

Psychotropic Medications for Children in Foster Care

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Disclosures

- I have no financial disclosures to make
- I have an active clinical practice and some of my patients are on significant combinations of medications that fall outside of my own monitoring guidelines

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Introduction

Over the last decade there has been an exponential increase in the use of psychotropic medications prescribed for emotional and behavioral disorders in children, particularly preschoolers.

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Introduction

- Research into the effects of these medications lags behind prescribing trends
- These trends and the lack of research to support current practice have important implications for our work with children

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“...data on safety and efficacy of most psychotropics in children and adolescents remain rather limited and are in sharp contrast with the advances and sophistication of the adult field. In child and adolescent psychiatry, changes in clinical practice have, by far, outpaced the emergence of research data and clinical decisions are frequently not guided by a scientific knowledge base.”

(Vitiello, B. et. al., JAACAP, 38(5), p.501, May 1999)

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Trends in Prescribing Practices-Child Welfare:

The few research studies available show rates of psychotropic medication use ranging from 13%-50% among children in foster care

(J Child Adolesc Psychopharmacol. 1999;9:3: 135-47 and 2006:16:4: 474-481; Peds 2008:121:1; e157-e163)

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Lack of Safety and Efficacy Studies of Psychotropic medications for children

- Brain continues to develop through adolescence
- Impact of adding psychoactive medications to a developing brain is unknown

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Lack of Safety and Efficacy Studies of Psychotropic medications for children

- Medications that were safe for use in adults that had unanticipated side-effects for children:
 - ◆ Tetracycline > dental discoloration
 - ◆ Stimulants > growth effects
 - ◆ Aspirin > Reye's syndrome

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Lack of Safety and Efficacy Studies –”off label prescribing

- FDA guidelines do not limit prescribing practice
- Medications are developed privately by Pharmaceutical companies
- FDA requires safety and efficacy studies for *target population* and *target purpose* only

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Federal government efforts at rectifying situation:

- Research on children is complicated and costly
- Child and Adolescent Psychiatry Trials Network (CAPTN)
- Research Units for Pediatric Psychopharmacology (RUPP's)

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Federal government efforts at rectifying situation:

- Pediatric Rule-FDA authority to require studies of meds safety and efficacy
- FDA Modernization Act-extends patent for 6 months in exchange for industry sponsored studies of already approved medications

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Diagnosis

- Diagnostic and Statistical Manual (DSM) was originally designed as a research instrument
- Problems with diagnosis leads to faulty treatment

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Diagnosis

- Children must meet adult criteria for many of the major mental illnesses including Depression, Bipolar Disorder, Anxiety, PTSD and Schizophrenia

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Diagnosis

- Shift to increasingly defining behavior as biologically determined.
- Comorbidity being seen as the norm so each symptom becomes a focus of medication intervention.
- Human Genome Project and increased understanding of Genetic influences in mental disorders – stay tuned

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Diagnosis

- Imaging studies-primarily a research tool at present
- Evolution of new generation of medications with improved safety profile
- “Listening to Prozac”-expanded role of psychotropic meds in the management of emotional disorders

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Societal and Professional Trends

- Desire for a “quick fix”
- Changing demands in the workplace can create “pathology”.
- Notion that “chemical imbalances” in the brain result in behavioral disorders justifies use of psychoactive agents.

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Influence of Managed Care

- Reimbursement rates “incentivize” brief med visits over psychotherapy
- Increased oversight of utilization for psychotherapy while medication visits typically are unlimited

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Influence of Managed Care

Belief that medications alone can treat mental disorders despite research that clearly shows combination treatment works best

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Influence of Managed Care

“It is important to balance the increasing market pressures for efficiency in psychiatric treatment with the need for sufficient time to thoughtfully, correctly, and adequately, assess the need for, and the response to medication treatment.” (AACAP policy statement 9/20/01)

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Implications for Practice

- Risk vs. benefit analyses are critical both in terms of treatment with medication or no treatment.
- Need for full disclosure about what is known about the medication and what is not known (specific to the experience of use in children).

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Implications for Practice

- Risks of undertreatment:
 - ◆ Kindling theory
 - ◆ Earlier presentation of mental illness is associated with worse prognosis.
 - ◆ Ex. Bipolar disorder – 15% mortality rate in adults compared to risks from Lithium treatment.

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Implications for Practice

- Role of prescriber in the informed consent process
- Individual beliefs/values of the patient (youth and parents) must drive decision-making.
- Review protocols are needed regarding psychotropic meds for child welfare.

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Implications for Practice

- Every child or adolescent has unique needs which require individualized treatment planning.
- At times, the appropriate treatment for a specific child will fall outside the parameters of these guidelines.
- Such cases should be considered for review

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Implications for Practice

- Medication should be integrated as part of a comprehensive treatment plan that includes:
 - Appropriate behavior planning
 - Symptom and behavior monitoring
 - Communication between the prescribing clinician and the youth, parents, guardian, foster parents, therapist(s), pediatrician, school and any other relevant members of the child or youth's treatment team

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Implications for Practice

Medication decisions should be appropriate to the diagnosis of record, based on specific indications (i.e., target symptoms), and not made in lieu of other treatments or supports that the individual needs.

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Implications for Practice

- There should be an effort, over time, to adjust medications doses to the minimum dose at which a medication remains effective and side-effects are minimized.
- Periodic attempts at taking the child off medication should also be tried and if not, the rationale for continuing the medication should be documented.

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Implications for Practice

Medication decisions need to be based upon adequate information, including psychiatric history and assessment, medication history, medical history including known drug allergies and consideration of the individual's complete current medication regimen (including non-psychoactive medications, e.g., antibiotics).

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Implications for Practice

“Anecdotally the prescribing of multiple psychotropic medications (“combined treatment” or “polypharmacy”) in the pediatric population seems on the increase. Little data exist to support advantageous efficacy for drug combinations, used primarily to treat co-morbid conditions. The current clinical “state-of-the-art” supports judicious use of combined medications, keeping such use to clearly justifiable circumstances.”

(AACAP policy statement 9/20/01)

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Implications for Practice

A child on more than one medication from the same class (e.g., two anti-psychotic medications) should be supported by an explanation from the prescribing clinician and may warrant review

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Implications for Practice

A child on more than three psychotropic medications should be supported by an explanation from the prescribing clinician and may warrant review

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Implications for Practice

Medication dosages should be kept within FDA guidelines (when available). The clinical wisdom, “start low and go slow” is particularly relevant when treating children in order to minimize side effects and to observe for therapeutic effects. Any deviations from FDA guidelines should be supported by an explanation from the prescribing clinician and may warrant review

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Implications for Practice

- Unconventional treatments should be avoided. Medications that have more data regarding safety and efficacy should be used over newly FDA-approved medications.
- The risk vs. benefit of a medication trial needs to be considered and continually reassessed, and justification should be provided, where the benefit of a medication comes with certain risks or negative consequences.

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Implications for Practice

Medication management requires the informed consent of the parents or guardians and must address risk/benefits, potential side-effects, availability of alternatives to medication, prognosis with proposed medication treatment and without medication treatment and the potential for drug interactions.

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Implications for Practice

Children on Psychotropic medications should be seen by their prescribing clinician no less than once every three months. This is a bare minimum and children in acute settings, displaying unsafe behavior, experiencing significant side-effects, or not responding to a medication trial or in an active phase of a medication trial should be seen more frequently.

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Implications for Practice

If laboratory tests are indicated to monitor therapeutic levels of a medication or to monitor potential organ system damage from a medication these lab studies should be performed every three months at a minimum (maintenance phase). If the medication is being initiated these lab studies will need to be performed more frequently until a baseline is achieved.

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Implications for Practice

Consider using patient information handouts:

Helping Parents, Youth and Teachers Understand Medications for Behavioral and Emotional Problems:

A Resource Book of Medication Information Handouts (2nd Edition)

Edited by Mina K. Dulcan, MD and Claudia Lizarralde, MD

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