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How to Prescribe Psychoactive Drugs to Youngsters?

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ABSTRACT

This article describes in what way prescribing psychoactive drugs to adolescents may be successful so that the prescribed medication is adhered to and continued. For the prescription to succeed individual aspects have to be taken into account, and also the parents and the social context of the adolescent. The introduction of the medication is also linked to a certain strategy, as is the start of the treatment. Therefore this article does not deal with what, which medication to prescribe for which complaint or disorder, but with how, in what way a proper medicinal treatment can be achieved. Furthermore there is a discussion of options when the prescribed medication is not adhered to. The suggested 'guidelines' are based on a couple of decades' experience supplemented by data from the literature. Where the physician is referred to, this may be a reference to a (youth) psychiatrist or a physician in mental health care.

INTRODUCTION

Adolescents are in an important and stressful transitional phase in their lives, that of the child into adult. They have to develop in all areas, acquire competences and autonomy, become more self-sufficient and independent. Those that exactly in this period get bogged down with or on account of complex issues or psychopathology, consequently have the feeling that they are getting even less control over their lives than the average adolescent. Quite the opposite: the problems of psychopathology frequently control them instead of the other way around. Hence their autonomy is more fragile than with peers without problems. When, within this context, they are given the advice to start taking psychoactive drugs, as a rule they will not easily be in favour of this, as they fear being influenced by the pills, precisely when they have no appetite for an outside factor (the medication) that just might take over control. On the other hand, the professional knows that psychoactive drugs may help and are frequently even necessary for the youngster to get control of the difficulties, and the youngster is often 'aware' that these drugs are required. The question is therefore what the best procedure is for doctors in these circumstances.

WHAT SHOULD BE TAKEN INTO ACCOUNT?

Although young people tend to present themselves as more self-sufficient and independent than they actually are, the parents still play an important role in their lives. And also older adolescents often are and remain loyal to their parents and their parents' beliefs, as can be seen in the following examples.

'Mart, 21 years old, has been hospitalised in connection with a psychosis. He is in complete agreement with the treatment plan in which the use of anti-psychotics has a prominent place. Every morning he comes to the nurses' station on his own initiative and asks for his medication. Despite this in all respects cooperative attitude his condition exacerbates by the week. It even leads to dangerous and sometimes suicidal behaviour of which he reports that voices tell him to throw himself under a car. The clinical team have no idea what causes the deterioration. At a certain moment in this period Mart's mother has an appointment with the family therapist. It strikes him that she is always carrying a large bag. On inquiry Mother tells him that this bag contains her medications. It turns out that Mother has lots of complaints, that she sees her general practitioner about them and gets prescriptions for her complaints. She gets the prescriptions filled at the pharmacy, puts the medicines in her bag and then does not take them. She thinks it rude to tell the general practitioner that she is actually firmly opposed to the use of medication.'

'Paula, 20 years old, is treated for bulimia nervosa and also complains of depression and impulsivity. Originally she takes an antidepressant in a high dosage. At a check up it becomes apparent that she will regularly stop her medication or reduce the dosage on her own initiative. The reason she gives is that she does not feel too good about the medication even though she feels it helps her against binge eating. As a result every few weeks there have to be discussions about what might help her and what she is willing to try. This considerably hampers a consistent medication policy. In a family consultation the doctor learns that the parents object to the use of psychoactive drugs, because they feel that they dull their daughter emotionally. For her part Paula strongly doubts her parents' affection for her and tries her utmost to respond to them. Not taking her medication is part of this effort.'

Sometimes there is the complicated situation that the adolescent is willing to take his medication, against the express wishes of the parents. There may be an underlying protest or any other form of opposition that may be sensed, but is not always clear. It is then unclear what an adequate policy would be. But simply to start, and in so doing taking the youngster's side against the wishes of the parents, entails the risk that the drugs will not be taken anyhow. And a few times the author noticed that the effects of the drugs that were actually taken in such a situation were non-existent.

An important part is played by the contacts with peers. Within the group of contemporaries it is not always usual or easy to be open about problems and it is even more difficult to have to admit to the use of medication. Often the youngster is embarrassed by the fact that pills have to be taken in order to keep his balance or in efforts to overcome problems and complaints and symptoms. A fear of rejection may lead to ignoring the medication advice or to not or irregularly taking the prescribed drugs.

'Ruben, 14 years old, always got his afternoon coverage for his ADHD in his lunch box, but he was afraid to take it, for fear his classmates would find out. Because then he would have to tell them he had 'a defect'.

