Guidelines for youth depression: time to incorporate new perspectives

Ian B Hickie and Patrick D McGorry

New guidelines are timely but miss an opportunity to emphasise early intervention for all young people

There are few mental health issues of greater concern to the wider community than the management of young people with depressive disorders. Consequently, the new draft clinical practice guidelines from *beyondblue: the national depression initiative*[1] are timely. The previous National Health and Medical Research Council *Clinical practice guidelines: depression in young people* were produced in 1997 and rescinded in 2004, and a variety of other international perspectives are now available.[2,3]

Internationally, the limitations of the clinical trial database, such as small and non-representative or restricted trial samples, and exclusion of more severe cases or patients with suicidal ideation, are widely recognised. Hence, the authors rely very heavily on "good practice points" that are said to be "based on lower quality evidence, expert opinion and current good practice".

Importantly, the new draft guidelines recognise that appropriate services are still not provided to about 75% of Australian young people with depression. They suggest there is a lack of clear evidence for primary (or universal) prevention and give qualified support for pre-emptive psychological strategies for those at high risk. Recent systematic reviews of school-based prevention and early intervention programs for anxiety and depression, however, support a more optimistic view (reporting effect sizes of 0.11–1.37 for anxiety, using data from 20 programs;[4] and 0.21–1.40 for indicated depression interventions, based on 28 programs[5]). These effect sizes were often clinically important and support the notion that school-based programs should be pursued more assertively.

Other key issues covered by the guidelines include the challenges associated with engaging young people with our health care systems, the lack of focus on improving long-term outcomes, and the fact that more severe bipolar and psychotic disorders emerge against the background of earlier depressive disorders.

In Australia, surveys of young people have highlighted attitudinal and knowledge barriers[6] and the clinical reality that under-recognition of and lack of access to evidence-based psychological therapies are still common.[7] Unfortunately, the guidelines overemphasise and reinforce stereotypes of young people who are reluctant to seek care, parents who are unaware of the nature of the disorder, the complexity of clinical assessment and lack of access to specialist mental health services. These are artefacts of the current failure to respond to youth mental health as a salient public health issue. We would encourage the authors to take full advantage of the opportunity to add depth to the emerging field of youth psychiatry and to support the development of enhanced models of empowering, collaborative and youth-focused clinical practice.[8]

The most novel outcome in the new draft guidelines is the Expert Working Committee's decision to focus on the age range of 13–24 years, rather than a more restricted focus on 12–18 years. This is consistent with current understanding of the continuities in brain and social development,[9] the pattern of incidence of mental disorders and the changing sociology of adolescent and early adult development.[10] There is clear evidence of multiple transitions in both the genetic and environmental determinants of depressive disorders from the onset of puberty right through to the early adult period.[11] The key developmental processes in the brain — synaptic pruning and maturation of the white matter tracts — are continuous throughout these years.[9]

However, in key areas, the guidelines fall back on the traditional divide between adolescents (13–18 years) and young people (19–24 years). While this reflects the reality that most treatment studies have used a 13–18-years age range, it ignores the fact that the division at 18 years is based on legal and educational boundaries rather than clinical, developmental, neurobiological or cultural considerations, and thus is not soundly based. What is desperately needed in both clinical research and service development[12] is a shift away from this artificial divide to the more inclusive age range of 12–25 years.

Short-term treatment recommendations are spelt out in the guidelines, at least for those under 18 years of age. Specific psychological therapies are the preferred first-line intervention for most patients, while new antidepressant drugs are reserved for those with more severe disorders or those who fail to respond to psychological interventions. The small risk of increased suicidal ideation in young people commencing newer antidepressant drugs (4% for active treatments versus 2% for placebo[13]) is appropriately re-emphasised.

Previously, wide media coverage of United States Food and Drug Administration warnings about antidepressant drugs resulted in major changes in clinical practice in the US.[14] Clearly, the authors expect a similar outcome in Australia, suggesting that these new guidelines may even lead to "a net saving in the area of pharmacotherapy". This is inconsistent with the more serious emphasis that the rest of the document puts on providing evidence-based care for many more young people. Importantly, it has been suggested that the fall in antidepressant use in the US was associated with an increase in suicides in young people.[14] Previous population-based data have indicated a positive relationship between exposure to antidepressants and reduction in suicides. In those under the age of 18 years, most suicide attempts occur in the month before treatment and then decline sharply once treatment has commenced.[15]

We need to move beyond endless debate about the appropriate threshold for providing active care — the real treatment issue is one of appropriate sequencing of treatments. Wherever possible, clinical care should start with engagement of the young person and his or her family and then be linked with active provision of relevant information and evidence-based psychological therapies. A clinical staging model[16] combined with appropriate stepped care may therefore offer a useful clinical approach. In a basic stepped-care model, those presenting with early or less severe forms of illness are initially offered appropriate non-pharmacological interventions. If the condition is more severe, the clinical situation worsens or the young person fails to respond to psychological therapies, then antidepressant therapy may well have a crucial role to play. The guidelines fail to emphasise the emerging importance of early intervention services.

