

## Depression in young people

It has been estimated that 1 in 10 young people between the ages of five and 15 years have a clinically diagnosable mental disorder and that the prevalence of depression in this age group is around 0.9%.<sup>1,2,3</sup> There have been calls for surveys to be repeated as these prevalence figures are now over a decade old and there is little published data to show how the rate of diagnosed depression has changed in recent years, despite the perception that children and young people are more troubled than in previous generations.<sup>4</sup> More contemporaneous data show that the total number of referrals to Child and Adolescent Mental Health Services (CAMHS) in Wales approximately doubled between April 2010 and July 2014.<sup>5</sup>

This bulletin discusses the various tiers of mental health provision for young people, some appropriate non-pharmacological management strategies, and the appropriate use of medication in this population.

A 2014 enquiry conducted by the Welsh Government highlighted concern over the increasing use of prescription medication for mental health problems in children and young people.<sup>5</sup> A subsequent study, published in 2015, analysed routinely collected primary care prescribing data in Wales and found that 'incident' or new antidepressant prescribing for young people has been increasing since 2006.<sup>6</sup> It was found that three times more young females than young males received a new prescription for antidepressants, that prescribing was twice as high in deprived areas compared to more affluent areas, and that most prescribing was in the 15-18 years age group.<sup>6</sup>

The majority of prescriptions written in primary care were new rather than repeat, but nearly 70% of patients with a new prescription received at least one subsequent prescription for antidepressants in the following year.<sup>6</sup> Further research showed that referrals to CAMHS from general practice were more likely to be rejected than those from other sources – sometimes without the child being seen.<sup>7</sup>

### Summary

- A depressive episode should be stratified as mild, moderate, or severe according to the ICD-10 criteria, and be treated accordingly.
- It can be useful to use a systematic assessment, specifically asking about depression and suicide rather than relying on the person volunteering this information.
- 'Watchful waiting' may be appropriate for some patients with mild depression. During this period, practical assistance can be helpful.
- If pharmacological therapy is to be considered, this should be following diagnosis and assessment by an appropriate specialist.
- Patients and their parents or carers should be given enough information so that they can give meaningful and properly informed consent before any form of treatment is initiated.
- Fluoxetine is the only antidepressant with a marketing authorisation for use in young people.

*"These results may reflect the limited availability of alternatives to medication for this population and further highlight the need for support for children and young people seeking help for mental health problems in primary care."<sup>6</sup>*

### Diagnosis

Depression is a major risk factor for suicide in adolescents and suicide is one of the leading causes of death in this group. Additionally, depression may also lead to, or occur in tandem with, other problems such as social and educational impairment, smoking, substance misuse, and obesity. Mental health problems at a young age can have long-lasting adverse effects, impacting healthy development into adulthood. Accurate diagnosis and appropriate treatment is therefore essential.<sup>3,8</sup>

Depression in adolescents is more often missed than in adults, possibly because of the similarity of some of the signs and symptoms to those normally seen fluctuating at this age.<sup>8</sup> The ICD-10 criteria (see Table 1) are applicable to this age group and are preferred to aid in categorisation of depression by the National Institute for Health and Care Excellence (NICE), although the difficulty in diagnosing depression with a single symptom count is acknowledged.<sup>9</sup> Further, difficulties may arise when the presenting problems are less typical, such as unexplained physical symptoms, eating disorders, anxiety, refusal to attend school or decline in academic performance, and behavioural problems.<sup>8</sup>

Table 1. ICD-10 criteria for depressive episodes<sup>9</sup>

Ask about key symptoms:
<ul style="list-style-type: none"> <li>• Persistent sadness or low mood – may present as irritability</li> <li>• Loss of interest or pleasure (anhedonia)</li> <li>• Fatigue or low energy</li> </ul>
If any key symptom present, ask about associated symptoms:
<ul style="list-style-type: none"> <li>• Poor quality sleep or increased need for sleep</li> <li>• Diminished ability to think or concentrate</li> <li>• Loss of confidence or self-esteem</li> <li>• Change in appetite with corresponding weight change</li> <li>• Suicidal ideation or behaviour</li> <li>• Change in psychomotor ability, agitation, or retardation</li> <li>• Unreasonable self-reproach or excessive/inappropriate guilt</li> </ul>
Diagnosis
<ul style="list-style-type: none"> <li>• <b>Mild depressive episode</b> – persistent sadness or low mood (or irritability) with either anhedonia or tiredness, plus two associated symptoms.</li> <li>• <b>Moderate-to-severe depressive episode</b> – as above but with three or more associated symptoms.</li> <li>• <b>Severe depressive episode (with psychotic symptoms)</b> – as above but with seven or more associated symptoms (+ psychotic symptoms).</li> </ul>

