Towards the Rational Use of Psychotropic Medications

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Building Bridges Initiative

- The BBI links residential providers with community based services and supports (2006 Summit), Joint Resolution

- Emphasizes:
  - Family Driven
  - Youth Guided
  - Culturally Appropriate
  - Coordinated Systems of Care

- TRANSFORMATION

- Tip Sheets available at: buildingbridges4youth.org

- Now collaborating on outcomes?
The American Association of Children's Residential Centers

Towards Rational Use Of Psychotropic Medications

Redefining Residential
One through Eleven

Creating Non-Coercive Environments
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.

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 traumatized children.
Medications are being prescribed to more kids & at younger ages

Between 1999 - 2007, the use of antipsychotics in 2 to 5 year olds doubled (Olfson et al, 2010).

Growing concern over the lack of established evidence

Diagnostic Challenges

Diagnostic overlap & “poor temporal stability”

Disruptive Mood Dysregulation Disorder

Trauma....
In total, the use of antipsychotic drugs nearly tripled from 1995 to 2008 in the U.S.

Between 1993 and 2002, office visits involving the prescription of atypical antipsychotics to children and youth increased five-fold.

Foster care youth are disproportionately prescribed psychotropics.

A 2012 study indicated that more than 40% of Foster Care youth are on 3 or more psychotropic medications.
While gains have been made in the last decade establishing the evidence base for some psychotropic medications for certain psychiatric conditions, important gaps in the evidence base remain (Jensen et al., 1999; McClellan & Werry, 2003; Vitiello, 2007).

There is scant evidence in adults or children for specific combinations of psychotropic medications used together or for the use of multiple medications ("polypharmacy") (Chen et al., 2011; Jureidini, Tonkin, & Jureidini, 2013).
Challenges to Our Evidence Based Emphasis

- The youth in residential care are often the most complex.
- Because of this, very little research is available to guide the multidisciplinary care offered within Residential.
- This creates significant changes in our use of medications.
CYMBALTA

- Adolescent clients prescribed Cymbalta?
- It functions as an SNRI
- Does it work?
Cymbalta vs Prozac vs Placebo

- A Double-Blind Efficacy and Safety Study of Duloxetine Fixed Doses in Children and Adolescents with Major Depressive Disorder, May 2014
- 463 children & adolescents
- 36 weeks (10 weeks of treatment)
- 2 doses of Cymbalta (60mg & 30mg)…224 youth
- 20mg of Prozac…117 youth, considered active controls
- Placebo…122 youth
- Outcome Measures: Childrens Depression Rating Scale, Adverse Events, Columbia Suicide Severity Rating Scale
Authors note that the results are “inconclusive” because neither the drug (Cymbalta), nor the active control (Prozac), “separated from placebo” at study endpoint.
8.4 Pediatric Use

Efficacy was not demonstrated in two 10-week, placebo-controlled trials with 800 pediatric patients with MDD, age 7-17. Neither Cymbalta nor the active control (indicated for treatment of pediatric depression) statistically separated from placebo. Duloxetine steady state plasma concentration was comparable in children (7 - 12 years), adolescents (13 - 17 years) and adults. Cymbalta has not been studied in patients under the age of 7. Thus, safety and effectiveness in the pediatric population has not been established [see Boxed Warning and Warnings and Precautions (5.1)].

Decreased appetite and weight loss have been observed in association with the use of SSRIs and SNRIs. Pediatric patients treated with Cymbalta in MDD clinical trials experienced a 0.2 kg mean decrease in weight at 10-weeks, compared with a mean weight gain of approximately 0.6 kg in placebo-treated patients. The proportion of patients who experienced a clinically significant decrease in weight (>3.5%) was greater in the Cymbalta group than in the placebo group (11% and 6%, respectively). Subsequently, over the six-month uncontrolled extension period, most Cymbalta-treated patients trended toward recovery to their expected baseline weight percentile based on population data from age- and gender-matched peers. Perform regular monitoring of weight and growth in children and adolescents treated with an SNRI such as Cymbalta.
TADS - One Year Follow-Up

FIGURE 1. Depression Scores From Baseline to End of Naturalistic Follow-Up for 327 Adolescents With Major Depressive Disorder Treated With Fluoxetine, Cognitive-Behavioral Therapy (CBT), or a Combination

