<table>
<thead>
<tr>
<th>Document name:</th>
<th>Antidepressants for the treatment of depression in line with NICE CG90 (October 2009) and NICE CG28 - Management of depression in children and young people</th>
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<tr>
<td>Portfolio</td>
<td>Medicines Management</td>
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<tr>
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<td>Guideline</td>
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<td>Staff group to whom it applies:</td>
<td>All prescribers, pharmacy and clinical staff within the Trust</td>
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<tr>
<td>Approved by:</td>
<td>D&amp;T Sub-Committee</td>
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<td>Developed by:</td>
<td>Lynn Haygarth on behalf of the Drug and Therapeutics Sub-Committee.</td>
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<td>Director leads:</td>
<td>Medical Director</td>
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<tr>
<td>Contact for advice:</td>
<td>Medicines Information <a href="mailto:Med.information@swyt.nhs.uk">Med.information@swyt.nhs.uk</a></td>
</tr>
</tbody>
</table>
Abbreviations used in this document

APC  Area Prescribing Committee
BNF  British National Formulary
BP   Blood pressure
COPD Chronic Obstructive Pulmonary Disease
CVA  Cerebrovascular Accident
D&T  Drug and Therapeutics Sub-Committee
DVLA Drivers Vehicle Licensing Agency
ECG  Electrocardiogram
GP   General Practitioner
INR  International Normalised Ratio
LFT  Liver Function Test
MAOI Monoamine-oxidase inhibitor
MDD  Major Depressive Disorder
NICE National Institute for Health and Clinical Excellence
NSAID Non-Steroidal Anti-Inflammatory Drug
PPI  Proton pump inhibitor
PTSD Post Traumatic Stress Disorder
® Denotes trade name of drug
RIMA Reversible inhibitor of mono-amine oxidase
SNRI Serotonin and noradrenaline reuptake inhibitor
SPC Summary of Product Characteristics
SSRI Selective Serotonin Re-uptake Inhibitor
SWYPFT South West Yorkshire Partnership NHS Foundation Trust
TCA Tricyclic Antidepressant
U&E Urea and Electrolytes

Serotonin and 5HT (5 Hydroxytryptamine) are the same.
Noradrenaline and norepinephrine are the same.

Other Trust guidance that is related to this guideline:

Medicines Code Section 17 - Use of unlicensed medicines and clinical queries.

Shared Care guidelines
Phenelzine
Venlafaxine at doses of 300mg and above.

Prescribing Guidance
Guidance for the use of lithium December 2010
Good practice for prescribing in Dementia Version 1.1 October 2010
Guidelines for bipolar disease September 2010
Psychotropic medicines in women with mental disorder of child bearing age, during pregnancy
and breastfeeding  Version 2 October 2010
Key Messages for the use of antidepressants in SWYPFT
NICE Clinical Guideline no.23

- Antidepressants are not recommended in mild depression. Watchful waiting, problem-solving and exercise are preferred.
- When an antidepressant is prescribed, a generic SSRI is recommended e.g. fluoxetine.
  - Sertraline is advocated for patients with pre-existing comorbidities.
  - Be alert for risk of upper GI bleed in the elderly and in those co-prescribed aspirin / NSAIDs.
- All patients should be informed that response to treatment may take four to six weeks and about the withdrawal effects of antidepressants (discontinuation symptoms).
- For severe or resistant depression a combination of antidepressant and CBT is recommended.
- Service users with two prior episodes and functional impairment should be treated for at least 2 years.

Formulary choices for antidepressants include
Fluoxetine (20mg capsules and liquid 20mg/5ml), citalopram, sertraline, lofepramine, amitriptyline, clomipramine, imipramine, mirtazapine, venlafaxine (immediate release tablets), moclobemide, trazodone, duloxetine, nortriptyline.

With shared care agreement - High dose venlafaxine, phenelzine, lithium augmentation,

Trust prescribing Guidance Key Points
Citalopram and escitalopram doses have changed. The maximum dose for citalopram is 20mg in elderly and 40mg in adults. The maximum dose for escitalopram is 10mg in elderly and 20mg in adults. Due to a risk of prolongation of the QTc interval they should not be co-prescribed with antipsychotics and other drugs with a potential to prolong the QTc interval eg methadone.
- Paroxetine should be reserved for existing service users prescribed this and for service users with post-traumatic stress disorder.
- Agomelatine is classed as red and prescribing will remain in secondary care.
- Phenelzine and high dose venlafaxine are classed as amber by the SWY APC and reserved for use with a shared care guideline.
- Venlafaxine ensure generic tablets of standard preparation (immediate release) venlafaxine are prescribed. If an extended release preparation is required then ensure venlafaxine XL tablets are prescribed as these are cheaper than capsules.
- Escitalopram is not generally approved for use in depression in the Trust. It maybe approved via the clinical queries mechanism.
- Where Lithium is prescribed arrangements must be in place for ongoing monitoring and a completed lithium book issued.
- When treating psychotic symptoms in depression consider oral risperidone (unlicensed).
  - Ensure arrangements are in place for physical health monitoring.
- Lamotrigine is no longer recommended as a routine augmentation strategy for depression.
- Always get pharmaceutical advice when switching antidepressants or considering add on therapy.
  - Quetiapine is licensed for add on therapy for major depressive disorder.
- Dosulepin should not normally be prescribed. Existing and new prescriptions should be logged with the Trust clinical queries mechanism.
- When combinations of antidepressants are required it is important to get pharmaceutical advice. The Trust clinical queries mechanism is available for advice when dealing with treatment resistant depression and for patients with other co-morbidities.
- Reboxetine is no longer recommended for the treatment of depression. Existing prescriptions should be logged with the Trust clinical queries mechanism.
Algorithm for Treatment of Depression with Antidepressants for Moderate or Severe Depression
(Augmentation, ECT and amber drugs to be started in secondary care)

For full prescribing information please refer to full Summary of Product Characteristics, the current BNF and local shared care guidelines where available.

Give therapeutic dose of antidepressant:
Consider SSRI (e.g. fluoxetine) and see information on individual antidepressants. Discuss treatment choices with patient. Give written information Consider:
- Type of symptoms
- Side effect profile
- Drug – Disease interactions e.g. consider sertraline in patients with ischaemic heart disease
- Drug - Drug interactions
- Discontinuation effects / suicidal thoughts and behaviour at initiation/dose increases

Assess over 2-4 weeks – longer in older people e.g. 6 weeks

Psychological Therapies at any stage e.g. CBT

Consider ECT for severe, life-threatening depression and when a rapid response is required, or when other treatments have failed. Do not use ECT routinely for people with moderate depression but consider it if their depression has not responded to multiple treatments.

