

## Antidepressant Treatment Guidelines (Children and young people under 18 years)

### Depression in children and young people

Give advice about self-help materials or other methods used or considered potentially helpful by the patient or their parents or carers. If a child or young person with depression presents acutely having self-harmed, the immediate management should follow [NICE guideline on self-harm](#). Further management should then follow [NICE guidance - identification and management of depression in children and young people](#). The stepped-care model of depression draws attention to the different needs – depending on the characteristics of their depression and their personal and social circumstances – see NICE guidance for full details.

#### First choice antidepressant AGC

For moderate to severe depression (5 to 18-year-olds) – appropriate psychological therapy (follow NICE recommendations), with or without fluoxetine. (Tier 2 or 3 CAMHS).

- Fluoxetine

#### Second choice antidepressant AGC

For depression unresponsive to treatment/recurrent depression/psychotic depression - Intensive psychological therapy, with or without fluoxetine, sertraline, citalopram, augmentation with an antipsychotic (A SC). (Tier 3 or 4 CAMHS).

- Sertraline
- Citalopram

**Mild depression** (including dysthymia) - Watchful waiting (usually 2 weeks), CBT, IPT or NDST (Tier 1 managed in primary care and community settings)

**Moderate to severe depression** (5- to 11-year-olds) - IPT, CBT, family therapy, psychodynamic psychotherapy, with or without fluoxetine (tier 2 or 3 CAMHS)

**Moderate to severe depression** (12- to 18-year-olds) - Individual CBT, with or without fluoxetine. If needs not met, IPT-A, family therapy, brief psychosocial intervention, or psychodynamic psychotherapy, with or without fluoxetine. (Tier 2 or 3 CAMHS)

**Depression unresponsive to treatment/recurrent depression/psychotic depression** - Intensive psychological therapy, with or without fluoxetine, sertraline, citalopram, augmentation with an antipsychotic. (Tier 3 or 4 CAMHS).

#### Combined treatments for moderate to severe depression

- Following multidisciplinary review, offer fluoxetine if moderate to severe depression in a young person (12–18 years) is unresponsive to a specific psychological therapy after 4 to 6 sessions. Fluoxetine was the only antidepressant with UK marketing authorisation for use in this indication for children and young people aged 8 to 18 years (August 2022).
- Consider combined therapy (fluoxetine and psychological therapy) for initial treatment of moderate to severe depression in young people (12–18 years), as an alternative to psychological therapy followed by combined therapy. See [NICE's information on prescribing medicines](#).
- Following multidisciplinary review, cautiously consider fluoxetine (off-label use) 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.

## How to use antidepressants in children and young people

An antidepressant should only be prescribed following assessment and diagnosis by a child and adolescent psychiatrist\*. Do not offer antidepressant medication to a child or young person with moderate to severe depression except in combination with a concurrent psychological therapy.

- When an antidepressant is prescribed, use **fluoxetine** as this is the only antidepressant for which clinical trial evidence shows that the benefits outweigh the risks. The starting dose should be 10 mg daily, increasing to 20mg daily after 1 week if clinically necessary. There is little evidence regarding the effectiveness of doses higher than 20 mg daily, however, consider in older children of higher body weight and/or when, in severe illness, an early clinical response is considered a priority. Lower doses should be considered in children of lower body weight.
- **Make arrangements for careful monitoring of adverse drug reactions, as well as for reviewing mental state and general progress; for example, weekly contact for the first 4 weeks of treatment and monitor progress on a regular basis and focus particularly on emergent adverse drug reactions.**
- Monitor closely for the appearance of suicidal behaviour, self-harm or hostility, particularly at the beginning of treatment.
- After response to treatment with fluoxetine, continue for at least 6 months after remission (defined as no symptoms and full functioning for at least 8 weeks); ie, for 6 months after this 8-week period.
- If treatment with fluoxetine is unsuccessful or is not tolerated because of side effects, consider use of another antidepressant - sertraline or citalopram are the recommended second-line treatments (off label, see [NICE's information on prescribing medicines](#)).

NICE NG134 (June 2019) state that children and young people presenting with moderate to severe depression should be reviewed by a CAMHS team before prescribing. If in the opinion of the patient's GP, the long wait for assessment by CAYP mental health services would be clinically inappropriate or present an unacceptable risk for their patient, Frimley ICB supports the initiation of fluoxetine in primary care at the same time as signposting to relevant local support, together with referral to Talking Therapies for those  $\geq 17$  years, if this is within the GP's scope of practice.

**Sertraline or citalopram** should only be used after advice from a senior child and adolescent psychiatrist, after a fair trial of the combination of fluoxetine and a psychological therapy, depression is sufficiently severe and/or causing sufficiently serious symptoms (such as weight loss or suicidal behaviour) to justify a trial of another antidepressant, other causes such as bipolar disorder or substance misuse have been ruled out and the patient / family have been fully involved in discussions about the likely benefits and risks of the new treatment. See the [MHRA's drug safety update on QT prolongation with citalopram and escitalopram](#).

The starting dose should be half the daily starting dose for adults, and gradually increased to the daily adult dose over the next 2 – 4 weeks if clinically necessary. There is little evidence regarding the effectiveness of higher doses, however, consider in older children of higher body weight and/or when, in severe illness, an early clinical response is considered a priority. Lower doses should be considered in children of lower body weight.

After response to treatment with citalopram or sertraline, medication should be continued for at least 6 months after remission. Where antidepressant medication is to be discontinued, the drug should be phased out over a period of 6 to 12 weeks with the exact dose being titrated against the level of discontinuation/withdrawal symptoms.

**Paroxetine, venlafaxine, and tricyclic antidepressants** should not be used for the treatment of depression in children and young people.

**Treatment of psychotic depression.** For children and young people with psychotic depression, consider augmenting the current treatment plan with a second-generation antipsychotic medication (off label), although the optimum dose and duration of treatment are unknown.