Psychiatric Medication Management Tools and Tips for the Child Welfare Professional

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FDA approval

This term refers to the granting of an indication for a medication. Specifically, the FDA has reviewed all the relevant research studies and concluded that the medication is safe and effective for a specific medical problem/symptom in a specific population within a specific dose range.

This leads to the development of a label for the drug.
What is “off label” use?

• The Food and Drug Administration regulates the safety of drugs in our country. Medications need to undergo a long process of investigation and testing before the FDA approves them as a medication. The results of these investigations and testing determine 1) what condition the medications have been proven to be useful for 2) what dose ranges have been evaluated 3) what population of individuals does the medication appear to have safety for and 5) other important information.

• US law also requires that each human and animal drug have a specific set of written documentation that accompanies the product and is consistent with the packaging of the product. This is called “the label” and is also known as “prescribing information” or “package insert.”

• Off Label is more of a slang term that indicates that the medication is 1) being used for a condition not listed in the indications 2) Being used at a dose outside the dosage range listed on the label 3) Used in a patient population not specified in the indications in which the medication is prescribed is not within the guidelines of the published FDA label for the medication.

• Often times a better term would be “off indication”.
Clinical Indication

- When Child and Adolescent Psychiatrists are asked to treat conditions for which there are no medications with an FDA label/indication for pediatric use, they make decisions based on clinical research, best practice guidelines, and adult prescribing information. This information forms the basis of a use of the medication based on the available evidence and is often referred to as a **clinical indication**.
It is common in Child and Adolescent Psychiatry that a medication is being used in an “off-label” manner.

DHHS workers and parents who have concerns about the evidence that exists for the off label use should speak to the clinician. In addition, the American Academy of Child and Adolescent Psychiatry maintains an online database which lists FDA approval status and research evidence quality.

https://www.aacap.org/App_Themes/AACAP/docs/medical_students_and_residents/residents_and_fellows/FDA_II_Mood_Stabilizing_Anticonvulsant_Agents.pdf
The topic of prescribing psychiatric medication for youth is vast. The issue of prescribing for youth in foster care and juvenile justice is even more complicated.

- Informed consent
- Decision making
- Discussing medication with youth
Those working for DHHS have a multiplicity of reasons for needing to either monitor or evaluate the efficacy of medication treatment of youth in their care.

- Serving as a steward for insuring child in their custody are getting all their general needs met while in a placement.

- Attempting to understand a youth’s future risk of violence or criminal behavior and being aware of how relevant the status of mental health treatment is to impacting that risk.

- Evaluating the role the mental illness may have played in the child’s current placement in JJ or DYCF.
Excellent informational site and curriculum developed by Dr. Jim Rogers is available at the website for the Texas Department of Family and Protective Services [http://www.dfps.state.tx.us](http://www.dfps.state.tx.us)

Under foster care medical services

Provides more detail and is comprehensive in scope.
Complexity of Presenting Problems

Youth involved with JJ and DCYF have a multiplicity of behavioral problems and psychosocial need. The profile of these youth differ greatly from the profile of youth who participate in medication research. This makes it hard to interpret if medication will be as helpful in youth with complex issues.
Complexity of JJ Youth

• Northwestern Juvenile Project conducted at Cook County Detention Center:

  1 in 10 Youth met criteria for PTSD of these youth:
  93% had at least one other psychiatric diagnosis
  50% had two or more additional diagnosis
Complexity of DCYF involved Youth

Typical Algorithm for complex case

Case example: MC is a 16 year old male committed to SYSC for multiple violations of probation. Most recently, MC became assaultive to police when they attempted to arrest him for breaking into his neighbor’s home. MC has an early childhood history of ADHD, exposure to sexual abuse and neglect. His mother is currently struggling with Bipolar Disorder and active substance abuse.

Upon commitment, MC tests positive for amphetamine, K2, and opioids. On initial interview he appears hostile, grandiose and reports auditory and visual hallucinations as well as a decreased need for sleep.
Substance Sobriety

Treatment of Psychotic Symptoms

Treatment of Mood Instability

Anxiety/Depression

ADHD
Examples of mental health diagnosis in which biological evidence for an underlying dysfunction is strong

ADHD
Schizophrenia
Examples of mental health diagnosis in which we have not yet discovered a specific consistent pattern of biological dysfunction for which we have specific medications.

-Reactive Attachment Disorder, Intermittent Explosive Disorder
Pediatric Off Label Use

• Many medications used in Child and Adolescent Psychiatry are off label.