Ineffective or not tolerated

- Titrate up the dose
- Change to a different antidepressant at therapeutic dose
- Consider a second SSRI, lofepramine, mirtazepine or moclobemide. If severe depression consider TCA or venlafaxine (not dosulepin)

If good response and well tolerated, continue at therapeutic dose for at least 6 months, longer in older people.

- Augmentation Strategies
  - with Lithium – (ECG required prior to treatment)
    Add lithium to level of > 0.4mmol/L assess for at least 3 weeks
  - An antipsychotic e.g. oral risperidone
  - Another antidepressant e.g. add mirtazepine or mianserin to an SSRI – NB get pharmaceutical advice
- Consider amber drugs with shared care guidelines
  - phenelzine
  - high dose venlafaxine

If good response and well tolerated, continue at therapeutic dose for at least 6 months, longer in older people.

Withdraw slowly where necessary.
1. **INTRODUCTION**

This guideline has been produced to identify the antidepressant treatments of choice available in the SWYPFT and outline their safe and effective use. It is written in line with NICE guidance in particular “Treatment and management of depression in adults including adults with a chronic physical health problem (October 2009)”.

It also incorporates information for young adults and for use of antidepressants in line with the NICE guidance for ante and postnatal mental health and the NICE guidance for Depression October 2009.

The stepped care model in the NICE Clinical Guideline recommends that people with mild depression should not be offered drug treatment, but should receive advice on sleep and anxiety management, watchful waiting, exercise and guided self-help, together with brief psychological interventions.

**Indications for Antidepressants**

1. Moderate to severe depressive disorder – use in combination with psychological intervention.
2. Dysthymia.
3. Persistent mild depression.
4. Mild depression with a history of moderate/severe depression.

The following drugs are currently available to prescribe for the treatment of depression:

**(Formulary choices)**

**First line**

- Fluoxetine – (20mg capsules)
- Citalopram – (see appendix 2 for dosing information)
- Sertraline

**Second line**

- Consider a different SSRI
- Mirtazepine
- Moclobemide
- Lofepramine
- Trazodone
- Duloxetine

**In more severe depression consider**

- Clomipramine
- Amitriptyline
- Imipramine
- Venlafaxine (immediate release tablets)

**Third line - All these choices are specialist initiation**

- Agomelatine – classed as red by APC prescribing stays in secondary care
- Phenelzine – see shared care guideline classed as amber by APC

**Combination therapy**

- Lithium Augmentation see shared care guideline classed as amber by APC
- High dose venlafaxine see shared care guideline classed as amber by APC
- SSRIs with mianserin or mirtazepine
- Quetiapine as add on therapy to current antidepressant treatment

**When combinations of antidepressants** are required and any products that are not identified in the policy it is important to get pharmaceutical advice. The Trust clinical queries mechanism is
available for advice when dealing with treatment resistant depression and for patients with other co-morbidities. Contact locality pharmacist or medicines information. - Med.information@swyt.nhs.uk

2. GENERAL PRINCIPLES OF TREATMENT FOR DEPRESSION

- People with mild depression should not be offered drug treatment, but should receive advice on sleep and anxiety management, watchful waiting, exercise and guided self-help, together with brief psychological interventions.
- Choice of antidepressant should be made jointly by individual and clinician based on an informal discussion of benefits of the drug, side effect profile, and an availability of other non-pharmacological treatments. The view of the individual’s advocate/carer should be considered when appropriate. Patient choice and patient information leaflets should be given to service users and carers. These are available from pharmacy, the Trust intranet and the Choice and Medication website www.choiceandmedication.org/swyp/
- The likely outcome and side effects should be discussed. It is important to warn of the potential for discontinuation syndrome.
- The individual should be reminded of their duty to inform the DVLA and insurance of any change in their health, and implication for health and safety at work.
- Prescribe a dose of antidepressant that is likely to be effective and assess over four to six weeks (longer in older people). Antidepressants are thought to act by blocking the re-uptake of neuro-transmitters such as 5-HT/serotonin and noradrenaline, thus increasing the amount in the synaptic cleft. They can take up to 4 weeks to exert a full clinical effect. This can be longer in older people.
- Limited supplies of antidepressant medication should be issued.
- If effective continue treatment for four to six months at full treatment dose (one year in older people). Consider longer term treatment (at least two years) in recurrent depressive disorder.
- When there has been partial response it is important to consider a dose increase.
- If ineffective after or poorly tolerated consider a change of antidepressant (see algorithm, page 1).
- After commencing treatment, clinical response and side effects should be carefully monitored and recorded. In early stages clearly monitor for restlessness, agitation and suicidality (particularly in young people less than 30 yrs).
- Clear and effective communication with service users, carers and other professionals is essential. Other professionals should be informed if there is failure to attend follow up.
- Dosage should be tapered gradually on stopping, over at least four weeks (not required for fluoxetine). Paroxetine, venlafaxine, amitriptyline, imipramine and MAOI’s are more commonly associated with discontinuation symptoms.
- There are considerable risks in switching antidepressants. See switching advice from the Psychotropic Drug Directory 2009 or the Maudsley Prescribing Guidelines 10th edition and also contact the Medicines Information service provided by the Trust. Med.information@swyt.nhs.uk or your locality pharmacist.

3. CHOICE OF ANTIDEPRESSANT

In general choose antidepressants which are better tolerated and safe in overdose. There is most evidence for SSRI’s. Factors to consider include:
- previous treatment response
- tolerability and adverse effects of previously taken drugs
- likely side effects profile
- low lethality if history of, or likelihood of overdose
- concurrent physical illness and medication (co-morbidities)
• potential for drug interactions
• patient preference.
• cost effective for the whole health economy

SSRIs should be used with caution in people with history of gastric bleeding or stomach ulcers. The risk of gastric bleeding is increased when aspirin, clopidogrel or NSAIDS are co-prescribed. The elderly and those with a previous history of bleeding are at greatest risk. Gastroprotective drugs such as omeprazole or lansoprazole should be considered in patients taking SSRIs with risk factors such as bleeding.

