Commentary by an Academic Child and Adolescent Psychiatrist

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THE INTERESTS OF CHILDREN and adolescents with psychiatric disorders would best be served if academic child and adolescent psychiatrists, academic medical institutions, prescribing clinicians, child and family advocates, the National Institutes of Health (NIH), the Food and Drug Administration, and the pharmaceutical industry partnered to maximize the development and dissemination of safe and effective psychiatric medications. Before this critical goal can be achieved, however, each partner must demonstrate commitment, not only to its own core missions, but also to working to eliminate overt and covert conflicts of interest that can diminish professional integrity, public trust, and patient safety. This commentary focuses on identifying major barriers to reaching these goals, and on the role that academic child and adolescent psychiatrists can play in reducing them.

BARRIERS TO EFFECTIVE COLLABORATION

The barriers that make it difficult to achieve these goals are both external and internal to academic child and adolescent psychiatry. What are some of these barriers? First, the mass media tends to “dumb down” information and distort realities regarding childhood psychiatric illnesses and treatment. Media presentations about pediatric psychopharmacology

may be powerful and compelling, but not necessarily accurate. For example, an article may report that there has been a huge, say 300%, increase in prescribing of a psychiatric medication over several years (implying this is bad), but fail to mention that this increase was from a baseline of major underprescribing (often unacknowledged) to a current level that may still be insufficient (again, often unacknowledged).

A second barrier that is, in part, a result of these distortions, is public distrust of academic researchers, medication prescribers, and the pharmaceutical industry. The print and electronic media presentations have led the general public to believe that physicians, influenced by pharmaceutical sales representatives, prescribe medications in situations where they are neither indicated nor needed. The recent National Stigma Study of the General Social Survey (NSS-GSS; Davis et al. 2003) found that among the surveyed individuals, 86% of respondents agreed somewhat or strongly with the statement, “Doctors today are overmedicating children with common behavior problems.” Fueling this public distrust are various pharmaceutical industry policies and practices, such as direct-to-consumer advertising (e.g., the parade of pharmaceutical commercials during evening news broadcasts); failing to alert the public regarding emerging safety data about major medication side effects (e.g., increased deaths among patients taking Vioxx); and aggressive promotion to physicians by

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means of free lunches, drug samples, etc. The quest for profit margins can appear to prevail over commitment to personal and public health.

A third barrier is persistent social stigma, which makes it difficult to have an open and serious dialogue about pediatric psychopharmacology. For example, the NSS-GSS (Davis et al. 2003) found that 45% of respondents agreed somewhat or strongly with the statement, "Getting mental health treatment would make a child an outsider at school," whereas 43% agreed that, "A child would suffer as an adult if others learned that he or she received mental health treatment when young." In addition, the lack of parity for mental illness insurance coverage with physical medical illness likely helps to sustain the perception of social stigma when mental health financing is not considered a critical function in the field of medicine.

A fourth barrier is an inadequate clinical workforce to assess, diagnose, and treat youngsters and their families. Because there are only about 6,000 practicing child and adolescent psychiatrists to take care of an estimated 7.5 million children and adolescents with impairing psychiatric disorders, most prescribing of psychiatric medications to children and adolescents is done by primary-care clinicians (pediatricians and family practitioners) and adult psychiatrists, who lack the training and experience necessary to be expert pediatric psychopharmacologists. For example, pediatricians, who complete 3 years of residency, are required to have only 1 month of training in behavioral and developmental pediatrics, and none in child and adolescent psychiatry. Adult psychiatrists, who complete a minimum of 4 years of residency, are required to have only 2 months of training in child and adolescent psychiatry. Clearly, these brief training periods facilitate the "sampler" approach to child psychopathology and treatment, at best, and misunderstanding/cynicism about the enterprise, at worst.

GOALS FOR REDUCING THE BARRIERS

What can we do, as academic child and adolescent psychiatrists, to overcome these barriers?

The fundamental missions of all domains of medicine, including academic child and adolescent psychiatry, are to: (1) develop sound and unbiased evidence to support safer and more effective treatments for serious psychiatric illnesses (research), (2) educate the next generation of clinicians (training), (3) facilitate the application of new research findings to children in need (clinical application), and (4) educate the public and the media regarding the true benefits and risks of treatment, including pediatric psychopharmacology (public education and advocacy). Recommendations for change include the following:

Research

Given public perceptions about the pharmaceutical industry, particularly regarding biased design, analysis, or interpretation of research studies, and, by extension, to physicians, regarding the profit motive we need to do whatever is necessary to reduce conflict-of-interest with industry. Recently, the NIH implemented bold measures to eliminate industry conflicts for all intramural government scientists. The basic principle behind these measures appears to be the need to separate research conducted in the public interest (NIH) from research conducted in the shareholders' interest (industry). Although these measures are controversial, and require financial sacrifices by some researchers, they appear to be helping to restore public confidence in NIH-funded research.

It would likely increase the public's trust if similar measures could be implemented in academia and in the extramural side of NIH, especially for review panel members. However, there are multiple complex issues that need to be considered and are beyond the scope of this brief commentary. Most importantly, creative collaborations between academia and industry need to be encouraged, as long as safeguards are in place to prevent individual financial gain from influencing the process of discovery and application of new and safe treatments for children. At the very least, there must be complete transparency. Requiring complete financial disclosure, i.e., revealing the amount of money an individual investigator/reviewer received for an activity with in-

dustry, would give the public a more accurate measure of the potential conflict.

Training

We need to make entry into training in child and adolescent psychiatry easier for medical students and for pediatricians-in-training who decide to switch specialties, i.e., we need to expand the workforce of experts in pediatric psychopharmacology. Fortunately, this is a major goal of the American Academy of Child and Adolescent Psychiatry, and academic programs must work hand-in-hand with the Academy to ensure that recruitment remains front and center in the field's agenda.

Clinical application

We need to translate what we learn from research into models of care, evidence-based practices, and ongoing training opportunities that will make it possible for pediatricians and family practitioners to assess, diagnose, and treat children and adolescents with psychiatric disorders. Also, as child and adolescent psychiatrists, we need to develop financially viable programs of ongoing consultation to pediatricians and family practitioners. This will require creative partnerships with federal and state governments as well as various medical societies.

Public education and advocacy

Finally, from a public education perspective, we need to stay "on message." We have a fundamental responsibility to present clear and reasoned explanations about the nature of the problems from which our patients suffer, and the nature of the treatments that we offer. This message starts with several basic points.

- Mental illness in children and adolescents is a major public health problem, with at least 10% of this population having a persistent and impairing mental disorder (U.S. Public Health Service 2000).

- Most children with these disorders do not receive an evaluation, much less medication or any other treatment.
- The mass media can and must responsibly educate the public with thoughtful and accurate information about diagnosis and treatment.
- Practitioners who overprescribe exist, but are rare; as is true for all specialties of medicine.

Hopefully, these recommendations will provide a stimulus for academic leaders in child and adolescent psychiatry to take clear and explicit positions and actions to move forward a thoughtful, transparent and effective agenda regarding pediatric psychopharmacology. Our young patients and their families deserve no less.

DISCLOSURE

Dr. Riddle has no conflict of interest or financial ties to disclose.

REFERENCES

- Davis JA, Smith TW, Marsden PV, General Social Survey 2002. CPANDA ed. Princeton, NJ, Cultural Policy and the Arts National Data Archive (producer and distributor), 2003.
- U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC, Department of Health and Human Services, 2000.

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