Prescribing Antidepressants for Kids Can Be Tricky

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

MONTREAL — Prescribing antidepressants to children comes with its own set of challenges, Dr. Neil S. Kaye said at the annual meeting of the American Academy of Psychiatry and the Law.

For one thing, it's difficult to comply with the visit schedule suggested by the Food and Drug Administration, said Dr. Kaye, a psychiatrist in private practice in Wilmington, Del.

The agency's "Medication Guide: About Using Antidepressants in Children and Teenagers" recommends: "After starting an antidepressant, your child should generally see his or her health care provider:

- ▶ Once a week for the first 4 weeks.
- ▶ Every 2 weeks for the next 4 weeks.
- ▶ After taking the antidepressant for 12 weeks.
- ▶ More often, if problems or questions arise."

After 12 weeks, "we get to become providers again," Dr. Kaye said, noting that the visit schedule goes back to whatever the physician thinks is appropriate.

"You'll see it's almost impossible to comply" with that schedule for the first 12 weeks, Dr. Kaye said. "Nobody has enough time slots; there aren't enough doctors available; and managed care doesn't really want to pay for that."

Dr. Kaye wrote to one senator complaining about the recommendations. "He said …his office's view after contacting the FDA was that the FDA didn't really intend for that to be what is said and done, even though it's what they've written," he said.

Doctors need to make themselves available to parents whose children are taking these drugs, Dr. Kaye continued. "When you look at cases that have been litigated, one of the major issues is doctors and their staffs not returning phone calls in a timely manner," he said. "That breeds anger, that breeds malpractice, that breeds bad outcomes. We need to return patients' [and parents'] calls. It sounds simple, but it needs to be said."

Physicians also need to alert parents that their children may get worse initially, "either because of the drug or because the drug has not yet started and the disorder is still going on," he said. "And we need to let everyone know what [side effects] to watch for," including akathisias, restlessness, and induction of hypomania.

Dr. Kaye noted that the media have jumped on the story of problems with prescribing antidepressants. "As of Sept. 8, there were more than 3.6 million Internet articles on this topic," he said. "This is hot."

The media have done an effective job of scaring people away from antidepressants, according to Dr. Kaye, who has consulting arrangements with many pharmaceutical companies. "Twenty-five percent of people surveyed say antidepressants are harmful to someone who's depressed and suicidal. That's a big number of people who will be driven away from what could be life-saving treatment because of the hype and what the media has done."

How have physicians responded to the hype? "We're scared," he said, noting that there has been a big drop in the number of antidepressants being prescribed. And the number of doctors willing to prescribe them seems to be decreasing as well.

"Pediatricians and primary care doctors are saying, 'This is too litigious; we're not going near this—you have to see a specialist,' " he said. "And of course there aren't enough psychiatrists to take on those patients in a timely manner, so a crisis is being developed, without a doubt." ■

Paternal Depression Common, Adversely Affects Child Behavior

BY PATRICE WENDLING
Chicago Bureau

QUEBEC CITY — Paternal depression is relatively common and can negatively affect child behavior, Shreya Davé reported at the annual meeting of the North American Primary Care Research Group.

She presented a cross-sectional study in which questionnaires were sent to 2,352 biological fathers with children aged 4-6 years from 13 general practices in greater London and Hertfordshire, England.

Questionnaires included a diagnostic depression measure and standardized inventories on child behavior, parenting, couple relationship, alcohol use, and demographics.

Mothers were sent a similar but smaller packet. Their responses were used to assess child behavior and were thought to be a more objective way to assess the relationship of paternal depression and child behavior, said Ms. Davé, a research fellow in the department of primary care and population sciences at University College London.

The prevalence of paternal depression was 8% in the study, with 29 of the 365 fathers who responded scoring positively for depressive symptoms. Of the 365 responders, 12 (3%) fathers had major depressive symptoms and 17 (5%) had mild or moderate depressive symptoms.

