CORRESPONDENCE

Antipsychotic Prescription in Children and Adolescents: An Analysis of Data From a German Statutory Health Insurance Company From 2005 to 2012

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More Patients in Less Time

In my opinion, prescriptions of antipsychotic drugs in the child and adolescent psychiatric setting have definitely increased.

In addition to improved diagnostic tools, more attention to prodromal phases of psychological disorders, and improved diagnostic tests, the factor of treatment time and the scarce resource “treatment place” have an (important) role in the increase in prescriptions. The treatment times in hospitals are continually decreasing, the therapeutic teams are forced to treat increasing numbers of patients in the same amount of time and while staff numbers are dropping. Long waiting times for patients and few enticements for the treating staff to accommodate long treatment periods, since these are sanctioned by the healthcare system, make longer treatment periods without medication less attractive. In this setting, using medication rapidly creates a solution, albeit only an apparent one. Since hardly any antipsychotic drugs have been approved for the use in children and adolescents—which creates additional hurdles—it is not surprising (from a cost point of view too) that the main medication prescribed consists of atypical neuroleptic drugs.

In order to counteract the prescription of antipsychotic drugs in children and adolescents, changes are required in the healthcare system. Longer and more effective treatment periods, which are possible if the hospitals and practices are granted the necessary requirements (greater numbers of treatment places and qualified staff, as well as sufficiently long periods of treatment) the numbers of prescriptions would drop. This would be beneficial for the healthcare system when looking at the longer term, rather than merely a government’s term in office. In conclusion: antipsychotic drugs should be prescribed by all means, but only on the background of a validated, sufficiently long, and multimodal treatment that is not primarily concerned with aspects of costs in the short term.

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The author declares that no conflict of interest exists.

Administering Shortages

Conduct disorders, such as were cited in the article as the reason for prescribing medication, have not actually increased over recent decades. They therefore cannot explain the 2.5–3-fold increase in prescriptions. However, what immediately draws attention is the finding that only about a quarter (27.9%) of antipsychotic prescriptions in children and adolescents were issued by child and adolescent psychiatrists/psychotherapists. Almost three quarters came from pediatricians, general practitioners, and representatives of other specialties, who do not have any special competences in this respect.

These specialists receive their information primarily from pharmaceutical representatives, whose overarching purpose is to increase their companies’ turnover. Another problem that was mentioned is the lack of psychotherapy services for children and adolescents. This is a health political deficit that should not be “covered up” by antipsychotic prescriptions.

Ultimately it is utterly irresponsible that children and adolescents with conduct disorders have no recourse to help in any form other than by having their symptoms sedated and thus being subdued, by taking antipsychotics that massively interfere with the cerebral metabolism. The distress and despair of such children and their families are not taken seriously. The causes of abnormal behavior are not even the subject of any research.

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Turning Children Into Psychiatric Patients

In contrast to the meta-analysis, the “German Health Interview and Examination Survey for Children and Adolescents” (KiGGS) 2013 found emotional problems, hyperactivity problems, abnormal behaviors, and problems with peers in 17% of surveyed persons aged 11–17.

According to Table 3, 61.5% of prescriptions of risperidone were issued for hyperkinetic disorders and 36.5% for conduct disorders. These are present in 40–60% of hyperkinetic disorders.

If these were all treated with risperidone there would be no conduct disorders treated without comorbid hyperkinetic disorders. Pediatricians treat hyperkinetic disorders in a guideline conform manner with stimulants, not with risperidone. If a comorbid additional conduct disorder is present and stimulants do not yield any improvement then risperidone treatment will be started. Unfortunately conduct disorder is not always coded as F91 or F90.1.

Service provision for children and adolescents with abnormal behavior and their families by means of social educational interventions, such as continued family support, accessible and long term social competence groups and anti-aggression groups, training for parents and teachers is not sufficient, not widely available, and not always free of charge. Turning children and adolescents into psychiatric patients—that is, allocating a diagnosis with an F code from ICD-10 for behaviors that should be influenced socio-pedagogically—is intended to create treatment places whose costs are reimbursed. Months of waiting and locations that are difficult to reach, rather than support that seeks out the family are demotivating.

Doctors have to alleviate the suffering of patients and their families and prevent an increase in symptoms and the development of comorbid disorders. What is wrong if the reason for anti-psychotic prescribing lies in the fact that “that drug treatment can be started more rapidly than psychotherapy”? The responsibility does not lie with those who administer the lack of social educational and therapeutic care and have to witness the continued suffering.

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In Reply:

We thank our correspondents for their responses to our article (1). We agree with Neraal that antipsychotic prescriptions (if indicated at all) should generally take second place to psychotherapeutic treatments in conduct disorders. In several regions of Germany the deficit in psychotherapeutic services is indeed still substantial.

On the other hand, it needs to be pointed out in this context that traditional individual psychotherapy is usually not indicated in conduct disorders and that there are no indications of its efficacy in this setting (2). The current UK guidelines are methodologically of a high quality and recommend, depending on age group, primarily parent training programs or multimodal interventions (for example, multisystemic therapy) (3). Especially the latter forms of therapy are hardly available at all in Germany and should be disseminated, in order to help avoid unwarranted antipsychotic prescribing.

As far as the prescribing specialty is concerned it needs to be borne in mind that we analyzed all antipsychotic prescriptions (first prescriptions and subsequent ones). If a pediatrician issues a follow-on prescription for risperidone for a child with conduct disorder and substantial impulsiveness after the initial diagnostic assessment and prescription has been performed by a child and adolescent psychiatrist, then we think that this is most likely safer (and guideline conform [3]), as long as potential adverse

events are monitored appropriately, than if the therapy had been initiated by a colleague from another specialty.

With regard to Kohns' mention of the KiGGS study, we would like to point out that, by contrast to the meta-analysis cited in our article, the KiGGS data is cross sectional and not based on clinical diagnoses, but on symptom screenings of various child and adolescent psychiatric disorders.

In our study, 19.4% of all patients with a prescription for risperidone (data not shown in the article) had a diagnosis of ADHD without comorbid conduct disorder. In our opinion, this would indicate a significant proportion of non-guideline-conform treatments.

We wholeheartedly agree with the complaints raised by both Kohns and Calia regarding the unsatisfactory service provision for children and adolescents with conduct disorders. In our view, however, what is particularly aggravating is the lack of evidence based therapeutic services (for example, the popular anti-aggression training sessions with a group consisting only of children with conduct disorders are ineffective and therefore contraindicated). Happily, many of our European neighbors have long risen to the huge societal challenges posed by conduct disorders and antisocial behavior not only in childhood but also in adulthood and have accordingly initiated comprehensive changes to the provision of healthcare services. These initiatives have sprung not least from solid economic considerations, since high quality evidence based therapeutic and prevention programs can save costs in the long term (4). In view of the enormous extent of the “new morbidity,” such an initiative would be extremely welcome in Germany too.

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Prof. Bachmann has received lecture fees from Actelion, Novartis, and Ferring as well as payment from BARMER GEK for writing a chapter in a book. He has served as a study physician in clinical trials for Shire and Novartis.

PD Dr. Hoffmann is active on behalf of a number of statutory health-insurance companies (BARMER GEK, DAK, TK, and various corporate health-insurance funds) in the setting of contracts for third-party payment.