



Prescribing psychotropic medication to children in general practice

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Summary

Child and adolescent mental health problems are common in the community, but the scientific basis for the treatment of many of these conditions is still in its infancy. Conditions for which a moderate level of skill in pharmacological management is required include obsessive-compulsive disorder, tic disorders, attention deficit hyperactivity disorder in the primary school-aged child, and persistent enuresis. Greater skill is required in the treatment of anxiety disorders, depression, attention deficit hyperactivity disorder in teenagers, and aggressive behaviour associated with autism and intellectual disability. Only clinicians with advanced skills should consider treating juvenile onset bipolar affective disorder, children with psychotic-like symptoms, and attention deficit hyperactivity disorder in preschoolers or in children with intellectual disability.

Key words: antidepressants, attention deficit hyperactivity disorder.

(*Aust Prescr* 2005;28:116–18)

Introduction

'You are always on your own when prescribing psychotropic medication to children.'

This statement was made, not by a general practitioner or a paediatrician, but by a leading paediatric psychopharmacologist. It is a pithy reminder that the scientific basis to the pharmacological management of children with psychiatric conditions is limited and that institutional support for such prescribing is qualified. This said, there is good evidence for the pharmacological management of some childhood disorders.

Psychiatric disorders in childhood are too common for treatment to be the exclusive domain of specialist services. Several conditions can be managed by general practitioners depending on their level of skill. However, many general practitioners report limited exposure to child and adolescent psychiatric problems in their undergraduate and postgraduate training.

General considerations

Many childhood problems can be resolved without drugs. If prescribing is being contemplated there are some important considerations¹:

- be clear what you are prescribing for
- do not allow yourself to be rushed into a treatment decision
- follow the published mg/kg dose recommendations, but be prepared to use doses in the upper range if there is a poor response to treatment
- be familiar with the drug's adverse effect profile
- give a drug an adequate trial in time and dose before considering a change in treatment
- when stopping treatment, pay attention to whether doses should be tapered to avoid the development of a discontinuation syndrome (examples include the selective serotonin reuptake inhibitors (SSRIs) and clonidine)
- if multiple medications seem necessary, it is time to obtain a specialist review.

Conditions requiring a moderate skill level

These conditions are usually easy to recognise and have proven treatments.

Obsessive compulsive disorder

The content of the obsessions, particularly if they are of a sexual nature, can be distressing and may lead to secondary depression. Obsessive compulsive disorder can be very disabling.

Obsessive compulsive disorder responds well to cognitive behaviour therapy, the selective serotonin reuptake inhibiting drugs such as sertraline and fluvoxamine, and the serotonergically active tricyclic clomipramine.² The doses required to achieve remission may be higher than those used in the treatment of childhood depression. Once symptoms are suppressed treatment should be continued for at least 12 months to minimise relapse.

Tourette's syndrome

This syndrome and other chronic tic syndromes are more likely to cause embarrassment than impairment. Associated problems such as obsessiveness or hyperactivity may cause the patient most difficulty.

Tics can be suppressed with clonidine, low doses of high potency antipsychotics such as haloperidol, or one of the atypical antipsychotics such as risperidone. Tics fluctuate in intensity and frequency, therefore the recurrence of tics following adequate suppression is not an automatic indication for a dose increase or a change in treatment. Owing to the chronic nature of the condition, treatment is usually required for many years.

Attention deficit hyperactivity disorder (ADHD)

In carefully selected children aged 6–12 years ADHD responds well to the psychostimulants methylphenidate or dexamphetamine. These are well-researched medications and are relatively safe if used appropriately.³ In many states general practitioners are not permitted to prescribe them. Other non-stimulant treatments include atomoxetine and clonidine. Atomoxetine was released in Australia in 2004, so clinicians are still becoming familiar with prescribing the drug. Early experience suggests a longer lead time to clinical response than is seen with psychostimulant drugs. Clonidine is more commonly prescribed in Australia in combination with a psychostimulant than it is alone.

Enuresis

Bedwetting that has not responded to behavioural treatments, including the 'bell and pad', may respond to medication. Although tricyclic antidepressant drugs are effective for this condition, their benefit does not justify the risk when safer alternatives, such as intranasal desmopressin, are available.

Conditions requiring a medium to high skill level

These conditions may have a wide differential diagnosis or require complex therapy.

Anxiety

Anxiety disorders are common in children, but often cause only mild impairment and respond well to psychological treatments. They therefore rarely warrant pharmacological treatment. Indications for medication include school refusal that is unresponsive to other treatments and the incapacitating anxiety that occurs in panic disorder.

Fluoxetine, fluvoxamine and sertraline have all proven superior to placebo in randomised controlled trials. Benzodiazepines are discouraged in children with anxiety because they have no significant benefit over placebo. For cases of overwhelming distress arising from acute psychological trauma I would, in the past, have recommended short-term treatment with the relatively sedating antipsychotic thioridazine. As its use is now restricted, the atypical antipsychotics are reasonable alternatives.

