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Contents

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Version	Date	Type of Change	Summary of Changes	Author
4.1	April 2022	Scheduled Review	Formulary status of escitalopram updated. Removed citalopram as the first line for depression. 1st line and 2nd line antidepressant choices changed in line with NICE (ng222) Vortioxetine added to the policy at glance. Updated to include NICE recommendation on psychological therapy in combination with anti-depressant when treating children and adolescent. Update of diagnostic criteria in line with ICD-11. Update to assessment for suicide and risk factors for suicide. Guidance on ECG monitoring for escitalopram and citalopram included as appendix. Treatment of depression in people with personality disorder and psychotic depression included. Link to deprescribing policy included. List of psychological therapies extended on appendix 2. *Assess response to treatment* section updated on appendix 2. *SSRIs and venlafaxine should initially be prescribed at half the normal starting dose and titrated to normal antidepressant dosage* added. Pregabalin risks in pregnancy added.	Caroline Mollison

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2. Policy at a Glance

Step 1

Screening for depression
- During the last month have you been bothered by feeling down, depressed, or hopeless?
- During the last month have you often been bothered by having little interest or pleasure in doing things?

Always ask people with depression directly about suicidal ideation and intent.

Screening for Anxiety
- During the past four weeks, have you been bothered by feeling worried, tense, or anxious most of the time?
- Are you frequently tense, irritable, and having trouble sleeping?

Step 2

Treatment of mild depression/generalised anxiety disorder
- See NICE NG 222 for a full list of non-pharmacological treatment options.
- An SSRI antidepressants can be offered as a treatment option and would normally be taken for a period of 6 months once symptoms are resolved.
- Prior to starting medication use shared decision making to provide information on treatment options, the gradual development of the full antidepressant effect, interactions, adverse effects, possible discontinuation symptoms and recommended duration of therapy (at least 6 months after remission following 1st episode, longer (at least 2 years) where increased risk of relapse such as previous episodes of depression, presence of residual symptoms and/or concurrent physical health problems and psychosocial difficulties) and agree an appropriate treatment option with the individual.

Step 3

- **Pharmacologic treatment of moderate or severe depression in adults**
- Offer a high intensity psychological intervention and an antidepressant
- 1st line for most people is a SSRI as well tolerated and good efficacy e.g., sertraline 50mg OD or fluoxetine 20mg OD. Or a SNRI may be used e.g. duloxetine or venlafaxine – consider that venlafaxine is generally less well tolerated, can increase blood pressure and a minimum daily dose of 150mg is required for dual uptake inhibition i.e., an effect on serotonin and noradrenaline. Duloxetine may be considered where there is co-morbid neuropathic pain. Or another antidepressant may be used if indicated e.g. mirtazapine may be considered where there is co-existing insomnia and/or lack of appetite associated with depression. If some improvement seen by 4 weeks, continue treatment for another 2 to 4 weeks.
- 2nd line antidepressant: If no/minimal signs of any improvement in the first three weeks either: increase the dose in line with the SPC if there are no significant side effects or switch to an alternative SSRI, SNRI or mirtazapine. Citalopram/escitalopram usually a 2nd line SSRI option due to possible QTc effects.
- 3rd line: If still no or limited response within four weeks to at least 2 antidepressants consider vortioxetine 10mg OD or consider an augmentation strategy. Also consider referring to mental health services. Venlafaxine MR 225mg should be prescribed as 150mg MR and 75mg MR given once a day as this is substantially more cost effective than the 225mg strength.
- For specialists*, in more severely ill patients consider clomipramine or amitriptyline or consider adding the following to an antidepressant: lithium** (>0.4mmol/L), quetiapine (150-300mg/day) or aripiprazole (2.5-10mg/day). 2nd line augmentation strategies: risperidone (1-2mg/day), olanzapine (2.5-5mg/day) or mirtazapine. Prescribing in children should be initiated by a specialist.
- **Pharmacologic treatment of generalised anxiety disorder**
- SSRIs and venlafaxine should initially be prescribed at half normal starting dose and titrated to normal dose.
- 1st line: sertraline (unlicensed)
- 2nd line: If no response consider switching to an alternative SSRI or venlafaxine
- If no response to 1st or 2nd line treatments or if unable to tolerate antidepressants, consider: Pregabalin 200 to 600 mg/day in 2 divided doses (consider risks in pregnancy – see section 8.4).

Considerations when choosing an antidepressant

Fluoxetine should be used 1st line in children and adolescents at an appropriate diose.
All antidepressants may increase the risk of **suicidal ideation** in children and young adults, monitor closely.
Seizures: use SSRIs, avoid TCAs
Renal, liver impairment or elderly: start low & increase slowly, consider mirtazapine or an SSRI with a shorter half-life.
Increased risk of bleeding: mirtazapine 1st line. Consider adding a PPI when using other antidepressants.
CVD: sertraline, fluoxetine or mirtazapine recommended.
Some SSRIs, tricyclic antidepressants, trazodone, and venlafaxine have been reported to cause QTc interval prolongation. Citalopram, escitalopram, and tricyclic antidepressants are contra-indicated in patients with known QTc interval prolongation. Citalopram & escitalopram are contra-indicated with medicines that prolong the QTc interval.
Hyponatraemia: lower risk: mirtazapine & trazodone, elderly/those with a low BMI are prone. Monitor sodium.
BPSD: Use an antidepressant when there are significant depressive features.

Advice & Support SWLStG Medicines Information (020 3513 6829) – for Croydon Maudsley Advice Line (020 3228 2317)
For professionals: https://bnf.nice.org.uk/ www.medicines.org.uk https://www.evidence.nhs.uk/
For patients & carers: http://www.choiceandmedication.org/swlstg-tr/ (medicines & comparison charts)
https://www.nhs.uk/pages/home.aspx www.swlstg.nhs.uk/patients-carers/advice-and-support/ ***Referral** - Practitioners without a special interest in mental health are advised to refer all patients with severe, chronic, resistant depression, patients at significant risk of suicide or any children and adolescents with depression to mental health services. ****** **Medicines are for secondary care initiation only**

3. Definitions & Key Terms

Term	Definitions/Explanation
ACE inhibitors	Angiotensin Converting Enzyme Inhibitors – medicines used to treat heart failure and high blood pressure
BMI	Body Mass Index
BP	Blood Pressure
BPSD	Behavioural and Psychological Symptoms of Dementia
CAMHS	Children and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CVD	Cardiovascular Disease
ECG	Electrocardiogram
GAD	Generalised Anxiety Disorder
FBC	Full Blood Count
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies
ICD	International Classification of Disease
INR	International normalised ratio - a measure of how long it takes for blood to clot
MHRA	Medicines and Healthcare products Regulatory Agency
MAOIs	Monoamine oxidase inhibitors – antidepressant medicines
NSAIDs	Nonsteroidal anti-inflammatory drugs – medicines used to manage pain and inflammation
OCD	Obsessive Compulsive Disorder
OD	Once daily
ON	Once at night
PPI	Proton Pump Inhibitor
PRN	Pro Re Nata - "when necessary"
QTc	A measurement of the cardiac electrocardiogram
SPC	Summary of Product Characteristics
SSRI	Selective Serotonin Re-uptake Inhibitor (antidepressant)
TCA	Tricyclic Antidepressant
U+E's	Urea and Electrolytes – used to measure kidney function
WCC	White Cell Count

4. Introduction

This guidance has been developed to aid clinicians working in South West London to prescribe for patients with a diagnosis of depression and/or generalised anxiety disorder (GAD).

This guidance is intended to aid clinical decisions concerning the treatment of depression and anxiety in line with local prescribing policy and formulary advice, national treatment guidance and technology appraisals.

5. Purpose & Scope

This document is to be shared across healthcare organisations in South West London, including those working in primary and secondary care and acute care organisations to ensure there is consistency and a shared understanding of the treatment of depression and anxiety.

6. Screening questions

Screening questions are useful tools to assess whether a patient should be further investigated for depression and anxiety. Those with long term physical health conditions should be targeted as these are associated with higher levels of depression than the general population[1]. See Policy at a Glance.