• Usually a result of fiscal concerns; costs a great deal for pharmaceutical companies to do drug trials on those under the age of 18.

• It is logistically more problematic and difficult to enroll children and adolescents in clinical trials.
Initial Questions

• What is the primary problem the youth worker is concerned with?

• How likely is that problem to be impacted by a medication?

• How much improvement can be expected by medication alone?
• What is the primary problem the youth worker is concerned with? —> **Identify target illness or symptom.**

• How likely is that problem to be impacted by a medication? —> **What is the evidence base?**

• How much improvement can be expected by medication alone? —> **What is the efficacy of the medication?**

• How will be know the target illness or problem is responding to the treatment? —> **ratings scales, SUDS**
Identification of Target Illness or symptom

- Well defined (for psychiatry) illness in which medication is addressing hypothesized biological dysfunction. “Disease model”, for example: schizophrenia vs.

- Poorly understood diagnosis for which multiple causes contribute, for example: reactive attachment disorder. In this type of problem medication tends to target different symptoms in contrast to one underlying biological dysfunction.
Psychiatric Medication Treatment Worksheet

Name of Youth: ___________________________________ D.O.B: ________________________________

Allergies:* ____________________________ Current Medical Problems:* ________________________________

Name of medication: __________________________________________________________

Starting dose: ___________ End dose: ___________

Condition or symptom to be impacted by medication: ________________________________________

Date projected to begin evaluating efficacy of medication: __________

Means of evaluating medication effect: ________________________________________________

Date of medication review: ________________________________
ADHD

- In general, medications for ADHD are very effective.
- Rates of effectiveness come close to the same rate we see with antibiotics for infection.
- For stimulants, effect of the medication can be seen within the same day when the correct dose is used.
- Non stimulant forms tend to have lower effectiveness but are still helpful, with Strattera being more helpful than Wellbutrin. Non stimulants take weeks to show their effect.
ADHD Medications

Stimulants: This general term refers to both chemical structure and mechanism of action of the drug.

There are two general classes of stimulants prescribed for ADHD deriving from the two parent drugs: Methylphenidate and Amphetamine.

Methylphenidate products:
Ritalin, Methylin, Metadate, Ritalin SR, Metadate ER, Methylin ER, Metadate CD, Ritalin LA, Concerta

Amphetamine products:
Adderall, Dexedrine Spansules, Adderall XR, Vyvanse
Who probably should not take stimulants or should do so only with caution and careful evaluation:

• Those with active substance abuse behaviors should probably be limited to Vyvanse or Concerta.

• Those with a history of a structural cardiac abnormality.

• Those individuals with the following physical complaints: history of dizziness, or fainting (especially with exercise), shortness of breath with exercise, palpitations, history of seizures may need a cardiologists screen.

• Those with the following family history: Death of a family member due to sudden cardiac death, cardiac death before age 35, family history of cardiac conditions such as QT syndrome, Wolf Parkinson White etc.
Typical Side Effects of Stimulants

- Appetite Suppression
- Insomnia
- Headaches
- Irritability
- GI cramps
- Depression/Sadness
- Tics
- “Zombie symptoms”
- Bipolar Activation/Psychosis

Generally easily managed by dose adjustments, changing timing of administration and changing the formulation of the medication.
Medical issues which need to be followed over time.

- Blood pressure and pulse
- Height, weight, body mass index, growth percentiles (for younger youth)
- Liver function lab studies (infrequent)
How do we monitor effectiveness of the medication ADHD Rating Scales before and after starting treatment.

Rating scales are best when provided by teachers or others who see the youth during the time the medication is working.

ADHD youth are usually not good at self evaluation and self monitoring.

You do not need to buy a rating scale. There are free scales available on the web. The Vanderbilt ADHD Diagnostic Teacher form; [http://www2.massgeneral.org/schoolpsychiatry/screening_adhd.asp#Vanderbilt](http://www2.massgeneral.org/schoolpsychiatry/screening_adhd.asp#Vanderbilt)
Non Stimulant Medications

- **Strattera (Atomoxetine):** Takes 6-8 weeks to show an effect, usually needs to be dosed between 1.5-2.1 mg per kilogram. Very helpful for kids with co-morbid anxiety and depression.

- **Wellbutrin (Buproprion):** Also takes weeks to show an effect, can sometimes help or worsen anxiety and depression, increases seizure risk. Highly misused in adult prison population locally.