SSRIs when compared to TCAs are safer in overdose and easier to use in therapeutic dosage. There has been substantial publicity surrounding the SSRIs and their potential for increasing the risk of suicide. Paroxetine has been linked with withdrawal symptoms.

TCAs (except lofepramine) are unsafe in overdose due to cardiotoxicity, they have more side effects and require dose titration. It is considered that 125-150mg daily of a TCA (140-210mg for lofepramine) for four to six weeks is the minimum dose and time necessary to see a response. A dose less than this may be sub-therapeutic. **TCAs are not recommended for the over 75’s.**

**Dosulepin** (dothiepin) is no longer recommended for use in any age group. Existing patients should be logged with the trust clinical queries mechanism.

Venlafaxine is described as an SNRI. It has become generic and the immediate release tablets are cheaper and should be chosen for prescribing in a twice daily dose regimen. If an extended release preparation is essential it should be prescribed as tablets as these are cheaper than the capsules. Doses above 300mg requires shared care agreement (see SWYPFT Shared Care Guideline).

St John’s Wort should not be prescribed.

Page1 shows an algorithm, which reflects key points of the NICE guidance and accompanies this document. These should be read in conjunction with the locally agreed shared care guidelines.

Table 1 gives information on individual antidepressants and some considerations for choice and dosage.

Clinicians are recommended to use the current version of the BNF [www.bnf.org](http://www.bnf.org) and the summary of product characteristics [www.medicines.org.uk](http://www.medicines.org.uk) of the individual drugs when prescribing.
### Table 1  Antidepressant choices *(information on non-formulary drugs in italics)*

