

Evidence-Based Treatment in the Field of Child and Adolescent Psychiatry

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The requirement to base one's practice on evidence is growing rapidly worldwide. This requirement makes sense if you look quite soberly at the issue. Who would not want his or her treatment to be based on the best possible evidence regarding safety and efficacy? Unfortunately, there is a relative lack of good safety and efficacy data in the field of child and adolescent psychiatry.

There is longstanding agreement that a randomized controlled trial (RCT) is the best research design when it comes to examining the efficacy of a specific treatment. Systematic reviews, which consider data from multiple RCTs, are at the top of the evidence hierarchy. However, we lack a focus on assessing the quality of RCTs and systematic reviews, because there are many parameters that can downgrade the quality of these methods. In some cases, this means that the evidence is very uncertain, even when it is based on RCTs and systematic reviews.

Evidence-based practice is a thorough, explicit, rational, and thoughtful use of the best evidence available when making decisions related to the assessment and treatment of an individual patient. In this context, it is essential to integrate individual clinical expertise and the patient's preferences—as well as the patient's parent's or guardian's preferences, if appropriate—with the best available external evidence (1).

In many medical specialties, medical practitioners have used the approach of evidence-based treatment for a long time. However, in the field of child and adolescent psychiatry, there is still a long way to go.

The childhood cancer specialties have been based on evidence for many years. For example, for the treatment of children with leukemia, there are now clear, step-by-step protocols that are followed. Evidence from RCTs has helped oncologists to learn more about which treatments are best, and

evidence from high-quality trials has improved cancer survival rates: the annual reduction from 1978 to 2005 in the risk of death from childhood cancer ranged from 2.7% to 12% (2).

When one looks at the Cochrane Systematic Reviews published in the field of child and adolescent psychiatry, there is a lack of reviews and RCTs of good quality and therefore a lack of evidence. There is one new review from 2015 that investigated cognitive behavioral therapy for anxiety disorders in children and adolescents (3). This review included 41 studies and suggested that cognitive behavioral therapy is an effective treatment for child and adolescent anxiety disorders as compared with wait-list controls; however, the evidence that suggests that cognitive behavioral therapy is more effective than active control interventions, treatment as usual, or medication is limited and inconclusive. Another review published in 2009 investigated the efficacy of pharmacotherapy for anxiety disorders in children and adolescents and suggested that medications improve core symptoms (4). However, all of the trials had a high risk of systematic errors, which contributes uncertainty to the meta-analytic estimates. When one looks at the Cochrane Systematic Reviews that have investigated the efficacy of treatment for attention-deficit/hyperactivity disorder, the picture is the same: there is a lack of high-quality RCTs, which makes the evaluation of treatment efficacy uncertain (5-7). Another review that investigated the efficacy of antidepressant and psychological treatments alone and in combination for depression in children and adolescents concluded that there is very limited evidence upon which to base conclusions about the relative efficacy of psychological interventions, antidepressant medications, or a combination of these (8). A Cochrane Systematic Review that investigated the benefits of antipsychotic medication for childhood-onset

schizophrenia concluded that there was little conclusive evidence regarding the effects of antipsychotic medication for those individuals with early-onset schizophrenia (9).

This leaves the clinicians who work in the field of child and adolescent psychiatry with a poor foundation for evidence-based therapy, and they are often forced to rely solely upon their clinical experience. Why are there fewer high-quality treatment studies in this field than in the field of childhood cancer? One reason may be that, unlike most other medical disorders, psychiatric disorders may not be considered “real diseases” in the minds of many people; this may contribute to the poor availability of research funding for child and adolescent mental health problems. The Danish Council for Independent Research has recently given 153.8 million DKK to fund projects in the field of health and illness, but none of this money was given to projects in the area of Child and Adolescent Psychiatry. This is a serious problem, because the mortality rate among individuals with certain mental illnesses (e.g., depression) is higher than that of the general population, and the burden of such diseases in the long run is higher than the disease burden of many cancers (10). Still, there is a lack of evidence for effective treatments, and there are also problems with getting children with depression into clinics that can provide appropriate assessment and diagnosis. There is wide regional variation with regard to the availability of mental health assessment, and treatment is often based on the local standard of practice without the consideration of external evidence (2). In addition, the adverse effects of treatment are sometimes not adequately assessed in the existing treatment studies, which is another huge problem (11).

The extent of actual external evidence in the field of child and adolescent psychiatry can practically be read as “No evidence for anything.” It is important to remember that the absence of evidence is not evidence of the absence of effect. The lack of external evidence underlines first the need for more high-quality research in the area. Increased research funding for the field of child and adolescent psychiatry is of crucial importance, and this is the take-home message for health care policy makers. This does not mean that the interventions that are currently used in this field are worthless or that they should not be used by clinicians. Rather, it means that there is a lack of external evidence to support the available treatments. It is always the patient who is the main focus of evidence-based treatment, as stated by the late David Sackett, who was one of the founders of evidence-based practice (1). He emphasized that the experiences of clinicians should be looked at as internal evidence and that this type

of evidence is equally as important as external evidence. He stated that “the practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.” When Sackett used the term *individual clinical expertise*, he was referring to the proficiency and judgment that individuals acquire through clinical experience and clinical practice (12). This means that clinicians must continue to use their “best practice” approaches, because there is also no evidence that these approaches do not represent good treatment. It is important to understand this assertion. At the same time, it must also be understood that there really is a pressing need for additional high-quality intervention studies in the field of child and adolescent psychiatry.

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