January 2004
Vol 1, Issue 1

Center for Mental Health Services Research
University of Massachusetts Medical School

CMHSR

Issue Brief

Issues in Pediatric Prescribing of Psychopharmacological Agents: Perspectives of Pediatricians, Caregivers and Case Workers

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In recent years there has been a marked increase in prescriptions for psychotropic medications written for children and adolescents, including a 3 to 5-fold increase in anti-depressant prescriptions, a 7-fold increase in amphetamine prescriptions, and more than a 2-fold increase in the prescriptions of antidepressants to preschoolers.[1,2]

Who has been writing these prescriptions for children and adolescents? Most stimulant medication prescriptions originate from primary care providers.[3] One study showed that pediatricians wrote 59% of methylphenidate prescriptions,[4] and another study found 58% of pediatricians prescribed SSRIs to their patients, with 31% prescribing SSRIs in combination with other psychotropic medications.[5] In Massachusetts, over 1/4 (28%) of all psychoactive medications prescribed in 2001 to children were prescribed by pediatricians.

Little is known about the types of training pediatricians have in diagnosing and treating psychological disorders in children and adolescents. Studies have found more than half of children receiving stimulant medications do not meet criteria for Attention Deficit Hyperactivity Disorder (ADHD).[6,7] This indicates that pediatric stimulant prescribing is inconsistent with current diagnostic guidelines.

Studies in Massachusetts

In the Commonwealth, two studies were undertaken by researchers at the CMHSR to further examine issues in pediatric prescribing. The first study involved in-depth interviews with 23 pediatricians about their training and experiences with prescribing psychoactive medications. The groups conducted with: 1) caregivers of children with SED who have taken psychoactive medications, 2) pediatricians who have prescribed such medications, and 3) case workers who have connected their clients to professionals for medication or medication evaluations.

Pediatrician Interview Study

Training: All interviewed pediatricians reported prescribing psychoactive medications to their patients. However, almost two-thirds (64%) reported no specialized training in psychopharmacology.

Connections with Psychiatry: On average, 59% of the pediatrition's patients with DSM-IV diagnoses who were not already connected with a psychiatrist, were referred to one. Once seen by other clinicians, the pediatricians reported they rarely got even basic information (e.g. diagnosis, medication information, recommendations) from their colleagues. On average, they reported *never* receiving information from psychiatrists 59% of the time, while only 18% indicated that they received helpful information most of the time.

Comfort with Psychiatric Diagnosis: Most pediatricians indicated that they were very or somewhat comfortable diagnosing Depression (86%), ADHD (82%) and Eating Disorders (82%) without specialty consultation. However, most indicated that they were somewhat or very uncomfortable making diagnoses of Bipolar disorder (91%), Post Traumatic Stress Disorder (PTSD) (77%), Tourette's Syndrome (68%) and Autism (65%) without specialty consultation.

Comfort with Psychopharmacological Treatment: There was a very high level of comfort prescribing the stimulants that are typically used in treating ADHD, a relatively high degree of comfort prescribing SSRIs, and a relative lack of comfort prescribing virtually all other classes of psychopharmacological agents. No pediatricians interviewed reported being comfortable in treating bipolar disorder or PTSD with medication without

specialty consultation. Despite the relatively low level of expressed comfort prescribing many medications, most found themselves in situations where they prescribed them on occasion.

Focus Groups

Caregivers. Caregivers reported lengthy times (8 months - 14 yrs) to secure appropriate treatment for their children. A common theme was that caregivers felt their children's pediatricians didn't really listen to their concerns about their children. For example, one caregiver said she'd asked her pediatrician for a testing referral for 2 ½ years but the doctor refused. Until their children were properly diagnosed, many felt they had spent months or years bringing their children to treatment that was ineffective or not as helpful as it could have been. Another recurrent theme was that once psychological testing was initiated, correct diagnoses led to treatment plans (including medication changes) which were helpful. Caregivers also reported a lack of continuity in care due to a high turnover rate among clinicians, resulting in long gaps in care.

Pediatricians. A primary theme in this group was the great difficulty in getting referrals for psychiatric care for their patients, usually because clinicians aren't taking new patients, or because of insurance issues. They also noted that some patients are reluctant to see psychiatrists, or simply can not wait months for an appointment and would prefer to have their pediatricians prescribe for psychiatric issues. In the meantime, patients and caregivers get frustrated, angry and begin "demanding medication from me."

Case Workers. Participants were concerned about the lack of psychiatric providers, and difficulties in the continuity of care for therapy and medication. Participants also noted that pediatricians were very likely to diagnose ADHD and prescribe stimulant medication for their clients. They expressed concern that other psychiatric and behavioral issues were overlooked.

Policy Implications & Future Directions

Pediatricians report limited training and comfort with prescribing medications for behavioral health problems, particularly outside the realm of ADHD and stimulant medications. As it is likely that such demands on pediatricians will continue to increase, additional training in psychopharmacological issues for children would be useful and welcome by many pediatricians. This can take the form of formal training and continuing education, or through having trained psychopharmacologists as part of pediatrics clinics for additional support.

A frustration commonly reported by physicians, caregivers and case workers was a lack of access to child psychiatric services, both for patients and for support and consultation for pediatricians. Programs and services to improve access are greatly needed.

While pediatricians felt comfortable diagnosing and prescribing for ADHD, caregivers and case workers thought pediatricians are too quick to diagnose and prescribe for ADHD and are likely to overlook other issues, such as depression or learning disabilities. In many instances, caregivers found their children only began to be treated properly with medication after a thorough psychological testing and assessment battery. Without a clear diagnostic picture, children are at risk of being incorrectly treated. While this up-front expense may seem large, it can be cost-beneficial when it prevents years of incorrect treatment and medication.[8] Increasing access to and reimbursement for psychological and neuropsychological testing for children with medication needs is warranted.

In most health care arenas, it is common practice for a specialist to send a treatment note along to the referring physicians. Not so for pediatricians who refer to psychiatrists. Copies of treatment notes to the referring doctors would be very helpful for pediatricians managing medications for their patients.

Alignment of child psychiatric services with physician groups is needed for pediatricians to have ready access to referrals, and formal and informal consultations. In many clinics and practices, this kind of arrangement does appear to be working well. Such an arrangement also reduces referral waits, and promotes continuity of care.

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