7. Diagnosis

7.1. Assessment of depression

- Severity of depression is likely to be greater when more symptoms are present with functional and social impairment, and a longer duration of symptoms.[1,2,3]
- Symptoms should be present for at least two weeks and each symptom should be present at sufficient severity for most of every day.
- Assess for these symptoms to make a diagnosis of depression using the ICD 11[3]:

Core Symptoms: At least one occurring most of the day, nearly every day during a period lasting at least two weeks	1. Depressed mood
	2. Diminished interest in activities
Accompanied by Other Symptoms:	1. Difficulty concentrating
	2. Feelings of worthlessness or excessive or inappropriate guilt
	3. Hopelessness
	4. Recurrent thoughts of death or suicide
	5. Changes in appetite or sleep
	6. Psychomotor agitation or retardation
	7. Reduced energy or fatigue

Mild	The individual is usually distressed by the symptoms and has some difficulty in continuing to function in one of more domains (personal, family, social, educational, occupational, or other important domains). There are no delusions or hallucinations during the episode.
Moderate (with or without psychotic symptoms)	Several symptoms are present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall. The individual typically has considerable difficulty functioning in multiple domains (personal, family, social, educational, occupational, or other important domains).
Severe with or without psychotic symptoms)	Many or most symptoms are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree. The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational, or other important domains).

- Depression can be present with somatic symptoms, manifesting as physical symptoms that suggest illness or injury, but cannot be explained fully by a general medical condition.

7.2. Assessment of Anxiety disorder

- The symptoms must be present for most days for at least several months, for more days than not:
  - General apprehension (i.e. free-floating anxiety)
    Or
  - Excessive worry focused on multiple everyday events, most often concerning family, health, finances, and school or work
- Together with additional symptoms such as:
  - muscular tension or motor restlessness
  - sympathetic autonomic over-activity
  - subjective experience of nervousness, difficulty maintaining concentration, irritability, or sleep disturbance

However, if the person does not fulfil these criteria (sub-threshold symptoms), they should not be dismissed as they may still have potential for considerable morbidity.[3]

7.3. Assessment of the risk of suicide

- Ask all patients with depressive symptoms about suicidal ideation and current intent at assessment, follow-up and on initiation and dose changes of antidepressants. Suggested questions are below. In depression the more actions a patient has taken to attempt suicide and the fewer barriers there are to stop them undertaking the act, the higher risk of suicide (in personality disorder the clinical picture may be more complicated).[1,4] Those depressed with a diagnosis of bipolar disorder are known to have a higher risk of suicide than those with depression alone.

When assessing the risk of suicide, ask the person:

- Do you have thoughts about death or suicide?
- Do you feel that life is not worth living?
- Have you made a previous suicide attempt?
- Is there a family history of suicide?

If the answer to any of these questions is yes, ask about their plans for suicide:

- Have you considered a method?
- Do you have access to the materials?
- Have you made any preparations (for example, written a note)?

Also ask about any pive factors, for example:

- What keeps you from harming yourself?
- Is there anything that would make life worth living?

Risk factors for suicide[5]

Class	Risk factors include:
Demographic and social	Lack of social support, no confidants Male gender Unemployed Living alone Unmarried Stressful life events (e.g. recently bereaved, debt/financial worries, loss of attachment/major relationship instability, job loss, moving house) LGBT Ethnic minority group
Personal background	Substance misuse Family history of mental disorder, suicide or self-harm. Close to someone who died by suicide (family or non-kin) Exposure to suicidal behaviour of key others (family, peers, favourite celebrity)

	Use of suicide-promoting websites or social media Access to lethal means; (If unable to remove lethal means ensure mitigation within a robust Safety Plan).
Clinical factors in history	Previous self-harm or suicide attempt(s) (regardless of intent, including cutting) Mental illness, especially recent relapse or discharge from in-patient mental health care Disengagement from mental health services Impulsivity or diagnosis of personality disorder Long-term medical conditions; recent discharge from a general hospital; pain. Recently started on antidepressant therapy
Mental state examination and suicidal thoughts	High degree of emotional pain and negative thoughts (hopelessness, helplessness, guilt – e.g. 'I'm a burden') Sense of being trapped/unable to escape (sense of entrapment) and/or a strong sense of shame Suicidal ideas becoming worse Suicidal ideas with a well-formed plan and/or preparation Psychotic phenomena, especially if distressing; persecutory and nihilistic delusions, command hallucinations perceived as omnipotent (pervasive).
High Risk Groups include:	Young and middle-aged men. People in contact with the criminal justice system. Specific occupational groups, for example, doctors, nurses, veterinary workers, farmers, agricultural workers.

7.4. Rating scales

- Rating scales can be helpful in detecting depression and in assessing severity but should not be used alone to determine the presence of depression which needs treatment.[4]
- Questionnaires which are validated for use in primary care are:
    - Patient Health Questionnaire-9 (PHQ-9, freely available): A 9 item self-rating depression scale. A score ≥12is the recommended threshold for considering treatment.
    - Anxiety Scale (GAD7, freely available): scores ≥5, 10 and 15 for mild, moderate and severe anxiety, respectively.

7.5. Consider co-morbidities, social and cultural factors

- Consider co-existing psychological and psychiatric disorders such as bipolar disorder, dementia, eating disorders, obsessive compulsive disorder, post-traumatic stress disorder and substance abuse.[1,4]
- Grief reaction can be difficult to distinguish from depression. The first line of management should be bereavement counselling rather than medicines.
- **Dementia** may present as depression as they share symptomatology (disorientation, memory loss, and distractibility).
    - Approximately a third of people with dementia develop depressive symptoms. Pseudo-dementia describes cognitive impairment due to depression in the elderly.
    - A primary diagnosis of depression is suggested by:
        - Preservation of a reasonable memory.
        - Personal or family history of depression.
        - A successful trial of treatment for depression which alleviates symptoms of dementia.
- **Parkinson's Disease** is associated with a high prevalence of co-morbid psychiatric disorders. Approximately half of people with Parkinson's disease develop depression during their illness.
- Consider underlying medical conditions with known associations with depression:
    - Chronic diseases (e.g. chronic pain, diabetes and cardiac disease)
    - Cerebrovascular disease (stroke, subarachnoid haemorrhage)
    - Endocrine disorders (hypothyroidism, Cushing's syndrome, adrenal insufficiency, hyperparathyroidism, hypopituitarism)

- Kidney disease (suggested rates of depression exceed those seen in other chronic illnesses and depression is vastly under recognised and undertreated in this population.)
- Cancer (e.g. pancreatic)
- Autoimmune conditions

- Consider the effect of substances of abuse and psychiatric side effects of medicines:
  - Carbon monoxide poisoning
  - Substance misuse (e.g. alcohol, anabolic steroids, cannabis, cocaine & opiates)
  - Centrally acting anti-hypertensives (such as methyldopa), lipid-soluble beta-blockers (e.g. propranolol), central nervous system depressants, opioid analgesics, retinoids (e.g. isotretinoin), interferons & steroid withdrawal.
- Consider socio-cultural differences in presentation: e.g.: Asian women presenting with somatic symptoms rather than mood symptoms.
- Severe agitation accompanying severe depression should prompt urgent referral to specialist mental health services.
- It is advisable to use an assessment tool, such as the Anticholinergic Effect on Cognition (AEC) scale available online http://www.medichec.com/, to assess the anticholinergic burden of prescribed medicines before adding antidepressants to older patients' treatment.

8. Treatment

8.1. Mild depression or sub threshold symptoms

- Antidepressants are not recommended unless the symptoms inhibit treatment of a physical health condition, there is a history of moderate or severe depression, symptoms persist after other interventions or symptoms are protracted (more than 2 years).[1]
- Watchful waiting, guided self-help, internet based cognitive behavioural therapy (CBT), group CBT, a structured group physical activity programme or referral to community based Improving Access to Psychological Therapies (IAPT) programme may be useful.
- IAPT services all accept self-referral from patients with borough-based GPs and referrals from GPs for the treatment of anxiety and depression.
- Although St John's wort may be of benefit in mild or moderate depression, it should not be prescribed because of uncertainty about appropriate doses, persistence of effect, variation preparations and potential serious interactions with other medicines.

