

Should antidepressants be used to treat depression in children and adolescents?

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Summary of advice:

- Antidepressants may increase suicidal thoughts, but there is no compelling evidence of an increased risk of actual suicide.
- Behavioural therapy and other psychosocial interventions are considered first line treatment for depression in young people.
- If drug therapy is indicated, fluoxetine is the best choice of antidepressant for adolescents or children.
- It is important to maintain regular contact with young patients with depression and to monitor the risk of suicide, especially in the few weeks following a first antidepressant prescription.

Depressive disorder is a major health issue for adolescents in New Zealand, affecting between 4 to 8% of 15 year olds, rising rapidly to rates of 17 to 18% by the age of 18.¹⁻⁶ In young people, depressive disorder is pervasive and affects not only function but overall development.⁷ It is associated with poor academic functioning, social dysfunction, substance abuse, attempted and completed suicide.⁷⁻¹² Co-morbidity is high, with up to half of those with major depressive disorder having another psychiatric disorder at some stage in their life.⁷⁻¹³

Despite this high prevalence, it is estimated that over three quarters of depressive disorder in adolescents is undetected. Health professionals are being encouraged to screen for depression and to provide treatment. However FDA black box warnings about the potential for newer antidepressants to increase the risk of suicide have led to concern about the place of antidepressants in the management of depressive disorders in children and adolescents.




Monitoring suicide risk

Monitoring suicide risk is complex. The New Zealand Guidelines Group offers practical advice on how to investigate suicidal ideation. Questions a clinician may consider include:

- How has your mood been lately?
- Has anything been troubling or worrying you?
- Have you had times when you have been feeling sad or down?
- Have you ever felt like life is just getting on top of you?
- Do you sometimes wish you could just make it all stop, or that you could just end it?
- Have you thought about how you might do this?
- Have you ever wished you were dead?
- Have you ever thought about taking your own life?

If the patient endorses any of these statements, the clinician then needs to determine level of intent, existence of a plan, access to means, underlying mental health problems and availability of support and protective factors.


 From guideline “Assesment and Management of People at Risk of Suicide”. Complete document available from:


http://www.nzgg.org.nz/guidelines/0005/Appendix_2_Assessment_Risk.pdf

How should depression in young people be treated?

There are two major approaches to managing depression in children and adolescents – psychological and pharmacological.

Choosing a treatment involves a team approach including GP, family and patient. With more severe depression, specialist mental health professionals should also be involved. There is no simple tool for determining who will and who will not respond to treatment.

 More detailed information on how to assess risk and manage depression can be found in the UK based National Institute of Clinical Excellence (NICE) guidelines and the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) toolkit. This document contains useful flow charts for clinical management and assessment. The New Zealand Guidelines Group (NZGG) is due to release their guidelines on treating depression in children and adolescents shortly.

 Websites and a list of resources can be found at the end of this article.

Psychological treatments recommended as first line


There is evidence that cognitive behavioural therapy and interpersonal therapy are both effective in the treatment of depression in children and adolescents.^{14, 15} Psychological therapies are recommended as first line treatment, especially in mild to moderate depression.^{10, 16} Even for more severe depression up to 13% of young people respond to support and monitoring.¹⁷

A “stepped care” method should be used, so that simpler and less risky approaches are tried first, dependent on severity of depression. For mild depression, start with “active monitoring” followed by one of the psychological therapies if there is no response.^{10, 16} For more severe depression, specialist referral is recommended.



For active monitoring:

- Provide psychoeducation (educate about depression, how to treat it and how to recognise signs of relapse)
- Provide supportive counselling
- Facilitate parental and patient self-management
- Refer for peer support
- Regularly monitor for depressive symptoms and suicidality

 See GLAD-PC toolkit for a clinical management flow chart.

Referral to a child and adolescent mental health service or to a clinical psychologist is currently the best method for accessing psychological treatment, but may not be available in all areas. Other resources could be trialled where psychological therapies are unavailable (see below).

