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EDITORIAL

# Prescribing Antidepressants: Writing a Prescription is the Easiest Part

For my first editorial as interim editor of our Journal, I am fortunate to have the opportunity to write about something I am passionate about: optimal use of antidepressant medications in young people. The impetus for this is a position paper in this issue written by Canadian experts about how to use antidepressants based on a synthesis of the evidence commissioned by the Canadian Agency for Drugs and Technology in Health (Garland et al., 2016) .

As the authors discuss, since their 2008 review, there have been a few new studies about the efficacy of antidepressants in depressed youth, where RCTs for escitalopram, duloxetine and desvenlafaxine have reported non-significant benefits, and one RCT with citalopram was significant and positive. The authors also caution us about evaluating the evidence in light of variable quality of studies, selection bias towards youth with low suicidality, comorbidity and substance use, as well as high placebo response rates. There is still no evidence for the use of antidepressants for treatment of depression in children, and few studies have adequately addressed the issue of how to use non-pharmacologic treatments in tandem with medications for depression in youth.

The story for anxiety disorders is better, with significantly larger SSRI treatment effect sizes cited as compared to effects for depression. That being said, only one trial (Strawn et al., 2015) has occurred since 2007 in pediatric anxiety disorders (duloxetine for GAD) which showed a small positive effect. There is more evidence for CBT for anxiety disorders with 2 head to head studies showing equal benefit to SSRIs. One recent study (Piacentini et al., 2014) suggests that antidepressant and CBT combination therapy is the best for pediatric anxiety disorders.

The thing I like most about this paper is the proposed steps the authors suggest for clinicians to follow when initiating and monitoring antidepressants. Seven of these 9 steps are suggested to occur before even starting the medication! These critical baseline and early treatment phases are often overlooked for so many reasons. In my experience, treatment response is either difficult to interpret or treatment is stopped prematurely when any of these stages are missed. For me, these first 7 stages represent the processes of motivation enhancement, informed decision making and building alliance with youth - all critical aspects of commitment to therapy. They are particularly important when engaging the youth and their family in treatment.

One key aspect of treatment with SSRIs is the assessment of suicidality. Specific and repeated clinical assessment of current and recent suicidality helps clarify the significance of suicidal thoughts and behaviours in the life of the youth. Discussion of their experiences helps convey our interest in their level of suffering and also provides an opportunity for psycho-education and increasing self-awareness about the impact of these thoughts and behaviours on their lives. This often provides useful information for both the youth and the clinician when the youth experiences an increase in agitation or suicidality throughout the course of therapy.

While I applaud the 9 proposed steps, they also raise other important questions that need answering about clinical care of youth on antidepressants. How feasible is it to monitor youth on a weekly basis? What is the role of physician assistants or psychiatric nurses in medication and risk monitoring? What is the best way to evaluate treatment response and does doing so systematically enhance clinical outcomes and patient satisfaction? How can psychiatrists help family physicians and therapists assess suicidality and manage suicide risk behaviours to potentially reduce the need for specialty referral?

This position paper provides important knowledge for clinicians to use in office settings. The next steps are to continue to test how effective they are when implemented. I suspect the toughest aspect will be for physicians to be comfortable with regular monitoring, especially monitoring of suicidal thoughts and behaviours. I am reminded of colleagues who presented at our recent annual meeting who spoke of the need for a national suicide strategy for youth. Were the recommendations of Garland et al to be effective, I think they would serve as a sound foundation for the strategy in clinical settings.

**Khrista Boylan**, Interim Editor

## References

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