

Practice & Policy Brief



Psychotropic Medication and Children in Foster Care:

Tips for Advocates
and Judges

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JoAnne Solchany, PhD, ARNP

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Editor:

Claire Sandt Chiamulera

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About the ABA's Improving Understanding of Maternal and Child Health Project:

This project seeks to help legal professionals improve health outcomes for vulnerable young children who are involved in the legal and judicial systems. It develops new materials and provides training and technical assistance to improve child health-related knowledge and skills of attorneys and judges who handle cases involving very young children.

About the ABA Center on Children and the Law: The ABA Center on Children and the Law, a program of the Young Lawyers Division, aims to improve children's lives through advances in law, justice, knowledge, practice, and public policy. Its areas of expertise include child abuse and neglect, child welfare and protective services system enhancement, foster care, family preservation, termination of parental rights, parental substance abuse, child and adolescent health, and domestic violence.

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Children who enter foster care face many changes and challenges that can lead to mental health disorders treated with psychotropic medications. Many have experienced abuse and neglect. Some have witnessed violence and trauma. Others have parents who suffer profound mental health issues. Regardless of what led to their involvement in the child welfare system, all face separation, broken relationships, and confusion. Increasing their vulnerabilities are risk factors such as poverty, neighborhood violence, exposure to parental mental illness, racial discrimination, lack of food, and homelessness.

The paths to a mental health diagnosis are numerous and complex. Genetically some of these children are already prone to disruptions in their mental health. Mental health disorders such as attention deficit disorder or bipolar disorder, even borderline personality disorder, are thought to have genetic components that place children at risk for developing the same disorders as their parents. Environmental experiences are also linked to mental health issues such as conduct disorder, depression, and anxiety disorder. Exposure to violence is directly linked to post traumatic stress disorder and depression.

The Role of Medication in Healing

For children and teens in foster care who struggle with mental health disorders, the goal is to help them heal and function optimally. Among their needs are to:

- understand what is happening to them, why they are not living with their parents, and their options.
- be able to feel their emotions and work through them, but know how to manage them in age-appropriate ways so they do not interfere with their success, growth, and development.
- be able to communicate with those who advocate for them and make decisions on their behalf.
- feel stable or organized in their thinking so they can reclaim age-appropriate power and take charge of their lives.

The paths to a mental health diagnosis are numerous and complex.

Medications can help children and teens in foster care, but they can also further impair them, derail them, and sabotage them. Without a clear understanding of their mental health issues, misdiagnoses can be made and incorrect medications can be prescribed. If there is no reliable caregiver who can describe the child's struggles, information collected can be biased and incomplete. If emotional trauma underlies the presenting symptoms and is not addressed, medications can have no effect or increase problems. If medications are prescribed but other therapies are not provided and supervision of the medication is inadequate, healing and stabilization supporting healthy growth will not occur. Finally, if caregivers are not adequately trained and educated in caring for a child with significant emotional and psychological needs, medications can often be given to the child to "manage their behaviors" rather than to truly treat the child's illness.

To adequately and successfully represent and speak for a child or teen in foster care, the child's advocate must be able to communicate with the child and discuss the child's experiences. Does the child manage his or her acting-out behaviors and emotions, use positive social skills, think clearly, and track the ongoing events in their lives? Children and teens also need to be safe. Depression or suicidal thinking must be addressed. Self-abusive behaviors must be contained and risk-taking behaviors reduced. Medications can be part of a successful intervention and treatment plan. Working with children and teens in foster care requires a solid understanding of the positive and negative aspects of medication use in this population.

Common Child and Adolescent Diagnoses

Statistics on the presence of psychiatric diagnoses in children in foster care vary from a low of 29% to a high of 96%.¹ Diagnoses in school-age children and adolescents fall into several groups, including mood disorders, thought disorders, and behavioral disorders. The most common diagnoses can be found in Table 1.

Children and adolescents can also experience mental retardation, fetal alcohol syndrome, learning disorders, communication disorders, pervasive developmental disorders (including autism), feeding/eating disorders, adjustment disorders, and dissociative disorders. Adolescents aged 14 and older can be diagnosed with borderline personality disorder. At age 18, other personality diagnoses can be applied, although features of these disorders can begin to emerge earlier during childhood and adolescence.

Table 1:

Common School-age Child and Adolescent DSM-IV-TR Diagnoses

Mood Disorders

- Depression
- Depression with psychotic features
- Bipolar disorder

Mood disorders are a group of disorders that reflect disturbances in mood stability. Mood issues are the primary feature of the disturbance and children/teens seem stuck in a cycle of depressed mood as in depression or fluctuate their moods quickly, from depressed to euphoric or angry, as in bipolar disorder.