What is really required in Australia is a fundamental commitment to increase access to evidence-based care systems for young people from 12 to 25 years of age. While various state and national planning documents and the recent Council of Australian Governments deci-

sions on health reform point the way for future service reforms, we still lack the real investment and commitment to turn these treatment guidelines into accessible and responsive clinical services systems.

Acknowledgement

beyondblue have funded previous and current research at ORYGEN Youth Health.

Competing interests

We are members of the Board of *headspace*. Ian Hickie is a member of the National Advisory Council on Mental Health.

Author details

Ian B Hickie, AM, MD, FRANZCP, Professor of Psychiatry and Executive Director[1]
Patrick D McGorry, PhD, FRCP, FRANZCP, Professor of Youth Mental Health,[2] Clinical Director,[3] and Executive Director[4]
1 Brain and Mind Research Institute, University of Sydney, Sydney, NSW.
2 University of Melbourne, Melbourne, VIC.
3 ORYGEN Youth Health, Melbourne, VIC.
4 ORYGEN Research Centre, Melbourne, VIC.
Correspondence: ian.hickie@sydney.edu.au

References

1 *beyondblue: the national depression initiative*. Draft clinical practice guidelines: depression in adolescents and young adults, March 2010. http://www.beyondblue.org.au/index.aspx?link_id=6.1247&tmp=FileDownload&fid=1625 (accessed May 2010).
2 National Collaborating Centre for Mental Health, for the National Institute for Clinical Excellence (UK). Depression in children and young people: identification and management in primary, community and secondary care. National Clinical Guideline 28. London: British Psychological Society, 2005.
3 Cheung AH, Zuckerbrot RA, Jensen PS, et al; GLAD-PC Steering Group. Treatment and ongoing management guidelines for adolescent depression in primary care (GLAD-PC): II. Treatment and ongoing management. *Pediatrics* 2007; 120: e1313-e1326. doi: 10.1542/peds.2006-1395.
4 Paus T, Keshavan M, Giedd JN. Why do many psychiatric disorders emerge during adolescence? *Nat Rev Neurosci* 2008; 9: 947-957.
5 Arnett JJ. Adolescence and emerging adulthood: a cultural approach. 4th ed. Upper Saddle River, NJ: Prentice Hall, 2009.
6 McGorry PD, Purcell R, Hickie IB, Jorm AF. Investing in youth mental health is a best buy. *Med J Aust* 2007; 187 (7 Suppl): S5-S7.
7 Hickie IB, Luscombe GM, Davenport TA, et al. Perspectives of young people on depression: experiences, attitudes and treatment preferences. *Early Interv Psychiatry* 2007; 1: 333-339.
8 Hickie IB, Fogarty AS, Davenport TA, et al. Responding to experiences of young people with common mental health problems attending Australian general practice. *Med J Aust* 2007; 187 (7 Suppl): S47-S52.
9 Scott E, Naismith S, Whitwell B, et al. Delivering youth-specific mental health services: the advantages of a collaborative multi-disciplinary system. *Australas Psychiatry* 2009; 17: 189-194.
10 Neil AL, Christensen H. Efficacy and effectiveness of school-based prevention and early intervention programs for anxiety. *Clin Psychol Rev* 2009; 29: 208-215.
11 Calear AL, Christensen H. Systematic review of school-based prevention and early intervention programs for depression. *J Adolesc* 2010; 33: 429-438.
12 Kendler KS, Gardner CO, Lichtenstein P. A developmental twin study of symptoms of anxiety and depression: evidence for genetic innovation and attenuation. *Psychol Med* 2008; 38: 1567-1575.
13 Bridge JA, Iyengar S, Salary CB, et al. Clinical response and risk for reported suicidal ideation and suicide attempts in pediatric antidepressant treatment: a meta-analysis of randomized controlled trials. *JAMA* 2007; 297: 1683-1696.
14 Gibbons RD, Hur K, Bhaumik DK, Mann JJ. The relationship between antidepressant prescription rates and rate of early adolescent suicide. *Am J Psychiatry* 2006; 163: 1898-1904.
15 Simon GE, Savarino J, Operskalski B, Wang PS. Suicide risk during antidepressant treatment. *Am J Psychiatry* 2006; 163: 41-47.
16 McGorry PD, Hickie IB, Yung AR, et al. Clinical staging of psychiatric disorders: a heuristic framework for choosing earlier, safer and more effective interventions. *Aust N Z J Psychiatry* 2006; 40: 616-622. ❑