, infectious mononucleosis, etc.).

*Reassess diagnosis first (e.g., bipolar disorder), rule out psychostimulant or substance abuse related psychosis.

Level 3
Inadequate response

- If receiving psychosocial intervention alone, add medication.
- If on medication alone, add psychosocial intervention.
- Non-response to fluoxetine: switch to citalopram, escitalopram.
Major Depression in Children and Adolescents Ages 6 to 17 Years Old (continued)

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 – see above), 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, bupropion or venlafaxine.
- Consider augmentation of SSRI with bupropion, thyroxine, lithium, buspirone, mirtazapine, aripiprazole, quetiapine, or risperidone (adult data only).
- If psychotic/severe: ECT (for adolescents).

**After maximum medical benefit:**

- Maintenance for 9 to 12 months.
- Discontinuation over 3 to 4 months (if stable, return to premorbid functioning and no anticipated increase in stressors).
- Factors favoring maintenance treatment:
  - 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

**Always monitor:**

- Adverse events
- Treatment adherence
- Treatment or illness emergent suicidality
- Treatment or inherently emergent comorbidity
- Potential development of (hypo)mania