8.2. Moderate or severe depression

- Non-pharmacological interventions via referral to local psychological therapist or IAPT should be considered along with antidepressant medicines.
- Prior to starting medication use shared decision making to provide information on treatment options, the gradual development of the full antidepressant effect, interactions, adverse effects, possible discontinuation symptoms and recommended duration of therapy (at least 6 months after remission following 1st episode, longer (at least 2 years) where increased risk of relapse such as previous episodes of depression, presence of residual symptoms and/or concurrent physical health problems and psychosocial difficulties) and agree an appropriate treatment option with the individual.
- 1st line antidepressant treatment for most working age adults is a SSRI e.g., sertraline or fluoxetine due to good tolerability and efficacy or a SNRIs e.g., venlafaxine (consider that tolerability is poorer than SSRIs and can raise BP), duloxetine may be considered where there is co-morbid neuropathic pain, or an alternative antidepressant may be used if indicated e.g. mirtazapine may be considered where there is associated insomnia and weight loss associated with depression.
- All anti-depressants show a pattern of response in which the rate of improvement is highest during weeks 1 and 2 and lowest during weeks 4-6.

- Anti-depressants should be continued for 6 months after abatement of symptoms in 1st episode depression. Long term treatment may be considered in chronic or relapsing depression or when the consequences of relapse are likely to be severe. Continuation of treatment for at least 2 years is recommended where there is a risk of relapse.
- If there is at least some improvement after four weeks of adequate treatment, continue treatment with the same antidepressant for another 2-4 weeks.
- If there is insufficient response after four weeks to a 1st line antidepressant, consider either increasing the dose in line with the SPC if there are no significant side effects or switching to a 2nd antidepressant (another SSRI, SNRI or mirtazapine).
- When depression is accompanied by symptoms of anxiety, the priority should usually be to treat the depression.
- When treating anxiety and comorbid depression or depressive symptoms, consider treating the anxiety disorder first (effective treatment of the anxiety disorder will often improve depressive symptoms).
- Depression as a 'behavioural and psychological symptom of dementia' should be treated taking into consideration co-morbidities in line with recommendations for treating elderly patients. See 'Appendix: Antipsychotic medicines for behavioral and psychological symptoms in dementia (BPSD)' in the 'Treatment with antipsychotics' guidelines for further information. [1,6]

8.3. Anxiety disorders

- Step 1: Following assessment and diagnosis; provide education about the nature of anxiety disorders and the options for treatment. Monitor the person's symptoms and functioning (active monitoring)
- Step 2: For those patients, whose symptoms have not improved after education and active monitoring, offer either individual non-facilitated self-help, individual guided self-help or psychoeducational groups depending on the person's preference. [7,8]
- Those with anxiety disorders whose symptoms have not improved after steps 1 and 2 or those with marked functional impairment should be offered either individual high-intensity psychological interventions or medication.
- Those with anxiety alone or generalised anxiety disorder requiring treatment should have a 1st line antidepressant (SSRI). Sertraline (off-label) should be prescribed 1st line (NICE). If no response, consider switching to an alternative SSRI or venlafaxine. Patients who have not responded to a first and second antidepressant or do not tolerate antidepressants may have a trial of pregabalin (prescribed twice daily and titrated up to 600 mg/ day if necessary).

8.4. Considerations when initiating an anti-depressant

- If a patient is at high risk of suicide, consider limiting the quantity of medication supplied to them.
- The absence of any improvement after 2 weeks is a very strong indicator of non-response to that medication.
- Patients should be made aware of the time taken for antidepressants to work.
- Vortioxetine can only be prescribed in a first episode of depression following an inadequate response to two antidepressants within the current episode in adults. A flexible approach should be taken when treating recurrent episodes of depression where previous episodes responded well to vortioxetine.
- Agomelatine, bupropion, and reboxetine are non-formulary in South West London for the treatment of depression and anxiety.
- Non-reversible monoamine oxidase inhibitors (MAOIs) such as phenelzine, should be initiated only by specialist mental health professionals with expertise in treating mood disorders in line with the RCPsych position statement.[11]
- Dosulepin, trimipramine and liothyronine should not be prescribed.
- There is the potential for increased levels of agitation, anxiety and suicidal ideation during the initial stages of treatment with antidepressants and patients should be advised as such. Short term (two weeks) benzodiazepine or promethazine may be prescribed for anxiety and/or agitation. Longer

durations of treatment with benzodiazepines should not be prescribed to prevent the development of dependence. [1,4,6,9,10]

- SSRIs are known to cause insomnia and should where possible be taken in the morning. The first choice of treatment is to offer sleep hygiene advice;
    - establish fixed times for going to bed and waking up (and avoid sleeping in after a poor night's sleep)
    - try to relax before going to bed
    - maintain a comfortable sleeping environment: not too hot, cold, noisy, or bright,
    - avoid napping during the day.
    - avoid caffeine, nicotine, and alcohol within 6 hours of going to bed.
    - Consider complete elimination of caffeine from the diet.
    - Avoid exercise within 4 hours of bedtime (although exercise earlier in the day is beneficial).
    - Avoid eating a heavy meal late at night.
    - Avoid using smartphones, tablets or other electronic devices for an hour or so before you go to bed as the light from the screen on these devices may have a negative effect on sleep
    - Avoid watching or checking the clock throughout the night.
    - Only use the bedroom for sleep and sexual activity
- Following sleep hygiene advice, short-term (2 weeks) hypnotics may be prescribed for insomnia. zopiclone 3.75-7.5mg ON PRN or short-term concomitant treatment with a benzodiazepine if anxiety, agitation and/or insomnia are problematic

- **Risk of seizures**
    - SSRIs are low risk and those with lowest risk of interaction with antiseizure medicines are preferred (citalopram, escitalopram, followed by sertraline). Mirtazapine and duloxetine are also low risk in people with epilepsy. Tricyclic antidepressants should be avoided if possible. [6]

- **Hyponatraemia**
    - All antidepressants increase the risk of hyponatraemia and patients should be observed for signs of hyponatraemia (cramps, dizziness, nausea, lethargy, confusion and seizures) especially within the first month of treatment. The elderly, women, people with renal impairment and medical co-morbidities, those prescribed concomitant therapy with medicines known to be associated with hyponatraemia i.e. diuretics, NSAIDs, ACE inhibitors, cancer chemotherapy and those with low BMI are at high risk of drug-induced hyponatraemia and require sodium level monitoring before starting anti-depressant treatment, at 2 and 4 weeks after starting treatment then at 3 and 6 months. Further monitoring should occur if there is reason to suspect the risk has changed (e.g. additional medicines or change in medical conditions).[6,12]

- **Renal and liver failure**
    - Antidepressants may accumulate in renal & liver failure. Start low and increase the dose slowly. Monitor patients for adverse effect and be cautious when prescribing medicines with anti-cholinergic side effects as this may cause urinary retention. Avoid medicines known to cause QTc prolongation, as electrolyte changes are common in patients with renal impairment. The risk of GI bleed with SSRI is inversely proportional to renal function. Paroxetine, at doses at the lower end of the therapeutic range appears to be the safest SSRI in hepatic impairment, although cases of hepatoxicity have been reported.[6,12,13] For further advice contact your local medicines advice line.

- **Bleeding risk**
    - Do not normally offer SSRIs to patients taking non-steroidal anti-inflammatory drugs (NSAIDs) or aspirin (anti-platelet effect) because of the increased risk of gastrointestinal bleeding. Consider offering an antidepressant with a lower propensity to cause bleeding such as mirtazapine.

- If an alternative anti-depressant is not suitable, SSRIs may be prescribed at the same time as NSAIDs or aspirin if gastroprotective medicines (for example, proton-pump inhibitors) are also offered.
- Consider offering mirtazapine to patients taking heparin, aspirin or warfarin, however mirtazapine may slightly increase INR.[13]

- **History of overdose**
  - SSRIs are safer than venlafaxine, TCAs and MAOIs in overdose
  - Avoid TCAs in those with a known history of overdose. If a tricyclic antidepressant has to be used, lofepramine is safer in overdose. [1,9]

- **Cardiac disease**
  - In acute coronary syndromes, the current best evidence is for sertraline, fluoxetine and mirtazapine as these do not increase the risk of subsequent cardiac events.
  - ECGs and correction of electrolyte imbalance should be considered before starting treatment
  - Where possible, avoid TCAs in patients at high risk of cardiovascular disease, arrhythmias and cardiac failure. TCAs may also be associated with an increased risk of myocardial infarction. [6,12]

- **QTc prolongation**
  - Sertraline and mirtazapine have no effect on QTc at therapeutic concentration. SSRIs and venlafaxine generally have almost no effect on QTc. Trazodone is very rarely associated with ventricular arrhythmias Citalopram and escitalopram and tricyclic antidepressants are contra-indicated in patients with known QTc interval prolongation.
  - Escitalopram and citalopram are contra-indicated in those on concomitant medicines that prolong the QTc interval.
  - Patients should be closely monitored if QTc prolonging antidepressants are prescribed for patients with a history of cardiovascular disease. Anti-depressants that prolong QTc should be avoided in those at high risk of torsade de pointes e.g. untreated electrolyte abnormalities or malignant arrhythmias. Some antidepressants are contraindicated in some conditions that may prolong QTc.
  - All SSRIs have reports to the MHRA that they cause QTc prolongation. Mirtazapine (as yet) does not. Venlafaxine is known to cause QTc prolongation in overdose at the same rate as SSRIs. [6,12,14]

- **Pregnancy & Lactation**
  - See the British Association for Psychopharmacology consensus guidance on the use of psychotropic medication preconception, in pregnancy and postpartum available at https://www.bap.org.uk/pdfs/BAP_Guidelines-Perinatal.pdf

Please note the following updates for pregabalin and risks in pregnancy issued by the MHRA.

