



## Depression or distress? Examining SSRI prescribing in primary care

Differentiating short-term psychological distress from depression can be difficult, particularly at the first consultation. Diagnostic and management uncertainty may lead to the overdiagnosis of depression and potentially inappropriate use of medicines, e.g. for grief or loneliness, when non-pharmacological interventions would be more effective. This article includes personalised prescribing data to allow clinicians to reflect on their practice and identify opportunities to optimise patient care.

### KEY MESSAGES:

- Approximately 9% of the population in New Zealand aged 18 years and older was dispensed a selective serotonin reuptake inhibitor (SSRI) in 2018
  - People of European ethnicity were 1.5 times more likely to be dispensed a SSRI than Māori and approximately four times more likely than Asian or Pacific peoples
  - Dispensing rates of SSRIs are highest in people aged ≥ 80 years (11% of this age group)
- It can be difficult to differentiate short-term psychological distress from depression; avoid making a diagnosis of depression at the first consultation unless the patient has severe symptoms with marked functional impairment or has a history of depression. If there is immediate concern for the patient's safety, refer them to emergency mental health services.
- Clinicians often see patients when their symptoms are at their worst and discussing their mental health with an empathetic practitioner can provide substantial relief
- Non-pharmacological strategies, e.g. sleep hygiene, exercise, re-engaging with hobbies, connecting with family/friends, should be recommended to all patients with distress or depression
- Combined pharmacological and psychological treatment is recommended for people with moderate to severe depression or symptoms that persist despite other interventions.
- Active follow-up is important for all patients presenting with distress or depression. Put a plan for review in place, e.g. a phone call from the practice nurse after 24–48 hours and a follow-up appointment in one to two weeks to assess their symptoms.

## Distressed or depressed?

Depression is typically diagnosed based on a combination of symptoms such as low mood, loss in pleasure or enjoyment in activities, feelings of low self-esteem, self-worthlessness, guilt, and somatic symptoms, e.g. agitation, disrupted sleep, loss of appetite, weight loss or gain, low energy, loss of libido. The number and severity of symptoms within a defined period, e.g. previous two weeks, is used to diagnose depression and classify severity (see: "Tools for assessing patients with depression").


However, it can be difficult to determine whether symptoms are caused by depression or short-term distress (e.g. due to stress, grief, health concerns), particularly at the first consultation.<sup>1,2</sup> Patients with short-term distress can score highly on a depression inventory such as the Patient Health Questionnaire-9 (PHQ-9), which could lead to initiation of pharmacological treatment.<sup>1</sup> Many of these people will experience a substantial improvement in their symptoms in the following weeks, and will have a lower score on the PHQ-9 when re-screened.<sup>1</sup> This improvement may mean that the patient no longer meets the threshold for a depression diagnosis or that pharmacological treatment is no longer recommended. Patients who are initiated on an antidepressant at the first consultation may attribute the improvement in their symptoms to the medicine, when it is likely that they would have improved anyway.

## Talk first, prescribe later (if necessary)

It is crucial that patients presenting with mental health concerns receive immediate management, but in many cases an appropriate initial treatment is a discussion with an empathetic practitioner. This can provide substantial relief, regardless of whether any other treatment is initiated.

The following strategies may be useful for managing patients presenting with mental health concerns:<sup>1</sup>

- Avoid making a diagnosis of depression at the first consultation unless the patient has severe symptoms with marked functional impairment or has a history of depression. Many people will experience an improvement in their symptoms following the initial consultation and with non-pharmacological interventions (see below).
- The PHQ-2\* can be used as a quick screening tool to rule out depression in patients presenting with somatic symptoms. If screening indicates that depression is possible, a more comprehensive depression inventory, e.g. PHQ-9, can be used
- Patients should be asked about suicidal ideation and intent. If they are at immediate risk of harming themselves or others, they should be urgently referred (i.e. the same day) to mental health services.

