



Why are pediatric primary care providers reluctant to prescribe antidepressants to teens?

“Primary care provider decisions on how to treat adolescent depression are influenced by the family’s beliefs and preferences...”

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Recently, our research group conducted a survey with a unique sample of pediatric primary care providers (PCPs) who work within an integrated behavioral health network [1]. In this network, PCPs screen adolescents routinely at well child visits, have access to on-site mental health therapists, and PCPs and mental health specialists share documentation through the same electronic health record. Prior pediatric provider surveys had found few providers in a general sample will prescribe antidepressants to adolescents [2,3]. We were interested to find similarly low rates in our network. This is in line with national surveys, which show potential evidence of underprescribing of antidepressants for adolescents; only 14% of adolescents with a primary mood disorder receive antidepressant treatment [4].

As an adolescent medicine specialist and a mental health services researcher, I have found that an adolescent’s and parent’s acceptance of a depression diagnosis and need for treatment is quite complex. In the primary care office, the teen, the caregiver(s) and the PCP gather together to ask: does this teen have depression? and do they need treatment? In our survey, hypothetical scenarios made it quite apparent that a teen fit all current DSM criteria for depression diagnosis. Initial depression treatment options include frequent monitoring by the PCP, referring to psychotherapy, prescribing antidepressants or a combination of approaches including lifestyle changes such as sleep hygiene [5]. In our study, almost all PCPs would refer to psy-

chotherapy, but only a third would prescribe antidepressants, even for a severely depressed teen [1]. The three key factors that influenced willingness to prescribe antidepressants were: depression knowledge, the PCP’s own comfort with handling psychosocial problems in their patients and whether an on-site mental health therapist is present within the primary care office.

Depression knowledge

Of course, not having adequate knowledge and training in depression diagnostic criteria and management would limit a PCP’s comfort to prescribe an antidepressant. Pediatric PCPs often feel uncomfortable managing adolescent depression and many feel they have inadequate training [2–3,6]. They would rather the patient be seen by a child psychiatrist [7], which is unfortunately impossible for all depressed adolescents simply due to insufficient numbers of child psychiatrists [8]. There is also frequently a lack of opportunities for PCPs to observe and learn from experienced mental health diagnosticians or participate in detailed psychiatric evaluations. Residents are only required to spend 1 month on an adolescent medicine rotation and child and adolescent psychiatry is not listed as a key required subspecialty [9]. Further, pediatric attendings having limited mental health training may feel uncomfortable providing guidance to trainees.

There may be a lack of opportunities for pediatric trainees to obtain experience in prescribing antidepressants due to their attend-



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ings deciding to refer to child psychiatry, or parents not accepting a diagnosis. Common pediatric illnesses such as otitis media include a visual diagnosis, which can be confirmed by an attending's physical examination skills. This is in contrast to a depression diagnosis, which may require prolonged history taking, which would take time for the attending physician to confirm. The attending may instead prefer to refer to child psychiatry to confirm the diagnosis and recommend treatment [7]. Pediatric trainees learn the importance of obtaining history from a parent and to ask whether the parent notices changes in the child such as pain due to an ear infection. In depression, when parents do recognize the symptoms, their adolescent children are more likely to use mental health services [10]. Unfortunately, half of parents may not recognize or acknowledge that their adolescent is depressed and this may lead to not accepting treatment such as an antidepressant [11].

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A PCP may understand the pharmacology and biological basis of an antidepressant, but not understand how therapy and medication can be combined. A PCP may be unfamiliar with what actually occurs during a therapy visit, which can vary substantially across different therapists. When PCPs refer a patient to a medical specialist, they commonly receive a letter from the consultant describing their interpretation of the diagnosis and treatment recommendations. This feedback provides continuing medical education to the PCP. Such letters, however, may be less common after referral to a mental health therapist, particularly if the therapist lacks administrative support or the adolescent or family has concerns about confidentiality [12]. Feedback from mental health therapists can provide confirmation of the diagnosis and information about response to therapy to guide whether to re-evaluate a diagnosis or include antidepressants along with therapy in the treatment plan.