- A new study has suggested pregabalin may slightly increase the risk of major congenita malformations if used in pregnancy. Patients should continue to use effective contraception during treatment and avoid use in pregnancy unless clearly necessary.
- Health care professionals should continue to provide advice potential risks in pregnancy and the need to use effective contraception.
- Avoid use of pregabalin in pregnancy unless benefit clearly outweighs potential risks to the foetus – must ensure patient is aware of risks and benefits and alternatives and are part of the decision-making process
- Advise patients who are planning a pregnancy or who become pregnant whilst on pregabalin to make an appointment to discuss their medicines and health conditions
- For further information click here[16]

- **Alcohol or illicit substance misuse**
    - If alcohol or use of illicit substances are considered to be a primary factor in contributing to depression or anxiety consider referring to local Drug and Alcohol Teams before initiating treatment.
- **Psychotic depression**
    - People with depression and psychotic symptoms should be referred to specialist mental healthy services.
    - An antipsychotic medicine and an antidepressant should be considered.
    - Consider continuing the antipsychotic for a number of months after remission, if tolerated.
    - For more information on the prescribing and monitoring of antipsychotics see the SWLSTG Treatment with Antipsychotics guideline or for Croydon refer to the mental health resources in the A-Z for Croydon section of the SWL Integrated Medicines Optimisation website.

- **Personality disorder**
    - Do not withhold treatment for depression because of a coexisting personality disorder.
    - Consider a combination of an antidepressant medicine and a psychological treatment.
    - Treatment
    - Extend the duration of treatment if needed, up to a year

8.5. Severe, chronic or resistant depression

- Practitioners without a special interest in mental health are advised to refer all patients with severe, chronic, resistant depression or are at high risk of suicide to mental health services.
- In more severely ill patients, and in other situations where maximising efficacy is of overriding importance, consider clomipramine, venlafaxine (⩾150 mg/day), escitalopram, sertraline, amitriptyline, or mirtazapine in preference to other antidepressants.
- Treatment of chronic or resistant depression may involve augmenting an antidepressant with a second antidepressant or other agents. Consider adding aripiprazole, lithium, quetiapine, mirtazapine or olanzapine as augmentation strategies.
- For patients who have responded well to a combination of an antidepressant and an augmenting agent, both medications should be continued after remission if the side effects are tolerable. If one medication is stopped, it should be the augmenting agent. [1,6,9]
- For further information, advice & support on medicines - see Policy at a Glance

8.6. Depression in children & young people (under 18 years)

- For mild depression, children and young people should be offered a choice of psychological therapies only. Antidepressant medication should not be used for the initial treatment of children and young people with depression.
- Children & young people presenting with moderate to severe depression should be assessed for suitability of antidepressant initiation by the local CAMHS service.
- Do not offer antidepressant medication to a child or young person with moderate to severe depression except in combination with a concurrent psychological therapy.
- Fluoxetine is the antidepressant of choice in those aged 8 and above. It is usually initiated at 10mg per day (half a 20mg orodispersible scored tablet) increasing to 20mg each day after a week if necessary. Doses above fluoxetine 20mg/day are unlicensed. NICE state: 'There is little evidence regarding the effectiveness of doses higher than 20mg daily although higher doses may be

considered in older children of higher body weight and/or when in severe illness when an early clinical response is considered a priority' and 'those with lower body weight or intellectual disabilities may require lower doses'.

- All other antidepressants are unlicensed for use in children and adolescents**.**
- Poor or no response to fluoxetine & psychological therapies may warrant switching antidepressants after exclusion of other contributing factors. Sertraline (start at 25mg each day and gradually increase to the adult dose over 2-4 weeks) and citalopram (start at 10mg each day and gradually increase to 20mg each day over 2-4 weeks) are second line agents.
- TCAs and paroxetine should not be used.
- All antidepressants have regulatory warnings over the risk of suicide, aggression and paucity of evidence of therapeutic benefit in children and young people with depression. Children and young people should be monitored for the appearance of suicidal behaviour, self-harm or hostility on initiation and dose changes of antidepressants.
- Evidence supports the use of sertraline in those 6 years and above. TCAs are not effective in pre-pubertal children. [6,17,18]

8.7. Anxiety & generalised anxiety disorder in children and adolescents

- Medicines used to treat anxiety in children and adolescents should only be tried after failure of non-pharmacological interventions. There is some evidence that medication can be effective in treating anxiety in children and adolescents, at least in the short term. Meta-analysis showed that anxiolytic medication to be associated with a significantly greater clinical response than a placebo drug (58.1% vs 31.5%). Selective serotonin reuptake inhibitors (SSRIs) are regarded as the pharmacological treatment of choice for anxiety disorders in children and adolescents because of their effectiveness and safety profile.
- Sertraline is licensed for the treatment of obsessive-compulsive disorder in patients 6 years and over. Sertraline is not licensed for the treatment of other anxiety disorders in this age group. All other SSRIs are not licensed for anxiety disorders in children and young people and therefore SSRIs should be initiated by a specialist. [6,8,18,19]

8.8. Post traumatic stress disorder and social anxiety disorder

- Do not offer pharmacological treatments for the prevention or treatment of PTSD in children and young people aged under 18 years.[20]
- Medication should not usually be offered for the management of social anxiety disorder.[21]

9. Monitoring Patients on antidepressants

All people on antidepressants should have an annual review to assess efficacy, tolerability and need for ongoing treatment.[1,22]

The annual review should include the following:

1. Care/crisis plan completed or updated with the patient:
   - To identify potential triggers and precipitating factors that could lead to worsening of their condition including psychosocial stressors, personality factors, relationships
   - To include support strategies to manage triggers identified.
   - To include risk assessment and monitoring and suicidal ideation.
   - Signpost to and provide information about Stay alive app (a suicide prevention resource). This can be used by someone who is having thoughts of suicide or by someone who is concerned about someone else who may be considering suicide. Further information available via https://www.prevent-suicide.org.uk/find-help-now/stay-alive-app/
   - Share with patient, GP and other relevant people involved in the person's care.

2. Provide verbal and written information on antidepressants including side effects and risks of abruptly stopping antidepressant medications.
3. Review therapeutic response to the antidepressant since the last appointment (including severity and frequency of episodes).
4. Assess medicines adherence (Refer to SWLStG Trust Adherence Policy for additional advice)
5. Assess for side effects and consider using rating scales such as ASEC
6. Confirm the current physical health and mental health medicines the patient is taking and check for potential medicines interactions
7. Review for any comorbid conditions including alcohol and substance misuse, psychiatric and physical health disorders.
8. Review if current antidepressant medication(s) and treatment plan is still appropriate or whether a change is required.
9. A medication review should also take place if the patient is on dosulepin, trimipramine or Liothyronine (T3) for depression.

The following physical health monitoring should also be considered:

All antidepressants (except agomelatine) are associated with hyponatraemia.

In the presence of risk factors check sodium level at 2 and 4 weeks and, when stable, every 3 months.