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<tr>
<th>Drug</th>
<th>When to choose</th>
<th>Comments</th>
<th>Dose and range for depression</th>
<th>Cost of 28days Drug Tariff</th>
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<tbody>
<tr>
<td><strong>SSRIs</strong></td>
<td></td>
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<tr>
<td>Citalopram</td>
<td>First line</td>
<td>Half life extended in older people. Risk of prolongation of QT interval. Cannot be used with other drugs that prolong the QT interval eg antipsychotics.</td>
<td>Tablets 20mg daily Max 40mg(elderly 20mg) Drops 16mg (8 drops) daily Max 32mg(elderly 16mg)</td>
<td>20mg tablets £1.32 16mg as drops £20.16</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>Not generally available in SWYPFT for depression Maybe used via the clinical queries mechanism.</td>
<td>Confusion over strengths and names with citalopram. Risk of prolongation of QT interval. Cannot be used with other drugs that prolong the QT interval eg antipsychotics.</td>
<td>Tablets 10mg daily Max 20mg (elderly 10mg)</td>
<td>10mg £14.91</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>First line</td>
<td>Long half life, risk of drug interactions Cost of 60mg increases so use 3 x 20mg</td>
<td>Capsules 20mg daily Max 60mg (elderly usual max 40mg) 10mg liquid dose daily (Prozac) licensed in children over 8. This comes as 20mg/5ml.</td>
<td>As 20mg caps £1.70 As 60mg caps £54.21 As liquid 10mg £4.83</td>
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<tr>
<td>Paroxetine</td>
<td>Not for depression only for PTSD Not recommended for new users.</td>
<td>Licensed for PTSD Increased risk of withdrawal effects, risk of akathisia existing clients should complete course and discontinue slowly</td>
<td>Tablets 20mg each morning Max 30mg but doses above 20mg are not recommended</td>
<td>20mg tablets £2.34</td>
</tr>
<tr>
<td>Sertraline</td>
<td>First line</td>
<td>Recommended for patients with ischaemic heart disease. Suitable for people with comorbidities Also licensed for PTSD</td>
<td>Tablets 50mg daily Max 200mg</td>
<td>50mg £1.62 100mg £1.45</td>
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<tr>
<td><strong>TCAs</strong></td>
<td></td>
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<tr>
<td>Amitriptyline</td>
<td>Second Line Not for over 75s</td>
<td>Cardiotoxic in overdose (except lofepramine). Risk of cardiac and anticholinergic SEs</td>
<td>Dose titration required</td>
<td></td>
</tr>
<tr>
<td>Clomipramine</td>
<td>Second line in more severe depression</td>
<td>Has anticholinergic and cardiovascular side effects. Consider if an obsessive component</td>
<td>Cap10mg daily titrated over 10 days to 100-150mg daily Max 250mg Max elderly 75mg</td>
<td>150mg As 3 x50mg caps £7.89</td>
</tr>
<tr>
<td>Drug</td>
<td>When to choose</td>
<td>Comments</td>
<td>Dose and range for depression</td>
<td>Cost of 28days</td>
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<tr>
<td><strong>TCAs contd</strong></td>
<td></td>
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<td></td>
<td>Drug Tariff</td>
</tr>
<tr>
<td><strong>Dosulepin</strong> <em>(dothiepin (Prothiaden®))</em>*</td>
<td><strong>Don’t choose. Review existing patients</strong></td>
<td>Most toxic in over-dose. High incidence of anticholinergic side effects</td>
<td>Tablets 75mg titrate to 150mg daily</td>
<td>150mg 2x 75mg tablets £2.64</td>
</tr>
<tr>
<td><strong>Imipramine</strong></td>
<td>Second line in more severe depression</td>
<td>Increase heart rate. Cardiotoxic in overdose. Side effects not tolerated by older people. Less sedating than amitriptyline</td>
<td>Tablets 25mg at night titrated to 150-200mg over two weeks Normal max 200mg but can go to 300mg hospital in-patients</td>
<td>150mg As 6x 25mg tabs £7.26</td>
</tr>
<tr>
<td><strong>Lofepramine</strong> <em>(Gamanil®)</em></td>
<td>Second line</td>
<td>Much less toxic in overdose than other TCA’s. May cause hepatic problems</td>
<td>The dose ranges from 70mg to 210mg daily. Max licensed dose is 210mg.</td>
<td>140mg As 2x70mg tabs £11.14</td>
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<tr>
<td>Nortriptyline <em>(Allegron ®)</em></td>
<td>Third line</td>
<td>Considered to have more noradrenergic properties. Toxic in overdose.</td>
<td>Tablets 75-100 mg daily.</td>
<td>100 mg as 4 x 25mg tablets approx £8.00</td>
</tr>
<tr>
<td><strong>SNRIs</strong></td>
<td></td>
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<td>Drug Tariff</td>
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<tr>
<td><strong>Venlafaxine</strong> <em>(Efexor, Venalic®)</em></td>
<td>Second line for more severe depression</td>
<td>Blood pressure monitoring required. Using 75mg tablets reduces the cost Consider higher doses in patients not responding to treatment with first and second line antidepressants</td>
<td>Standard dose of 37.5mg in twice daily can be increased to 75mg twice daily. 300mg is 2x75mg tablets (150mg) twice daily. Shared care agreement for dose therapy above 300mg.</td>
<td>150mg as 2x75mg tablets £4.02</td>
</tr>
<tr>
<td>Duloxetine <em>(Cymbalta®)</em></td>
<td>Second line</td>
<td>Emerging evidence for use when there are symptoms of pain. Available as Yentreve for stress incontinence. Confusion could occur</td>
<td>Starting and maintenance dose 60mg 30mg starting dose may be considered in older persons</td>
<td>60mg capsules £27.72</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>30mg capsules £22.40</td>
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<td></td>
<td></td>
<td>More costly as no generic form available</td>
</tr>
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<td>Drug</td>
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<tr>
<td><strong>Others</strong></td>
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</tbody>
</table>
| Agomelatine (Valdoxan®)                  | Third line  
Specialist only for severe depression or unresponsive to 2 or more other antidepressants | LFTs are required at commencement of therapy and at 6, 12 and 24 weeks  
No shared care agreement  
May be useful if insomnia is a problem or if sexual dysfunction has occurred with other antidepressants | 25mg standard dose may increased to 50mg at bedtime  
Prescribing remains in secondary care. (No shared care agreement) | 25mg tablets £43.77  
More costly as no generic form available |
| Mirtazapine NASSA                        | Second line  
Or  
Third line as add on therapy to an SSRI | Risk of weight gain. Low risk of agranulocytosis.                        | 15mg to 45mg. If 15mg starting dose is used it can be sedating | 30mg as plain tablets £1.95  
Orodispersible £2.86 |
| Moclobemide Reversible inhibitor of monoamine oxidase RIMA | Second line | Not widely used. Some drug interactions and food interactions, but less than phenelzine | The recommended starting dose is 150mg twice a day. In clinical practice doses of 300mg twice a day are required (BNF max). | 600mg As 2x300mg tablets £10.14 |
| Phenelzine (Nardil®) Monoamine oxidase inhibitor MAOI | Third line in atypical depression  
Specialist only  
Always get pharmaceutical advice when prescribing. | 2 week waiting essential when switching  
High incidence of side effects, drug interaction and food interactions in particular with tyramine causing severe headache – maybe fatal immediate medical attention required. Must give MAOI card | 15mg three times a day, increased if necessary after at least two weeks to four times a day. The last dose should be taken before 3pm. BNF max 30mg three times a day. Reduce to the lowest effective dose. | 45mg as 15mg tablets £15.75  
90mg as 15mg tablets £31.50  
Store in a refrigerator |
<p>| Reboxetine (Edronax®)                     | No longer recommended                               | Review existing patients                                                 | Lack of evidence over which therapeutic dose. Unlicensed                                      | Not available on the NHS              |
| St John’s Wort                           | Not recommended                                     | High incidence of interaction with prescribed medicines. Although trials consider that it may be effective in mild to moderate depression (11) |                                                                                               |                                       |</p>
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<tr>
<td><strong>Add on therapy /Augmentation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mianserin (Bolvidon®) Tetracyclic</td>
<td>Usually in combination with an SSRI third or fourth line.</td>
<td>Sedating, Low toxicity in overdose, Risk of agranulocytosis, FBC required monthly for first 3 months</td>
<td>30mg starting dose increasing if required to 90mg</td>
<td>60mg As 2x30mg tablets £30.18</td>
</tr>
<tr>
<td>Lithium (Camcolit® Priadel®)</td>
<td>Third line as augmentation therapy Recommended by NICE as an adjunct in treatment-resistant depression, in patients whose depression has failed to respond to several antidepressants.</td>
<td>Monitoring required at commencement of therapy including ECG and 3 monthly thereafter in line with NPSA alert and SWYPFT prescribing guidance. Be alert for drug interactions in particular with NSAIDs. Ensure purple booklet is issued and arrangements made for follow up monitoring. Shared care guideline.</td>
<td>Start at 400mg in adults (lower in older persons or with co-morbidities) Increase if required after 5 to 7 days. A plasma level of 0.6-1.0 mmol/l should be aimed for and regular monitoring of plasma levels, renal function and thyroid function is essential. See NPSA and Trust guidance for lithium.</td>
<td>Keep to same preparation Lithium carbonate as Priadel® 200mg tablets 400mg tablets As Camcolit® 250mg tablets 400mg tablets Liquid as lithium citrate 520mg/5ml</td>
</tr>
<tr>
<td>Risperidone (Risperdal®)</td>
<td>As augmentation strategy when psychotic symptoms are present.</td>
<td>Although unlicensed this is recommended by NICE. Physical health monitoring required – weight, U&amp;Es, LFTs, blood glucose in line with Trust reference guide.</td>
<td>Start at 2mg on first day (500 micrograms to 1mg in older people). Can increase to 4mg.</td>
<td>2mg tablets £1.05 approx</td>
</tr>
<tr>
<td>Quetiapine XL (Seroquel XL®)</td>
<td>Third line Augmentation in MDD for depressive symptoms. It should be used as add on to existing antidepressant therapy.</td>
<td>Licensed use but costly. Only XL formulation is licensed for use. Liquid or orodispersible preparations are NOT available.</td>
<td>The starting dose of quetiapine is 50mg XL for two days increasing to 150mg XL. This may be an effective treatment dose but can be increased to 300mg XL once daily if response is inadequate. More side effects are seen at high doses.</td>
<td>150mg as one XL capsule daily £66.00 300mg as one XL capsule daily £85.00</td>
</tr>
<tr>
<td>Tryptophan (L-Tryptophan) (Optimax®)</td>
<td>Third or fourth line.</td>
<td>Previous risk of eosinophilia myalgia is no longer relevant.</td>
<td>1g three times a day</td>
<td>500mg tablets as two tablets, three times a day £47 approx</td>
</tr>
</tbody>
</table>

Other combinations that are known to be in use include
- Venlafaxine and mirtazapine
- Duloxetine and mirtazapine
- Lithium, phenelzine and L-tryptophan
- Lithium SSRI and L-tryptophan

Information is available on these including risks and benefits in the Maudsley prescribing guidelines. These must be logged with the Trust clinical queries mechanism where advice can be given by the D&T. Often these have been recommended by a second opinion and the D&T will support these. The use of **escitalopram** for depression is also supported under these circumstances via the clinical queries mechanism. (See Section 17, Medicines Code). **Caution** escitalopram has been linked to a risk of QT prolongation and should not be used in combination with other drugs that prolong the QT interval e.g. antipsychotics and methadone.

