How do the parents of adolescents and children make sensible decisions now?

I have for many years supported the parents and carers of children and adolescents who have mental illness. Indeed in the workshops I have run for General Practitioners to help them cope with their own inappropriate responses to stress, mental illness of their offspring has been identified as a major stressor in their lives.

I now run support groups for these parents including one for The Capio Nightingale Clinic's Adolescent Unit in Chelsea for parents and carers of those children admitted to the hospital.
One of the recurring themes they want to discuss is the evidence base for all the therapies that their children receive, both psychological and pharmacological.
It is indeed a poor reflection on the whole medical profession that this evidence base is not extensive for any of the therapies that are used.

As has been pointed out by many of the rapid responses there may be as many flaws in the research governing the use of psychological therapies in this age group, as pharmacological ones . If the children are denied pharmacological treatments for depression, will the others be sufficient?
Is there a difference in the safety of the drugs if they are used in hospital rather than on outpatients?
Is the risk/benefit profile altered by the use of the drugs by adolescent psychiatrists compared to use by General practitioners?

Are the outcomes different when drugs are prescribed at the same time as frequent psychotherapeutic contact?

Surely these matters are of such importance that large scale studies should be carried out to assess the comparative risk/benefit ratio of all therapeutic modalities which may be offered to this age group. These studies would have to be large and multi-centre, if not multinational. Who will fund them especially if the new European Clinical Trials Directive has to be followed?.

They must exclude the possibility of a type 11 error.

Metanalysis should be carried out as a matter of urgency.

We need to understand why there is a difference between risk/benefit in those above and below 18 (if indeed there is).

We need a biological marker independent of age if possible so that those aged 16-17 who may derive benefit are not precluded a useful treatment, and those aged 19-20 who may be harmed are not given such therapy.

If indeed as this paper suggests some doctors lack the skills to understand the evidence base and trials what chance the parents.

Perhaps more importantly what chance the children who do not wish their parents to be involved in their therapeutic decisions following the lines of the 'Gillick Competencies'

The parents of this age group want to be totally involved in the therapeutic decisions concerning their children, because they both care desperately and also as a way of dealing with thier own axnieties.

Indeed some spend many hours performing literature searches worthy of a PhD. This itself helps them and is a common coping strategy. There needs to be transparency in all therapeutic research.

In research concerning children there needs to be super transparency both on the part of researchers and those performing reviews. Anything less is unacceptable.

Competing interests: Malcolm VandenBurg runs support groups for the parents of children who have mental illness. He is also a Pharmaceutical Physician who has been funded by the industry to carry out research on antidepressants.

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