It is prudent therefore, to determine which friends are aware of the problems, what their position is and whether the young person would be willing to tell them that he is taking prescribed drugs. The doctor should show understanding towards the embarrassment the adolescent feels about himself as a person who fails, who does not adequately and under his own steam manage his development into adulthood and who also has a problem acknowledging this. The school or work situation should also be determined. When we consider their age, many youngsters are in their first job, are in a training on the job or they are employed on a trial basis. Their labour status is therefore fragile. They often lack the courage to tell their employer about their problems, much less to be forthcoming about their medication. Quite apart from this there are work situations that become risky when a person is unable to keep a keen watch, whether this is the result of the drugs that have to be taken or of the problems these drugs must tackle. In education the youngster often notices that psychoactive drugs interfere with his powers of concentration and that they make him drowsy, not to mention possible movement disorders or other side effects. All this may result in their feeling less certain in their functioning when they are under the influence of psychoactive drugs. It is only when they can, and wish to uphold the taking of psychoactive drugs to third parties, that proper and faithful adherence can be counted on.

Young people are often insecure, and when there are mental or psychiatric problems playing a part, as a rule that insecurity

will increase even more and they feel they have (too) little control over themselves. Their autonomy is still under development, and this alone makes the autonomy of youngsters with mental problems even less strongly developed. Psychoactive drugs do 'something' to the psyche, therefore to you as a person, and as a result these youngsters will feel even less self control. Not only would they like to resolve their problems through their own efforts, but when it is suggested to them that they should start taking medication, it is in their interest that they perceive the decision as much as possible to be their own. Casually writing a prescription, saying: "take these drugs, they'll help you" is not often acceptable to them. When they do accept this, the doctor should become wary: will the drugs be taken in the proper way? This should specifically be taken into consideration.

Besides the matter of autonomy there is that of identity [1]. From the start the diagnosis changes the identity of the youngster, and the corresponding medication contributes even more. There will only be room for medication in the youngster's mind if he can bear that change. It goes without saying that there is no need for the doctor to consider all aspects in every medication contact. Usually an agreement is reached in the first consultation, after which taking the prescribed drugs may or may not be accepted. But in a follow-up consultation after an initial 'yes' reservations may arise, or it may appear that the agreement was not honoured. In such a case it is useful to do the groundwork of the first consultation once more.

LITERATURE

There is a paucity of literature on how to prescribe, certainly compared to the articles and books concerning what to prescribe. Towbin [2] underlines the necessary cooperation with parents, as well as the fear of loss of control and embarrassment vis-à-vis contemporaries in the case of a teenager. He also points out that youngsters are not yet quite capable of self-observation of their complaints and of the effects of the medication. Also the youngster's IQ should be factored in, as well as his background and culture. Towbin finds it important to keep up the contact with both the youngster and the parents after the first consultation, especially when there is the risk of side-effects occurring sooner than symptom reduction. And it is self-evident that there should be informed consent of all parties concerned. O'Brien [3] points out the psychological effect when medication is suggested. This can be interpreted by the youngster as quality care or, quite the opposite, lack of involvement: the therapist replaces personal attention with a little pill. So prescribing medication is by no means an emotionally neutral affair. When there is simultaneous psychological treatment it is prudent to suggest deciding on the medication policy together with that therapist. It is interesting that O'Brien mentions the effects on a family's balance that result from one family member taking medication. A family has usually become accustomed to a problematic youngster and he will now presumably change his behaviour. This may require (re-) adjustments, certainly when the problem child is also the family scapegoat. He cautions that psychoactive drugs reduce complaints and tackle symptoms but cannot cure a disorder. Nor do they improve skills, although these may be more readily acquired with the aid of medication. Although medication can improve a youngster's self-reliance, it can also have a lessening effect because a certain dependency has arisen. Dilallo [1] also adds that it is important to determine which place is taken by medication in the whole set of interventions and treatment. And it is true that the youngster's autonomy should be respected and enhanced, but this is only possible when the youngster has become knowledgeable where his complaints and the treatment options are concerned. Consequently psycho-education precedes medication consultation. And (actually in all cases) there should be room for hope by finding out what the actual discrepancy is between the youngster's (developmental) objectives and the position he is actually in. Then there can be information about what the (positive) effect might be on this discrepancy, assuming everybody's (unexpressed) wish for a normal development. Dilallo suggests that the therapist and the youngster together consider what is possible and desirable, a confrontational, enforcing and patronizing approach is out of the question. Fenton [4] refers to the experiences with medication for somatic complaints and illnesses. He names six elements that forecast success: being open to medication advice, the gravity of the condition, the advantages that have been experienced, the possible obstacles, the support within the family and the youngster's ability and discipline to adequately take the medication.