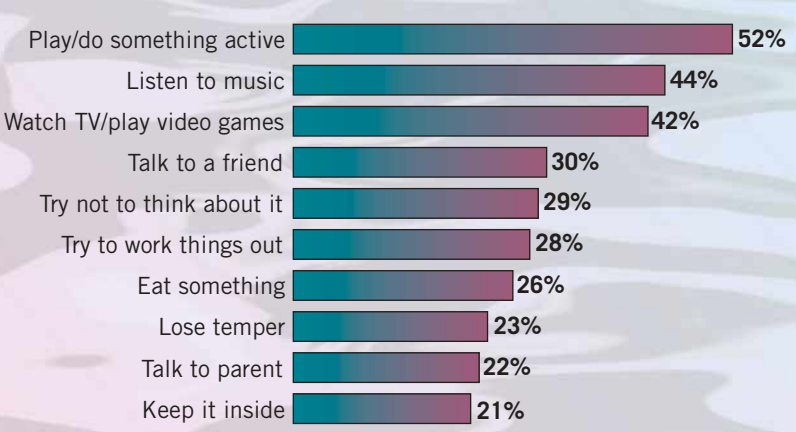
Fathers with major depression were almost 20 times more likely to have a child with peer problem signs and 13 times more likely to have a child with a low prosocial behavior assessment score, after controlling for maternal depression, couple relationship quality, paternal age, and number of children.

Study limitations were its cross-sectional design, low response rate, and wide confidence intervals resulting from the small number of participants, she said. But findings clearly point to the need for further studies.

"Family practice is an ideal location for assessment and prevention," she said. ■

DATA WATCH

Most Common Ways Children Say They Cope With Stress



Note: Based on a survey of 875 children aged 9-13 years conducted May 10 to June 7, 2005.
Source: KidsHealth KidsPoll

KEVIN FOLEY, RESEARCH

Screening at Well-Child Visits Helps Spot Parents at Risk for Depression

BY PATRICE WENDLING
Chicago Bureau

QUEBEC CITY — Brief depression screening during well-child visits can detect parents at risk and requires little extra time, Dr. Ardis L. Olson reported at the annual meeting of the North American Primary Care Research Group.

The U.S. Preventive Services Task Force recommends that all adults have brief depression screening, and pediatricians and family physicians may be the health professionals seen most by parents. Detecting parental mental health issues is an important way to lessen the impact of such issues on children.

In these cases, the role of the child's physician is not to diagnose depression, but to identify parents at risk for depression, encourage them to seek help, and refer them to available resources, said Dr. Olson of the departments of pediatrics and community and family medicine at Dartmouth Medical School, Lebanon, N.H.

As part of Dartmouth's parental well-being project, Dr. Olson and colleagues prepared practitioners to screen parents for depression with a two-question screener given during well-child visits over 6 months in six community pediatric practices in New Hampshire and Vermont.

Screening results were discussed with the parents, and a centralized telephone referral service was provided for those who screened positive.

The two questions were, "Over the past 2 weeks, have you felt down, depressed, or hopeless?" and "Over the past 2 weeks, have you felt little interest or pleasure in doing things?" If they answered yes to either question, they were then asked to identify if it had been for several days, more than half the days, or nearly every day.

Providers and staff also completed follow-up surveys during three 1-week periods.

The two-question screeners were collected during 7,990 of 16,716 well-child visits (48%). After removing screeners with incomplete data, a total of 6,446 were analyzed.

One in seven parents revealed mood or anhedonia symptoms (881 of 5,772 mothers and 88 of 674 fathers).

Of the parents screened, 1 in 20 was at risk for major depression (285 mothers and 34 fathers).

The screening also generated discussion with mothers with fewer symptoms, she said. One in five of these mothers (31 of 152) admitted possible depression and were willing to take action to treat it.

The discussion with parents about their screening results took less than 3 minutes in 90% of cases and more than 10 minutes in 1.4%.

Nurse practitioners were more likely than were physicians (46% vs. 37%, respectively) to refer screen-positive parents to their primary care or mental health providers.

Although physicians and nurse practitioners referred 21% of screen-positive parents to the support line, only 20 parents called the 800 number in the first 12 weeks of the study. Overall, 5% of referred parents received some telephone counselor assistance.

The findings demonstrate that community practices can implement routine, brief parental depression screening when administrative and leadership support is in place, Dr. Olson said. The staff of the six practices that participated in the study stressed that reduced staffing affected their ability to routinely screen.

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