Using antidepressants in children and young people

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/depression
NICE Pathway last updated: 10 September 2018

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.

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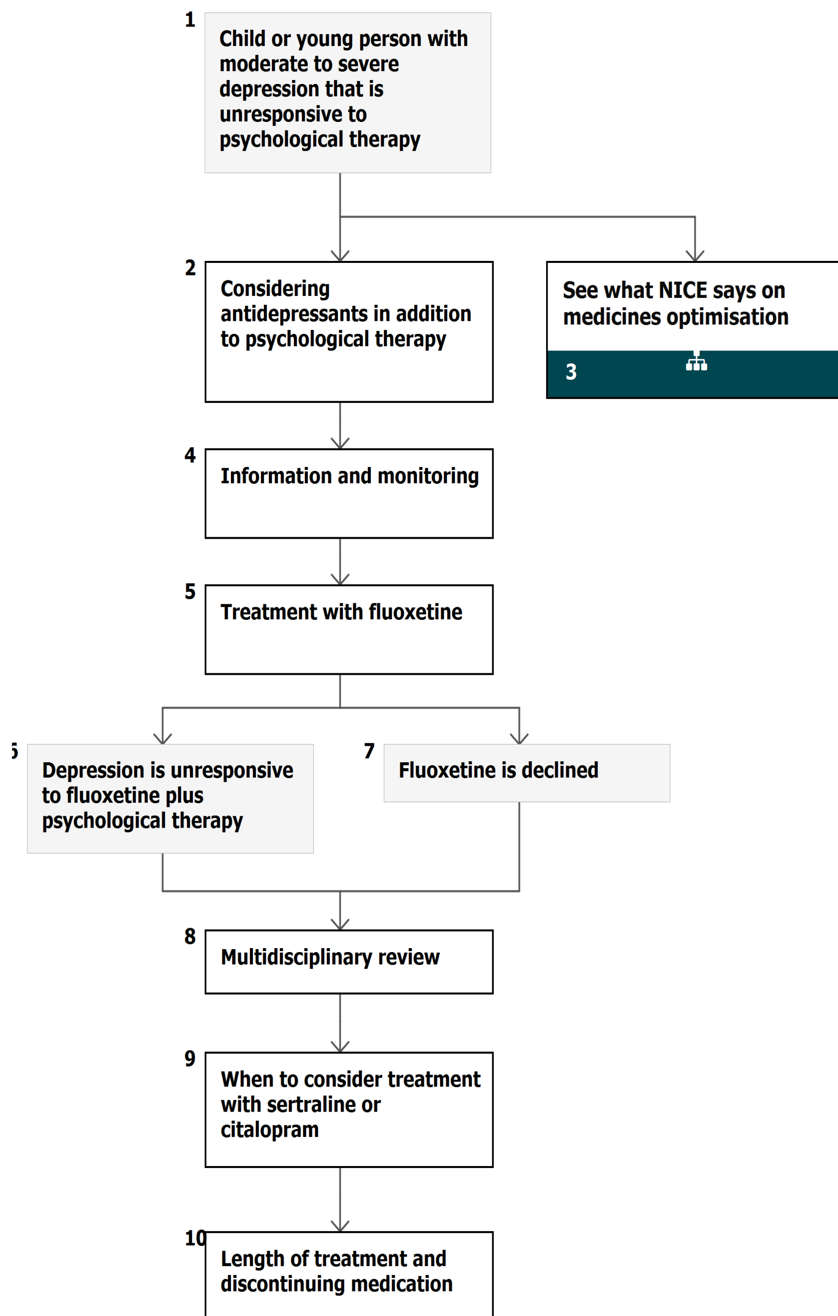

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1 Child or young person with moderate to severe depression that is unresponsive to psychological therapy

No additional information

2 Considering antidepressants in addition to psychological therapy

Do not offer antidepressant medication to a child or young person with moderate to severe depression except in combination with a concurrent psychological therapy. Specific arrangements must be made for careful monitoring of adverse drug reactions, as well as for reviewing mental state and general progress; for example, weekly contact with the child or young person and their parent(s) or carer(s) for the first 4 weeks of treatment. The precise frequency will need to be decided on an individual basis, and recorded in the notes. In the event that psychological therapies are declined, medication may still be given, but as the young person will not be reviewed at psychological therapy sessions, the prescribing doctor should closely monitor the child or young person's progress on a regular basis and focus particularly on emergent adverse drug reactions.

