High-quality antidepressant prescribing in children and young people: value of observational research

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BACKGROUND

We recently published a research article summarising visits made to secondary care specialists by children and young people prescribed antidepressants in primary care in England[1]. In a commentary on this article[2], Walkup and Strawn agree with us that there is a substantial gap in care of depression and anxiety in children and young people, but also argue that studies such as ours may actually make it harder to access evidence-based care. In response, we make the case that descriptive epidemiological studies such as ours, which summarise the current state of play and illustrate unmet healthcare needs, are vital in making the case to policy makers for improvements in care provision.

FINDINGS HIGHLIGHTED THROUGH DESCRIPTIVE EPIDEMIOLOGY

Our paper was intentionally neutral on the long-running debate about the benefits and risks of prescribing antidepressants to treat depression and anxiety in children and young people. The balance of this debate is likely to differ between countries with different rates of prescribing and systems of healthcare delivery. Instead, we used the National Institute for Health and Care Excellence (NICE) Guideline for depression in children and young people [CG134][3] as a benchmark to compare against current UK practice. The purpose of these guidelines is to provide best-practice treatment guidance tailored to the UK setting, based on the best available evidence and expert consensus. By summarising the differences between current guidelines and actual practice, we demonstrate weaknesses in the current approach which those involved in developing guidelines, and the policy makers who implement guidelines, should take note of. Why is it that general practitioners are prescribing antidepressants but not referring children and young people to mental health specialists as recommended? Is this a problem? Our study cannot answer these questions, but it does highlight the need to address them and understand why clinical practice deviates from guidance.

A second problem highlighted by our study is an information gap. It is difficult to describe clearly the current structure of child and adolescent mental health services in the UK, let alone know whether the right young people are getting the right treatment by

summarising treatment needs and rates of access to treatment. Recent reports by the Children's Commissioner for England on access to mental health services[4, 5] relied on the Mental Health Services Data Set, which they describe as having "certain limitations in terms of the quality and completeness of data", or on freedom of information requests. In our own study it was not possible to determine the reasons for antidepressant prescribing for a large proportion of patients. As we say in our paper, this does not necessarily imply poor medical practice. It does, however, make it difficult to determine the true scale of any treatment gaps for particular conditions. This could be seen as a problem for epidemiologists rather than clinicians and policymakers, but improved routine data collection regarding mental health diagnosis and treatment indications would make it much easier to understand current demand for services, where the gaps are, and how to improve care provision.

CONCLUSIONS

In summary, it seems reasonable that treatment guidance should reflect i) the best available evidence, ii) the current needs of the population, and iii) the availability of resources and organisation of services. Understanding the current needs of the population and where resources are most needed should help tailor care provision to the real world. Arguably, therefore, access to evidence-based care for large numbers of children with anxiety and depression can be improved rather than inhibited by good quality epidemiological research.

OTHER INFORMATION

Competing interests

CH was chair of the NICE Guideline for psychosis in children and young people (CG155) and a member of the NICE ADHD Guideline update committee (NG87). RMJ, RHJ, and CC declare that they have no competing interests

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