In response, the American Academy of Pediatrics has been advocating changes to ameliorate the insufficient mental health experience in pediatric training [13]. They advise PCPs to gain knowledge and skills in managing common mental health problems, but also to consider their unique role in building resiliency and helping patients overcoming barriers to seeking care. The American Academy of Pediatrics also advocates for collaborative mental healthcare and financing changes to allow PCPs to code and bill for mental health visits. These changes are important and necessary, but they assume that a PCP is willing to accept

them as a part of their training and responsibility to the patient as their PCP. This is unlikely to be the case for every PCP.

Comfort with handling a patient's psychosocial problem

In our study, independent of depression knowledge, providers who were uncomfortable with seeing patients for their psychosocial problems – especially when feeling a sense of burden – were less likely to prescribe antidepressants [1]. PCPs may be uncomfortable asking about issues like suicide in adolescents, recommended when prescribing antidepressants due to the US FDA black box warning [14]. We did not find that opinion about the black box warning was related to antidepressant prescribing, consistent with a recent study showing declines in antidepressant prescribing for children and adolescents occurred predominantly in the immediate post-FDA warning period (2006–2007) and have since resolved [15].

PCP decisions on how to treat adolescent depression are influenced by the family's beliefs and preferences [16]. Most parents prefer to treat with counseling only, a quarter prefer combining counseling and antidepressants and less than 1% of parents elect for antidepressants only [11]. Teens and parents have different barriers to treatment, which influence their treatment decisions and these include not viewing depression as a problem [11], poor prior experiences with medication or therapy [17] and a belief one should be able to handle mental health problems on their own without professional help [18]. This in turn makes navigating the treatment decision process more difficult for a PCP who may already be uncomfortable with the diagnosis and management of depression.

More research is needed to understand other factors that contribute to why some PCPs are uncomfortable with psychosocial problems and how it influences antidepressant prescribing. Factors to explore include the PCPs' personal and family experience with mental health problems and treatment, given that physicians are less likely to seek mental healthcare in medical school, despite medical students having higher rates of depression, and many agreeing they would feel less intelligent if they sought help [19].

Access to an on-site therapist

Having access to an on-site therapist located in the same physical space as the PCP can alleviate some current system inadequacies. PCPs we interviewed after our survey stated how useful it was to share the same lunch room with the on-site therapist and informally learn from them, have the opportunity to 'curbside' the therapist for feedback on a mental health diagnosis or to collaborate

on the approach to management for a specific patient. Often mental health providers use a team approach. This can work well with a PCP who may know a family well and the patient's medical history and a therapist who has had time to delve into more complicated personal and family issues. The PCP receives feedback on a patient's diagnosis, progress and response to medication from the therapist's notes through a shared medical record. One-third of pediatric training programs have some level of mental health integration, but it is yet to be seen whether this improves pediatric training and in turn comfort prescribing antidepressants [20].

Future perspective

As is often the case, PCP behaviors are a complex phenomenon and influencing them will likely require a range of interventions, which might include:

- Enhanced training in outpatient mental health with opportunities to prescribe antidepressants. Pediatric training programs should offer more rotations in outpatient mental health settings to allow trainees to observe in depth diagnostic assessments by mental health specialists and to be part of medication initiation and management. Pediatric attending physicians also require further training and support in mental health management.

- Enhanced training in behavior change and decision-making skills. Pediatric training programs should include training in motivational interviewing, behavior change theory and shared decision-making to support healthcare providers in treatment decision-making. This will better equip PCPs with skills to inquire about and effectively discuss possible parental and adolescent barriers to antidepressant initiation. New technologies such as decision aids may be able to be used to support PCPs in guiding parents and adolescents in the treatment decision process.

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