Fluoxetine in combination with cognitive behavioural therapy

If young people fail to respond to simpler approaches, if their depression is more severe or if psychological treatments are unavailable, fluoxetine may be considered. Combining fluoxetine with cognitive behavioural therapy is an effective treatment option.¹⁸

- A meta-analysis of the effectiveness of tricyclic antidepressants did not provide convincing evidence of effectiveness of these medications for children and adolescents.¹⁹
- Authors of a number of meta-analyses of SSRIs and other newer generation antidepressants concluded that the risk benefit ratio is only favourable for fluoxetine.¹⁸⁻²¹
- There is limited evidence that the other medications have anything more than a placebo response. Even for fluoxetine the overall response rate is low.²²

Training for health professionals:

- The Werry Centre in Auckland runs occasional workshops to teach cognitive strategies that can be used as a first step. Contact coordinator@werrycentre.org.nz
- The University of Auckland offers two papers teaching cognitive behavioural therapy for children and adolescents (block teaching, suitable for people from anywhere in New Zealand). For information contact **Janine Joubert** (j.joubert@auckland.ac.nz)
- The University of Otago (Christchurch School of Medicine) offers occasional workshops on Interpersonal Therapy training, as well as post graduate courses. For information contact **Associate Professor Sue Luty** (sue.luty@otago.ac.nz)

GPs may wish to consider consulting with a child psychiatrist before prescribing an antidepressant to a person under 18 years. Although there is little evidence to support the use of antidepressants other than fluoxetine, they may be effective for individuals.

The Child and Adolescent Psychiatry Trials Network, based in the USA, has recently commenced work on a “safety registry” for newer antidepressants. It is hoped to identify factors that predict benefit and harm and who should and should not receive a particular medication.²³

Other resources for treating depression in young people

Because of the limited availability of psychological therapies there has been some interest in the use of technology to deliver these interventions by way of the internet or computer games. Trials show computerised cognitive behavioural therapy compares well with that delivered by

a therapist and is a recommended intervention for adults in the NICE guidelines. Trials for adolescents lag behind but resources are being developed. The Australian based Inspire Foundation has created “Reach Out Central”, a user-friendly web-site with an interactive problem solving game for teenagers. This has not been evaluated but could be suggested as a self-help resource alongside active monitoring of mood and suicidal ideation.

In New Zealand, the Ministry of Health have produced a user friendly website aimed at young adults as part of their National Depression Initiative. “The Lowdown” provides interactive resources, chat and support.

Facilitating lifestyle changes, including regular exercise is also an effective management technique.

Useful websites and further reading

You can also visit these websites by linking from this article on the bpac website: <http://www.bpac.org.nz>

Guidelines

- NICE (UK) guidelines on depression in children and young people:

<http://www.nice.org.uk/guidance/index.jsp?action=download&o=29856> (full guideline)

<http://www.nice.org.uk/guidance/index.jsp?action=download&o=29858> (brief version)

- Guidelines for adolescent depression in primary care (GLAD-PC): <http://pediatrics.aappublications.org/cgi/content/full/120/5/e1313>

- GLAD-PC toolkit for primary healthcare professionals: <http://www.glad-pc.org/documents/GLAD-PCToolkit.pdf>

- The New Zealand Guidelines Group is due to release a set of guidelines on the management of adolescent and child



depression in primary care. The guidelines are drafted and are ready for consultation. <http://www.nzgg.org.nz>

Resources

- The Lowdown – Ministry of Health initiative, interactive website for young people: <http://www.thelowdown.co.nz/>

- Reach Out Central – information, support, and an interactive game for youth 16-25 years: <http://www.reachoutcentral.com.au/>

- Think Good - Feel Good: A Cognitive Behaviour Therapy Workbook for Children and Young People by Paul Stallard: a self-help book available as a paper back and as an e book. ISBN: 978-0-470-84290-4, Paperback, 198 pages, September 2002.

Other websites

- Child and Adolescent Psychiatry Trials Network: <https://www.captn.org/>

- The Werry Centre: <http://www.werrycentre.org.nz>



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