### 4. DISCONTINUATION SYMPTOMS

Stopping antidepressants abruptly can cause discontinuation/withdrawal symptoms.
- To minimise the risk, the dose should be reduced gradually over an extended period of time. Generally, antidepressant therapy should be discontinued over at least a 4 week period. (not fluoxetine, which has a long half life, and therefore does not need tapering), and the end taper may need to be slower.
- Discontinuation symptoms are particularly common with short-acting antidepressants such as venlafaxine and paroxetine.

- Discontinuation symptoms include
  - flu like symptoms,
  - insomnia,
  - excessive/vivid dreaming,
  - headache
  - anxiety
  - nausea
  - Irritability

- Symptoms are usually mild and self-limiting but can occasionally be severe, especially if the antidepressant is stopped abruptly.
- Onset is usually within 5 days of stopping, depending on the half-life of the antidepressant.
- If the symptoms are severe, reintroduce the original antidepressant and taper gradually while monitoring for symptoms.
- Not all symptoms are associated with every antidepressant and may not all be experienced. The perception of symptoms may be made worse if no prior warning is given.
- Symptoms of discontinuation may be misinterpreted as relapse of the original illness or a new physical illness.
- If symptoms are mild, discussion of the reason for the symptoms and reassurance of the self-limiting nature are required.
- The service user should be monitored for resolution of the symptoms.
5. SPECIAL CONSIDERATIONS /CIRCUMSTANCES

5.1 Psychotic Depression

A combination of an antidepressant and antipsychotic drug is recommended e.g addition of oral risperidone to current antidepressant. ECT may be considered. Quetiapine has a licence for augmentation in Major Depressive Disorder so it may be used in a dual role here.

When antipsychotics are prescribed there should be attention to physical health monitoring including weight, LFTs, U&Es, blood glucose.

5.2 Antidepressant-Induced Hyponatraemia

All antidepressants appear to have the potential to cause hyponatraemia. All patients taking antidepressants should be observed for signs of hyponatraemia (dizziness, nausea, lethargy, confusion, cramps, and seizures). Serum sodium should be determined and monitored for those at high risk. Risk factors include

- extreme old age
- history of hyponatraemia
- co-therapy with certain drugs (e.g. diuretics, NSAIDs, carbamazepine, cancer chemotherapy)
- reduced renal function
- medical co-morbidity (e.g. hypothyroidism, diabetes, COPD, hypertension, head injury, CVA, cancer)

5.3 Serotonin Syndrome

This may occur with simultaneous administration of two antidepressants so caution is advised, particularly when switching antidepressants. Symptoms include

- restlessness
- diaphoresis
- tremor
- slurring
- myoclonus
- confusion
- convulsions
- death in extreme cases

There is an information leaflet on serotonin syndrome ensure this is given to service users who are at risk. Appendix 1.

Trazodone in combination with an SSRI increases the risk of serotonin syndrome and is not recommended.
5.4 Young People

The NICE clinical guideline 28 covers
Using antidepressants in children and young people in the management of depression
This guideline covers children and young people up to their 18th birthday.

The major points are

- Medication should **not** be prescribed for mild depression.
- **First line treatment for moderate to severe depression in children and young people:** psychological therapies including
  - Information and advice on self help materials or strategies, exercise, sleep hygiene, anxiety management and nutrition.
- Do not offer antidepressant medication except in combination with a concurrent psychological therapy.
- **Fluoxetine** is the only antidepressant for which trials in young people show that benefit outweighs risk.
  - The effectiveness in children is not established.
  - It should only be prescribed after full assessment and diagnosis and MDT review.
  - Ensure weekly contact for at least the first four weeks. Assess for the emergence of adverse side effects such as anxiety, irritability, hostility, suicidal thoughts or self-harm.
  - Inform the patient and their parents/carers of these potential adverse effects and urge them to contact the prescribing doctor if they emerge.
  - Written and verbal information should be provided. This should also include details of delay in onset of effect, time course of treatment, the need to take medication as prescribed and the need to discontinue gradually at the end of treatment.
  - Start with 10mg per day as liquid Fluoxetine. This comes as 20mg/5ml. Then increase the dose after one week to 20mg capsules.
- If fluoxetine is unsuccessful after an adequate trial at adequate doses and the depression is sufficiently severe to justify the trial of another antidepressant, NICE recommends citalopram or sertraline as second line treatments. Consult the NICE guideline before prescribing [www.nice.org.uk](http://www.nice.org.uk). Ensure prescribing is logged as unlicensed use with the clinical queries mechanism.
  - Starting doses should be low.
- **Prozac** brand of fluoxetine is the only licensed product for the treatment in the over 8 years old. No other treatment is licensed under the age of 18. Patients and parents or carers should be informed of the implications of this and formal consent obtained.
- Do **not** use paroxetine or venlafaxine, tricyclic antidepressants or St John’s Wort.
- Other antidepressant should start with half the daily adult starting dose. Increase if necessary over 2 to 4 weeks to the usual daily adult dose.
- There is little evidence regarding the effectiveness of doses above 20mg daily for fluoxetine or upper daily adult doses for other antidepressants.
- Higher doses should only be considered in older children of higher body weight and young people when the severity of the illness makes an early clinical response a priority.
5.5 Pregnancy

