



## RESEARCH BRIEF

## Half of Children and Adolescents Who Are Prescribed Antidepressants Don't Receive Psychotherapy

October 2008

### Highlights

- Studies suggest that psychotherapy can improve the effectiveness and safety of antidepressant treatment for depression among adolescents.
- The Food and Drug Administration recommends weekly monitoring of children and adolescents who are using a specific class of antidepressants — selective serotonin reuptake inhibitors or SSRIs — especially during the first four weeks of treatment.
- About 50 to 60 percent of children and adolescents taking an antidepressant medication do not receive psychotherapy. The rate did not change significantly after the FDA issued a warning in 2004 that antidepressants may cause suicidal tendencies in adolescents.
- About one-quarter of children and adolescents who fill a new prescription for an antidepressant do not receive any outpatient treatment — such as a doctor's office visit — in the 60 days after filling the prescription. The rate did not change significantly after the FDA issued a warning in 2004 that antidepressants may cause suicidal tendencies in adolescents.

### Introduction

Two recent major randomized clinical trials of adolescent depression treatment found benefits from combining cognitive-behavioral therapy with antidepressant medications.

The Treatment for Adolescents with Depression Study concluded that among adolescents with moderate to severe depression, treatment with fluoxetine (Prozac, a SSRI) in combination with cognitive-behavioral therapy resulted in higher clinical response rates than fluoxetine or cognitive-behavioral therapy alone. The study also found that adding cognitive-behavioral therapy to medication therapy may enhance the safety of the drug by reducing suicidal thinking and behavior<sup>1</sup>.

Another study — the Treatment of SSRI-Resistant Depression in Adolescents (TORDIA) Randomized Controlled Trial — found that for depressed adolescents who did not respond to an adequate initial treatment with a SSRI, the combination of cognitive-behavioral therapy and a switch to another antidepressant resulted in a higher rate of clinical response than did a medication switch alone<sup>2</sup>.

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<sup>1</sup> March JS, Silva S, Petrycki S, et al: The Treatment for Adolescents With Depression Study (TADS): long-term effectiveness and safety outcomes. *Archives of General Psychiatry* 64:1132–1143, 2007

<sup>2</sup> Brent D, Emslie G, Clarke G, et al: Switching to another SSRI or to venlafaxine with or without cognitive behavioral therapy for adolescents with SSRI-resistant depression: the TORDIA randomized controlled trial. *JAMA* 299:901–913, 2008



In 2004, the Food and Drug Administration mandated that a 'black box' warning be added to the prescribing and promotional information for all antidepressants. The warning specifically states "antidepressants increase the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder and other psychiatric disorders." Anyone considering the use of antidepressant must "balance this risk with clinical need. . . . Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior."

This Thomson Reuters Research Brief addresses the following questions: 1) To what extent is psychotherapy being used with juveniles taking antidepressants? 2) To what extent is medical monitoring occurring for juveniles in the 60 days following initiation of antidepressant therapy?

## Methods

The data for this study come from the MarketScan<sup>®</sup> Commercial Claims and Encounters Database, from Thomson Reuters, and cover the period from 2002 to 2006. The MarketScan Research Databases reflect the combined healthcare service use of individuals covered by Thomson Reuters' clients nationwide. The Commercial Database represents the inpatient, outpatient, and outpatient prescription drug experience of 15 million individuals annually during the study period.

The study was limited to children age 6 to 17 who filled a new prescription for an antidepressant within each year from 2002 through 2006. All children included in the study had continuous enrollment in the database with information on medical and pharmacy utilization during the three months prior and six months following antidepressant initiation. We noted which children had received psychotherapy using CPT codes related to individual or group psychotherapy (90804-90824, 90826-90829, 90843-90849, 90853, 90855, 90857, M0064, H004, H1011). We noted when children received outpatient visits by examining the date on outpatient claims for any outpatient service.

## Observations

- Only 40 to 50 percent of children and adolescents filling a new prescription for an antidepressant also receive psychotherapy. This is true even of children who filled an antidepressant prescription three or more times.
- The use of psychotherapy rose only slightly after the FDA black box warning was initiated.
- Twenty to 25 percent of children and adolescents who filled a new prescription for an antidepressant had no office visits whatsoever in the 60 days following initiation of therapy.
- The percentage of patients who had an office visit rose only slightly after the FDA warning was initiated.

## Conclusion

Prior research has shown that less than 5 percent of adolescent patients receiving antidepressants met the FDA recommendation of seven visits in three months<sup>3</sup>. This study confirms that prior work and extends it by examining the receipt of psychotherapy and any outpatient care after antidepressant initiation. The low rate of psychotherapy may be a result of a shortage of child psychiatrists and limitations on insurance reimbursement for psychotherapy. Clearly, there is a need for more guidance regarding when psychotherapy should be provided

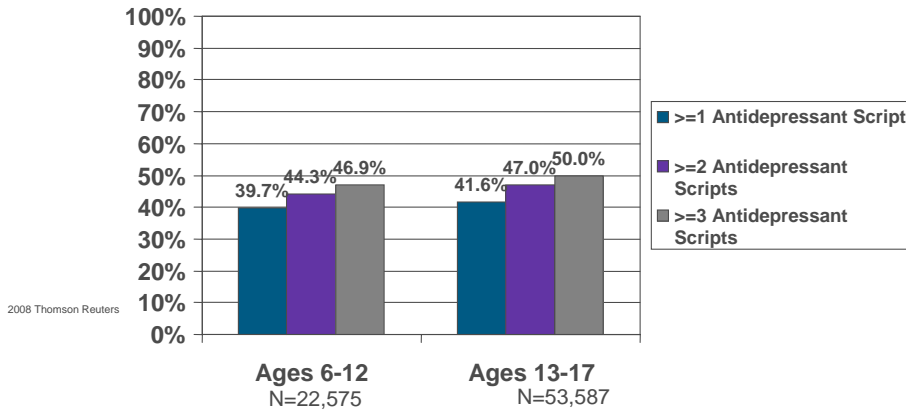
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<sup>3</sup> Morrato EH, Libby AM, Orton HD, et al: Frequency of provider contact after FDA advisory on risk of pediatric suicidality with SSRIs. *American Journal of Psychiatry* 165:42-50, 200

