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Research report

Recent trends in the incidence of anxiety and prescription of anxiolytics and hypnotics in children and young people: An e-cohort study

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ABSTRACT

Background: Little is known regarding the recognition of anxiety in children and young people (CYP) in primary care. This study examined trends in the presentation, recognition and recording of anxiety and of anxiolytic and hypnotic prescriptions for CYP in primary care.

Method: A population-based retrospective electronic cohort of individuals aged 6–18 years between 2003 and 2011 within the Secure Anonymised Information Linkage (SAIL) Databank primary care database was created. Incidence rates were calculated using person years at risk (PYAR) as a denominator accounting for deprivation, age and gender.

Results: We identified a cohort of 311,343 registered individuals providing a total of 1,546,489 person years of follow up. The incidence of anxiety symptoms more than tripled over the study period (Incidence Rate Ratio (IRR)=3.55, 95% CI 2.65–4.77) whilst that of diagnosis has remained stable. Anxiolytic/hypnotic prescriptions for the cohort as a whole did not change significantly over time; however there was a significant increase in anxiolytic prescriptions for the 15–18 year age group (IRR 1.62, 95% CI 1.30–2.02).

Limitations: There was a lack of reliable information regarding other interventions available or received at a primary, secondary or tertiary level such as psychological treatments.

Conclusions: There appears to be a preference over time for the recording of general symptoms over diagnosis for anxiety in CYP. The increase in anxiolytic prescriptions for 15–18 year olds is discrepant with current prescribing guidelines. Specific guidance is required for the assessment and management of CYP presenting with anxiety to primary care, particularly older adolescents.

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1. Introduction

Mental health issues are of growing concern and a source of controversy in children and young people (CYP) in the United Kingdom (U.K). They are associated with significant morbidity and have been found to contribute to adverse life outcomes (such as educational underachievement) and serious disruptions to CYP's lives and those of their families (Patel et al., 2007). It is estimated from Office of National Statistics population survey data that, at

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any one time, four per cent of CYP, have a clinically diagnosable or relevant emotional disorder (anxiety or depression; Office of National Statistics, 2004). Anxiety disorders are thought to be among the earliest psychiatric conditions to manifest with an estimated median age of onset of 11 years (Kessler et al., 2005). Earlier age of onset appears to be associated with greater severity and poorer long term outcomes (Ramsawh et al., 2011). Concerns are amplified by the persistence of childhood or adolescent mental health issues into adulthood (Costello et al., 2006) where up to a fifth of the adult population may be affected by a common mental disorder at any one time (McManus et al., 2009; Leray et al., 2011).

There are fears that we are medicalising unhappiness with consequent over diagnosis and excessive treatment (Dowrick and Frances, 2013). This is particularly relevant in CYP where there is a

normal developmental range of anxiety-related phenomena (e.g. stranger anxiety, fear of the dark, existential questioning) as they develop cognitively and emotionally and engage with the world. Significant increases in the rates of psychotropic prescriptions in CYP have been found in America (Olfson et al., 2002), Europe (Steinhausen and Bisgaard, 2014) and the UK (Middleton et al., 2001; Rani et al., 2008) over the past three decades. Such findings contribute to concern over the medicalisation of normal human experience, particularly following the release of the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5; American Psychiatric Association, 2013). This revision has been heavily criticised for pathologising normal human behaviour such as eccentricity, loneliness and sadness (Watts, 2012), and for its potential to cause excessive and inappropriate use of medication in children (Gaughwin, 2014).