THE FIRST CONSULTATION

The context of the medication consultation is of particular importance. Understandably, not only should the parents preferably be present [5], but first of all there is the question whose wish it actually is that medication should possibly be taken? Is it the youngster who would like this, is there a more or less mandatory requirement from the school ('without medication you cannot be here') or is it the advice of some other care professional? And do parents and youngster both want medication just as much? If it is the parents' wish it is important to know what they expect from medication, do they look upon it as a necessary evil, a useful tool or are they envisaging a miracle drug that solves all problems? For it regularly happens that medication is asked for and that other forms of assistance are deemed undesirable or superfluous. The first consultation should provide clarification of these matters first and foremost, before there is any discussion of medication.

'Tom did not want pills, whereas he was evidently suffering due to his complaints. He admitted as much. But he was almost constantly in conflict with his parents, and they urged for medication.'

The second step is psycho-education, teaching and testing the knowledge the parties concerned have of both the disorder and the medicinal treatment options. They should be really good at (co-)assessing the positive effects medication can have. Should the information leave doubts and/or questions then a second consultation may be needed. In the meantime they have time to reflect and deliberate with themselves and others. Actively refer them to information, for instance on the internet. Make sure that they also search the internet themselves. It is sometimes advisable to warn them against sites that only list complaints or sweeping objections.

Nonetheless, in certain cases the practitioner must stress his expertise when it is clear that medication is an essential condition for profiting from other treatments, as in the case of psychoses. On the other hand in other cases, such as major depressive disorder, it must be stressed that the gravity of this condition will not be lessened in the short term without any drugs. In such cases a more or less binding advice is appropriate. But, here as well, the strongest possible intrinsic motivation should be developed, otherwise even clear advice runs the risk of coming to grief. So all the time it is a matter of finding a balance between on the one hand the position of the expert and on the other that of the therapist who closely watches the youngster's sensibilities and respects them. We need to pay extra attention to side effects that may or will occur. Information about side effects must be absolutely straightforward and unambiguous. When the information they find on the internet and elsewhere does not correspond with the data given by the practitioner, this will greatly weaken that indispensable trust. Also bear in mind that, the younger the adolescent, the more the good effects and the side effects may differ from those found with grownups: after all the immature nervous system does not always give identical reactions.

When the youngster and/or the parents readily consent to the medication advice and, in the doctor's opinion, are not interested enough in further information, it may be advisable to recommend them to think things over for a week or so. There is always the risk that a quick 'yes' is later followed by objections that have since cropped up: 'You agree to this now, but think about it carefully for a while. I much prefer discussing objections that you may have now, before we are really going to start'. And if there are objections, be open to them, ask at length what they are thinking of, what they are worried about, what bothers them or what fundamental objections there may be. These objections may derive from their religious beliefs, be related to ideas about body and health, but may also have to do with personal ideas, such as the notion that everybody should tackle their mental problems without outside help. Emphasize that you as the physician do not determine that the adolescent is or is not going to take medication. It is the physician's task to determine which drug will be prescribed, that is after all his unalienable expertise. And always realize: a motivated patient does not always make a convinced taker [6].

When real agreement is reached, it makes sense to suggest taking the medication on a tryout basis: if it does not come up to the expectations, the medication can be stopped immediately. In this way the young person still owns the decision. Depending on the kind of drug and the period after which an effect may be expected, there might for instance be a four-week trial period and then a stop anyhow. Continuation will only take place if the youngster asks for this. Keep the initial dosage at a moderate level, if need be at such a moderate level that there will not be noticeable effects but in

any case at such a moderate level that almost certainly there will not be side effects. Should side effects occur this is frequently a reason for youngsters to bail. 'I told you, these drugs don't do a thing, and they only bother me'. In this way the first experiences will be safe. Sometimes a little suggestion helps. When the dosage is 50 mgs, half a 100 mg pill is felt to be more acceptable than 2 whole 25 mg pills.

When at the follow-up appointment no side effects are reported, the dosage may be increased. Along with the information that the dosage will be reduced again should unexpected side effects manifest themselves. Once more the youngster keeps maximum control. This approach does not go for those drugs where the positive effects must absolutely be achieved. Then side effects have to be taken into the bargain. But also in these cases attention should be paid to the inconveniences that are experienced. And stipulate that in the event of doubt unscheduled contact is always possible.

'Harry took an antipsychotic drug for the first time on Thursday. Although the initial dosage was low, during the weekend there were muscular complaints that he found distressing. The general practitioner sent him to the ER where doctors were unable to supply any clarification. It used up a lot of time and money and certainly did not put his mind at ease'.