Medication Class	Recommendation	Reference
SSRIs	**Citalopram and escitalopram**: Contra-indicated in patients with known QT-interval prolongation or congenital long QT syndrome or when used together with medicinal products that are known to prolong the QT-interval. For patients with history of arrhythmia, heart failure, left ventricular hypertrophy, previous arrhythmia or MI, ECG should be carried out at baseline and a week after each dose increase and then periodically. ECG should be carried out if signs of cardiac arrhythmia occur during treatment. U+E's need to be corrected prior to treatment **For other SSRIs** consider ECG at baseline where: Cardiac disease Altered metabolism e.g. liver disease Where Signs of cardiac arrhythmia stop Treatment and perform an ECG	Mandatory SPC[23] Maudsley Guideline Recommendation[6]
Mirtazapine	FBC and stop treatment if signs of agranulocytosis, i.e. fever, sore throat, stomatitis or other signs of infection. Most likely to occur within 4-6 weeks of starting treatment. Increased monitoring of glycaemic control in patients with diabetes.	Mandatory SPC[23] SPC recommendations[23]
Venlafaxine	Baseline Blood pressure (BP) monitoring BP should be reviewed periodically, after initiation of treatment and after dose increases.	Mandatory SPC[23]
Agomelatine	Liver Function Tests Baseline then at 3, 6, 12 and 24 weeks and when clinically indicated	Mandatory SPC[23]
Tricyclics and related antidepressants	Patients at risk of serious arrhythmia where use of a TCA cannot be avoided require ECG at baseline and a week after each dose increase and then periodically - seek advice from cardiology.	Maudsley Guideline Recommendation[6]

	Monitoring of cardiac function and ECG if risk factors for, or existing cardiovascular disease, and in the elderly Full Blood Count (FBC) at Baseline and periodic: (imipramine, lofepramine) White Cell Count (WCC) if signs of agranulocytosis: (Imipramine, trazodone) Hepatic enzymes: (imipramine, trazadone) U+E's baseline and correct: (clomipramine)	SPC recommendations[23]
MAOIs	Baseline and Frequent BP monitoring	Mandatory SPC[23]

For RAG ratings of individual antidepressants please see the SWLNETFormulary

10. Switching & stopping antidepressants

- Abrupt stopping of anti-depressants can increase the risk of relapse.[6]
- The faster the discontinuation the greater the risk of relapse and withdrawal symptoms. The nature of the taper is as important as the duration. Linear reductions of dose do not equate to linear reductions of pharmacological effect and tapering regimes should take this into account.[24]
- All antidepressants have a risk of discontinuation effects. These may range from anxiety symptoms to flu-like symptoms and 'electric shock' effects. Discontinuation effects are not harmful but can be very uncomfortable. Antidepressants should be tapered down gradually to reduce the risk of discontinuation effects. If discontinuation effects occur a slower taper should be instigated. This is less likely to be required with fluoxetine because of its long half-life.
- Switching antidepressants may involve cross tapering or stopping one antidepressant before starting another. Advice can be sought before attempting to switch by contacting your local Pharmacy Medicines Information for advice.
- For more detailed advice on stopping antidepressants see the SWLSTG Deprescribing Psychotropic Medicines Policy

11. Mental health services contacts

- Contact details for mental health services can be found through the Trust's public website
  http://www.swlstg.nhs.uk/
  https://www.slam.nhs.uk/

12. Monitoring & Compliance

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
The CCGs receive prescribing review information on prescribing antidepressants as part of the London wide QIPP initiative	Each CCG will have their own lead.	See London Procurement Partnership website.	QIPP data is sent quarterly by the London Procurement Partnership to CCGs and NHS Provider Trusts.	Each CCG and organisation is responsible for reviewing and reporting to their prescribing lead group.	The Mental Health Interface Prescribing Forum will suggest possible actions required for CCGs or acute provider organisations to aid compliance with this policy. Each CCG and organisation is responsible for acting on their own results from compliance with this policy.	The medicines ratification body in each organisation is responsible for ensuring action s identified and carried out from review of compliance of this policy.

13. Training

Medicines used in the treatment of depression and anxiety are incorporated in e-learning for prescribers and Nurses (SWLStG).
Mental Health awareness for GPs e-learning is available on elearning for healthcare.
Numerous elearning on mental health is available on the centre for pharmacy postgraduate education (CPPE).
Suicide Awareness Training is available via Zero Suicide Alliance.

14. Associated Documents & References

- South West London Joint formulary
- Physical monitoring of Mental health medicines for GPs summary
- Other mental health prescribing policies for South West London are available: http://www.swlstg.nhs.uk/health-professionals

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14. BNF British National Formulary - NICE

15. British Association for Psychopharmacology consensus guidance on the use of psychotropic medication preconception, in pregnancy and postpartum https://www.bap.org.uk/pdfs/BAP_Guidelines-Perinatal.pdf
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21. NICE Guideline. Social anxiety disorder CG159 https://www.nice.org.uk/guidance/cg159
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15. Appendices

Appendix 1- Advice on QT Prolongation with Citalopram and Escitalopram

This summary guidance has been produced by the Trust in order to assist clinicians in the management of patients who may be on high doses of citalopram or escitalopram, or those on citalopram or escitalopram in combination with another medication associated with QT prolongation.

Summary

- Citalopram and escitalopram are **contraindicated** in patients with known QT interval prolongation or congenital long QT syndrome. Additionally, use of citalopram and escitalopram is **contraindicated** with other medicinal products known to prolong the QT interval (1-2).
- It is not advisable to prescribe citalopram or escitalopram with other medicines that can prolong QT interval. Prescribers to review and consider switching citalopram and escitalopram to an alternative antidepressant for patients with risk factors for developing QT prolongation (See Table 1 and 2). Any use of citalopram or escitalopram with other medications that prolong QT would be classed as off-label use. The off-label use of escitalopram and citalopram in conjunction with other drugs likely to prolong QTc interval is an approved Off-label use (see medicines formulary policy). Clinicians must ensure risks and benefits have been discussed with the patient and a shared decision made. This discussion should clearly be documented in the patient's electronic care record.
- ECG and other risk factors should be monitored when prescribed in conjunction with other medicines likely to prolong QTc interval (3).

Supporting information

- QT interval varies with heart rate, so the figure quoted is usually the 'corrected' QT interval (QTc). Various figures have been quoted for a 'normal' QTc but it's somewhere in the range of 380ms to 470ms, with QTc intervals of 440ms and 470ms are generally accepted as the upper limits of normal for adult men and women respectively (4). Generally, QTc of >500ms is associated with increased risk of arrhythmias, particularly the ventricular arrhythmia 'torsades de pointes' which is occasionally fatal (4-5). Please see Appendix 3 for the management of ECG changes.
- Citalopram and escitalopram are associated with dose-dependent QT interval prolongation. Caution is advised in patients at higher risk of developing Torsades de Pointes (e.g. those with congestive heart failure, recent myocardial infarction, bradyarrhythmia or a predisposition to hypokalaemia or hypomagnesaemia because of concomitant illness or medicines) (1-2).
- See Table 1 for risk factors for QTc prolongation and arrhythmia (4-5):

Factor	Symptom
Cardiac	Long QT Syndrome, bradycardia, ischaemic heart disease, myocarditis, myocardial infarction, left ventricular hypertrophy
Metabolic	Hypokalaemia, hypomagnesaemia, hypocalcaemia
General cardiovascular risk factor	Smoking, obesity, impaired glucose tolerance
Others	Extreme physical exertion, stress or shock, anorexia nervosa, extremes of age, female gender, concurrent use of more than one QT-prolonging drug

- See Table 2 for medicines associated with QT prolongation (list not exhaustive) (4-5):

Non-psychotropic medicines	Psychotropic medicines
Anti-arrhythmic drugs • Amiodarone, disopyramide, dronedarone	Antihistamines • Hydroxyzine, promethazine
Antibiotics • Macrolides (e.g. erythromycin, clarithromycin, azithromycin) • Quinolones (e.g. levofloxacin)	Antipsychotics (examples, all have potential) • Chlorpromazine, clozapine, haloperidol, olanzapine, paliperidone, quetiapine, risperidone

Anti-fungals • Fluconazole, ketoconazole	Antidepressants • Amitriptyline, clomipramine, dosulepin, doxepin, imipramine, lofepramine
Anti-motility and anti-emetics • Domperidone, ondansetron	Others • Methadone
Antimalarials • Quinine, chloroquine	

- See Table 3 for the effect of some psychotropic medicines on QTc prolongation (5,6)