 For further information on suicide prevention, see: [www.bpac.org.nz/2017/suicide.aspx](http://www.bpac.org.nz/2017/suicide.aspx)

## Tools for assessing patients with depression

**The PHQ-9 questionnaire** is a validated tool to detect and assess the severity of depression that takes less than five minutes to complete.<sup>5</sup> The PHQ-9 tool can also be used to monitor the patient's response to treatment.<sup>5</sup> Available from: [www.cqaimh.org/pdf/tool\\_phq9.pdf](http://www.cqaimh.org/pdf/tool_phq9.pdf)


**The GAD-7 questionnaire** can be used to assess the severity of illness in patients with generalised anxiety. Available from: [www.nzgp-webdirectory.co.nz/site/nzgp-webdirectory2/files/pdfs/forms/GAD-7\\_Anxiety.pdf](http://www.nzgp-webdirectory.co.nz/site/nzgp-webdirectory2/files/pdfs/forms/GAD-7_Anxiety.pdf)

**The Geriatric Depression Scale** is a 15-part questionnaire for screening for depression in older people, where a score  $\geq 7$  is indicative of depression, available here: [www.bpac.org.nz/BPJ/2011/July/appendices.aspx#ap1](http://www.bpac.org.nz/BPJ/2011/July/appendices.aspx#ap1)

**The Edinburgh Postnatal Depression Scale (EPDS)** is a validated tool to detect and assess the severity of depression in postpartum women. Available from: [www.healthnavigator.org.nz/tools/e/edinburgh-postnatal-depression-scale/](http://www.healthnavigator.org.nz/tools/e/edinburgh-postnatal-depression-scale/)

[healthnavigator.org.nz/tools/e/edinburgh-postnatal-depression-scale/](http://www.healthnavigator.org.nz/tools/e/edinburgh-postnatal-depression-scale/)

**The anxiety and depression checklist (K10)** is a simple tool for assessing patients with symptoms of depression and anxiety. Available from: [www.beyondblue.org.au/the-facts/anxiety-and-depression-checklist-k10](http://www.beyondblue.org.au/the-facts/anxiety-and-depression-checklist-k10)

 *bestpractice* by BPAC Clinical Solutions offers a range of electronic decision support tools for assessing and managing patients with depression. These modules are part of a nationally-funded suite of resources available free-of-charge to all primary care practices in New Zealand. There are separate modules for managing adults, elderly people, young people and women in the antenatal and postnatal periods with depression. The assessments incorporate the PHQ-9, GAD-7, and EPDS questionnaires and the K10 checklist. For further information, see: [www.bestpractice.net.nz/feat\\_mod\\_NatFunded.php](http://www.bestpractice.net.nz/feat_mod_NatFunded.php)

- The key factors in overcoming psychological distress or depression are: developing coping strategies, building resilience to prevent or reduce relapses and establishing reliable family/whānau or social support
- Discuss mood fluctuations or distress in response to a certain trigger, and how these changes differ from depression; ensure that patients understand that pharmacological treatment does not provide a “quick fix” and may not be the right approach for them
- If a trigger for the patient’s symptoms can be identified, e.g. work stress, relationship breakdown, financial concerns, health worries or loneliness, helping patients to find coping strategies and a pathway toward resolution (if possible) is crucial to their recovery
- Discuss non-pharmacological strategies with all patients, including:
  - Behavioural activation, e.g. re-engaging with social activities, friends/family/ whānau, hobbies, volunteering
  - Sleep hygiene; for more information, see: [www.bpac.org.nz/2017/docs/insomnia-patient.pdf](http://www.bpac.org.nz/2017/docs/insomnia-patient.pdf)
  - Exercise
  - Limiting alcohol and avoiding illicit drugs
  - Self-guided, individual or group psychological treatments, e.g. cognitive behavioural therapy (CBT), mindfulness (see “Patient Resources”)
  - Engagement with Kaupapa Māori mental health services if this aligns with the patient’s beliefs
- Establish a clear plan for review, e.g. arrange a phone call within 24–48 hours and a follow-up appointment in one or two weeks to assess the patient’s symptoms
- Patients can be rescreened using the PHQ-9 to assess the success of interventions

\* The PHQ-2 comprises two questions, and an answer of yes to either warrants further investigation: 1. Have you felt depressed, down or hopeless for all or most of the past month? 2. Have you lost interest or pleasure in all or most activities over the past month?