*Derived from the random coefficients regression model with adjustments for fixed and random effects.*
Fig. 1 Average ADHD and ODD Symptoms and Columbia Impairment Scale scores through 36 months. Comb = combination of medication management and behavior therapy; Med = medication management; Beh = behavior therapy; CC = usual community care.
Other concerns

- Depakote in Bipolar Disorder
- Lithium
- The TEAM study
- Geodon
Rational Use of Psychotropics

- Assessment, Diagnosis & Treatment Planning
- Medication Management, Monitoring & Quality Improvement
- Developmental Context & Discharge Planning
- Collaboration & Innovation
- Overcoming Barriers
The “reason for referral” may appear quite different once the child is in a therapeutic milieu.

Trauma **MUST** be considered in the clinical conceptualization. A trauma assessment (ACEs?) must be an integral part of the diagnostic process.

Developmental considerations are essential in the diagnostic formulation. A diagnosis of Bipolar disorder in an 8 year old may look quite differently in a 14 year old.

Youth and families should be fully involved in making and supporting both pharmacological and non-pharmacological treatment decisions. It is critical that youth and families are provided psychoeducation regarding medication, that their attitudes towards and beliefs about medications are respected, and that open dialog is encouraged. Youth responses to medication will be variable (Foltz & Huefner, 2013).
Wherever possible, minimizing medication use to the **lowest effective dose** and **fewest number** of medications should be the goal.

Rational use of medication also must **attend to duration of psychotropic treatment**. Longer term treatment regimens are sometimes utilized based on research of short-term outcomes, despite emerging evidence of potential risks of such sustained usage on the developing brain and body, for example increased risk of obesity and cardiovascular and endocrine abnormalities in chronic antipsychotic usage.

**Careful monitoring** of the impact of medication trials will improve outcomes.

**Information has to be communicated** across treatment providers about the benefits, drawbacks, and responses to medications in the child’s care and treatment, and the concomitant risk of communication breakdowns.

**Training regarding psychotropic medication** for employees at all levels, youth, families, advocates, funders, and external stakeholders will develop understanding of both reasonable expectations and limitations to psychotropic medication use, as well as the range of potential adverse effects, and will elevate the perceived and actual importance of monitoring and communicating regarding medication response, drug interactions, etc.
Developmental Context & Discharge Planning

- Youth change in response to their ongoing experience. Development of resiliency, executive functions, and coping abilities will result from treatment or simply maturation, and medications that are “necessary” early in an episode of care may need to be reconsidered periodically.

- Discharge and transition planning must minimize post-discharge instability in medication... It is critical to collaborate actively with youth, family, caregivers, and community providers while also building new partnerships and improving effectiveness of communication between settings, in order to reduce adverse events and the potential need for readmission.
Psychiatrists and other prescribing practitioners who work in youth residential treatment settings should not operate in a “vacuum.” Reliable communication strategies must be established for efficient collaboration with psychiatrists & prescribers and residential providers.

Collaborations with research institution partners can develop or enhance an evidence base for psychotropic medication use in residential treatment, and improve diagnostic and clinical understanding.

This level of collaboration will enhance the dissemination of valuable information, research, outcomes, and advocacy for children & families.
Overcoming Barriers

- Dialogue with Team members. Examine the assumptions of the strengths & limitations of medication. Recognize that psychiatrists & medications are one piece of the overall treatment approach.

- The treatment team must recognize that *health is not the absence of symptoms.*

- Promote increased use of *family-driven* and *youth-guided* practice and facilitate youth and families in becoming much more able to see themselves as *agents of their own change* as opposed to their relatively passive role in the traditional medication compliance regimen.
Conclusions

- AACRC urges its members as well as other practitioners in the field to implement the rational approach to psychotropic medication described in this paper and the specific practices identified, and to be active consumers of the evidence basis for psychotropic medication.

- Judicious use of these medications alongside other therapies will allow for the children and families we serve and support to grow and thrive to the best of their ability.
Conclusions

- The goal of our efforts has to stay focused on the engagement, success, and happiness of youth & families.

- Establishing standards of care must be examined, practiced, and re-examined. The youth in residential care are often not the subjects of common research.

- While the challenges within residential care are often underestimated, the outcomes will be enhanced through careful monitoring, collaboration, and participation of providers, youth & families.
Questions? Contact

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