- **Catapres/Kapvay/clonidine/Intuniv/Tenex/Guanfacine:** These are often called alpha agonists by physicians. Takes some time to have an effect. Seems to be helpful with curbing impulsivity less so helpful with attention. Can help with sleep.
Reactive Attachment Disorder and Disinhibited Social Engagement Disorder

• Really no medication trials that have demonstrated effectiveness in treating these conditions especially DSED. The definition of the disorder has changed. Causes of the problem are multifactorial and greatly impacted by attachment, environment and personal development. Very unlikely to have one underlying biological mechanisms to “treat”. Medication use here is “off label”

• Medication intervention is secondary and oriented at treating the most disruptive symptoms rather than a presumed biological pathology.

• Usually the physician will target one of the following symptom areas: depression, withdrawal, irritability, emotional reactivity.

• Range of medications used: Antidepressants, anti anxiety agents, antipsychotics, mood stabilizers, sleep medication, alpha agonists etc.
Tracking medication use in the complex disorders like RAD

- Document what the treatment goal is and the timeline to treatment and follow up.
- Fill out a baseline level of symptoms update as you go.
- Improvement in many areas takes many weeks if not months in some cases.
PTSD

• Medications can be effective especially when paired with psychotherapy interventions such as Trauma Focused CBT and DBT

• Again, doctors are usually more likely to be targeting a specific set of problematic PTSD symptoms:
PTSD symptom management

Hypervigilance/marked physiologic symptoms: Tenex, clonidine, 
Nightmares/Flashbacks: Prazosin 
Persistent negative beliefs, distorted cognitions, inability to exhibit positive states: SSRI antidepressants 
Severe flashbacks, mood reactivity/irritability may require atypical antipsychotics.
The only two medications FDA approved for treating PTSD at this time are:

- sertraline (Zoloft)  SSRI antidepressant
- paroxetine (Paxil) SSRI antidepressant

Not FDA approved but clinically useful:

- alpha agonists: clonidine, tenex, prazosin
- other SSRI antidepressants: fluoxetine (Prozac), citalopram (Celexa), escitalopram (Lexapro)
- Mood stabilizers: Lithium, Seroquel,
Bipolar and Mood Disorder Not Otherwise Specified

Over the years, many youth with mood instability and chronic irritability were labelled as having Bipolar Disorder and Mood Disorder NOS. DSM V has a new diagnostic category which better describes these children and is referred to as: Disruptive Mood Dysregulation Disorder.
Medications Utilized in Bipolar Disorder/ Mood Disorder and Disruptive Mood Dysregulation Disorder

• Mood stabilizers are a generic term used to encompass many types of medication used in this clinical problem and largely consist of anti seizure medications, and antipsychotic medications.
Anti seizure medications

Depakote, Depakene (valproic acid)* **:
Lamictal (lamotrigine):
Carbatrol, Tegretol (carbamazepine)* **:

- These medications were initially developed to treat seizure disorders but were subsequently found to help with treating mood disorders:

  They need weeks to have an effect.
  Require some ongoing laboratory monitoring*.
  Have blood levels which can be measured and may relate to clinical effect**.
Monitoring Symptoms

• Free online symptoms tracking list:

• Adolescent/young adult http://www.dbsalliance.org/site/PageServer?pageName=wellness_trouble_tracker

• School age child http://www.thebalancedmind.org/learn/library/mood-charts
Youth must be very compliant. Can not miss 3-4 doses in a row. Slow, specific dose escalation. Can take 8-12 weeks to reach goal dose. Steven Johnson’s rash (Toxic Epidermal Necrolysis) Ask if will interfere with oral contraception.
Big Issues-Depakote

- Severe onset of abdominal pain, vomiting, dark urine, swelling of face, yellowing of eyes—severe inflammation of the liver and or pancreas.

- Adverse effects on fetal development.
Big Issues- Carbamazepine Products

- Life threatening rash- Steven Johnson Syndrome
- Suppression of certain blood cells- platelets, white blood cells.
Lithium

• In its own category.

• Very helpful in reducing suicidality and aggression.

• Measurable blood level.

• Dangerous in an overdose.
Antipsychotics/Neuroleptics

- Despite the term, these medications are used for a range of problems including mood stabilization in Bipolar Disorder/Mood Disorder NOS/Depression with Psychosis.