### Non-pharmacological interventions are appropriate for older people too

There are many factors that increase the likelihood of psychological distress or depression in older people, including loss of independence, limited mobility, chronic illness, bereavement, social isolation and loneliness. Older people living in residential care may be at greater risk for depression than those who are community-dwelling.<sup>3</sup> Antidepressants are only likely to provide benefit to those with moderate to severe symptoms of depression, and will not treat sadness, loneliness or grief. The risk-benefit analysis for initiating an antidepressant

in an older person is also influenced by the increased risk of adverse effects, e.g. hyponatraemia, anticholinergic effects, falls, gastro-intestinal bleeding and medicine interactions. Psychological treatment is just as effective in older people, however, they are less likely to be referred for this.<sup>3, 4</sup> Non-pharmacological strategies tailored to the patient’s capabilities should be recommended first-line or in conjunction with antidepressants if indicated.

### Further information:

- Read more about diagnosing depression in elderly people, here: [www.bpac.org.nz/BPJ/2011/July/causes.aspx](http://www.bpac.org.nz/BPJ/2011/July/causes.aspx)
- Age Concern New Zealand provides visiting services and group activities for older people, [www.ageconcern.org.nz](http://www.ageconcern.org.nz)

## Antidepressants are usually only indicated for patients with moderate to severe depression

Antidepressant treatment is associated with a substantial placebo component and the benefit of treatment is proportional to the severity of the depression, i.e. no benefit over placebo for mild depression, but a substantial benefit in patients with severe depression.<sup>6</sup> People can experience potentially significant adverse effects when initiating or discontinuing an antidepressant, including suicidal ideation, sexual dysfunction, nausea, anxiety, insomnia, sweating, agitation and electric shock sensations.<sup>1</sup> Therefore, in people with mild depression, the risk of adverse effects are likely to outweigh any possible benefits of antidepressants. Furthermore, once people are initiated on an antidepressant it can be difficult to discontinue treatment e.g. due to discontinuation adverse effects or because the patient believes that pharmacological treatment is necessary, and this may lead to long-term use.<sup>1</sup>

### Practice points for prescribing antidepressants:

- Guidelines typically recommend treatment with antidepressants for people with moderate to severe depression and depression that is resistant to non-pharmacological treatments<sup>2, 6</sup>
- Antidepressants may also be considered for patients presenting with mild symptoms who have a previous history of severe depression, depending on their preference for pharmacological treatment<sup>1, 2</sup>
- After starting an antidepressant, it will often take several weeks before any benefit occurs and patients may require dose adjustments to find their ideal therapeutic level
- Some patients will not respond to the first medicine they are prescribed and will require a change in treatment

- Non-pharmacological treatments, i.e. psychological and behavioural interventions, should be continued along with any pharmacological treatment
- Review patients two weeks after initiating an antidepressant (or sooner if clinically indicated) and then again at four to six weeks.<sup>2</sup>
- Antidepressants should ideally be continued for at least one year\* following recovery from a single episode of depression, or for at least three years following recurrent episodes.<sup>7</sup>

\* In some cases it may be appropriate to discontinue after six months

### SSRIs are the first-line antidepressant

Selective serotonin reuptake inhibitors (SSRIs) are generally recommended first-line for the treatment of depression due to their more favourable adverse effect profile compared to other antidepressants.<sup>7</sup> There are five fully subsidised SSRIs available in New Zealand: citalopram, escitalopram, fluoxetine, paroxetine and sertraline. All SSRIs have similar pharmacological properties and are similarly effective for the treatment of depression. However, adverse effects, medicine interactions and patient tolerance may vary. These factors, along with any history of previous response, co-morbidities, concurrent medicines and patient preference will influence selection.

### Selecting a SSRI:

- If the patient has previously benefited from a particular SSRI, try that medicine again
- If initiating a SSRI for the first time, sertraline, citalopram and escitalopram are reasonable first choices:
  - Sertraline or escitalopram are preferred if the patient is pregnant, or could become pregnant, or is breastfeeding<sup>8</sup>
  - Citalopram and escitalopram are contraindicated in people with QT prolongation<sup>9</sup>
- Fluoxetine and paroxetine have a higher potential for medicine interactions compared with sertraline, citalopram and escitalopram
- Paroxetine is associated with a higher risk of discontinuation syndrome than other SSRIs
- Refer to the NZF for information on medicine interactions, cautions and contraindications, and dosing regimens: [www.nzf.org.nz/nzf\\_2287](http://www.nzf.org.nz/nzf_2287)


N.B. The funded brands of sertraline, paroxetine and fluoxetine will be changing from 1 April, 2020 (see: “Changes are coming for the funded brands of sertraline, paroxetine and fluoxetine”).