- The risks of medicine should be balanced against the risks of symptom relapse. Uncontrolled symptoms may affect the mother/child relationship directly or via an increase in risk taking, such as co-morbid alcohol, drug and nicotine use.
- Risks associated with use of medicine to treat depression during pregnancy include, teratogenicity and neonatal side effects. The latter may be toxicity or withdrawal effects (usually mild and self limiting). Little is known of the developmental effects of foetal exposure to antidepressants.
- With all woman of childbearing potential discuss contraception and the risks of symptom relapse and the use of medicine in pregnancy.
- Most of the danger for organ damage is in weeks 3 to 8 post conception. This may be before a woman is actually aware she is pregnant. All women of childbearing age should be advised about the importance of effective contraception. The woman should be encouraged to plan her pregnancy in conjunction with the psychiatrist or other clinician.
- Treatment options will depend on the patients previous history and the patient and clinicians preferences. These may include switching pharmacological treatment; consider non-pharmacological treatments such as cognitive behavioural therapy, a treatment break during the first trimester, continuing current effective treatment with monitoring or reducing or stopping treatment before delivery. Consult the Trust prescribing guidance for psychotropic medicines in pregnancy, NICE, specialist texts such as Drugs in Pregnancy, Maudsley Prescribing Guidelines and Psychotropic Drug Directory, National Teratology Information Service (0191 232 1525) or medicines information/specialist mental health pharmacist for advice 01924 327619 med.information@swyt.nhs.uk.
- It is important to ensure all healthcare professionals involved in the pregnancy and delivery, are aware of any medicine being prescribed.
- Exposure to SSRIs and SNRIs in late pregnancy may increase the risk of persistent pulmonary hypertension of the newborn.
- NICE recommends that paroxetine is stopped if a woman is planning a pregnancy or has an unplanned pregnancy
- Venlafaxine may be associated with increased risk of high blood pressure at high doses
- The choice of antidepressant may also be influenced by the woman’s intention or not to breast-feed.

5.6 Management of Sleep Disturbance

It is not necessary to prescribe sedating antidepressants e.g. mirtazapine for the management of sleep disturbance associated with depression. For some service user it may be appropriate to prescribe a short course of hypnotics in line with the prescribing guidance for hypnotics.

5.7 Harmful or Dependent Alcohol Drinker

Depression is a common symptom in this group which could be attributable to the drinking. This requires careful assessment and in particular a risk assessment for potential overdose. If an antidepressant is to be chosen after careful review (consider an SSRI.)
5.8 Older People

Treatment for depression in older people should follow the same principles as for other patient groups. Many treatment regimens have not been studied directly in the elderly. Evidence suggests that response to treatment may be slower and it is important to continue any treatment option for six weeks or more to assess for response. If there has been some response but not an adequate response it is important to increase the dose and continue monitoring before considering augmentation strategies.

Pharmacodynamic and pharmacokinetic age related changes alter response to medicine. This makes older people more prone to side effects due to increased end organ sensitivity, reduced circulation and reduced renal and hepatic clearance. This is particularly important with tricyclic antidepressants and other medicines that have anticholinergic side effects are very sedative or have a long half-life. Generally initiation doses are lower than those used in younger adults but maintenance doses may be the same. Gradual and careful titration is required. Response to treatment may take longer. Monitoring of adverse effects should be more frequent.

SSRI’s are associated with an increased risk of bleeding. This may be particularly important in the very elderly and those with established risk factors. Caution is advised with concomitant use of anticoagulants and medicines that may affect platelet function such as NSAIDs or other drugs which may increase the risk of bleeding.

**Antidepressants: risk of fractures:** A review of epidemiological studies, mainly in patients aged 50 years or older, shows an increased risk of bone fractures in patients receiving SSRIs and TCAs. The mechanism leading to this increased risk is unclear. Healthcare professionals should be aware of a small increased risk of fractures associated with the use of TCAs and SSRIs, and should take this risk into account in their discussions with patients and in prescribing decisions.

**Antidepressants: risk of falls:** Antidepressants have long been recognized as a contributory factor to falls and many studies show an association between antidepressants and falls. There are extensive data for TCAs and related drugs, and for SSRIs, but few data for other classes of antidepressants. Sedation, insomnia and impaired sleep, nocturia, impaired postural reflexes and increased reaction times, orthostatic hypotension, cardiac rhythm and conduction disorders, and movement disorders have all been postulated as contributing factors to falls in patients taking antidepressants. Sleep disturbance is a cardinal feature of depression, and all antidepressants have effects on sleep. TCAs and related drugs cause marked sedation with daytime drowsiness. SSRIs and related drugs have an alerting effect, impairing sleep duration and quality and causing insomnia, which may result in nocturia and daytime drowsiness. Daytime drowsiness is a significant risk factor for falls, both in untreated depression and in depression treated with antidepressants. Clinically significant orthostatic hypotension is common with TCAs and related drugs, the older MAOIs and SNRIs. It occurs less commonly with SSRIs, and rarely with moclobemide. It is not reported as a significant adverse effect of hypericum (St John's wort). There are insufficient data to exonerate any individual antidepressant or class of antidepressants as a potential cause of falls. The magnitude of the increased risk of falling with an antidepressant is about the same as the excess risk found in patients with untreated depression.

Sertraline is recommended for comorbidities as they have reduced risk of drug interactions.

Sertraline has been recommended for use when the there is concomittant ischaemic heart disease.
5.9 Table 2 Some significant drug interactions with antidepressants in the formulary – this list is not exhaustive