Medicine	Severe effect (>17ms)	Moderate effect (>9 and <16ms) or in overdose	Mild effect (>5 and <9ms) or only in cases of overdose or intoxication	No effect at therapeutic concentration	Not known
Antipsychotics	Quetiapine Pimozide Sertindole Thioridazine Melperone	Amisulpride OD Chlorpromazine Clozapine Levomepromazine Risperidone Sulpride Ziprasidone	Amisulpride Flupenthixol Fluphenazine Haloperidol Olanzapine Promethazine	Aripiprazole Benperidol Cariprazine Loxapine Lurasidone Paliperidone Zuclopenthixol	
Antidepressants	Amitriptyline Imipramine Nortriptyline Doxepin Desipramine	Clomipramine Fluoxetine	Citalopram Escitalopram Mianserin Trazodone Venlafaxine	Duloxetine Fluvoxamine Mirtazapine Paroxetine Reboxetine Sertraline Trimipramine	
Others	Lithium Methadone		Bupropion Chloral	Atromoxetine Carbamazepine Diazepam Lamotrigine Methylphenidate Moclobemide Tranylcypromine Valproate Vortioxetine	Buspirone

Questions and answers

1. Can I still prescribe citalopram or escitalopram?

Yes, the Trust is not advising against the use of citalopram or escitalopram, however where these two medicines are used it is important that the doses used do not exceed the BNF licensed dose, and not in combination with other medicines causing QT prolongation. Please note that citalopram can be used up to 60mg/day upon the recommendation of the National OCD/BDD service (Consultants).

2. Do all patients on citalopram or escitalopram need to be reviewed and switched to another antidepressant (if one is still required)?

The Trust would always welcome more frequent review to minimise any unnecessary prescribing, but there is no automatic need to switch patients – if their dose is within the BNF licensed dose and they are not on any other medicine that prolongs the QT interval, then it is acceptable to leave them on citalopram or escitalopram. Patients should be informed of the side effects of citalopram/escitalopram and written information should be provided. This should be documented in the patient's electronic care record.

3. Do patients on citalopram or escitalopram and other medications that cause QT prolongation need reviewing and switching?

Yes, the manufacturer's summary of product characteristics (SPC) states that this combination is **contra-indicated**. Examples where switching to an alternative antidepressant include:

- Patients taking a combination of citalopram/escitalopram and antipsychotic(s) including depots/Long-acting injections (LAI). Consider switching to an alternative antidepressant (See Question 6 for further information).
- Patient with congenital long QT syndrome or known pre-existing QT prolongation taking citalopram/escitalopram. Seek advice from cardiology.

- Patient taking amitriptyline for neuropathic pain and citalopram/escitalopram for depression. Consider switching to an alternative antidepressant.

4. What if patients are on other medications (e.g. antipsychotics) that cause QT prolongation as well as citalopram or escitalopram and the clinical decision is made to continue as this was the only effective antidepressant; should there be increased monitoring of ECG, BP and pulse?

This course of action would be against the advice of the company and the MHRA and in contravention of the SPC. Any use of citalopram or escitalopram with other medications that prolong QT would be classed as off-label use. There must be clear documentation on what monitoring will be occurring, who is responsible and documentation of the risks vs benefits. The patient must be informed of off-label use and risks associated.

5. If a patient is stable on a dose of citalopram or escitalopram which is above the BNF maximum dose, their ECG is 'normal', and the consultant has the discussion with the patient and the patient doesn't want to reduce, do they have to reduce anyway or is it sufficient to document the discussion?

The Trust's position is that the recommendations from the regulatory authorities must be followed. To do otherwise would be against all advice and would be extremely difficult to justify if the patient were to come to harm as a result of their treatment. The use of citalopram or escitalopram above the BNF maximum doses would be classed as off-label and would require an SDTC2 form to be completed.

6. Where a change of medication is necessary, what should be used instead of citalopram or escitalopram?

The choice of antidepressant for an individual patient will depend upon several clinical factors, and it would be inappropriate to adopt a "one size fits all" approach and suggest a single alternative. Citalopram and escitalopram are SSRI antidepressants and is often used because it has few drug interactions. The medicine that most closely matches that description is sertraline, which may be an appropriate alternative for many patients. However, the final decision should be made by a clinical team with knowledge of the patient's history and all relevant clinical factors.

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Appendix 2 - Guideline for Management of Depression and Generalised Anxiety disorder in Adults in Primary Care v4.0

This guidance is intended to support clinicians in South West London in the management of depression and anxiety in line with the NICE (see below for links) and the local prescribing policy

<table>
<tr><th colspan="4">STEP 1 Recognition, assessment and initial management</th></tr>
<tr><th colspan="3">Depression</th><th>Generalised Anxiety</th></tr>
<tr><td>Screening</td><td colspan="3">Assess whether a patient should be further investigated. Review those with long term physical health conditions as they are associated with higher levels of depression compared to the general population.
Undertake screening questions for both Anxiety Spectrum Disorder and Depression before choosing pathway with predominant symptoms to continue</td></tr>
<tr><td>Questions to ask</td><td colspan="3">NICE recommends that any patient who may have depression (especially those with a past history of depression or who suffer from a chronic physical illness associated with functional impairment) should be asked the following two questions:
□ During the last month have you been feeling down, depressed or hopeless?
□ During the last month have you often been bothered by having little interest or pleasure in doing things?
Always ask people with depression directly about suicidal ideation and intent.</td><td>Use the recommended NICE anxiety case finding questions (GAD 2 questions):
□ During the past four weeks, have you been bothered by feeling worried, tense or anxious most of the time?
□ Are you frequently tense, irritable and having trouble sleeping?</td></tr>
<tr><td rowspan="2">Assessment</td><td colspan="4">If screening identifies a possible depression/anxiety, a more comprehensive assessment must be conducted, refer to links below:
If GPs do not feel competent to perform a mental health assessment in patients with chronic physical health problems, they should consult an appropriate professional</td></tr>
<tr><td colspan="3">A record of a bio-psychosocial assessment should be completed on the same day the diagnosis of depression is recorded in the patient record.
Assessment of depression can be aided using the ICD 10 symptoms below & the Patient Health Questionnaire (PHQ) available on : EMIS WEB Mentor or
http://www.patient.co.uk/doctor/patient-health-questionnaire-phq-9
http://www.psycho-oncology.info/PHQ9_depression.pdf</td><td>Assess the symptoms using Generalised Anxiety Disorder Assessment (GAD 7) available on EMIS Web Mentor or
http://www.patient.co.uk/doctor/generalised-anxiety-disorder-assessment-gad-7</td></tr>
<tr><td>Questions to ask</td><td colspan="3">Core symptoms
• Depressed mood
• Diminished interest in activities
• At least one of these, most days, most of the time for at least 2 weeks
Take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.
Additional Symptoms
• Difficulty concentrating
• Feelings of worthlessness or excessive or inappropriate guilt
• Hopelessness
• Recurrent thoughts of death or suicide
• Changes in appetite or sleep
• Psychomotor agitation or retardation
• Reduced energy or fatigue
Severity — Functioning domains (personal, family, social, educational, occupational, or other important domains).
Mild — Distressed by the symptoms, some difficulty in continuing to function in one of more domains. No psychotic symptoms
Moderate (with or without psychotic symptoms) — Several symptoms present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall. Considerable difficulty functioning in multiple domains.
Severe (with or without psychotic symptoms) — Many or most symptoms are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree. The individual has serious difficulty continuing to function in most domains.</td><td>The symptoms must be present for most days for at least several months, for more days than not:
• General apprehension (i.e. free-floating anxiety)
Or
• Excessive worry focused on multiple everyday events, most often concerning family, health, finances, and school or work
• Together with additional symptoms such as:
○ muscular tension or motor restlessness
○ sympathetic autonomic over-activity
○ subjective experience of nervousness, difficulty maintaining concentration, irritability, or sleep disturbance
However, if the person does not fulfil these criteria (sub-threshold symptoms), they should not be dismissed as they may still have potential for considerable morbidity.</td></tr>
<tr><td>Rating scales</td><td colspan="3">Depression self-administered Scale (PHQ-9): ≥12 (max 27) threshold for treatment.</td><td>Anxiety Scale (GAD7): ≥10 further evaluation is recommended</td></tr>
<tr><td>Risk Assessment & monitoring</td><td colspan="4">Assessing Risk of Suicide: Ask all suspected patients with depressive symptoms about suicidal ideation and current intent at assessment, follow-up and on initiation and dose changes of antidepressants.
If a person with depression presents considerable immediate risk to themselves or others, refer them urgently to specialist mental health services.
Suicide prevention training is available online. The training is designed to give you knowledge, skills and confidence to have a conversation about suicide through scenario-based training:
Suicide Awareness Training</td></tr>
<tr><td>Questions to ask</td><td colspan="4">• Do you have thoughts about death or suicide?
• Do you feel that life is not worth living?
• Have you made a previous suicide attempt?
• Is there a family history of suicide?
If yes, ask about plans and protective factors
• Do you have the means for doing this available to you?
• Have you made any plans for ending your life?
• What has kept you from acting on these thoughts?</td></tr>
<tr><td>Appropriate Treatment</td><td colspan="3">Refer to page 2 prescribe in line with NICE Guidance Depression in adults: The treatment and management of depression in adults http://www.nice.org.uk/guidance/CG90 and SWL formulary</td><td>Refer to page 2 Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management: http://www.nice.org.uk/guidance/cg113 and SWL formulary</td></tr>
<tr><td>Advice & Support</td><td colspan="4">For professionals: https://bnf.nice.org.uk/ www.medicines.org.uk
SWL&STG Medicine Information and Patient help line 0203 513 6829 or SWL&STG For Health Professionals: https://www.swlstg.nhs.uk/health-professionals
SLAM Medicines Advice Line (020 3228 2317)
For patients & carers: https://www.choiceandmedication.org/swlstg-tr/ https://www.nhs.uk/ https://www.swlstg.nhs.uk/patients-carers/advice-and-support
Homeless Persons Units: https://www.homeless.org.uk/ Employment: https://www.citizensadvice.org.uk/</td></tr>
</table>