A systematic assessment that involves specifically asking about depression (and suicide) is thought to be better than relying on the person volunteering the information.<sup>9</sup> Use of the ‘three key questions’ (see Box 1) has long been recognised as useful to detect depression in adult patients in primary care. Recent research using these questions in adolescent patients concluded that they can also be usefully employed in this age group.<sup>10</sup>

### Box 1. Two key questions and a help question

**Question 1** During the past month have you often been bothered by feeling down, depressed, or hopeless?

**Question 2** During the past month have you often been bothered by little interest or pleasure in doing things?

**Question 3** Is this something with which you would like help?

### Stepped care

Guidance from NICE recommends a stepped-care approach to address the differing needs that children and adolescents have with respect to the characteristics of their depression and their personal and social circumstances (see Table 2).<sup>11</sup> Healthcare professionals in primary care settings should be familiar with screening for mood disorders and have access to specialist support.<sup>11</sup>

Table 2. The stepped-care approach<sup>11</sup>

Focus	Action	Responsibility*
<b>Detection</b>	Risk profiling	Tier 1
<b>Recognition</b>	Case identification	Tiers 2 to 4
<b>Mild depression</b>	Watchful waiting	Tier 1
	Non-directive supportive therapy/CBT/guided self-help	Tier 1 or 2
<b>Moderate-to-severe depression</b>	Brief psychological therapy +/- fluoxetine	Tier 2 or 3
<b>Depression unresponsive to treatment/recurrent depression/psychotic depression</b>	Intensive psychological therapy +/- fluoxetine (or other medication under specialist care)	Tier 3 or 4

\***Tier 1** – including GPs, paediatricians, health visitors, school nurses, social workers, teachers, juvenile justice workers, voluntary agencies, and social services. **Tier 2** – CAMHS provided by specialist professionals working with primary care. **Tier 3** – CAMHS specialised services for more severe, complex, or persistent disorders. **Tier 4** – tertiary-level services.

Detection and risk profiling should include the evaluation of:

- recent and past psychosocial risk factors such as: age, gender, family discord, bullying, physical, sexual or emotional abuse, co-morbid disorders, (including drug and alcohol use), and a history of parental depression

- the natural history of single loss events
- the importance of multiple risk factors
- ethnic and cultural factors
- factors known to be associated with a high risk of depression and other health problems such as: homelessness, refugee status, and living in institutional settings.<sup>11</sup>

NICE recommends that ‘watchful waiting’ may be appropriate for those diagnosed with mild depression who do not want, or are likely to recover without, an intervention. It is essential that follow up is arranged within two weeks. If symptoms continue beyond four weeks and there are no significant co-morbid problems, patients should be offered individual non-directive supportive therapy, group cognitive behavioural therapy, or guided self-help for up to 2-3 months. Referral criteria are shown in Box 2.<sup>11</sup>

### Box 2. Referral criteria

#### Management can remain at Tier 1 if exposure to:

- Single undesirable event with no other risk factors.
- Recent undesirable event in the presence of two or more other risk factors, but with no evidence of depression and/or self-harm.
- Recent undesirable event, where one or more family members have multiple-risk histories for depression, but no evidence of depression and/or self-harm in the child or young person.

#### Refer to Tier 2 or 3 if:

- Depression with two or more other risk factors.
- Depression where one or more family members have multiple-risk histories for depression.
- Mild depression with no response at Tier 1 after 2-3 months.
- Moderate, severe, or psychotic depression.
- Signs of recurrence of depression in those who have recovered from moderate or severe depression.
- Unexplained harmful self-neglect of at least one month’s duration.
- Active suicidal ideation or plans.
- Referral requested by patient, parent, or carer.

It is recognised that not all services are available in all areas, which can be a source of frustration. It is often helpful when patients are given practical assistance with contributory factors, where possible. During a period of watchful waiting it can be beneficial to encourage structured exercise, offer advice on sleep hygiene, and a healthy diet. Positive coping strategies, such as hobbies and pastimes should be encouraged. Where applicable, alcohol and cannabis use should be addressed. Relaxation techniques can be advocated for

anxiety and, if bullying is an issue, school involvement and support will be useful. Following a negative life event, discussion and referral to support services such as the Samaritans or Childline can be useful.<sup>9</sup>

### Pharmacological therapy

Antidepressant medication should not be the initial treatment for young people with mild depression and, in those with moderate-to-severe depression, should not be prescribed without appropriate, concurrent psychological therapy. An antidepressant should only be prescribed following diagnosis and assessment by a child psychiatrist.<sup>11</sup> **The only licensed pharmacological therapy for depression in young people, aged 8-18 years, is fluoxetine** (see Box 3). The risk-benefit ratio is considered to be unfavourable for all other SSRIs (including citalopram), venlafaxine, and the tricyclic antidepressants.<sup>11</sup>

Table 3. Summary of NICE “Do not do”<sup>11</sup>

Do NOT use antidepressants for initial treatment of mild depression.
Do NOT prescribe antidepressants in moderate-to-severe depression without offering concurrent psychological therapy.
Do NOT use tricyclic antidepressants.
Do NOT use paroxetine or venlafaxine.