Depression

Depression in children and adolescents can be overlooked as it often has an insidious onset and is characterised by irritability rather than low mood. By the time the patient is evaluated by a doctor the symptoms may have been present for many months. There is no need to rush into treatment. It is wise to review the mood state of the patient on at least two occasions before recommending pharmacotherapy. The Adverse Drug Reactions Advisory Committee recommends that drugs should only be used as part of a comprehensive management program.⁴

Fluoxetine is the only antidepressant considered from trial evidence to possibly have a satisfactory risk:benefit ratio in this age group.⁵ Patients should be monitored regularly during the first weeks of treatment for the emergence of agitation, suicidal thoughts or intent, or self-harming behaviour, as one in 20 will develop problems. Remission of depressive symptoms may take up to three months. Treatment should be continued for at least nine months after remission has been achieved.

ADHD in adolescents

ADHD persisting into adolescence is the rule rather than the exception, but patients may find it difficult to access specialist services for treatment. Psychostimulant drugs remain the first-line treatment, but some patients complain of adverse effects including dysphoria. Teenage patients may be pressured to give or sell their tablets to peers. For such reasons some adolescent patients need to switch to one of the non-stimulant treatments. ADHD presenting for the first time in adolescence is atypical and warrants a specialist assessment.

Aggressive behaviours associated with autism and intellectual disability

Aggression arises from a combination of limited problem-solving skills and a low threshold to arousal. Medicines are not first-line treatment, however controlled trials have found risperidone superior to placebo in treating such symptoms.⁶ In my experience, while the initial impact on behaviours can be dramatic, the effectiveness of risperidone usually declines over time. For this reason the benefit of continuing treatment should be reviewed every three to six months. Other atypical antipsychotics and pericyazine are prescribed for the same indication, but the evidence is less robust. Clonidine as a monotherapy offers an alternative strategy for reducing arousal. Patients whose aggression arises in the context of obsessive compulsive disorder-like behaviour may respond to SSRIs.

Conditions requiring advanced skills

General practitioners should only consider these treatment options if they have had specific training or if they work in close collaboration with child mental health services.

ADHD in preschoolers and the intellectually disabled

The evidence base for the efficacy of pharmacological treatments in preschool children is limited. Young children are more prone than older children to experience adverse effects with methylphenidate. Psychostimulant medication will alleviate hyperactive behaviours in children with autism or intellectual disability, but may exacerbate obsessive compulsive disorder-like behaviours.

Juvenile onset bipolar affective disorder

This diagnosis is controversial, yet most people with bipolar disorder have the onset in adolescence. Children identified with the condition usually have severe and complex problems that are better managed by a specialist team. Pharmacological treatment typically comprises a mood stabiliser such as sodium valproate, lithium or lamotrigine augmented with one of the atypical antipsychotics. Antidepressant medications are usually avoided owing to the risk of precipitating mania.

Psychotic symptoms

Psychotic-like symptoms in young people are as likely to arise from non-psychotic conditions such as substance abuse, dissociative states, post-traumatic stress disorder and obsessive compulsive disorder as they are from schizophrenia or severe mood disorder. For this reason specialist evaluation is recommended. Some younger or intellectually disabled children who engage in antisocial behaviour will report that a voice in their head commanded them to act in that manner. Such children are usually describing their own thoughts.

Conclusion

Psychiatric disorders are common in childhood. While many problems can be managed without drugs, some conditions require pharmacotherapy. However, the evidence supporting this therapy in children is often limited. Some conditions can be successfully managed by the general practitioner provided they have the appropriate level of skill.

References

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Further reading

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Professor Hazell has received a speaker fee from Pfizer to talk to general practitioners about the evidence for treatment of child and adolescent depression. He has received travel funds from Eli Lilly to attend a conference and present a paper on attention deficit hyperactivity disorder (ADHD). His service has been in receipt of payment from Eli Lilly for speaker fees, his participation in advisory boards, and research on atomoxetine for ADHD. His service has received funds for his participation in research on extended-release methylphenidate for ADHD. His service has received payment from Novartis for his participation on an advisory board for ADHD.

Self-test questions

The following statements are either true or false (answers on page 131)

1. Benzodiazepines are recommended for the treatment of severe anxiety in childhood.
2. Irritability may be a sign of childhood depression.

Wallchart

Copies of the wallchart 'Medical management of severe anaphylactoid and anaphylactic reactions' are still available from *Australian Prescriber*. This A3-sized chart was published as an insert to *Australian Prescriber* Vol 24 No. 5, 2001. It was endorsed by the Australasian College for Emergency Medicine, the Australasian Society of Clinical Immunology and Allergy, the Australian and New Zealand College of Anaesthetists, the Royal Australasian College of Physicians, the Royal Australian and New Zealand College of Radiologists, and the Royal Australian College of General Practitioners.