Anxiety Disorders

- Obsessive-compulsive disorder
- Post traumatic stress disorder
- Generalized anxiety disorder

With anxiety disorders, the underlying feature is rooted anxiety. This can be a general state where anxiety is present fairly consistently as in generalized anxiety disorder, where the anxiety is manifested in repetitive behaviors or chronic worries as in obsessive compulsive disorder, or the anxiety is generated by a trauma or extreme stressor has triggered other symptoms such as hypervigilance and nightmares as in post traumatic stress disorder.

Thought Disorders

- Schizophrenia
- Psychotic disorder

Thought disorders are those that interfere with coherent, rational thinking and the ability to process incoming information and events. There can be disturbances in thinking and the ability to make sense of things. There can also be additional symptoms, such as visual hallucinations, hearing voices, or believing things are happening when they are not.

Attention-Deficit and Disruptive Behavior Disorders

- Attention-deficit hyperactivity disorder
- Conduct disorder
- Oppositional defiant disorder

This group of disorders is rooted in the ability to manage one's behavior and attention. ADHD is related to the ability to pay attention, prioritize, and process information. Conduct disorder is essentially a disregard for rules and authority figures and may involve criminal involvement. Oppositional defiant disorder is generally a reluctance to follow caregiver rules or school rules.

Elimination Disorders

- Enuresis
- Encopresis

These disorders involve an inability to manage one's elimination of either urine or stool after successful potty training. The underlying issues often involve anxiety or trauma.

Other Disorders of Infancy, Childhood or Adolescence

- Separation anxiety disorder
- Reactive attachment disorder
- Anorexia
- Bulimia

Separation anxiety disorder is rooted in difficulty separating from a caregiver. Reactive attachment disorder reflects a traumatized pattern of relationships. Anorexia/bulimia are eating disorders that often first appear in adolescents.

Note: the DSM-IV-TR refers to the Diagnostic Statistical Manual of Mental Disorders IV, Text Revision

Diagnoses in Infants, Toddlers, and Preschoolers

Diagnoses among children aged six and under are best addressed by using the alternative diagnostic classification system of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R).² Through this system, young children can be seen through a developmental lens as well as a mental health lens. The relationships the child experiences are also explored, as young children are especially vulnerable to the abilities and emotional states of their caregivers. Common diagnoses in young children include:

- post traumatic stress disorder
- deprivation/maltreatment disorder
- anxiety disorders, i.e., separation anxiety disorder, generalized anxiety disorder
- depression
- adjustment disorder
- regulation disorder
- sleep behavior disorder
- relationship disorders

Infant and young child mental health is often misunderstood. These children are often underdiagnosed for depression, problematic grief, trauma, and anxiety. Understanding how the child's relationships play a role is crucial, and often overlooked.

Callie, age 5

Callie was so distractible that any environmental change or sound caused her to lose focus to the point she could not refocus without a great deal of support and management. In school this led to children avoiding her, getting frustrated with her, and Callie becoming sad, depressed, and withdrawn because she could not successfully socialize with other kids or keep track of what was being taught. At home it led to constant supervision and frustration for Callie.

Placing Callie on a low dose of a stimulant, a typical ADHD medication, helped her focus, stay on task, and get along with other children. The medication chosen was a short-acting medication, at the lowest effective dose. Her success was monitored through home and school reports, as well as Callie's report. Regular therapy continued and was aimed at developing better social skills and managing her emotions.

A Multimodal Approach to Managing Mental Health Disorders in Children

Managing mental health issues and the symptoms experienced by children and adolescents involves many modalities:

- **Medication treatment, or psychopharmacology**, can alleviate or lessen the symptoms that accompany many mental health disorders. For example, medication may decrease the impulse to tantrum, help a child regulate physiologic responses to emotions, or eliminate auditory hallucinations. In addition, proper medication support can provide behavioral stability and support with emotional regulation that a child or teen may need to readily engage in other forms of therapy. For example, a very depressed teen who cannot control her crying when she needs to be able to talk about her abuse and history can feel more in control emotionally with the right medication, allowing her to discuss the important issues and aid in her healing.
- **Behavioral therapy**, for example using reward charts, can help increase positive behaviors and decrease negative acting out.
- **Cognitive behavioral therapy** can help correct a pattern of negative thoughts that interfere with the ability to relate to others.
- **Play therapy** can help heal past trauma and facilitate a child's return to normal functioning.
- **Child-parent psychotherapy** involves working directly with the parent and child to address issues within their relationship and help the child increase healthy ways of interacting and functioning. Parents are helped to become more reflective, develop a deeper understanding of their child and their role in their child's life. They also learn how to interact with their child in ways that promote a healthy and secure attachment and to support a healthy growth and development trajectory. Parent coaching can also be an element of this modality.
- **Dialectical behavioral therapy (DBT)** can provide important skills, such as distress tolerance and emotional regulation, in struggling adolescents and help them integrate them into their daily interactions.