It is best to start at the beginning of the week. Since side effects only occur after a few days it is possible to get into contact with the prescribing physician so that finding help elsewhere is unnecessary. It may help to supply a cell phone number with the message that they should call if there are questions. Experience shows that this is so reassuring that this number will only rarely be used. And there is only a sporadic misuse of this telephone number. Conversely sometimes the start may be best placed in the weekend, notably when an effect will immediately show (as in stimulants). Then the effects are experienced in a safe environment and possible side effects are not yet harmful to school or work.

In order to facilitate the regular taking of medication it may be linked to fixed rituals, like brushing the teeth and the like. Sometimes a reward system is helpful.

Increase the dosage to the desired level in the follow-up contacts, but always be guided by the effects and side effects. When the side effects become (too) bothersome a lowering of the dosage must be considered to prevent the youngster from stopping at their own initiative. After all medication adherence is of utmost importance.

The request for a different drug, for whatever reason, should sometimes be allowed, but not at any price. After all, a certain drug was started for clear reasons, which is why originally this drug was chosen over another drug. Should the patient have justified objections, then agree to his wishes, with the understanding that the medicinal briefing should take place as in the beginning. But also set a comndition: if the adolescent insists on a different drug, one that is not the physician's first choice, this may be granted on condition that, should the drug turn out to be inadequate, the doctor's choice is then followed. In the case of predictable side effects, the drug's inevitability can be pointed out, or that there are drugs to counter the effects. In fact this only goes for antipsychotics, but those are also the drugs that cause the most complaints. Once again reassurance serves medication adherence.

Regularly youngsters enquire about their medicines in combination with alcohol.

Honest information is required here. It is not just the medication that is in their interest, but also still being able to partake in the nightlife with their peers. As a rule a moderation of their alcohol intake is quite feasible. When there are clear risks of nasty consequences of the combination they should be insistently briefed. Put it to them (without being prompted) that many psychoactive drugs bring about sexual functional disorders. Lessened or complete loss of libido in the case of girls may result in a fear that the relationship with their boyfriend becomes strained; for boys, on top of this, there is a serious risk of erectile dysfunction and ejaculatory issues. Approach these complications too just as seriously to prevent the adolescents from arranging their medication on their own.

AFTER THE INITIAL PHASE: CONTINUATION AND COMPLIANCE

It is not just having to start medication that is troublesome for youngsters, keeping it up is as least as difficult. In Geneesmiddelen bulletin nr 50 [Medicinal products bulletin] [7] there is a report that overall some 40 % of prescriptions is not adhered to as intended. For youngsters it is of great importance to get control of their mental complaints and psychiatric disorders because their mental condition has a direct influence on the mental development into adulthood.

Faithfully taking their medication is then the most important factor, enabling a qualified opinion of the usefulness of the prescribed medication balanced against the possible disadvantages. But ambivalences and doubts that were present at the outset may manifest themselves again in the follow-up. This may be the result of improvements ('why should I still take them, after all I am much better now') or, quite the reverse, the complete absence of improvements ('those drugs do not accomplish anything, so I am no longer taking them'). Side effects may also bring about a lack of adherence. Lessened sexual capacity may be a threat to a less than stable courtship making being alone again extra hard to bear. And also a side effect like dullness is sometimes hard to bear or an inconvenience for a proper functioning at school or work. Antipsychotics, especially the atypical ones, quite frequently result in significant weight gain or otherwise there are bothersome neurological side effects in the case of traditional medicines. In other words, it is easy for the motivation to continue taking the prescribed medication to become strained.

LITERATURE

The literature about therapy compliance only partially contains findings about young people, most articles concern adults. This survey restricts itself to that small number as they are in line with the results of the research in adult patients. Nagae, Nakane, Honda, Ozawa and Hanada [8] report that parental involvement, in which the parents indicate to their child that the medication helps, promotes compliance. The confidence the youngster has in his parents' judgment is a prerequisite. Research by Ramdour, Duxbury, Becket and Wilson [9] in youngsters aged 14 – 18 who were taking antipsychotics revealed that 40 % (!) of them did not take the medication as prescribed. They did not sufficiently perceive the benefits and exaggerated the side effects. Lack of insight in their condition often played a part, as well as the need to have personal control over medicine decisions. Hamrin and McGuinness [10] have verified the risks of non-compliance. Then relapses occur more frequently, the youngsters suffer from their condition for a longer period and the disorder can easily deteriorate, the school results suffer and there are more attempted suicides. O'Brien, Crickard and Holmes [11] describe that bringing in the parents is effective. They more often have a positive attitude versus medication than their offspring. Lukin (2012) also reports greater compliance when there are no family disputes and when the advantages have been properly clarified. So it is important to devote a lot of attention to the youngster's expectations. He also mentions the height of their IQ as a factor that matters.

