WA PSYCHOTROPIC DRUG COMMITTEE (WAPDC) ALERT

Antidepressant Therapy in Children and Adolescents.

Position statement

The Chief Psychiatrist recommends caution when prescribing antidepressant medications for children and adolescents. Although antidepressants can be valuable medications in the correct circumstances, the possible clinical benefits must be considered against the potential risks of harm in the context of inconclusive safety and efficacy data regarding antidepressant medications in the younger population.

Recommendations

- Children and adolescents should only be prescribed antidepressant medication within the context of a comprehensive management plan which includes careful monitoring of the emergence of suicidal ideation and behaviour particularly at the beginning of treatment.¹

- The patient (or those with authority to give consent on their behalf) should provide informed consent, which should be documented.²

- Clinicians should use careful risk/benefit analysis and advise young patients and their families of the small chance of suicidal thoughts emerging during the early phase of treatment with SSRIs.³

- Currently available evidence supports the use of fluoxetine over other antidepressants if pharmacological treatment of Major Depressive Disorder (MDD) is required in children or adolescents.²,⁴

- NICE guidelines recommend avoiding tricyclic antidepressants, paroxetine and venlafaxine for the treatment of depression in children and adolescents.⁵ There is insufficient information to make recommendations about the use of other antidepressants in children and adolescents.

- Prescribers and other health care professionals are asked to report to Adverse Drug Reactions Advisory Committee (ADRAC) any case of emergent or worsening suicidal ideation or behaviour and self-harm in children or adolescents treated with an antidepressant. This information is required to aid in the understanding of the frequency of these reactions and their possible causal relationships to the drugs.¹
Background

A review of evidence indicates there is still considerable uncertainty in the literature and debate continues about both the benefits and potential risks of antidepressant use in children and adolescents. 4, 6

Major Depressive Disorder (MDD)

- Currently available evidence supports the use of fluoxetine over other antidepressants if pharmacological treatment of MDD is required in children or adolescents. 4, 4

- A comprehensive meta-analysis, published in August 2016 7 has shown that most currently available antidepressants do not seem to offer a clear advantage in children and adolescents with Major Depressive Disorder (MDD) with the exception of fluoxetine. 4

- In the United States, fluoxetine is approved for MDD in young people without a specified lower age limit. 1

Paroxetine, venlafaxine and tricyclic antidepressants should not be prescribed for children and adolescents. 5

The NICE Guidelines 2005 (amended 2015) recommend antidepressant therapy for children and adolescents be used only for moderate to severe illness and only in combination with psychotherapy. 5

Concerns have been raised about the potential for antidepressants particularly Selective Serotonin Reuptake Inhibitors (SSRIs), to cause suicidal thoughts and behaviour. 3 These concerns prompted the US Food and Drug Administration (FDA) in 2004 to place a boxed warning on all antidepressants describing an increased risk of suicidality in paediatric patients. Australia's Therapeutic Goods Administration followed suit with similar precautions 1 and in 2007, the FDA warning was expanded to include young adults (18-24 years). Doubts have since been raised about the appropriateness of these warnings. 8

A consensus statement by the World Psychiatric Association (WPA) in 2008 concluded that there is a small risk of SSRIs inducing suicidal thoughts in patients up to the age of 25 and that this risk needed to be balanced against the known benefits of treating depression and in preventing suicide. 3

The term ‘suicidality’ itself is variably used in the literature which adds to the complexity of this issue. The absolute link between suicidal ideation and action is not established and there is evidence which contradicts the assumption of the link between ideation and completed suicides. 2

In Australia currently, there are no antidepressant medications licensed for the treatment of children and adolescents (persons aged less than 18 years). Fluvoxamine and sertraline are licensed for Obsessive-Compulsive Disorder in children. 1 The WA Statewide Medicines Formulary may include some agents with restrictions for use in this population.

Conclusion

Antidepressants should be used judiciously, monitored carefully, and the risks and benefits assessed in each individual case. Patients and care providers should be informed of the risks and informed consent documented. Pharmacological treatment remains an
important option in young people where non-pharmacological interventions have been inadequate.

References: