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Best interests

FROM THE EDITOR

By Joe Bouch

Determining the patient's best interests is an underpinning principle of capacity legislation (Brindle & Branton, pp. 430–437, Box 2) and surely of all clinical practice. It is perhaps nowhere more controversial than in the use of medication to treat young people with mental health problems – described as a 'blunt' approach and 'bad medicine' by Des Spence (2010), a practising GP and regular columnist in the *BMJ*. A more measured *JAMA* editorial (Varley 2009) discusses some of the concerns: the substantial increase in the use of antipsychotics in young people (including children younger than 5 diagnosed with bipolar disorder); diagnostic problems, including the overlap of bipolar disorder with behaviour disorders and the possible discontinuity between child and adolescent and adult forms of bipolar disorder; the relative prioritising of medications and psychosocial interventions; the long-term health implications of prolonged treatment with second-generation antipsychotics (not least obesity); and the extent to which the evidence base is formed by industry-sponsored investigations. It is clear, then, that determining appropriate treatment and the best interests of a young person with an affective disorder is unlikely to be straightforward.

Dubicka *et al* (pp. 402–412) consider prescribing by examining and reflecting critically on the evidence without shying away from the controversial issues. Accurate diagnosis, necessary for both good prescribing (British Pharmacological Society 2010) and steering clear of causing avoidable harm, is problematic. So, too, is the evidence base, which is sparse and at times depends on extrapolating from the adult literature. Even randomised controlled trials, often referred to as the gold standard (e.g. Coia, pp. 474–475), are not necessarily so and are 'particularly weak in relationship to generalisability and most especially in the assessment of harms' (Rawlins 2008). Importantly, Dubicka *et al* do not consider pharmacological treatment as a standalone intervention but always in addition to 'specialised treatment as usual' (STAU). Distinct from specialised psychological treatments such as cognitive–behavioural therapy and interpersonal therapy, STAU comprises no fewer than 16 elements (Box 1, p. 404) and describes the complex and multifaceted quality of 'ordinary' multidisciplinary and multi-agency clinical practice.

Capacity and best interests decisions

Such 'ordinary' practice is outlined in the article by Biswas & Hiremath (pp. 440–447), which is my Editor's pick for this issue. Based on a real clinical case, it brings to life how to support a patient making an important decision for themselves, when to apply capacity legislation and how to implement it. It exemplifies thoughtful clinical practice and teamwork. Although describing a mature adult with intellectual disability facing surgery for breast cancer, the principles could equally apply to initiating medical treatment in a young person diagnosed with an affective disorder.

British Pharmacological Society (2010) *Ten Principles of Good Prescribing*. BPS (http://www.bps.ac.uk/uploadedfiles/PMeBulletinUploads/BPSPrescribingStatement03Feb2010.pdf).

Rawlins M (2008) *De Testimonio*: on the evidence for decisions about the use of therapeutic interventions. *Clinical Medicine* **8**: 579–88.

Spence D (2010) Bad medicine: medicated minors. *BMJ* **341**: c3907.

Varley KV, McClellan J (2009) Implications of marked weight gain associated with atypical antipsychotic medications in children and adolescents. *JAMA* **302**: 1811–2.