## Changes are coming for the funded brands of sertraline, paroxetine and fluoxetine

From 1 April, 2020, the sole subsidised brands of sertraline, paroxetine and fluoxetine will change (Table 1).


**Table 1.** Brand changes for sertraline, paroxetine and fluoxetine

Medicine	Sole supply brand (Supplier)	Date of listing	Sole subsidised supply date	Brand (Supplier) to be delisted
<b>Sertraline</b>	Setrona (Douglas)	1 October, 2019	1 April, 2020	Arrow-Sertraline (Teva)
<b>Paroxetine</b>	Loxamine (Mylan)	1 October, 2019	1 April, 2020	Apo-Paroxetine (Apotex)
<b>Fluoxetine</b>	Fluox (Mylan)	1 November, 2019	1 April, 2020	Arrow-Fluoxetine (Teva)


 Patient information leaflets explaining these changes for each medicine are available from: [www.pharmac.govt.nz/medicines/my-medicine-has-changed/](http://www.pharmac.govt.nz/medicines/my-medicine-has-changed/)

Effective communication about brand change, provision of adequate information and reassurance is essential to ensure that patients remain satisfied with and adherent to their treatment. Changing a funded brand of medicine

may give rise to the nocebo effect, i.e. adverse symptoms induced independently of the active component of the treatment.


 For further information on the nocebo effect and strategies to minimise this, see: [www.bpac.org.nz/2019/nocebo.aspx](http://www.bpac.org.nz/2019/nocebo.aspx)



 For further information on the use of SSRIs and other antidepressants in the treatment of depression, see: [www.bpac.org.nz/2017/depression.aspx](http://www.bpac.org.nz/2017/depression.aspx)

N.B. A future article will cover the use of antidepressants in antenatal and postnatal depression.

## SSRI use in New Zealand: your prescribing data

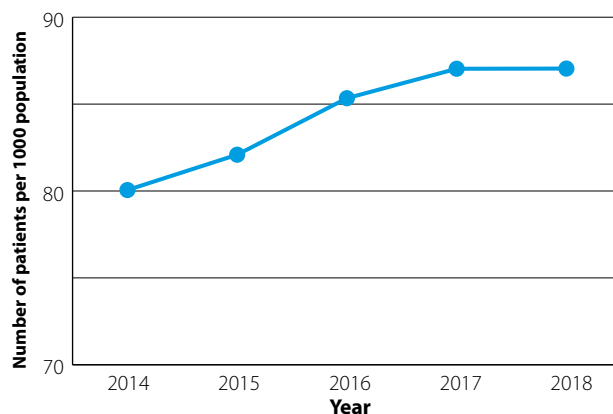
 **Are you a prescriber? Login to see how your personalised and practice prescribing data compares to that of your peers.**

### SSRI use nationally has increased over the past five years

In 2018, approximately 9% of people in New Zealand aged 18 years and older (approximately 300,000 people) were dispensed a SSRI (Figure 1). The number of people receiving these medicines increased by 9% (after adjusting for population growth) between 2014 and 2017, and then levelled off between 2017 and 2018 (Figure 1).<sup>\*</sup> The reason for this increase is not known, but may involve factors such as more people having and seeking help for mental health problems, as well as better awareness and recognition by clinicians. It is possible that the threshold for prescribing may have lowered as SSRIs are considered safer and better tolerated than older tricyclic antidepressants, thereby increasing use of this type of antidepressant.

N.B. Indications for treatment are not included in the Pharmaceutical Collection data, therefore, it is not possible to determine the proportion of SSRI prescribing for depression compared to the other indications for these medicines (see NZF for other indications).

\* Venlafaxine dispensing also levelled off during this time period, therefore increased venlafaxine use is not a likely explanation for the reduction in SSRI prescribing.<sup>10</sup>



**Figure 1.** The number of patients aged  $\geq 18$  years (per 1,000 registered patients) who were dispensed a SSRI from community pharmacies in New Zealand annually from 2014 to 2018. Note the starting value on the Y axis.