Following multidisciplinary review, cautiously consider fluoxetine[1] if moderate to severe depression in a child (5–11 years) is unresponsive to a specific psychological therapy after 4 to 6 sessions, although the evidence for fluoxetine's effectiveness in this age group is not established.

Fluoxetine should be prescribed as this is the only antidepressant for which trials show that benefits outweigh the risks.

Do not use:

- paroxetine and venlafaxine
- tricyclic antidepressants
- St John's wort.

If patient is taking St John's wort (over the counter), inform them of the risks (there are no trials in children and young people upon which to make a clinical decision; unknown side-effect profile; known interactions with drugs, including contraceptives) and advise discontinuation while monitoring for recurrence of depression and assessing for alternative treatments in accordance with NICE's recommendations.

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[1] At the time of publication (April 2015), fluoxetine did not have a UK marketing authorisation for use in children under the age of 8 years. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

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Interactions

Consider possible interactions with:

- other drugs (including recreational)
- alcohol
- complementary and alternative medicines.

3 See what NICE says on medicines optimisation

See medicines optimisation

4 Information and monitoring

Provide information

Inform patients and their parent(s)/carer(s) about the:

- rationale for drug treatment
- delay in onset of effect
- time course of treatment
- possible side effects
- need to take the medication as prescribed.

Supplement discussion with written information appropriate to the needs of the patient and parent(s)/carer(s), including the latest patient information advice from the relevant regulatory authority.

Monitoring

Unless medication needs to be started immediately, monitor symptoms that might be subsequently interpreted as side effects for 7 days before prescribing. Inform patients and their parent(s)/carer(s) that if there is any sign of new symptoms of these kinds, they should make urgent contact with the prescribing doctor.

Arrange to carefully monitor adverse drug reactions (for example, weekly for the first 4 weeks of treatment) and record in the notes.

Ensure patients are monitored for suicidal behaviour, self-harm or hostility by the prescribing

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doctor and the professional delivering the psychological therapy, particularly at the beginning of treatment.

If one is needed, use a recognised self-report rating scale such as the MFQ.

5 Treatment with fluoxetine

The starting dose should be 10 mg daily, increased if necessary to 20 mg daily after 1 week. Consider lower doses for children of lower body weight.

There is little evidence regarding the effectiveness of doses of fluoxetine higher than 20 mg daily, but higher doses may be considered in older children of higher body weight and/or when, in severe illness, an early clinical response is considered a priority.

6 Depression is unresponsive to fluoxetine plus psychological therapy

No additional information

7 Fluoxetine is declined

No additional information

8 Multidisciplinary review

If depression is unresponsive to combined treatment with a specific psychological therapy and fluoxetine after a further 6 sessions, or the patient or parent(s)/carer(s) have declined offer of fluoxetine, make a full needs and risk assessment:

- review the diagnosis
- examine the possibility of comorbid diagnoses
- reassess the possible individual, family and social causes of depression
- consider whether there has been a fair trial of treatment
- assess for further psychological therapy for the patient and/or additional help for the family.

Psychological therapy

Following multidisciplinary review, consider:

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- an alternative psychological therapy which has not been tried (individual CBT, IPT or shorter-term family therapy for at least 3 months), or
- systemic family therapy (at least 15 fortnightly sessions), or
- individual child psychotherapy (approximately 30 weekly sessions).

Providing psychological therapies for children and young people

Ensure psychological therapies are provided by:

- therapists who are also trained in child and adolescent mental health
- healthcare professionals who have been trained to an appropriate level of competence in the therapy being offered.

Develop a joint treatment alliance with the family. If this proves difficult consider providing the family with an alternative therapist.

9 When to consider treatment with sertraline or citalopram

If fluoxetine is unsuccessful or not tolerated, consider the use of another antidepressant (sertraline or citalopram are the recommended second-line treatments[1]).