As a matter of fact the same factors emerge that are important right from the outset.

CONTINUED CONTACTS

If the physician wants to attain medication compliance regular contacts are required, once again preferably together with (one of) the parents. The parents are often able to give a more realistic report of what went well with the medication and what the condition of the child is. It may be desirable that they supply the medication and thus safeguard compliance. But first and foremost the physician must be available for questions and doubts, be open to complaints and grievances, and willing to consider wishes for a change in medication or a different dosage of the present medication. A linear procedure: "this is your disorder, these are your complaints, this is what I am going to prescribe for this is in accordance with the directives, and then you will notice this, that and the other", rarely works with youngsters. Especially in the case of youngsters, a circular approach is required, which includes the parental presence, their involvement and cooperation, in which every small step is discussed and evaluated all the time. Subsequently the next step, another small one, is suggested and brought in line with the wishes, ideas and findings of the adolescent.

TOOLS

In this context new possibilities for the promotion of therapy adherence are the cell phone and Apps. Mulder [6] notes the possibilities of Treatment Adherence Support Therapy.

THE YOUNGSTER DOES NOT WANT TO TAKE MEDICATION. WHAT TO DO?

With some regularity it happens that the youngster does not want to take medication, not even when his parents are in favour or even urge the youngster to take it. You can go over all the pros and cons one more time, but if you do this too often they will bail anyhow: they feel railroaded (justifiably so!) into following the advice. It is better to leave the discussion for what it is: "It is clear, you do not feel like taking my advice. So be it. After all it is your decision. By now you are aware of all considerations. I would like to suggest that when you get home,

you go over everything once again for yourself. Should you change your mind, you can call me. If not, talk things over with your therapist what the consequences might be in the follow-up. For my part, I will also give him my information. I wish you the best of luck!"

When there is no hard rejection, but when doubt predominates, the following can be done. Together with the adolescent and his parents (after all they will also feel the implications of a 'no') draw up a chart with four quadrants in which the advantages and disadvantages are set out for both compliance and non-compliance. Then the results of each choice become more visible than when only words are used. In a strategic approach the physician can emphasize the advantages of non-compliance as well as the disadvantages of compliance, assuming that the adolescent, in all circumstances, ultimately wants a life in which he can function as well as possible with his contemporaries. Another approach might be suggesting a second opinion from a colleague, or referring the youngster to go over the advice with his general practitioner [12,13].

RECOMMENDATIONS

The procedure is summarized below.

- In the first place determine the context of the consultation. Whose wish is it for the youngster to take medication?
- Find out if the parents are for or against medication and whether the adolescent would dare tell his friends. Find out what ideas the youngster has about what medication can do to his self-awareness, and whether he can live with the fact that his self-awareness will be partly determined by the medication.
- Determine the understanding the youngster and the parents have regarding the disorder, the likely effects of medication and point out the place pharmacotherapy has in the framework of the treatment.
- Be frank and open about possible side effects, what can be done about them and what has to be lived with.
- Allow for a period of reflection in case the parties concerned or the physician himself are in doubt.
- Make abundantly clear that it is the adolescent who decides whether medication will be taken, but that it is the physician who determines which substance is prescribed.
- When there are doubts arrange a trial period.
- Always start (unless the situation does not allow this) with a dosage that is so low that in all probability side effects will not occur, nor will a positive effect in this phase. And start at the beginning of the week so that side effects can be discussed before the weekend.
- Slowly increase the dosage guided by the positive effects and the side effects: they should never be so strong that it is the reason for the youngster to stop taking the medication. Always keep up contacts about this, also with the parents, by telephone or vis-à-vis.
- Take the wish for a different substance, unless this drug will be without effect or even damaging, seriously, for it supports the feeling of autonomy in the youngster. Arrange a trial period and evaluate. Should the new drug have better results, do not persist in the role of the expert physician, but grant the wish.
- Take side effects seriously and understand that it is precisely these that can be very restrictive for youngsters (Sexual dysfunctions, weight gain, motor impairments). Discuss the options of a different substance or of counteragents.
- When the youngster keeps having doubts determine the advantages and disadvantages of compliance and non-compliance.
- Keep monitoring the taking of medication and also get your info from the parents. When there is doubt about taking medication as prescribed or even lowering the dosage there must be an all-party consultation.
- Use modern tools such as e-mail contact, alarm systems on cell phones, and apps.

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