### Points for reflection

- Consider your antidepressant prescribing data, how does it compare to that of your peers in terms of number of patients and their age and ethnicity?
- Do you initiate patients on antidepressants at the first consultation? What factors do you take into consideration when making the decision to delay or prescribe immediately?
- Do you review patients who have been on antidepressants long-term to see if treatment is still indicated?
- Antidepressant use nationally is highest among people aged over 80 years and older people are less likely to be referred for psychological treatment. Is your threshold for prescribing an antidepressant to an older person lower than for someone younger? Do you consider non-pharmacological interventions as effective and accessible for older people?



If you are a New Zealand prescriber, see your personalised and practice prescribing data on the bpac<sup>nz</sup> website:

[www.bpac.org.nz/2019/ssri.aspx](http://www.bpac.org.nz/2019/ssri.aspx)

 A clinical audit of SSRI prescribing is available here: [www.bpac.org.nz/Audits/ssri.aspx](http://www.bpac.org.nz/Audits/ssri.aspx)

## SSRI use varies by ethnicity

In 2018, approximately 35% fewer Māori were dispensed SSRIs than people of European ethnicity. Asian and Pacific peoples had the lowest SSRI dispensing rates (Figure 2). Interpretation of these data are challenging as the ideal level of prescribing is not known, i.e. this may represent undertreatment of some groups and overtreatment of others.<sup>4</sup>

A New Zealand-based study including over 15,000 people found that Māori, Asian and Pacific peoples were less likely to have been diagnosed with depression or anxiety, despite reporting higher levels of distress than Europeans, suggesting that these mental health conditions may be underdiagnosed and consequently undertreated in these groups.<sup>11\*</sup>

However, there is also evidence of overtreatment. A report on the trends in mental health service use and unmet need included as part of the New Zealand Mental Health and Addiction Inquiry (2018) found that approximately 10% of Pacific peoples, 20% of Māori and 40% of people of other ethnicities who reported mild symptoms<sup>†</sup> were dispensed an antidepressant, even though these medicines are only recommended for those with moderate to severe symptoms or persistent symptoms.<sup>4</sup>

There is likely to be a number of factors influencing the differences in SSRI dispensing between ethnic groups in New Zealand including cultural differences in the presentation of mental illness and acceptance of mental illness diagnosis and treatment, accessibility and cost of non-funded treatments.<sup>4</sup>

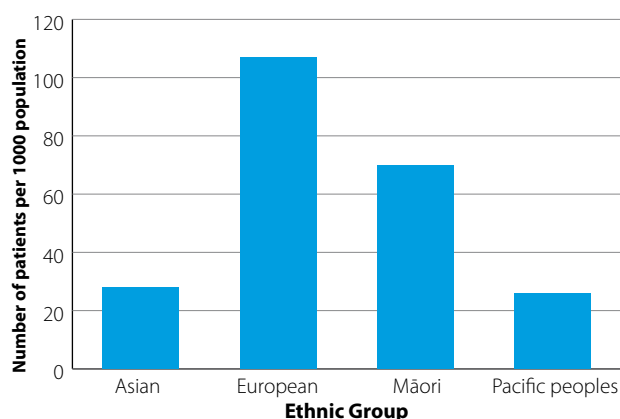
\* Psychological distress was assessed using the Kessler-6 scale; participants rated six items on a five-point scale to assess their risk of developing anxiety or depression.<sup>11</sup>

† As determined by their score on the Kessler-10 (K10) psychological distress questionnaire.

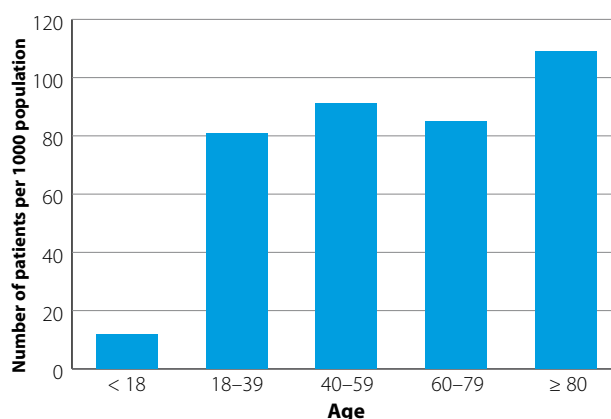
## Trends in SSRI use by age in New Zealand in 2018

