UKMi North West

NICE Bites

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A summary of prescribing recommendations from NICE guidance

Depression in children and young people

NICE CG28; 2005 (updated 2015)

This guideline covers the identification and treatment of depression in children (aged 5 to 11 years) and young people (12 to 18 years) in primary, community and secondary care.

Definition of terms

ICD-10	International statistical Classification of Diseases
CAMHS	Child and Adolescent Mental Health services
CBT	cognitive behavioural therapy
IPT	interpersonal therapy
MFQ	mood and feelings questionnaire
ADR	adverse drug reaction
U	unlicensed

Assessment – also see NICE pathway: depression

- The ICD-10 uses a list of ten depressive symptoms and divides depression into 4 categories:
  - not depressed (<4 symptoms),
  - mild depression (4 symptoms),
  - moderate depression (5 or 6 symptoms),
  - severe depression (≥7 symptoms with or without psychotic symptoms).
- For a diagnosis of depression, symptoms should be present for at least 2 weeks and every symptom should be present for most of the day.
- Consider the following when assessing a child/young person with depression and record in the notes:
  - potential comorbidities,
  - social, educational and family context for the patient and family members,
  - quality of relationships with family, friends and peers.
- Ask the child/young person and their parents/carers directly about:
  - alcohol and drug use,
  - experience of being bullied or abused,
  - self-harm,
  - ideas about suicide.
- Give young people the opportunity to discuss these issues initially in private.
- If a child/young person presents acutely having self-harmed immediate management should follow NICE pathway: self-harm

Safeguarding children

- Be aware of or suspect abuse as a contributory factor or cause of symptoms/signs of depression in children. Abuse may also co-exist with depression. See NICE pathway: child maltreatment.

Box 1: Service provision

Tier 1 - primary care workers e.g. GP, health visitor, teachers.
Tier 2 - CAMHS professionals relating to primary care workers including clinical child psychologists, specialist paediatricians (mental health), educational psychologists, child and adolescent psychiatrists/psychotherapists, counsellors, community nurse/nurse specialists and family therapists.
Tier 3 - CAMHS multi-disciplinary team providing specialised services for more severe, complex or persistent disorders.
Tier 4 - tertiary-level services such as day units, highly specialised outpatient teams and inpatient units.

Box 2: Stepped care model

Step	Focus	Action	Responsibility
1	Detection	Risk profiling	Tier 1
2	Recognition	Identification	Tiers 2 to 4
3	Mild depression	Watchful waiting Non-directive supportive therapy/ group CBT/ guided self-help	Tier 1 Tier 1or 2
4	Moderate to severe depression	Brief psychological therapy +/- fluoxetine	Tier 2 or 3
5	Depression unresponsive to treatment/ recurrent / psychotic depression	Intensive psychological therapy +/- fluoxetine /sertraline/citalopram Augmentation with an antipsychotic	Tier 3 or 4

Note: each step introduces additional interventions; higher steps assume previous interventions.

Step 1: Detection, risk profiling and referral – see NICE pathway

Step 2: Recognition – see NICE pathway

Step 3: Mild depression

Watchful waiting

- If a child/young person does not want an intervention or may recover with no intervention arrange a further assessment, normally within 2 weeks.
- Make contact with children/young people who do not attend follow-up appointments.
- Discuss choice of psychological therapies with children and young people and their family members/carers. Explain that there is no good-quality evidence that one type of psychological therapy is better than another.
- Following a period of up to 4 weeks watchful waiting, offer all children/young people with continuing mild depression without significant comorbid problems or signs of suicidal ideation, individual non-directive supportive therapy, group CBT or guided self-help for a limited period (approximately 2 to 3 months). This could be provided by trained professionals in tier 1 or tier 2 CAMHS.
- If mild depression is still unresponsive:
  - refer for review by tier 2 or 3 CAMHS,
  - follow guidance for moderate to severe depression in children/young people.
- Antidepressant medication should not be used for initial treatment of chidren/young people with mild depression.

Step 4 and 5: Moderate to severe depression

- Offer children/young people a specific psychological therapy (individual CBT, IPT, family therapy, or psychodynamic psychotherapy) for at least 3 months.

