Depression—Management

Rapid access to evidence-based interventions decreases morbidity associated with depression AND decreases a child’s risk of recurrent major depressive disorder (MDD) through early adulthood. Recommended medical follow-up for patients with acute depression symptoms is every 1–2 months, utilizing a stepped care approach.

MANAGEMENT/TREATMENT

Evidence-Based Primary Care Interventions

Active Monitoring—Treatment team member communicates with patient and family every 1–2 weeks until scores decrease 50% or symptoms remit. Focus on brain health and treatment plan adherence. Consider brief interventions (problem solving techniques, screens for co-morbid conditions, etc.)

Psychotherapy—Cognitive behavioral therapy (CBT) or interpersonal therapy for adolescents (IPTa)
- CBT focuses on how strong emotional responses interact with thoughts, behavior and body sensations
- IPTa helps reframe when major life event is causing significant change (such as parent divorce, injured athlete)

Medication—SSRIs. Do not initiate without psychiatrist support/consultation if high risk for bipolar disorder. Activation due to dose change occurs within days (lower dose or change Rx); activation due to mania occurs around 3–4 weeks after dose change. THC/marijuana increases levels of escitalopram and sertraline; monitor for serotonin syndrome.
- First line—Fluoxetine. FDA-approved for MDD for ages 8 and older, and for OCD ages 7 and older. Off-label used as 1st line for pediatric anxiety disorders and panic disorder.
- Good evidence but not FDA-approved for major depressive disorder—Sertraline

Medical Monitoring
Monitor all patients with active depression symptoms (PHQ9>10); recommend monthly encounters with medical provider for ongoing monitoring, unless care has been transferred to psychiatrist/psychiatric APRN who will make medical decisions.
- Assess response to treatment interventions (PHQ9 score change, adherence, progress in therapy and/or response to medication)
- Assess somatic responses and quantify functioning. Evaluate for side effects, adverse effects, effects on target symptoms
  - If not improving (PHQ9 score worse, same or decreasing less than 5 points), assess problem first:
    - Enhance current plan, remove obstacles or adjust meds
    - Step up care to augment treatment plan

WHEN TO REFER

Acute crisis support or rapid safety management support—Call current treatment team or Psychiatric Intake Response Center (PIRC) to coordinate rapid evaluation

Medical emergency or concern for ingestion/mental status change—Nearest emergency department

Psychiatric consultation—Physician Priority Link (same-day response) or Epic Link (within 72 hours)

For more information or additional copies of this tool, contact the Physician Outreach and Engagement team at Cincinnati Children’s.
Depression—Management

### Inclusion Criteria
Patients with diagnosed major depressive disorder (MDD)

### Severity Guides Initial Recommendations

**All Severity**
- PCP brief office interventions (promote brain health, self-care, depression education)
- Start at appropriate level for your patient’s PHQ9 score. Actively monitor. If no improvement, step up care to next level (regardless of score).

**Mild (PHQ9 5-9)**
- Active monitoring

**Moderate (PHQ9 10-14)**
- Psychotherapy; consider medication

**Moderate-Severe (PHQ9 15-19)**
- Psychotherapy AND
- Recommend medication

**Severe (PHQ9 >20)**
- Begin medication AND psychotherapy
- Recommend consultation as needed OR
- Refer to psychiatry for medication

### Active Monitoring
- Review treatment plan every 1–2 weeks
- Follow-up appointment monthly (office/telemedicine)

### Medical Monitoring
- All patients PHQ9>10 (prior to treatment)
  - Monitor at least MONTHLY (by either PCP or psychiatrist/psychiatric APRN for medical management, not a therapist alone)
  - Reassess PHQ9 score
  - Target symptoms and new concerns.
  - Assess response to current interventions.
  - Functioning
  - Adherence

### Referral
- Acute crisis support or rapid safety management support—Call current treatment team or PIRC to coordinate rapid evaluation
- Medical emergency or concern for ingestion/mental status change—Nearest emergency department
- Psychiatric consultation—Physician Priority Link (same-day response) or Epic Link (within 72 hours)

### FDA Indications

<table>
<thead>
<tr>
<th>First Line for MDD [OCD ages 7+]</th>
<th>FLUOXETINE (Prozac) liq, tab, cap</th>
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<tbody>
<tr>
<td>2.5–5 mg (8-10) +5–10 mg (&gt;10)</td>
<td>20 mg &lt;12yo 40 mg &gt;12 yo</td>
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<tr>
<td>No withdrawal</td>
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<tr>
<td>Monitor for Cyp 2D6 interactions from other medications</td>
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<table>
<thead>
<tr>
<th>Second Line for MDD, Ages 12+</th>
<th>ESCITALOPRAM (Lexapro) liq, tab</th>
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</thead>
<tbody>
<tr>
<td>2.5–5 mg + 5–10 mg</td>
<td>20 mg</td>
</tr>
<tr>
<td>Monitor for Cyp 2C19 interactions</td>
<td></td>
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<tr>
<td>Abrupt discontinuation “flu-like” syndrome</td>
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<thead>
<tr>
<th>Not Approved for MDD [Good evid] [OCD ages 6+]</th>
<th>SERTRALINE (Zoloft) Liq, tab</th>
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<tbody>
<tr>
<td>12.5–25 mg (&lt;12) 25–50 mg (&gt;12)</td>
<td>75–200 mg</td>
</tr>
<tr>
<td>Monitor for Cyp 2C19 interactions</td>
<td></td>
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<tr>
<td>Abrupt discontinuation “flu-like” syndrome</td>
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NOT RECOMMENDED in pediatric patients = Desvenlafaxine (Pristique), paroxetine (Paxil)
NOT RECOMMENDED for PCP to initiate without psychiatric consultation = Mirtazapine (Remeron), bupropion (Wellbutrin)
Venlafaxine (Effexor) has highest association with suicidal thinking—Triggered Black Box warning for suicidality of all antidepressants

For urgent issues or to speak with the specialist on call 24/7, call the Physician Priority Link® at 1-888-987-7997.