- Also used at times for severe, persistent symptoms in ADHD, PTSD, RAD, and in Conduct Disorder.
Atypical Antipsychotics

Newer medications in general.
Class of medication you are likely to encounter.
Specific set of problematic side effects:
Weight gain, metabolic syndrome, sedation, movement disorders,
Atypical Antipsychotics

- Risperdal, Risperdal Consta, (risperidone)
  Invega (Paliperidone),
- Zyprexa/Zydis (olanzapine)
- Clozapine (clozaril),
- Abilify (arapiprazole),
- Geodon (ziprasidone),
- Seroquel (quetiapine fumarate)
Antipsychotic Monitoring

Either PCP or psychiatrist needs to be monitoring as follows:

Initially monthly weight, blood pressure, pulse, body mass index.
Initially every 3-4 months blood work evaluating blood sugar control, cholesterol and lipids.
Neuroleptic Malignant Syndrome

- Fever
- Stiffness throughout the body “lead pipe rigidity”
- Autonomic instability (heart rate and blood pressure varying dramatically).
- Confusion
Conduct Disorder
Key points

• Medications can reduce symptoms and improve functioning however, alone, they rarely result in a youth being symptom free.

• Sometimes the problem treated by medication has no impact on the issues related to JJ or DCYF involvement.

• One medication is unlikely to cure multiple behavior problems.

• One youth is likely to have multiple concurrent psychiatric problems.
Sudden Withdrawal of a Drug Possible Effects

- Withdrawal
- Remergence of symptoms of treated condition
- New medical problems
Withdrawals of Concern

• Benzodiazepine Withdrawal: Worst outcome seizure and death. Symptoms of withdrawal and mortality are related to the total daily dose of medication and the duration of use. So youngster who has been taking several milligrams a day for weeks. Once a day dose is less likely to be of concern. Withdrawal syndrome looks identical to alcohol withdrawal.

• Examples of benzodiazepines: Ativan, Xanax, Klonipin,
Further additional Resources

• **General resource for child care workers:**

• **General resource for child care workers.** Some of the information is specific to Texas law but in general this document has lots of helpful information. Psychotropic Medication for Children in Texas Foster Care. [https://www.dfps.state.tx.us/Training/PsychotropicMedication/begin.sap](https://www.dfps.state.tx.us/Training/PsychotropicMedication/begin.sap)

• **Information for child care workers — specific medications.** Free accurate up to date information about specific medications prescribed for persons with alcohol, drug and mental health conditions through SAMHSA. Has a downloadable applications for Searchable Psychotherapeutic Medication Database. [http://www.attcnetwork.org/explore/priorityareas/wfd/mat/index.asp](http://www.attcnetwork.org/explore/priorityareas/wfd/mat/index.asp)

Resources continued


• **Another good resource for medication, diagnosis and treatment issues**. The American Academy of Child and Adolescent Psychiatry Facts for Families site. Available to all at: [http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families_Pages/Psychiatric_Medication_For_Children_And_Adolescents_Part_IITypes_Of_Medications_29.aspx](http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families_Pages/Psychiatric_Medication_For_Children_And_Adolescents_Part_IITypes_Of_Medications_29.aspx)

• **Excellent free resource for symptom rating scales** for various disorders can be found at the Massachusetts General Hospital School Psychiatry website. [http://www2.massgeneral.org/schoolpsychiatry](http://www2.massgeneral.org/schoolpsychiatry).

• **Free resources for symptom tracking and quantifying** can be found at the Depression and Bipolar Support Alliance “Wellness Options”: [http://dbsalliance.org](http://dbsalliance.org)


• **Good resource for determining the identity of a prescribed medication you might find**. You can identify a pill but also if need be type in the name of medication and get some basic information about what “class” of medication it is: [http://www.drugs.com](http://www.drugs.com).

• Video of dystonia with neuroleptics: [http://www.youtube.com/watch?v=Gjiy1rDZpp8](http://www.youtube.com/watch?v=Gjiy1rDZpp8). “Acute dystonia”, Psychiatry Teacher series by Newcastle University.
Resources continued

• **Good resource for looking up evidence base** for a particular problem. [http://effectivechildtherapy.com/](http://effectivechildtherapy.com/) This site was created by the Society of Clinical Child and Adolescent Psychology.

• **Good resource for looking up evidence based psychotherapy**. [http://thereachinstitute.org](http://thereachinstitute.org)

• Government resource which provides **some decision making resources** for caregivers and professionals. Agency for Healthcare Research and Quality. [www.ahrq.gov](http://www.ahrq.gov).