Access to services in primary care represents a key factor in the management of CYP mental health issues. Research utilising routinely collected data in primary care in the UK has identified a fall in recorded diagnoses and rise in recorded symptoms of depression alongside an increase in new antidepressant prescriptions in both adults (Rait et al., 2009) and CYP (Wijaars et al., 2012). Adult data suggests that this recording behaviour is being applied to anxiety disorders (Walters et al., 2012); however there are currently no such data available on CYP and little is known regarding the use of anxiolytics and hypnotics in this population in this setting. There are no specific National Institute of Clinical Excellence (NICE) guidelines available for the management of anxiety in CYP. There are NICE guidelines for anxiety (which relate principally to adults; NICE, 2011), depression for CYP (which includes mixed anxiety and depression; NICE, 2005) and for the assessment and treatment of social anxiety disorder (NICE, 2013). These all highlight some considerations for the management of anxiety in CYP. Psychological therapies should be the first line of treatment. Pharmacotherapy should not be routinely offered to treat social anxiety disorder in young people and antidepressants should only be offered for moderate to severe depression, in conjunction with psychological treatments. The relative effectiveness of psychological and pharmacological treatments for anxiety disorders in children and young people has been assessed in trials (RUPP, 2001; POTS, 2004; Beidel et al., 2007; Walkup et al., 2009). These findings suggest that CBT, sertraline and their combination are all possible options for the treatment of these disorders in childhood. However, uncertainties remain whether: there is an age below which medication is unsuitable; what the duration of treatment should be; and the impact of stopping a course of medication. These concerns, together with parental preference for psychological over pharmacological interventions for their children, are clearly reflected in these guidelines. There are no hypnotics or anxiolytics licensed in the United Kingdom for the treatment of anxiety in CYP. Hypnotics in CYP are only indicated for occasional use for night terrors and somnambulism (sleep-walking) and anxiolytics only to relieve acute anxiety (and related insomnia) caused by fear (e.g. before surgery) (British National Formulary Sections 4.1.1 and 4.1.2; British Medical Association and Royal Pharmaceutical Society of Great Britain, 2014).

This is the first study examining trends in the incidence of recorded: anxiety diagnoses, anxiety symptoms, mixed anxiety and depression, panic attacks/panic disorder and the use of hypnotics and anxiolytics in CYP in primary care using routinely collected data.

2. Aims

The aim of this study is to examine trends in the incidence of anxiety diagnoses and symptoms, recording of mixed anxiety and

depression, panic attacks/panic disorder, hypnotic and anxiolytic prescriptions in CYP in primary care.

3. Method

3.1. Design

A retrospective electronic cohort study was conducted utilising the Secure Anonymised Information Linkage System (SAIL databank; www.saildatabank.com) developed in the Health Information Research Unit (HIRU) at the College of Medicine, Swansea University.

3.2. Ethical approval

Approval was granted from the HIRU Information Governance Review Panel (IGRP), an independent body consisting of a range of government, regulatory and professional agencies, which oversees study approvals in line with permissions already granted to the analysis of data in the SAIL databank (Lyons et al., 2009; Ford et al., 2009). We plan to follow the key points of the MRC/Wellcome Trust data sharing policy

3.3. Data source

The Secure Anonymised Data Linkage (SAIL) databank is an expanding data repository (over 2 billion records) of anonymised person based linkable data to support research. SAIL was established by the HIRU at Swansea University in 2004 and forms part of the Health e-Research Collaboration UK (HeRC UK), led by the Medical Research Council (MRC) and based in the Centre for the Improvement of Population Health through e-Records Research (CIPHER). CIPHER is a UK Clinical Research Collaboration (UKCRC) Public Health Research Centre of Excellence set within the Farr Institute at the College of Medicine at Swansea University. Policies, structures and controls are in place to protect patient confidentiality, along with a high performance computing infrastructure and a reliable matching, anonymisation and encryption process, which is achieved in conjunction with the NHS Wales Informatics Service. Data are imported into SAIL via a split file approach, whereby demographic and clinical data are separated at source later to be re-joined fully encrypted with an allocation of a unique identifier. This split file method ensures anonymisation and confidentiality, whilst maintaining the facility of data linkage at the level of the individual to any of the datasets housed in SAIL (Lyons et al., 2009; Ford et al., 2009). This allows data from sources including general practice records, hospital admissions and demographic information to be linked at patient level whilst maintaining anonymity.

In this study data were utilised from: NHS Administrative Register (NHS AR) a register of all individuals registered with a Welsh General Practitioner or who have ever had contact with the NHS; General Practice Database (GPD) attendance and clinical information for all general practice interactions including symptoms, investigations, diagnoses and prescribed medication. Individual practices sign up, currently there are 195 practices (out of 474 in Wales) covering a population of over 1.9 million which contains regularly updated data; Welsh Index of Multiple Deprivation assigns all Lower Super Output Areas in Wales a deprivation score. This score is derived from eight separate domains of deprivation including income, employment and education.

The SAIL databank was interrogated using structured query language (SQL).

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