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Child psychiatrist offers advice on treating mental health disorders

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Melissa Jenco, News Content Editor

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With less than 7,000 child psychiatrists in the U.S., pediatricians often need to treat mental health disorders themselves.

John Huxsahl, M.D., a child psychiatrist at Mayo Clinic, aimed to take some of the confusion out of prescribing medications for such issues during his talk at the National Conference & Exhibition titled "Psychopharmacology in School-Aged Kids: Basics for Primary Care Pediatricians."

"Improving the skill and the comfort level of primary care physicians in treating mental health problems is essential," he said. "So the bottom line, as Uncle Sam would say, we need you."

When prescribing psychostimulants for attention-deficit/hyperactivity disorder, roughly 70% of patients will respond to the first stimulant, and 70% of the rest will respond to the second, according to Dr. Huxsahl.

Young children may not tolerate amphetamines, he said, but some research shows methylphenidates may produce fewer side effects, especially short-acting versions given at low doses.

Prescribers should conduct a thorough sleep history before starting stimulant treatment and follow up within 30 days of drug initiation. If the drug does not seem to be working, increase the dose before switching medications, and ensure the patient is taking the medication properly.

There are no recommendations that an electrocardiogram be performed routinely before giving a stimulant prescription, but doctors should ask about the patient's history of cardiac trouble or family history of sudden death before age 55 years.

If treatment with a psychostimulant or alternating psychostimulants isn't working, doctors can try atomoxetine or an alpha-2 agonist. Another option is prescribing one of those two drugs combined with a psychostimulant.

Dr. Huxsahl also discussed prescribing selective serotonin reuptake inhibitors (SSRIs) for depression and said, "bigger doses can rule the day."

There are three phases of treatment — acute (two to four months), continuation (four to nine months) and maintenance (one to three years). Some teenagers may want to stop the drug after feeling better, but physicians should talk to them about the risks of relapse.

"There is increasing data that says six to 12 months of continued treatment is even better," he said.

When pediatricians do take a patient off an antidepressant, they should see the patient within four to eight weeks, the most likely period of relapse. Children who have three episodes may need maintenance for life.

Dr. Huxsahl also discussed black box warning labels for SSRIs and said a Food and Drug Administration (FDA) meta-analysis of 24 placebo-controlled trials found relatively low risk of suicidal behaviors or ideation.

“The number needed to harm issue shows we are much better off, if you have a child in your office with a major depressive episode, treat them,” he said, adding they still should talk to parents about the possible risks.

Moving on to antipsychotics, Dr. Huxsahl found few in the audience who said they were comfortable prescribing such medications, a trend he’d like to change.

“You all prescribe medications that actually have potentially greater side effects,” he said.

The FDA has approved antipsychotics for treating irritability in children with autism and for acute mania. Other uses include tic disorders, disruptive behavior disorders and psychosis. However, doctors should watch patients for weight gain, glucose homeostasis, elevations in lipids, prolactin elevation and tardive dyskinesia.

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