<table>
<thead>
<tr>
<th>Antidepressant</th>
<th>Interacting drug</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRIs</td>
<td>Tramadol</td>
<td>Serotonin syndrome has been reported</td>
</tr>
<tr>
<td></td>
<td>NSAIDS and Aspirin</td>
<td>Increased risk of bleeding. If using combination use a PPI.</td>
</tr>
<tr>
<td></td>
<td>Antipsychotics</td>
<td>Raised antipsychotic levels particularly with fluoxetine, fluvoxamine and paroxetine. Significant when combined with clozapine and aripiprazole</td>
</tr>
<tr>
<td></td>
<td>Tamoxifen</td>
<td>Avoid potent 2D6 inhibitors (fluoxetine/paroxetine)</td>
</tr>
<tr>
<td></td>
<td>Triptan drugs for migraine</td>
<td>Serotonin syndrome has been reported</td>
</tr>
<tr>
<td></td>
<td>MAO-Bs selegiline and rasagiline</td>
<td>Serotonin syndrome has been reported</td>
</tr>
<tr>
<td></td>
<td>Warfarin and other anticoagulants</td>
<td>Increased risk of bleeding. Monitor INR closely</td>
</tr>
<tr>
<td><strong>Citalopram</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Escitalopram</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fluoxetine</strong></td>
<td>+ Clarithromycin</td>
<td>Isolated case of delirium has been reported. Prescribe with caution Serotonin syndrome has been reported</td>
</tr>
<tr>
<td><strong>Sertraline</strong></td>
<td>+ Erythromycin</td>
<td>Isolated case of delirium has been reported. Prescribe with caution Serotonin syndrome has been reported</td>
</tr>
<tr>
<td><strong>Duloxetine</strong></td>
<td>+ Ciprofloxacin</td>
<td>Is contra indicated in the UK specific product characteristics. Increases duloxetine levels</td>
</tr>
<tr>
<td><strong>Lithium</strong></td>
<td>+ NSAIDS</td>
<td>Raised lithium levels. PRN NSAIDs especially risky.</td>
</tr>
<tr>
<td></td>
<td>+ Tetracycline/Doxycycline</td>
<td>Observe for signs of lithium toxicity. Monitor serum lithium levels. Tetracycline known to have nephrotoxic potential</td>
</tr>
<tr>
<td></td>
<td>+ Co-trimoxazole</td>
<td>Lithium toxicity has been reported with this combination. Monitor clinical response for toxicity</td>
</tr>
<tr>
<td></td>
<td>+ Trimethoprim</td>
<td>Lithium toxicity has been reported with this combination. Monitor serum lithium levels</td>
</tr>
<tr>
<td></td>
<td>+ Metronidazole</td>
<td>Lithium toxicity has been reported with this combination. Monitor serum lithium levels. Frequent monitoring of urea and electrolytes during and for two</td>
</tr>
<tr>
<td><strong>Lithium contd</strong></td>
<td>weeks after completing a course of metronidazole is required.</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>+ Levofloxacin</td>
<td>A case of severe lithium toxicity with this combination.</td>
<td></td>
</tr>
<tr>
<td>+ ACE inhibitors</td>
<td>There are many cases of lithium toxicity especially in the elderly May reduce lithium levels by 20-30%</td>
<td></td>
</tr>
<tr>
<td>+ Theophylline / aminophylline</td>
<td>Renal clearance of lithium reduced, levels can rise within a few days. Only use when unavoidable with strict monitoring. Seek pharmaceutical advice.</td>
<td></td>
</tr>
<tr>
<td>+ Thiazide diuretics</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6 BIBLIOGRAPHY


National Institute for clinical excellence. (NICE). Clinical Guideline 45; Antenatal and postnatal mental health; February 2007 www.nice.org


Stockley’s Drug Interactions Eighth Edition
Appendix 1

SEROTONIN SYNDROME

Why have I been given this information?
You have been prescribed two drugs which can occasionally cause a condition called ‘Serotonin Syndrome’ if used together. These two drugs are; 
______________________ and _________________________

Serotonin is a natural brain chemical which has many roles in the body. People who do not have enough serotonin may become unhappy and depressed, as serotonin is a ‘happy hormone’ which can lift a low mood. A lot of medicines which treat depression work by increasing the levels of serotonin in the brain.

What is Serotonin Syndrome?
If two drugs that increase serotonin levels are taken together, the levels of serotonin in the body may get too high. High levels of serotonin can cause some unpleasant side-effects and can be dangerous if left untreated.

Which drugs can contribute to Serotonin Syndrome?
- Most antidepressants e.g. fluoxetine, venlafaxine…
- Some antipsychotic drugs e.g.risperidone.
- Some ‘mood stabilising’ drugs e.g. lithium .
- Some painkillers including tramadol and pethidine.
- Some antibiotics including erythromycin.
- Some migraine treatments especially a group known as Triptans which include sumatriptan (Imigran) etc.
- Some herbal remedies especially St John’s Wort
- Some ‘over-the-counter’ remedies including treatments for coughs and colds containing chlorphenamine or dextromethorphan.
- Some illicit drugs, including ecstasy.

If you need to buy an over-the-counter remedy, make sure that you let the pharmacist know which medication you are taking. The pharmacist will be able to advise you on which preparations are suitable for you.

What are the symptoms of Serotonin Syndrome?
Many cases of Serotonin Syndrome are mild. Symptoms may include restlessness, confusion, shivering, sweating, fever, diarrhoea, nausea or vomiting. There may also be loss of co-ordination, muscle ‘twitching’ and an exaggeration of normal muscle reflexes. In severe cases, headache and a ‘racing’ heart may also occur. Serotonin Syndrome usually occurs soon after a change in medication.

If you experience any of the above symptoms, please contact your doctor as soon as possible. He or she will be able to advise you on the best course of action.

Please note that this is not a full list
For more information contact Medicines information at Fieldhead Hospital
Telephone no: 01924 327619 email med.information @swyt.nhs.uk
Choice and medication website www.choiceandmedication.org.uk

Version 2 Updated June 2011.
Following the information regarding citalopram, Lundbeck have announced new recommendations for the use of escitalopram, which are outlined below:

- The maximum dose of escitalopram for all indications is now 20mg/day tablets.
  The maximum dose of citalopram for all indications is now 40mg/day tablets.
- In the elderly and those with impaired hepatic function the maximum dose of escitalopram is 10mg/day tablets.
  In the elderly and those with impaired hepatic function the maximum dose of citalopram is 20mg/day tablets.
- Escitalopram and citalopram are now contraindicated in those individuals prescribed other medications which prolong QT*.
- Escitalopram and citalopram are now contraindicated in those individuals with existing QT prolongation or congenital long QT syndrome.
- Caution is advised in those individuals at risk of Torsade de Pointes.

The following course of action is recommended:

- Any new prescriptions for citalopram & escitalopram should be within the above guidance. Patients currently prescribed citalopram & escitalopram outside of the above guidance should be reviewed as soon as possible and an ECG performed. Any dose reduction needed should be undertaken gradually. For some individuals, prescribers may feel the risk in changing someone's therapy needs to be balanced against the risk of QT prolongation (especially in an individual who may have taken the two drugs in tandem for some time).

A management plan for patients could be viewed as follows:

1/ In some people a switch to an alternative SSRI will be regarded as low risk, and a change can be made;
2/ In others in whom the switch might be destabilising, the ECG findings will give a guide
to how necessary the switch is. If the balance of risk suggests keeping the current regime,
unlicensed use forms can be completed for each individual. Otherwise a gentle switch to another
SSRI can be undertaken.

3/ A third group would be felt to be risky to undergo a switch in therapy, but the ECG findings or
other risk factors mean that removing citalopram or escitalopram is the best course. In this case
again a gradual taper & move to another SSRI would be reasonable.

