Medication in Child and Adolescent Psychiatry

(Update: Jan 26, 2006; UEMS-CAP)

Child and adolescent psychiatrists are medical doctors and entitled to prescribe medicines for their patients. They are trained to do so. Yet medication is used sparingly in child and adolescent psychiatry and more weight is given to the use of psychosocial interventions or psychotherapy.

Nevertheless, there are some conditions for which medication is a particularly powerful intervention. These include hyperkinetic (attention deficit/hyperactivity) disorder, obsessive-compulsive disorder, tic disorders, depression, psychosis, and the epilepsies. A number of children with anxiety disorders, post-traumatic disorders and sleep disorders will also be helped by medicines.

The purpose of medication is to relieve distress and improve functioning. It would be unacceptable to sedate a child to make him or her less troublesome to parents or teachers.

It is unusual for a medicine to be the only treatment intervention used and nearly always the prescription of a medicine is only part of a multimodal-multidisciplinary treatment approach.

Many medicines used in paediatrics and child and adolescent psychiatry have not been licensed by national or European regulatory authorities. A licence is a marketing authorisation granted by a regulatory authority in response to a pharmaceutical company's request in the light of evidence of safety and efficacy provided by the company. Pharmaceutical companies tend not to carry out evaluations of safety and efficacy on children because of ethical difficulties in obtaining consent and because of the cost. Medicines used in child and adolescent psychiatry are particularly likely to be licensed only for adults so that child and adolescent psychiatrists frequently have to prescribe 'off-licence'. Some medicines used in children are not licensed in Europe for any age group (e.g. melatonin). It is necessary for pharmaceutical companies to state that products that do not have a licence for children are 'not recommended' for them because without a licence they are not entitled to make such a recommendation. This causes anxiety among families and indeed doctors.

This is an unsatisfactory state of affairs for both children and their doctors and often gives rise to misunderstandings. There are welcome moves within Europe to encourage companies to carry out studies on new medicines for children.

Child and adolescent psychiatrists are acutely aware of the possibilities of misuse of medication and the risks of e.g. dependency arising from psychotropic medication. It would be unthinkable for such psychiatrists to knowingly cause their child patients any harm. But there is criticism of the use of such medication in the press and other media by some people who appear to have vested interests or simply do not realize the severity of much children and adolescent psychiatric disorder.

In fact, the use of medicines by psychiatrists to treat such disorder is judicious and based on a greater volume of evidence and knowledge than is sometimes realized. There have been more scientific studies of effectiveness in the field of medication (psychopharmacotherapy) than in any other field of psychiatric treatment for the young and there is thus a good evidence base for demonstrating effectiveness. Yet there is still a need for more research on safety and effectiveness particularly when atypical or mixed presentations of disorder are to be considered. This will necessarily involve the pharmaceutical industry in providing necessary funding and a need for doctors to work with these companies in an ethical and unbiased way. Frameworks and guidelines for this exist.