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Step 4 and 5: Combined treatments

- In young people (12 to18 years) consider initial treatment with combined therapy (fluoxetineU* and psychological therapy) as an alternative to a trial of psychological therapy first followed by drug treatment if unsuccessful.
- If moderate to severe depression in a child/young person is unresponsive to psychological therapy after 4 to 6 treatment sessions, carry out a multidisciplinary review.
- Following multidisciplinary review, if depression is not responding to psychological therapy as a result of other coexisting factors such as comorbid conditions, persisting psychosocial risk factors e.g. family discord, or presence of parental mental ill-health consider alternative or perhaps additional psychological therapy for the parent or other family members, or alternative psychological therapy for the patient.
- Following multidisciplinary review, if depression is unresponsive to a specific psychological therapy after 4 to 6 sessions in a:
  - young person aged 12 to18 years; offer fluoxetine,
  - child aged 5 to 11 years; cautiously offer fluoxetine.U<8 years Be aware evidence for effectiveness in this age group is not established.
- If depression is unresponsive to combined treatment with fluoxetine and specific psychological therapy after a further 6 sessions, or the patient or parent(s)/carer(s) declined fluoxetine, make a full needs and risk assessment:
  - review diagnosis,
  - examine the possibility of comorbid diagnoses,
  - reassess possible individual, family and social causes of depression,
  - consider if there has been a fair trial of treatment,
  - assess for further psychological therapy for the patient and/or additional help for the family.
- Following multidisciplinary review, consider:
  - 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).

Step 5: Psychotic/recurrent depression – see NICE pathway

How to use antidepressants in children/young people

- **Do NOT** offer an antidepressant to a child/young person with moderate to severe depression except in combination with a concurrent psychological therapy after assessment and diagnosis by a child and adolescent psychiatrist.
- Specific arrangements must be made for careful monitoring of ADRs, as well as reviewing mental state and general progress e.g. weekly contact with the child/young person and their parent(s)/carer(s) for first 4 weeks of treatment. Precise frequency needs to be decided on an individual basis, and recorded in the notes.
- If psychological therapies are declined, medication may still be given. As the young person will not be reviewed at therapy sessions, the prescribing doctor should closely monitor the child/young person's progress regularly and focus particularly on emergent ADRs.

Recommendations – wording used such as 'offer' and 'consider' denote the strength of the recommendation.

Drug recommendations – the guideline assumes that prescribers will use a drug's Summary of Product Characteristics (SPC) to inform treatment decisions

- Inform children/young people 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.
- Provide written information appropriate to the needs of the patient and parent(s)/carer(s), including any patient advice from the relevant regulatory authority.
- The prescribing doctor and professional delivering psychological therapy should monitor for suicidal behaviour, self-harm or hostility particularly at the beginning of treatment. 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, they should immediately contact the prescriber.
- If needed, use a recognised self-report rating scale e.g.MFQ.
- Fluoxetine is the only antidepressant with evidence that benefits outweigh risks in children/young people.
- Fluoxetine starting dose is 10mg daily, increased if necessary to 20mg daily after one week. Consider lower doses for children of low body weight.
- If fluoxetine is unsuccessful or not tolerated, consider using another antidepressant second-line; sertralineU or citalopramU. The following criteria must be met:
  - depression is severe and/or causing serious symptoms e.g. weight loss, suicidal behaviour,
  - there is clear evidence of a fair trial of combined treatment with fluoxetine and a psychological therapy,
  - reassessment of likely causes of depression and of treatment resistance e.g. bipolar disorder,
  - advice obtained from a senior child and adolescent psychiatrist,
  - an appropriate and valid consent form has been signed.
- The starting dose of second-line antidepressants should be half the daily starting dose for adults, if necessary increased gradually to the daily adult dose over 2 to 4 weeks. Consider lower doses in children of low body weight.
- There is little evidence regarding effectiveness of higher daily adult doses in children/young people. These may be considered in older children of higher body weight and/or in severe illness, if an early clinical response is a priority.
- Consider possible drug interactions including interactions with complementary and alternative medicines, alcohol and 'recreational drugs'.
- Continue medication for at least 6 months after remission (defined as no symptoms and full functioning for at least 8 weeks).
- Stop antidepressant medication over a period of 6 to12 weeks. Titrate dose against level of discontinuation or withdrawal symptoms.
- **Do NOT** use paroxetine, venlafaxine or tricyclic antidepressants in children/young people.
- **Do NOT** use St John's wort in children/young people as there is no evidence of effectiveness, it has an unknown side-effect profile and interacts with other drugs.
- If a child/young person is taking St John's wort (bought over the counter) inform them of the risk, advise stopping treatment and monitor for recurrence of depression. Assess need for alternative treatments.

* Fluoxetine is not licensed for use in young people without a previous trial of psychological therapy that was ineffective.

This bulletin summarises key prescribing points from NICE guidance. Please refer to the full guidance at www.nice.org.uk for further detail.
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