Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Guidance on the Pharmacological Management of Depression in Children and Young People

(med 8) Mild Depression

Treat with non-pharmacological/psychological interventions as first line treatment. If unresponsive follow the guidance for moderate-severe depression

N.B. severity of depression may be difficult to establish in LD patients

(med 8) Moderate-Severe Depression

Consider drug treatment in children & young people who have:-

- Difficulty engaging with psychological therapy (eg LD)
- Had a trial of psychological treatment with no response with documentation of outcomes
- Had a MDT review
- Been considered for alternative/additional psychological therapy

Best practice guidance is that medication should be offered in combination with psychological therapy. If psychological therapies are declined, pharmacological therapy can be offered and prescribed following the BNF and/or Trust off label and unlicensed guidance.

Antidepressants should only be initiated following assessment and diagnosis by a Child & Adolescent Psychiatrist or a Non-medical Prescriber within their scope of practice. Monitoring of medication can subsequently be done by NMP.

See NMP Policy to Practice on Trust intranet (Policies & Procedures, search term = NMP)

Under no circumstances should primary care be asked to initiate antidepressant treatment in children and adolescents.

(med 8) Psychotic depression

If the patient displays signs of psychoses

- Consider the use of adjunct atypical antipsychotic medication – with careful monitoring of side effects.
- consider early use of antidepressant medication
- Be alert to antidepressant monotherapy resistance – consider combination therapies
- Refer to EIP & psychosis pathway

Baseline Assessment (med 8)

- Request medical history from GP/School nurse
- Allergies/intolerance to medication & family history
- Other medication prescribed/used including use of herbal medication, particularly St John's Wort, and NSAIDs (SSRIs increase bleeding risk)
- Pregnancy/breastfeeding – seek advice from medicines information and/or obstetrician; consider referral to perinatal psychiatry service (Tees only); see NICE CG192 - Antenatal and postnatal mental health: clinical management and service guidance
- Substance misuse, sedative effect may be increased with excessive alcohol use
- History of self-harm, suicidal ideation
- Symptoms that might be considered side effects should be monitored for 7 days before initiating medication
- Family history of bipolar disorder
- Consider differential diagnosis and comorbidity e.g. bipolar disorder
- Any concurrent or past psychotropic medication, e.g. ADHD medication, antiepileptics etc.

Physical examination

- Citalopram – ECG, baseline QT interval (only if pre-existing cardia disease as per citalopram ECG guidance), & review (consider U&Es to check for electrolyte abnormalities that may increase risk of QTc prolongation, e.g. eating disorders)
- Antipsychotic medication – refer to Psychosis pathway

(Med 4) Information on medication to be provided verbal and written – Choice & Medication; Medicines for Children

(med1) First line treatment: Fluoxetine* (licensed for 8-18 years) but evidence of efficacy is not established.

- Start 10 mg daily, may increase if necessary to 20 mg daily after 1-2 weeks. *May increase up to **40 mg** in severe cases and/or older children with higher body weight following the off label/off license prescribing guidance. However there is little evidence in its effectiveness as antidepressant in doses higher than 20 mg daily. Higher doses may be beneficial for comorbid anxiety disorders and OCD*
- Must consider that Fluoxetine has a long half-life This has implications for reaching steady-state drug levels (takes 4 weeks) as well as for drug withdrawal, drug interactions and drug overdose. Fluoxetine persists for 5-6 weeks after discontinuation.
- Ensure regular contact (recommended at least weekly) for the first four weeks to check general progress, mental state (especially suicidal thoughts, behaviour, self-harm and hostility) and for the presence of adverse drug reactions (see CBNF). Contact should ideally be face-to-face, but not necessarily with prescriber. Encourage family to report concerns. Consider limiting prescriptions to 7 days' supply for first 4-6 weeks. Prescriber must review after 4-6 weeks.
- Fluoxetine has effect of enhancing serum levels of other drugs being used concurrently. Consider possible interactions with alcohol
- Informed consent should be obtained and documented
- Consider using ROMS to measure outcomes.
- **Sertraline and Citalopram are second line antidepressants. They are not licensed in under 18s for depression.**

(med 5) Good response

If patient responds positively to antidepressant treatment, no symptoms and full functioning for at least 8 weeks, they should continue on that treatment for at least 6 months
Consider longer term treatment e.g. up to 2 years for
•Recurrent depression
•Severe depression

(med 5) Partial response – consider:

•Check adherence
•MDT review (review effectiveness of psychological therapy)
•Titration and stabilisation on maximum dose

(med 5) No response
•Check adherence
•MDT review (review effectiveness of psychological therapy)
•Consider second-line medication – see advice in boxes below re. switching between SSRIs. N.B. long half-life of fluoxetine

(**med 1) Second-line medication: Sertraline***
(unlicensed – seek & record patient/carer consent in the EPR)

•If switching from Fluoxetine, consider the long half-life of this drug - reduce the dose and stop for at least 7 days (longer if >20 mg was prescribed) before initiating Sertraline.

•If switching from citalopram, consider the risk of serotonin syndrome, reduce the dose and consider stopping for up to 7 days before initiating sertraline (if no gap in treatment is clinically desirable, start sertraline at lower dose [25 mg daily])

•For age 12 -18 years start at 50 mg once daily, increase as necessary in steps of 50 mg daily at intervals of at least one week. Max dose 200 mg once daily

•For under 12's, there is no guidance in cBNF on dosage - start at lower dose and proceed with great caution

•Ensure regular contact (recommended at least weekly) for the first four weeks to check general progress, mental state (especially suicidal thoughts, behaviour, self-harm and hostility) and for the presence of adverse drug reactions (see CBNF). Contact should ideally be face-to-face, but not necessarily with prescriber. Encourage family to report concerns. Consider limiting prescriptions to 7 days' supply for first 4-6 weeks. Prescriber must review after 4-6 weeks.