Note that the Trust only approves escitalopram for generalised anxiety disorder. It is not
approved for use in depression except through the clinical queries mechanism.

For advice in specific cases, please feel free to contact the Medicines Information service (01924
327619 or med.information@swyt.nhs.uk)

*A list of common medications known to prolong the QT interval:

All antipsychotics
Venlafaxine
Tricyclic antidepressants
Antibiotics: Erythromycin, Clarithromycin, Ampicillin, Co-trimoxazole.
Antimalarials: Chloroquine, Mefloquine, Quinine.
Antiarrhythmics: Quinidine, Disopyramide, Procainamide, Sotalol, Amiodarone, Bretylium.
Others: Amantadine, Cyclosporin, Diphenhydramine, Hydroxyzine, Nicardipine, Tamoxifen.

NB: this is not an exhaustive list, please consult the BNF or Medicines Information service for
further information.
### Appendix 3 - Equality Impact Assessment Tool

To be completed and attached to any policy document when submitted to the Executive Management Team for consideration and approval.

<table>
<thead>
<tr>
<th></th>
<th>Does the policy/guidance affect one group less or more favourably than another on the basis of:</th>
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<tr>
<td>1</td>
<td>• Race</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ethnic origins (including gypsies and travellers)</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Nationality</td>
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<td>• Culture</td>
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</tr>
<tr>
<td></td>
<td>• Religion or belief</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sexual orientation including lesbian, gay and bisexual people</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Age</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>NO</td>
<td>Recommendations are given for treatment in both older people and adults which may differ from the general recommendations.</td>
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<tr>
<td>2</td>
<td>Is there any evidence that some groups are affected differently?</td>
<td>YES</td>
<td>Different age groups may respond differently to anti-depressants and there is guidance on this included in this document.</td>
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<tr>
<td>3</td>
<td>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>YES</td>
<td></td>
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<td>4</td>
<td>Is the impact of the policy/guidance likely to be negative?</td>
<td>NO</td>
<td></td>
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<td>5</td>
<td>If so can the impact be avoided?</td>
<td>N/A</td>
<td></td>
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<td>6</td>
<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
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<td>7</td>
<td>Can we reduce the impact by taking different action?</td>
<td>N/A</td>
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If you have identified a potential discriminatory impact of this policy, please refer it to the Director of Corporate Development or Head of Involvement and Inclusion together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Corporate Development or Head of Involvement and Inclusion.
# Appendix 4- Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

<table>
<thead>
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<th>Comments</th>
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</tr>
<tr>
<td>Is it clear whether the document is a guideline, policy, protocol or standard?</td>
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<tr>
<td>Are people involved in the development identified?</td>
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<tr>
<td>Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?</td>
<td>YES</td>
<td></td>
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<tr>
<td>Is there evidence of consultation with stakeholders and users?</td>
<td>YES</td>
<td>D&amp;T membership and Area Prescribing Committee representation</td>
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<td>Is the target population clear and unambiguous?</td>
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<tr>
<td>Are the intended outcomes described?</td>
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<tr>
<td>Are the statements clear and unambiguous?</td>
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<td>5. Evidence Base</td>
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<tr>
<td>Is the type of evidence to support the document identified explicitly?</td>
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<tr>
<td>Are key references cited?</td>
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<td></td>
</tr>
<tr>
<td>Are the references cited in full?</td>
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<td></td>
</tr>
<tr>
<td>Are supporting documents referenced?</td>
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<td></td>
</tr>
<tr>
<td>6. Approval</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Does the document identify which committee/group will approve it?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>7. Dissemination and Implementation</td>
<td>Via trust Intranet</td>
<td></td>
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<tr>
<td>Is there an outline/plan to identify how this will be done?</td>
<td>YES</td>
<td></td>
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<tr>
<td>Does the plan include the necessary training/support to ensure compliance?</td>
<td>N/A</td>
<td>Training via Medicines Management updates</td>
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<tr>
<td>8. Document Control</td>
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</tr>
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</tr>
<tr>
<td>Have archiving arrangements for superseded documents been addressed?</td>
<td>N/</td>
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</tbody>
</table>

9. **Process to Monitor Compliance and Effectiveness**

| Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document? | NA |
| Is there a plan to review or audit compliance with the document? | YES | In CAPE plan for 2011 via Hazel Baxter |

10. **Review Date**

| Is the review date identified? | YES |
| Is the frequency of review identified? If so is it acceptable? | YES |

11. **Overall Responsibility for the Document**

| Is it clear who will be responsible implementation and review of the document? | YES |

**Appendix 5- Version Control Sheet**

*This sheet should provide a history of previous versions of the policy and changes made*

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Status</th>
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<td>1</td>
<td>2004</td>
<td>Lynn Haygarth, Dr Cruickshank</td>
<td>Written in line with NICE guidance</td>
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<td>2</td>
<td>June 2006</td>
<td>Lynn Haygarth, Dr Cruickshank</td>
<td>Changed due to guidance received relating to venlafaxine</td>
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<td>3</td>
<td>July 2006</td>
<td>Lynn Haygarth, Dr Cruickshank</td>
<td>Altered due to error on version 2</td>
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<td>4</td>
<td>October 2007</td>
<td>Lynn Haygarth, Dr Cruickshank</td>
<td>Changes in line with NICE guidance</td>
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<td>5</td>
<td>July 2011</td>
<td>Lynn Haygarth, Chief Pharmacist</td>
<td>Changes in line with NICE clinical guidance 2009</td>
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<td>5.1</td>
<td>October 2011</td>
<td>Lynn Haygarth, Chief Pharmacist</td>
<td>ECT section updated in line with NICE guidance. Policy updated in line with comments from Joint Academic Psychiatry Seminar on venlafaxine XL combination therapy. Correction to strength of fluoxetine liquid.</td>
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<td>5.2</td>
<td>December 2011</td>
<td>Lynn Haygarth, Chief Pharmacist</td>
<td>Updated to include new dosage information for citalopram and escitalopram.</td>
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<td>5.3</td>
<td>March 2012</td>
<td>Lynn Haygarth, Chief Pharmacist</td>
<td>Updated to remove amber status and SCG for atomoxetine and consult with Barnsley. Adding sections on antidepressants and falls. Update fluoxetine dose in line with BNF Sept 2011.</td>
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