

CONCERNS OVER ANTIDEPRESSANT USE IN CHILDREN

According to a letter in the *BMJ* (2004; **328**: 711-712) the use of antidepressant drugs in children and adolescents appears to be increasing, even though there is little evidence for the effectiveness and safety of such pharmacological treatment in young people. Antonio Clavenna of the Mario Negri Institute for Pharmacological Research, Milan, Italy and colleagues analysed drug prescriptions written during 2002 for 568 770 Italian patients under the age of 18 years.

The team found that 1 600 (2.8 per 1 000) people had received at least 1 antidepressant, 1 200 of whom received a selective serotonin reuptake inhibitor (SSRI), and 297 a tricyclic antidepressant. Two-thirds of antidepressant prescriptions were for adolescents aged between 14 and 17 years, most of whom were girls.

The researchers note that the prescribing rates in Italy are lower than those reported for the USA (1 - 2%) and The Netherlands (4.4 per 1 000). However, about 28 000 youths are still being exposed to treatment with antidepressants, 21 000 of whom are receiving SSRIs. The team found that the rate of prescriptions for SSRIs had risen 4.5-fold between 2000 and 2002.

All the SSRIs prescribed are unlicensed paediatric drugs, with the exception of sertraline for obsessive compulsive disorder in children under 6 years. Clavenna *et al.* suggest that studies should be planned to guarantee effective and safe evidence-based therapeutic approaches for children, adolescents, and their families.

SSRI, SUICIDE LINK CALLED WEAK

The American College of Neuropsychopharmacology (ACNP) recently released a preliminary report concluding that popular antidepressant medications do not increase suicidal behaviours in patients under 18 years of age with depression.

'The evidence linking SSRIs to suicide is weak,' said J. John Mann, Professor of Psychiatry at Columbia University College of Physicians and Surgeons, and Co-Chair of the ACNP task force examining the issue.

The ACNP task force reviewed a subset of the clinical trial data available to the FDA on the use of SSRIs in children and adolescents with depression. The task force was formed following British regulators' warnings to physicians not to prescribe SSRIs to patients under the age of 18. The FDA issued weaker warnings in June 2003 noting the controversy and advising close monitoring of any patient under 18 taking SSRIs.

'The most likely explanation for the episodes of attempted suicide while taking SSRIs is the underlying depression, not the SSRIs,' said Graham Emslie, M.D., Co-Chair with Mann on the task

force. 'The potential benefits of SSRIs outweigh the risks.' Mann noted that suicide attempts and suicidal ideation in youths with depression is common, but completed suicide is rare.

The ACNP task force members emphasised that current data appear to be contradictory. In three trials, one showed robust efficacy, a second small efficacy, and the third no statistical difference from placebo. The differences among individual trial results, the researchers said, are likely due to differences in methodology and data reporting.

ACNP is strongly urging that all data held by pharmaceutical companies or the FDA be made available publicly so that ACNP and others can conduct complete, independent evaluations.

ANTIPSYCHOTIC MEDICATION ADHERENCE

Theresa Hudson and colleagues of the Veterans Affairs Medical Center, North Little Rock, Arkansas, USA, reported the results of a study aimed at identifying the most common barriers to medication adherence in a cohort of patients receiving outpatient and inpatient treatment for an acute exacerbation of schizophrenia. Hudson *et al.* compared clinical and demographical characteristics of patients with lower v. higher numbers of barriers, and characterised patients most likely to be non-adherent to antipsychotic medication.

Their report in the *Journal of Clinical Psychiatry* (2004; **65**: 211-216) asserts that the most common patient-reported barriers to taking antipsychotic medication were related to the stigma of taking medications, adverse drug reactions, forgetting to take medications, and lack of social support. Other factors noted include low patient education (less than 12 years of schooling), substance abuse, and symptom severity — these all contributed to non-adherence to medication.

They note that patients with a high number of the barriers were significantly less likely to adhere to their antipsychotic treatment than those with a low number, as indicated by both self reports (56% v. 79.7%) and medical record data (28.6% v. 49.3%).

A high number of barriers was also associated with significantly more alcohol or drug use problems, higher positive and negative syndrome scale scores, and a greater rate of akathisia than a low number of barriers. Hudson *et al.* believe that screening for these barriers together with substance abuse and symptom severity could help to identify those patients who would benefit most from an adherence intervention.

They conclude: 'Much more work is needed to further refine barrier assessments for schizophrenia and to develop strategies to identify patients likely to be non-adherent who would benefit from an adherence intervention.'