(med 1) Second-line medication: Citalopram*
(unlicensed – seek & record patient/carer consent in the EPR)

• If switching from Fluoxetine, consider the long half-life of this drug - reduce the dose and stop for at least 7 days (longer if >20 mg was prescribed) before initiating Citalopram.

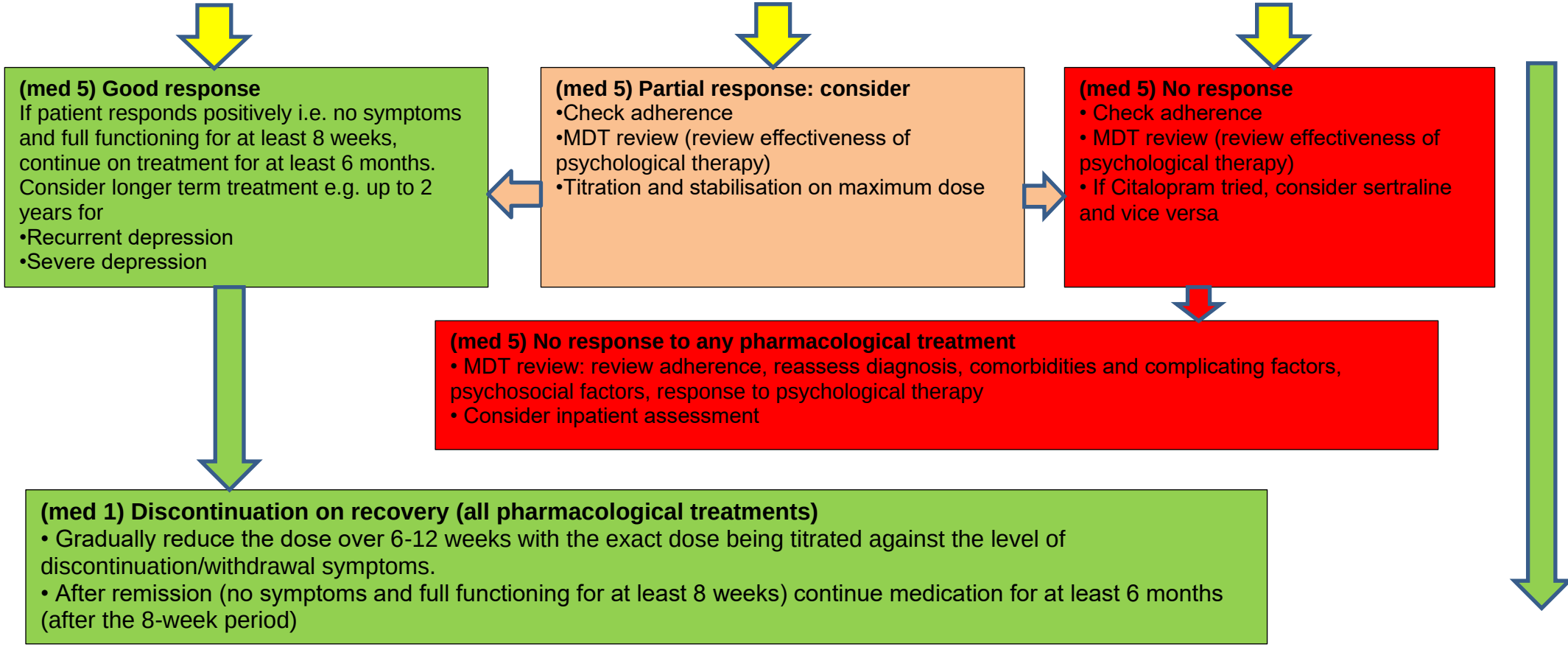
• If switching from Sertraline consider the risk of serotonin syndrome - reduce the dose and consider stopping for up to 7 days before initiating citalopram (if no gap in treatment is clinically desirable, start citalopram at lowest possible dose [10 mg daily])

• If pre-existing cardiac disease - baseline ECG prior to initiation (check QT interval). Contra-indicated in QTc prolongation. Can cause dose-dependent QTc prolongation, consider increased risk with other prescribed medications (refer to citalopram dose reduction & ECG algorithm)

• For age 12 -18 years start at 10 mg daily, increase if necessary to 20 mg daily after 2-4 weeks. **Max dose 40 mg daily**.

• For under 12's, there is no guidance in cBNF on dosage - start at lower dose and proceed with great caution

• Ensure regular contact (recommended at least weekly) for the first four weeks to check general progress, mental state (especially suicidal thoughts, behaviour, self-harm and hostility) and for the presence of adverse drug reactions (see CBNF). Contact should ideally be face-to-face, but not necessarily with prescriber. Encourage family to report concerns. Consider limiting prescriptions to 7 days' supply for first 4-6 weeks. Prescriber must review after 4-6 weeks.



Caution

Paroxetine and venlafaxine should not be used for the treatment of depression in children and young people.
Tricyclic antidepressants and St John's Wort should also not be used in children with depression

If being considered, Mirtazapine for depression requires clinical director approval via unlicensed/off-label approval form

See Safe Transfer of Care Guidance when considering appropriate transfer to primary care.

**Liquid preparations can be used in patients who will not/cannot swallow tablets, or need small or finely-tuned doses (e.g. LD patients)*

Ref: NICE Pathways – Depression in children and young people overview
https://pathways.nice.org.uk/pathways/depression-in-children-and-young-people
Taylor D, Paton C and Kapur S (2015). The Maudsley Prescribing Guidelines in Psychiatry, 13th Edition. Wiley-Blackwell.

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