Step 1 - Initial management of persistent sub threshold depressive symptoms or mild depression/suspected or known cases of GAD

Depression	Generalised Anxiety Disorder
Individual guided self-help or Group/individual CBT Computerised CBT or Group/individual behavioural activation Group exercise or meditation IPT/STTP/Counselling Detailed information on recommended psychological therapies can be found in the NICE Depression in adults guideline	Communicate the diagnosis of GAD Provide education about the nature of the anxiety disorder(s) and the options for treatment Monitor symptoms and functioning

If NO benefit from Low intensity psychosocial intervention, consider recommendations as per Step 2

STEP 2 - Moderate and Severe Depression/GAD that has not improved after Step 1

Psychological therapy should be offered **AND** Antidepressant medication	Individual non facilitated self-help Individual guided self-help Psychoeducational groups

1st line pharmacological treatment

SSRI is a good choice for most people e.g. Sertraline 50mg OD or fluoxetine 20mg OD. Or a SNRI e.g. venlafaxine (less well tolerated) or mirtazapine or an alternative appropriate antidepressant	**Sertraline ('off label')** Start at half the normal starting dose and titrate to antidepressant dosage
	Do not offer a benzodiazepine for the treatment of GAD in primary or secondary care except as a short-term measure during crises. Do not offer an antipsychotic for the treatment of GAD in primary care.

Assess response to treatment

Assess after 2 weeks of initiation, then every 2-4 weeks in the first three months, then every 3 months.
Under 25 years or suicide risk: Assess 1 week after initiation or increasing dose and frequently thereafter as appropriate until the risk is no longer considered clinically important. For people continuing with antidepressants to prevent relapse assess at least every 6 months.

2nd line pharmacological treatment
(If unable to tolerate treatment/No response to 1st line drug treatment after 4 weeks)

Alternative SSRI, SNRI, mirtazapine or alternative antidepressant	Alternative SSRI or SNRI such as **Venlafaxine (SWL approved indication)** Start at half the normal starting dose and titrate to antidepressant dosage

3rd line pharmacological treatment
(If unable to tolerate treatment/No response to a 2nd antidepressant within 4 weeks)

Vortioxidine 10mg OD Venlafaxine MR 225mg should be prescribed as 150mg MR and 75mg MR OD as this is substantially more cost effective than the 225mg strength. OR Alternative antidepressant/Augmentation strategy – Refer to GPwSI/Specialist	**Pregabalin initially** 75mg twice daily increased in steps of 150 mg daily if required, dose to be increased at 7day intervals, up to 300mg twice daily if necessary **(only if no response to SSRI or SNRI or if not tolerated)**

Continuity of Treatment after effective clinical response

First episode: at least 6 months Recurrent depression: 2 years	Continue for at least a year after response as likelihood of relapse is high.

STEP 3: Severe, Chronic or Resistant Depression/GAD with marked functional impairment or High Risk of Suicide or Inadequate response to Step 2

Refer

All Practitioners without a special interest in mental health are advised to refer all patients meeting the above Step 3 criteria
to: **Mental Health GPwSI/local Mental Health Team**

Considerations when choosing an antidepressant

SSRIs, (escitalopram and citalopram especially) , TCAs, trazadone & venlafaxine have been reported to cause QTc interval prolongation. Where possible avoid other QTc prolonging drugs or monitor ECG. Refer to current editions of the BNF and SWLSTG Prescribing Guidelines for product specific information.

- Renal/liver impairment & elderly: Start at low dose & increase slowly. Consider mirtazapine or an SSRI with a shorter half-life.
- CVD: sertraline is recommended. Mirtazapine may be used with caution.
- Seizures: avoid TCAs, use SSRIs.
- Increased risk of bleeding: mirtazapine 1st line. Consider adding a low cost PPI when using other antidepressants.
- Risk of hyponatraemia (cramps, confusion, seizures, nausea and dizziness) with all antidepressants; with the exception of agomelatine (non-formulary); particularly elderly and those with a low BMI are prone. Monitor sodium as per guidelines and consider trazodone.
- BPSD: Use an antidepressant when there are significant depressive features.
- All antidepressants may increase the risk of suicidal ideation in children and young adults, monitor closely.

Stopping and switching antidepressants; Refer to:
1. SPS website **Switching between antidepressants**.
2. Trimipramine withdrawal guidance
3. Dosulepin withdrawal guidance
4. SWL&STG de-prescribing policy

Available at https://www.swlstg.nhs.uk/resources/guidelines

Mental Health Services

SWLStG Mental Health Crisis Line (for patients/carers): 0800 028 8000
Kingston, Merton, Richmond, Sutton, Wandsworth

SLaM Mental Health Crisis Line: 0800 731 2864
Croydon

Kingston Wellbeing Service: 020 3317 7850 Self referral via phone GP referral	Sutton Uplift: 0800 032 1411 Self referral HCP referral
Merton Uplift: 020 3513 5888 **Self referral** HCP referral	Talk Wandsworth: 0203513 6264 Self referral **HCP referral**
Richmond Wellbeing Service: 0203513 6264 **Self referral** **HCP referral**	Croydon Wellbeing Service: 020 3228 4040 **Self referral**

For full guidance and references see: Depression & Anxiety Treatment Guidelines
https://www.swlstg.nhs.uk/resources/guidelines

Appendix 3 - Guideline for Management of Depression in Children and Young People in Primary Care v4.0

This guidance is intended to support clinicians in South West London in the management of depression in line with the NICE (see below for links) and the local prescribing policy

GPs should not initiate antidepressants without specialist advise for children & adolescents because of the risk of suicidal thoughts in the early stages of treatment

Recognition, assessment and initial management

Screening

Screening questions are useful tools to assess whether a patient should be further investigated for depression.
If a child or young person with depression presents acutely having self-harmed, the immediate management should follow NICE's guideline on self-harm as this applies to children and young people, paying particular attention to the guidance on consent and capacity.

Questions to ask

During the last month have you been feeling down, depressed or hopeless?
During the last month have you often been bothered by having little interest or pleasure in doing things?
If yes, during the last month, have you often been bothered by: Feelings of worthlessness**/** Poor concentration**/**Thoughts of death?
Give young people the opportunity to discuss these issues initially in private.

Core symptoms

- Depressed mood
- Diminished interest in activities

At least one of these, most days, most of the time for at least 2 weeks
Take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.

Additional symptoms

- Difficulty concentrating
- Feelings of worthlessness or excessive or inappropriate guilt
- Hopelessness
- Recurrent thoughts of death or suicide
- Changes in appetite or sleep
- Psychomotor agitation or retardation
- Reduced energy or fatigue

The ICD-11 uses a list of nine depressive symptoms (as above) and divides depression into 3 categories:

- mild depression
- moderate depression
- severe depression

Children and young people presenting with moderate to severe depression should be reviewed by CAMHS

Severity	Functioning domains (personal, family, social, educational, occupational, or other important domains).
Mild	Distressed by the symptoms, some difficulty in continuing to function in one of more domains. No psychotic symptoms
Moderate (with or without psychotic symptoms)	Several symptoms present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall. Considerable difficulty functioning in multiple domains.
Severe (with or without psychotic symptoms)	Many or most symptoms are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree. The individual has serious difficulty continuing to function in most domains.

