

Antidepressants for minors: Benefits, risks and Peter Gøtzsche

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In 1959, a year after imipramine launched, a meeting was convened in Cambridge England to review its action.¹ While praising the benefits it could produce, Danish psychiatrists at this meeting took a lead in describing the agitation and suicidality imipramine could cause.

In 2011, the Danish National Health Board advised Family Doctors that the prescribing of antidepressants to minors should be left to specialists.² Prescribing of antidepressants has since fallen in this age group in Denmark, while continuing to rise in Norway and Sweden and elsewhere, with antidepressants now probably the most commonly taken medicines by adolescent girls everywhere.³

In 2018, Professor Peter Gøtzsche drew attention to this in a post on Mad in America.² He linked the fall in part to his efforts to warn about the inefficacy of and hazards of antidepressants and suggested it should be made illegal to prescribe these drugs to minors. His vigorous efforts to raise concerns through letters to regulators and in a series of articles and presentations now face pushback.

This journal has invited commentary on the issue of the efficacy of and hazards from antidepressants in minors. I suspect that it is not clear to the journal whether the pushback is linked to a high-profile dispute between Gøtzsche and the Cochrane Collaboration, his possible role as a medico-legal expert or some ideological positions he has adopted.

At some cost, Gøtzsche has been to the fore in tackling issues like medical ghostwriting and access to clinical trial data that have concerned grandees of psychiatry linked to this journal like Sam Gershon and Barney Carroll.

Within medicine, the question of antidepressants and suicide in minors was the point in 2004 where these issues came to a head; the point where it became apparent that close to the entire literature on on-patent pharmaceuticals may be ghostwritten and that we lack access to the clinical trial data for treatments in common use.

Papers claiming antidepressants worked and were safe were at odds with data that led to Black Box Warnings linked to a lack of efficacy in depressive conditions against which to balance a risk of suicide.

A “secret” lay at the heart of these issues. Fluoxetine was and is still widely portrayed as having proven effective in minors. This

beachhead may underpin the increasing use of these drugs in this age group. In fact, fluoxetine was identical to paroxetine - negative on the primary outcome measure in trials submitted to regulators.³ It has more negative trials in minors than any other antidepressant. However, it was approved before the difficulties surrounding the use of these drugs for minors, centred on paroxetine, blew open. This prior approval seems to have made it difficult for regulators to admit that they had made a “mistake”.

Given the lack of transparency, it is not surprising that Peter Gøtzsche and others invoke conflicts of interest on the part of those who defend the treatments, or claim the biomedical model is wrong, and promote CBT as an alternative to medication.

It is equally unsurprising, given anxiolytic effects of SSRIs evident enough to warrant a use of these drugs without clinical trials, and trial evidence supporting a use of these drugs for OCD and other anxiety states, that some bristle at an ad hominem argument. Logically also claiming that antidepressants can cause suicide is incompatible with decrying a biomedical model - this is one of the best pieces of evidence we have for the biomedical model. And, it is not so long since there was a mania for recovered memory therapy delivered by therapists claiming to be administering CBT, which throws cold water on the idea that there are good guys or good treatments who can be turned to in lieu of antidepressants and their prescribers.

In addition to the “secret”, there is a mystery. When a Minister of Health in the UK can say that children's mental health is the greatest point of failure of the NHS, something is afoot. We don't understand what. Throwing medicines or therapies indiscriminately at this something might not be wise and might be part of the problem.

At present those pro and anti the meds share a common difficulty as regards clinical knowledge. When treating patients, the first scientific task is to decide whether apparent effects happening to the person in front of me stem from their treatment or not. If, based on standard canons of causality, it appears that their drug caused a behavioural change but the published evidence suggests that this drug does not cause that problem (or benefit), a second

scientific task involves reconciling the discrepancy. In the case of the SSRIs and harms like suicidality, the apparent discrepancy stems from ghostwritten articles that conceal the hazards and a lack of access to trial data. In the case of the SSRIs and benefits, designing trials to capture markets, like the depression market, has obscured their anxiolytic benefits and has given rise to conflicting perceptions.³

This is a crisis we have not resolved. If the medical profession is to survive, we must resolve it, if only because if the drugs work wonderfully well and are free of problems, health system managers will devolve prescribing to nurses, pharmacists and others, who are less expensive prescribers than doctors.

As regards giving antidepressants to minors, in June 2019 the European Medicines Agency has asked companies to include mention of enduring sexual dysfunction after treatment stops.⁴ Furthermore, in September 2019, Public Health England produced data showing that by people put on antidepressants risk remaining on them chronically with up to 10% of the UK population now taking antidepressants chronically.⁵ These are not drugs to give lightly to minors.

Meanwhile back at the ranch, Danish figures for antidepressant prescribing to minors had fallen before the Danish Health Board issued warnings. The figures have now come down to the levels found in Norway and Sweden. In 2010, the figures may have been higher in Denmark than elsewhere as the makers of citalopram and escitalopram, Lundbeck, are based there. As the numbers of minors put on

off-patent antidepressants has fallen, the numbers put on a branded melatonin have risen, and Lundbeck are now making more money than before.

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