Clinical context

The evidence search undertaken using the guideline scope and agreed selection criteria for pharmacological therapies enabled evidence-based recommendations to be made for the use of some medications. Clinical Consensus Recommendations (CCR) and Clinical Practice Points (CPP) were made based on evidence rendered that could inform practice but did not meet the 'evidence-based' criteria. This was coupled with discussion from GDG members including experienced psychiatrists and paediatricians with some input from an experienced pharmacist, around practice experience and wisdom as well as expertise from Lived Experience Advisors.

In summary, the evidence does not support the use of medication as a first-line treatment for anxiety in children and adolescents. Where a consideration of medication for anxiety is indicated the evidence supports the use of SSRIs as the first-line medications for treating anxiety in children and young people. There was no evidence to support the use of one SSRI over another and the guideline does not therefore make recommendations on which medication should be preferred. Prescribers are recommended to familiarise themselves with two or three SSRIs with respect initial and target doses and adverse effect profiles. No SSRIs, or other medications, are currently licensed by the TGA for use in anxiety or depression in Australia. As fluoxetine and escitalopram are currently the only SSRIs with marketing authorisation in children and adolescents (by the Food and Drug Administration for the treatment of major depressive episodes in the USA) it would seem sensible for clinicians to consider including these in their options.

While caution is required and a policy of start low and increase gradually is advised, it is also important to go slow and titrate medications up as required monitoring both positive effects and tolerability. SSRIs take several weeks to become effective for anxiety and the benefits when seen often continue to increase over time (months). For this reason, it is important to ensure that, before deciding that a particular medication has not been effective, you have persisted for long enough at the maximum tolerated dose (around eight weeks is generally recommended).

Clinicians need to be aware of the potential for adverse effects including behavioural activation, discontinuation syndrome, and activation syndrome (ie increased activity, impulsivity, disinhibition, restlessness, irritability, and insomnia) when using SSRIs and adjust their psychoeducation and monitoring accordingly. Discontinuation syndrome is increased in those who do not take their medication regularly and those who have been taking their SSRI or SNRI for over eight weeks and those prescribed short half-life medications such as paroxetine and venlafaxine. Symptoms include flu-like symptoms (chills, myalgia, excessive sweating, headache, nausea), brain buzz – shock like sensations, dizziness exacerbated by movement, insomnia, excessive (vivid) dreaming, irritability, and crying spells.

Serotonin syndrome is a rare but serious condition that is one danger associated with the simultaneous administration of two antidepressants or an antidepressant and another medication (see Table 2). Symptoms include restlessness, diaphoresis, tremor, shivering, myoclonus, confusion, convulsions, and death. Most cases however are self-limiting. Recognising the possibility of serotonin syndrome and diligent supportive care are the mainstays of treatment. All patients with moderate or severe serotonergic symptoms should be admitted to hospital.