Assessment

Consider the following when assessing a patient 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
- ideas about suicide

Ask the patients and their family/carers directly about:

- alcohol and drug use,
- experience of being bullied or abused
- self-harm
- ideas about suicide

Rating scales

The following tools are useful screening measures and useful in considering if symptoms are getting worse or better with treatment. However, depression and anxiety disorders are clinical diagnoses that are best made by specialists working with children and adolescents.
PHQ9-A RCADS Mood and Feelings Questionnaire (MFQ)

Risk Assessment & monitoring

Assessing Risk of Suicide: Ask all suspected patients with depressive symptoms about suicidal ideation and current intent at assessment, follow-up and on initiation and dose changes of antidepressants. If a person with depression presents considerable immediate risk to themselves or others, refer them urgently to specialist mental health services

Appropriate Treatment

Refer to page 2 & 3. prescribe in line with NICE Guidance: Depression in children and young people: Identification and management and SWL formulary
https://www.nice.org.uk/guidance/ng134/resources/depression-in-children-and-young-people-identification-and-management-pdf-66141719350981

Advice & Support

For professionals: https://bnf.nice.org.uk/ www.medicines.org.uk https://movingmedicine.ac.uk/disease/depression/?current_page=patient-information
SWLSTG Medicine Information and Patient help line 0203 513 6829 or SWLSTG For Health Professionals: https://www.swlstg.nhs.uk/health-professionals
SLaM Medicines Advice Line 020 3228 2317
For patients & carers: https://www.choiceandmedication.org/swlstg-tr/ https://www.nhs.uk/ https://www.swlstg.nhs.uk/patients-carers/advice-and-support
https://www.youngminds.org.uk/young-person/medications/ Healthy sleep tips for children and young people https://www.gosh.nhs.uk/conditions-and-treatments/procedures-and-treatments/sleep-hygiene-children/

Guideline for Management of Depression in Children and Young People in Primary Care v4.0

Mild depression; watchful waiting - for patients who do not want an intervention or may recover with no intervention

- Arrange a further assessment, normally within 2 weeks
- Make contact with patients who do not attend follow-up appointments
- Discuss choice of psychological therapies with patients and their family/carers. Explain that there is no good quality evidence that one type is better than the others

Advice and resources are available at HeadScape:
https://headscape-swlondon.nhs.uk/headscape/more-information/issues/depression/

5-11 year olds, after 2 weeks watchful waiting, without comorbid problems or active suicidal thoughts consider:

- Digital cognitive-behavioural therapy (CBT)
- Group CBT
- Group non-directive supportive therapy (NDST)
- Group interpersonal psychotherapy (IPT)

If these options do not meet the child's clinical needs, consider:

- attachment –based family therapy
- individual CBT

12-18 year olds after 2 weeks watchful waiting, without comorbid problems or active suicidal thoughts consider a choice of the following for a limited period (~2-3 months):

- digital CBT
- group CBT
- group NDST
- group IPT

If these options do not meet the child's clinical needs, consider:

- attachment –based family therapy
- individual CBT

Antidepressant medicines should not be used for the initial treatment of children and young people with mild depression

↓ 2-3 months ↓

If no response to psychological therapies refer for CAMHS review

Contact details for referrals to CAMHS (this includes access to psychological therapies) Waiting times may vary and where possible will be given on referral	
Croydon	Single Point of Referral
Richmond and Kingston	**Single point of referral** "Start my Referral" **Pre-consultation enquiries 020 8547 6171**
Merton	**Single point of referral** MertonSPAreferrals@swlstg.nhs.uk **Pre-consultation enquiries 0800 292 2505**
Sutton	**Single point of referral** SuttonCAMHS.Referrals@swlstg.nhs.uk
Wandsworth	**Single point of referral** wandsworthcamhsreferrals@swlstg.nhs.uk

Moderate depression
Children & YP presenting with moderate/severe depression should be reviewed by a CAMHS team

Discuss choice of psychological therapies with patients and their family/carers. Explain:

- What the different therapies involve
- The evidence for each age group
- How the therapies could meet individual needs, preferences and values

Advice and resources are available at HeadScape:
https://headscape-swlondon.nhs.uk/headscape/more-information/issues/depression/

5-11 year olds, consider:

- family based IPT
- family therapy
- psychodynamic psychotherapy
- individual CBT

12-18 year olds, offer

- Individual CBT for at least 3 months

If this does not meet the child's clinical needs, consider:

- IPT-A (IPT for adolescents)
- Family therapy (attachment-based or systemic)
- Brief psychosocial intervention
- Psychodynamic psychotherapy

Consider combined therapy (fluoxetine & psychological therapy for initial treatment as an alternative to psychological therapy followed by combined therapy.

If unresponsive after 4 to 6 sessions, carry out a multidisciplinary review

Following review, if depression is not responding due to coexisting factors – consider additional or alternative psychological therapy for the child or young person or for the parent or family members.

After review, cautiously consider fluoxetine if depression in child (5 – 11 years) has not responded to 4- 6 sessions of psychological therapy

After review, offer fluoxetine if depression in young person (12 – 18 years) has not responded to 4- 6 sessions of psychological therapy

If child or young person is unresponsive to combined psychological therapy + fluoxetine after a further 6 sessions, or fluoxetine was declined, the multidisciplinary team should make a full needs and risk assessment. Following multidisciplinary review, consider:

- an alternative psychological therapy not already tried (individual CBT, IPT or shorter-term family therapy for at least 3 months), or
- systemic family therapy (>15 fortnightly sessions), or

The use of antidepressants in children and young people GPs should only take on prescribing of antidepressants for those young people who are stable, have shown benefit and have a clear plan	
Do NOT offer an antidepressant to a child/young person with moderate to severe depression except in combination with a concurrent psychological therapy following assessment by a child and adolescent psychiatrist If psychological therapies are declined, medication may still be given with close monitoring by the prescribing doctor	
Medicines	**Monitoring**
Fluoxetine is the antidepressant of choice in those aged 8 and above. (all other antidepressants are unlicensed) Dose: Usually initiated at 10mg per day, increasing to 20mg each day after a week if necessary.	**Mental state -** Make specific arrangements for monitoring of mental state and ADRs e.g., weekly contact for the first 4 weeks. Inform patients and their family/carer(s) about the: rationale for drug treatment, delay in onset of effect, time course of treatment, possible side effects, and need to take the medication as prescribed. Written information available at: www.choiceandmedication.org/swlstg-tr or https://www.youngminds.org.uk/young-person/medications/
Poor or no response to fluoxetine & psychological therapies may warrant switching antidepressants after exclusion of other contributing factors.	**Suicidal behaviour-** Children and young people should be monitored by the prescriber &the professional delivering psychological therapies for the appearance of suicidal behaviour, self-harm or hostility on initiation and dose changes of antidepressants.
2nd line 'off-label' options include **sertraline & citalopram** Sertraline: start at 25mg daily and gradually increase to the adult dose over 2-4 weeks Citalopram: start at 10mg each day and gradually increase to 20mg each day over 2-4 weeks	**Sodium -** All antidepressants (except agomelatine) are associated with hyponatraemia. In the presence of risk factors check sodium level at 2 and 4 weeks and, when stable, every 3 months.
3rd line treatment options would be made by the specialist on an individual basis for those children who have not responded to the above or have experienced adverse effects.	**ECG** Citalopram/Escitalopram: ECG should be carried out at baseline and if signs of cardiac arrhythmia occur during treatment. Other SSRIs: consider ECG where: cardiac disease
Continue medication for at least 6 months after remission Stop antidepressant medication over a period of 6 to 12 weeks **TCAs and paroxetine should not be used.**	

Equality Impact Assessment for policy: Depression & anxiety treatment guidelines

			Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4.	Is the impact of the policy/guidance likely to be negative?	N/A	
5.	If so can the impact be avoided?	N/A	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Chief Pharmacist, together with any suggestions as to the action required to avoid/reduce this impact.