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NICE Bites

Attention deficit hyperactivity disorder

NICE CG72; 2008

Treatment and management

Drug treatment for children, young people and adults with attention deficit hyperactivity disorder (ADHD) should always be:

- part of a comprehensive treatment plan that includes psychological, behavioural, and educational or occupational needs,
- initiated by a healthcare professional with expertise in ADHD following a comprehensive assessment.

Do **NOT** start drug treatment for ADHD in children, young people or adults in primary care.

After dose titration and stabilisation by a specialist, GPs can continue prescribing and monitoring drug treatment under shared care arrangements.

If a child or young person is currently receiving drug treatment but has not been assessed in secondary care, then refer to a specialist in ADHD.

Pre-school children

Drug treatment is **NOT** recommended.

School-age children and young people with moderate ADHD and moderate impairment*

Drug treatment is **NOT** indicated first-line.

Reserve drug treatment for those with:

- moderate levels of impairment who have refused non-drug interventions,
- persistent significant impairment following a parent-training/education programme or group psychological treatment.

* *See full guidance for definition of these terms.*

School-age children and young people with severe ADHD and severe impairment*

First-line: drug treatment as follows:

- methylphenidate for ADHD without significant comorbidity or with comorbid conduct disorder,
- methylphenidate or atomoxetine in the presence of tics, Tourette's syndrome, anxiety disorder, stimulant misuse or risk of stimulant diversion.

Second-line: atomoxetine if methylphenidate is ineffective at the maximum tolerated dose or is poorly tolerated.

Third-line: dexamfetamine if no response to maximum tolerated doses of methylphenidate or atomoxetine.

Adults with ADHD

First-line: methylphenidate (unlicensed).
OR atomoxetine (unlicensed) if there are concerns about drug misuse and diversion.
Second-line: atomoxetine or dexamfetamine (unlicensed) if methylphenidate is ineffective or cannot be tolerated.

Do **NOT** use antipsychotics for ADHD in children, young people or adults.

Monitoring

For all drugs monitor:

- **Height** (children and young people) – every 6 months,
- **Weight** – 3 and 6 months after the start of treatment, then every 6 months,
- **Heart rate and blood pressure** before and after each dose change and every 3 months.

See full guidance for further monitoring recommendations for individual drugs.

Cautions and counselling

Atomoxetine

Warn parents/carers/adult patients about the potential for:

- suicidal thinking and self-harm,
- liver damage (rare).

Zaleplon, zolpidem and zopiclone for the short-term management of insomnia

NICE TA77; 2004

- For severe insomnia – only prescribe hypnotics for short periods of time* and after consideration of non-drug treatments.
- The Z-drugs and shorter-acting benzodiazepine hypnotics are clinically similar. Use the drug with the lowest cost.
- Patients who have not responded to one of these hypnotic drugs should NOT be prescribed any of the others.

* See individual Summary of Product Characteristics for details of dosage and administration

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Depression

NICE CG23; 2004 (amended 2007)

This guidance covers the management of depression in adults and follows a stepped care model.

Step 1: Recognition of depression

Step 2: Treatment of mild depression

Antidepressants are **NOT** recommended for the treatment of mild depression as the risk-benefit ratio is poor.

Consider an antidepressant only if:

- mild depression persists after other interventions, or is associated with psychosocial and medical problems,
- a patient with a history of moderate or severe depression presents with mild depression.

Step 3: Treatment of moderate to severe depression

Moderate depression (including atypical depression); offer antidepressants before psychological interventions.

Severe or chronic depression; offer a combination of an antidepressant and cognitive behavioural therapy (CBT).

Use a generic selective serotonin reuptake inhibitor (SSRI) e.g. fluoxetine or citalopram, which are associated with fewer discontinuation/withdrawal symptoms.

Continue antidepressants for at least 6 months after remission.

Antidepressants should not be stopped abruptly. Reduce the dose gradually over an extended period.

Dosulepin, phenelzine, combined antidepressants and lithium augmentation of antidepressants should only be initiated by a specialist mental healthcare professional.

Monitoring

See patients:

- after one week if at increased risk of suicide or younger than 30 years, and frequently until risk no longer significant.
- after two weeks if not at increased risk of suicide then, regularly e.g. every 2 to 4 weeks in the first 3 months.

Cautions and counselling

Consider toxicity in overdose in patients at significant risk of suicide. Highest risks of toxicity with:

- tricyclic antidepressants (except lofepramine),
- venlafaxine

Be aware of drug interactions with concomitant drugs.

When starting treatment tell patients about:

- potential side-effects,
- risk of discontinuation/withdrawal symptoms on stopping, missing doses or reducing the dose,
- delay in onset of effect.

St John's wort

This should NOT be prescribed or advised.

Tell patients using St John's wort about:

- different potencies of available preparations,
- interactions with other medicines (including oral contraceptives, anticoagulants and anticonvulsants).

Anxiety

NICE CG22; 2004 (amended 2007)

This guidance covers the management of generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults and follows a stepped care model.

Step 1: Recognition and diagnosis

Step 2: Treatment in primary care

Offer any of the following:

- **psychological therapy** – this is more effective than pharmacological treatment, OR
- **pharmacological treatment** – see below, OR
- **self-help** – bibliotherapy i.e. written material.

Pharmacological treatment

Panic disorder

First-line: SSRI licensed for panic disorder e.g. citalopram, paroxetine.
Second-line: imipramine or clomipramine (unlicensed indication).

Do **NOT** prescribe benzodiazepines, sedating antihistamines or antipsychotics for the treatment of panic disorder.

Generalised anxiety disorder

If *immediate management* is necessary consider:

- support and information, problem solving, self-help,
- short-term use of benzodiazepines for 2 to 4 weeks only,
- sedative antihistamines.

Long-term management

An SSRI licensed for generalised anxiety disorder e.g. paroxetine, escitalopram.

Venlafaxine (modified release) is also licensed for generalised anxiety disorder - *see full guidance for prescribing restrictions.*

Step 3: Review and offer alternative treatment

Step 4: Review and offer referral to specialist mental health services

If patient continues with significant symptoms after any two interventions then refer to specialist mental health services.

Monitoring

Review efficacy and side-effects within 2 weeks of starting treatment and again at 4, 6 and 12 weeks then every 8 to 12 weeks thereafter.

Cautions and counselling

When starting treatment tell patients about:

- potential side-effects,
- risk of discontinuation/withdrawal symptoms on stopping, missing doses or reducing the dose,
- delay in onset of effect.

Antidepressants should not be stopped abruptly. Reduce the dose gradually over an extended period.