Approximately 1.5% of people aged < 18 years in New Zealand (12,500 people) were dispensed a SSRI in 2018 (Figure 3). SSRI prescribing in young people has been trending upwards in New Zealand for several years, despite limited evidence supporting the use of antidepressants in this age group.<sup>12</sup> Fluoxetine is the only SSRI recommended for the treatment of depression in people aged <18 years, however, this is an unapproved indication.<sup>13</sup> Clinicians in primary care should consider consulting with a child and adolescent psychiatrist or a paediatrician before prescribing.

SSRI use increases with age (Figure 3), with the highest rates in those aged ≥ 80 years (11% of this age group were dispensed a SSRI). Within this age group, people of European ethnicity have the highest dispensing rate SSRIs; 11% of this group were dispensed an antidepressant in 2018 compared to 7% of Māori, 5% of Asian and 3% of Pacific peoples.<sup>10</sup> The risk of adverse effects of SSRIs is greater in older people, e.g. hyponatraemia, anticholinergic effects, falls, gastro-intestinal bleeding and medicine interactions. Therefore, in many cases non-pharmacological treatments may be preferred.




**Figure 2:** The number of patients aged ≥ 18 years (per 1,000 registered patients) who were dispensed a SSRI from community pharmacies in New Zealand in the 12 months from January, 2018 to December, 2018, by ethnicity.



**Figure 3:** The number of patients (per 1,000 registered patients) dispensed a prescription for a SSRI from community pharmacies in New Zealand from January, 2018 to December, 2018, by age.

## Resources

 Further information on diagnosing and treating distress and depression in primary care is available from the Goodfellow Unit:

- MedCase: “Depression or distress?”  
[www.goodfellowunit.org/medcases/depression-or-distress](http://www.goodfellowunit.org/medcases/depression-or-distress)
- Webinar: “Antidepressants in primary care” with Associate Professor David Menkes and Professor Bruce Arroll  
[www.goodfellowunit.org/events/webinar-antidepressants-primary-care](http://www.goodfellowunit.org/events/webinar-antidepressants-primary-care)
- Podcast: “Be careful about mental health labelling” with Professor Bruce Arroll  
[www.goodfellowunit.org/podcast/be-careful-about-mental-health-labelling](http://www.goodfellowunit.org/podcast/be-careful-about-mental-health-labelling)
- Podcast: “Exercise for the treatment of depression, anxiety and insomnia” with Dr Giresh Kanji  
[www.goodfellowunit.org/podcast/exercise-treatment-depression-anxiety-and-insomnia](http://www.goodfellowunit.org/podcast/exercise-treatment-depression-anxiety-and-insomnia)
- Podcast: “Improving treatments for depression” with Professor Bruce Arroll  
[www.goodfellowunit.org/podcast/improving-treatments-depression](http://www.goodfellowunit.org/podcast/improving-treatments-depression)
- Podcast: “Management of adult depression” with Dr David Codyre  
[www.goodfellowunit.org/podcast/management-adult-depression-david-codyre](http://www.goodfellowunit.org/podcast/management-adult-depression-david-codyre)

 Resources for patients:

- [www.depression.org.nz](http://www.depression.org.nz) – a wide range of resources including an online programme (“The Journal”), personal stories and self-tests for depression and anxiety
- [www.mentalhealth.org.nz/get-help/a-z/resource/13/depression](http://www.mentalhealth.org.nz/get-help/a-z/resource/13/depression) – education and patient resources that can be viewed online, printed or ordered
- [www.beatingtheblues.co.nz](http://www.beatingtheblues.co.nz) – an online CBT programme for depression and anxiety; patients are referred via the ManageMyHealth portal
- [www.moodgym.com.au](http://www.moodgym.com.au) – an online interactive self-help book for depression and anxiety
- [www.thelowdown.co.nz](http://www.thelowdown.co.nz) – a wide range of resources for depression and anxiety
- [www.sparx.org.nz/about](http://www.sparx.org.nz/about) – an online, CBT-based resource for young people with depression and anxiety

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