The use of antidepressants has been linked with suicidal ideation and behaviour, with children and young adults up to the age of 25 particularly at risk. Prescriptions should only be given for short durations and, where necessary, patients prescribed an antidepressant should be carefully monitored for suicidal behaviour, self-harm, or hostility, particularly on initiation of treatment or if the dose is changed.<sup>12</sup>

It is of course recognised that antidepressants other than fluoxetine are used and, in the Welsh Government report on antidepressant prescribing in children and young people, citalopram was found to be the most commonly prescribed antidepressant between 2003 and 2013. However, in the final two years of this study, fluoxetine had overtaken citalopram to become the most prescribed.<sup>6</sup>

Citalopram and sertraline are listed as options for use ‘off-label’ by NICE only when certain criteria have been met. These include an adequate trial and failure of fluoxetine, reassessment of the diagnosis, advice from a senior child and adolescent psychiatrist, and consent from the patient or carer following a full discussion of the risks and benefits of treatment.<sup>11</sup>

### Box 3. Licensed, off-label, and unlicensed medicines use<sup>13</sup>

The "Information for the Public" section of the NICE guideline informs patients and their parents or carers that their doctor should explain what 'off-label' prescribing entails.

**Licensed use** refers to a medicine being used within its marketing authorisation (MA), i.e. for the correct indication, at the correct dose, and for a patient group specified within its MA.

**Off-label use** occurs when a medicine is used outside the terms of a valid MA, e.g. at a different dose from the MA or in a different patient group. This is relatively common in some areas of medicine, such as paediatrics and psychiatry.

**Unlicensed use** differs from off-label use in that the medicine in question does not have a valid MA in the country in which it is being used, although it may have an MA elsewhere.

Further information is provided in the WeMeReC document Things to know about... licensed, off-label and unlicensed use (available at [www.wemerec.org/res\\_things2know.php](http://www.wemerec.org/res_things2know.php)).

#### Fluoxetine and other antidepressants for children and adolescents

**Fluoxetine** has an MA only for use in patients aged eight and above, for the treatment of moderate to severe depression that is unresponsive to psychological therapy after 4-6 sessions. It should be offered only in combination with concurrent psychological therapy.<sup>14</sup> No other antidepressant medicine has an MA for use in children or adolescents.

Prescribing fluoxetine for children or adolescents in any other circumstances than those outlined in the MA is considered off-label use, as is the prescription of any other antidepressant in this age group. The prescribing advice below, particularly with regard to consent and record keeping, should be followed.

#### General Medical Council (GMC) prescribing advice<sup>15</sup>

The GMC does not distinguish between off-label and unlicensed use, deeming all such use unlicensed. They advise that 'unlicensed' medicines may be used "where, on the basis of an assessment of the individual patient, you conclude, for medical reasons, that it is necessary to do so to meet the specific needs of the patient."

##### Prescribing may be necessary when:

- there is no suitably licensed product available, e.g. if the patient is a child and an adult medicine would meet their needs, when the dosage in the MA would not meet the patient's needs, or when a formulation that would meet a patient's needs is not specifically licensed for them.
- a licensed medication is not available, e.g. due to a supply shortage.

##### The prescriber should:

- be satisfied that there is sufficient evidence of safety and efficacy.
- take responsibility for the patient's care, future monitoring, and follow-up treatment (or arrange for another suitable doctor to do so).
- keep clear and accurate records and document the reasons for prescribing if this is not common practice.

##### Informing patients:

- Patients, parents, or carers should have sufficient information to make an informed decision and any questions should be answered honestly.
- Where prescribing is supported by clinical guidance, it might be sufficient to give general information about why the medicine is being used in this way.
- Where such use is not routine, or if there are licensed alternatives, an explanation should be provided.

### Resources

#### Clinical Knowledge Summaries:

Depression in Children [cks.nice.org.uk/depression-in-children](http://cks.nice.org.uk/depression-in-children)

Insomnia [cks.nice.org.uk/insomnia](http://cks.nice.org.uk/insomnia)

#### Royal College of Psychiatrists:

Depression in children and young people leaflets and information [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)

#### Support services:

Childline 0800 11 11 [www.childline.org.uk](http://www.childline.org.uk)

Samaritans 08457 90 90 90 [www.samaritans.org.uk](http://www.samaritans.org.uk)

Summaries of Product Characteristics (SPCs) should be consulted for full prescribing information.

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