Dose

The starting dose of antidepressants other than fluoxetine should be half the daily starting dose for adults, increased if necessary to the daily adult dose gradually over 2 to 4 weeks. Consider lower doses in children of lower body weight.

There is little evidence regarding the effectiveness of upper daily adult doses in children and young people, but these may be considered in older children of higher body weight and/or when, in severe illness, an early clinical response is considered a priority.

Special considerations for using sertraline and citalopram

Only use when the following criteria have been met:

- The patient and parent(s)/carer(s) have been fully involved in discussions about the benefits and risks.
- The patient and parent(s)/carer(s) have been provided with appropriate written information covering:
    - rationale for drug treatment

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- - delay in onset of effect
  - time course of treatment
  - possible side effects
  - need to take medication as prescribed
  - the latest patient information advice from the relevant regulatory authority.
- The depression is sufficiently severe and/or causing sufficiently serious symptoms (e.g. weight loss or suicidal behaviour) to justify trial of another antidepressant.
- There is clear evidence of a fair trial of fluoxetine with a psychological therapy (in other words that all efforts have been made to ensure adherence to the recommended treatment regimen).
- There has been a reassessment of the likely causes of the depression and of treatment resistance (for example, other diagnoses such as bipolar disorder or substance abuse).
- There has been advice from a senior child and adolescent psychiatrist (usually a consultant).
- The child/young person and/or someone with parental responsibility (or the young person alone, if over 16 or deemed competent) has signed an appropriate and valid consent form.

10 Length of treatment and discontinuing medication

Length of treatment

After remission (no symptoms and full functioning for at least 8 weeks) continue medication for at least 6 months (after the 8-week period).

Discontinuing medication

Phase out antidepressant medication over 6–12 weeks with the exact dose being titrated against the level of discontinuation/withdrawal symptoms.

[1] At the time of publication (March 2015), citalopram is not licensed for use in children and young people under 18 and sertraline is not licensed for use in children and young people under 18 for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

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Glossary

CAMHS

child and adolescent mental health services

CAPA

child and adolescent psychiatric assessment

CBT

cognitive behavioural therapy

CCBT

computerised cognitive behavioural therapy

DSM-IV

diagnostic and Statistical Manual of Mental Disorders

ECT

electroconvulsive therapy

HoNOSCA

Health of the Nation Outcome Scales for Children and Adolescents

ICD-10

International Statistical Classification of Diseases and Related Health Problems (tenth edition)

IPT

interpersonal therapy

K-SADS

schedule for affective disorders and schizophrenia for school-age children

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MAOI

monoamine oxidase inhibitor

MFQ

mood and feelings questionnaire

Mild depression

few, if any, symptoms of depression in excess of the 5 required to make the diagnosis, and symptoms result in only minor functional impairment, according to DSM-IV

Moderate depression

symptoms of depression or functional impairment are between mild and severe

NSAID

non-steroidal anti-inflammatory drug

SDQ

strengths and difficulties questionnaire

Severe depression

most symptoms of depression according to DSM-IV, and the symptoms markedly interfere with functioning. Can occur with or without psychotic symptoms

SSRI

selective serotonin reuptake inhibitor

Subthreshold depressive symptoms

fewer than 5 symptoms according to DSM-IV

TCA

tricyclic antidepressant

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Tier 1

primary care services including GPs, paediatricians, health visitors, school nurses, social workers, teachers, juvenile justice workers, voluntary agencies and social services

Tier 2

child and adolescent mental health services relating to workers in primary care including clinical child psychologists, paediatricians with specialist training in mental health, educational psychologists, child and adolescent psychiatrists, child and adolescent psychotherapists, counsellors, community nurses/nurse specialists and family therapists

Tier 3

specialised child and adolescent mental health services for more severe, complex or persistent disorders including child and adolescent psychiatrists, clinical child psychologists, nurses (community or inpatient), child and adolescent psychotherapists, occupational therapists, speech and language therapists, art, music and drama therapists, and family therapists

Tier 4

tertiary-level child and adolescent mental health services such as day units, highly specialised outpatient teams and inpatient units

Sources

Depression in children and young people: identification and management (2005 updated 2017) NICE guideline CG28

Your responsibility

Guidelines

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual

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needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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