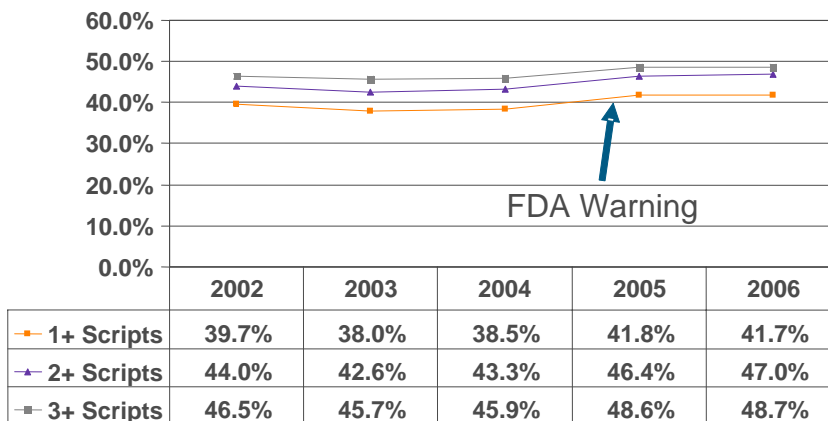


with antidepressant treatment and the potential benefits from increasing the relatively low rates of receipt in real-world settings.

**% Antidepressant Users with At Least One Psychotherapy Visit within Six Months Following Initiation of Treatment**



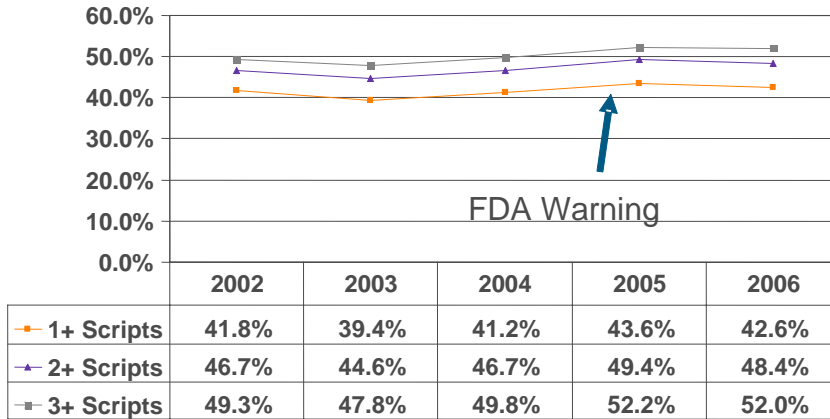
**% Childhood (Ages 6-12) Antidepressant Users with At Least One Psychotherapy Visit, by Initiating Year**



2008 Thomson Reuters

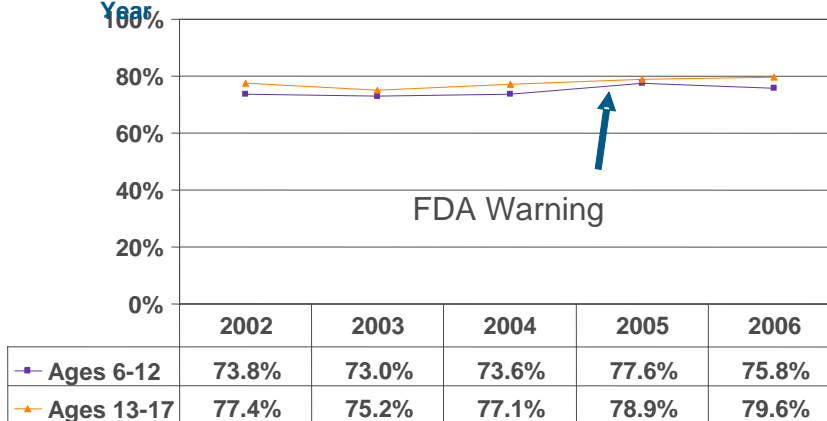


**% Adolescent (Ages 13-17) Antidepressant Users with at Least One Psychotherapy Visit, by Initiating Year**



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**% Antidepressant Users with 1+ Office Visits (For Any Reason) within 60 Days of Initiating Therapy, by Initiating Year**



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## Limitations

These analyses rely on administrative claims data, which are primarily used for reimbursement of medical services. Claims data are subject to: clinical coding errors, omission of clinical codes, missing services (e.g., services not submitted for insurance, services covered under other community or school programs). This analysis did not assess the efficacy of psychotherapy on lowering suicide rates nor compare outcomes between psychotherapy and non-psychotherapy patients. The study was unable to examine what type of psychotherapy was provided when it was provided.

## Authors

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## Notes

Some of these findings, and related findings, were reported in the journal *Psychiatric Services* (Mark TL, *Psychiatric Services*, 59(9):963, 2008) and were presented at the 24<sup>th</sup> International Conference on Pharmacoepidemiology & Therapeutic Risk Management in Copenhagen, Denmark.

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## Find out more

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