

Expert Panel Discussion and Recommendations

Selected clinical issues – major depression

Major depression and related disorders, such as mood disorder NOS, depression NOS, and dysthymia, are among the most common diagnoses in this population. Many of these youth have severe affective dysregulation complicating their diagnosis and treatment. The data guiding treatment of depression in this age group is sparse. This break-out group was charged with addressing the following issues:

- 1) Is there enough data to support the use of one antidepressant over others in previously untreated youngsters with depression?
- 2) What changes in practice have clinicians had to make and what precautions have clinicians had to take to use the SSRIs?
- 3) Is the Texas Children's Medication Algorithm Project¹ appropriate for the treatment of major depression in this population?
- 4) Under what circumstances is it warranted to deviate from the Texas Children's Medication Algorithm Project?
- 5) Insomnia and sleep disorders often accompany depression and there is evidence to suggest that the depression will not improve until the sleep disturbance remits. What is an appropriate treatment intervention for insomnia and sleep disturbances in depressed adolescents? What is an appropriate duration of treatment?

Panel Report

The panel thought that, if anything, depression was underdiagnosed in children and adolescents in the child welfare population. The panel discussed ways of improving the recognition of symptoms of depression, of establishing the diagnosis of depression, and of measuring symptom severity and treatment response. The use of observer-rated and self-rated symptom severity scales and diagnostic instruments as an aid in establishing diagnosis and monitoring response to treatment was recommended. No specific instrument was recommended, though the committee discussed the use of The Children's Depression Inventory, the Beck Depression Inventory, and the Child and Adolescent Needs and Strengths (currently in use in residential treatment settings in Illinois). Caution was raised regarding the use of self-rating scales and inaccurate reporting of symptoms. Diagnostic comorbidity was discussed with specific reference to substance abuse.

- 1) The panel noted that evidence-based psychotherapy should be tried first in adolescents newly diagnosed with depression unless the patient was severely impaired by the depression or was actively suicidal. As for a first line choice of antidepressants the panelists note that fluoxetine has more data supporting its use than other antidepressants. Sertraline and citalopram/escitalopram were named as viable alternatives. The panel recommended against using paroxetine as a first line treatment for depression. Several

¹ Hughes, C W, et al., Texas Consensus Conference Panel on Medication Treatment of Childhood Major Depressive Disorder. Texas Children's Medication Algorithm Project: update from Texas Consensus Conference Panel on Medication Treatment of Childhood Major Depressive Disorder. Journal of the American Academy of Child & Adolescent Psychiatry. 46(6):667-86.

panel members felt that symptoms should drive choice of antidepressant. They also noted that patients were often adamantly opposed to specific antidepressants, frequently fluoxetine, due to the amount of negative press. Patient preference should be considered in making a choice. The panel recommended different choices for bipolar depression, including lamotrigine.

- 2) The panel expressed concern about the attention paid to suicidal ideation/behavior that arises in the context of treatment with a selective serotonin reuptake inhibitor (SSRI) and the impact it may have on patient's access to them. The consensus was that if suicidal ideation arises in response to treatment with an SSRI the medication should be discontinued and an alternative tried. Most clinicians felt that switching to a second SSRI was the treatment of choice for SSRI-induced suicidal behavior. They stressed the need for increased monitoring of medication response and adverse effects early in the course of treatment with an SSRI.
- 3) The panel felt that the most clinicians already follow the Texas Children's Medication Algorithm Project for treating child and adolescent depression. They highlighted several points. First, the dosage of a medication should be maximized if there is a partial treatment response or a treatment nonresponse. They stressed the need for reassessing the diagnosis if a patient fails the first antidepressant trial. They concurred that a second SSRI trial is appropriate if the first trial fails. An antidepressant from a different class should be prescribed if a second SSRI fails. They also discussed augmentation strategies as an alternative.
- 4) The panel did not really address this issue but did refer to the Star – D (*-D) study as a potential guideline for treating adolescents with treatment resistant depression.
- 5) The panel did not address this question except to emphasize the need to evaluate treatment emergent sleep disruptions as iatrogenic or due to the treatment itself..