All of these treatments are valid and can help manage symptoms, facilitate healing, and return children to optimal functioning.

Managing mental health issues and the symptoms experienced by children and adolescents involves many modalities.

What are Psychotropic Medications?

Psychotropic medications are prescribed to manage psychiatric and mental health disorders or issues. They include mood stabilizers, antipsychotics, anti-anxiety medications, and stimulants. Within these types of medications are subtypes. (See Table 2 for a list of common psychotropic medications.)

Cole, age 7

Cole had lived with his mother who was using drugs and would often abandon him to care for his infant brother for days at a time when he was only three. He was also exposed to sexual and physical abuse by his mother's friends and colleagues. Cole, who was discovered by a neighbor stealing food from a garbage can, was disheveled and barely dressed; both he and his brother were placed in foster care.

Cole got lucky; his biological father, who had been looking for him since he was six months old, was located. He worked with social services to gain custody of his son and Cole was adjusting well (his infant brother was severely failure to thrive but was stabilized and adopted).

Cole's mother was eventually sentenced to eight years in prison. She was able to have phone and letter contact with Cole. She called frequently and often told Cole he would come live with her again one day and they would be a family. She even told him he would be able to come and stay with her in the prison for a weekend.

Cole began to hear voices. He would stay awake all night trying to avoid nightmares of people killing him or hurting him and his dad, and he began to think his head was going to "blow up." He stated, "You have got to stop these voices in my head, they are giving me a headache, I think there is a bomb in there." Some individuals thought this may be prepsychosis. Instead of putting him on medication therapy, they helped him take some control, reconfirming he was now living with his dad and would not go back to his mother. Phone calls/letters with his mom were stopped until the situation could be further assessed.

Within a week, Cole's symptoms vanished and he was back on track. He now knows he has the power to control when he communicates with his mom. His maternal grandfather has been supportive of this and has developed a positive, nonthreatening relationship with him. Cole continues regular, weekly therapy.

Table 2:

Psychotropic Medications

Medication Type	Subgroup	Common Medications	Typical Side Effects (not all inclusive)	Symptoms/ Issues Targeted
Antidepressants	SSRIs (Selective Serotonin Reuptake Inhibitors)	<ul style="list-style-type: none"> • Citalopram (Celexa) • Escitalopram (Lexapro) • Fluoxetine (Prozac)* • Fluvoxamine (Luvox) • Paroxetine (Paxil) • Sertraline (Zoloft) 	<ul style="list-style-type: none"> • Headache • Agitation • Nervousness • Feeling emotionless • Decreased appetite • Suicidal ideation • Stomach upset • Fatigue • Sexual dysfunction 	<p>Symptoms of depression including depressed mood, lethargy, anhedonia, inability to sleep, excessive sleep, and isolation/withdrawn behavior; can also be used in the treatment of anxiety.</p> <p>*Only antidepressant approved for use in children age 8 and older for depression</p>
	Tricyclics	<ul style="list-style-type: none"> • Clomipramine (Anafranil) • Amitriptyline (Elavil) • Desipramine (Norpramin) • Imipramine (Tofranil) • Doxepin (Sinequan) 	<ul style="list-style-type: none"> • Stomach upset • Headache • Tiredness • Appetite increases • Dry mouth • Urinary retention • Dizziness/drop in blood pressure when going from sitting to standing 	
	MAOIs (Monoamine oxidase inhibitors)	<ul style="list-style-type: none"> • Phenelzine (Nardil) • Tranylcypromine (Parnate) 	<ul style="list-style-type: none"> • Sleepiness • Dizziness • Feelings of skin prickling • Insomnia • Dry mouth • Diarrhea • Nervousness • Muscle aches • Weight gain • Sexual dysfunction • Blood pressure changes 	
	Others	<ul style="list-style-type: none"> • Trazodone (Desyrel) • Venlafaxine (Effexor) • Mirtazapine (Remeron) • Nefazodone (Serzone) • Bupropion (Wellbutrin) 	<ul style="list-style-type: none"> • Seizures • Headache • Appetite changes • Restlessness • Agitation • Hostility • Dizziness 	
Antipsychotics	Typical	<ul style="list-style-type: none"> • Haloperidol (Haldol) • Loxapine (Loxitane) • Thioridazine (Mellaril) • Thiothixene (Navane) • Fluphenazine (Prolixin) • Mesoridazine (Serentil) • Trifluoperazine (Stelazine) • Chlorpromazine (Thorazine) • Perphenazine (Trilafon) 	<ul style="list-style-type: none"> • Weight gain • Involuntary repetitive movements • Agitation • Dizziness • Excess salivation • Lowered white blood cell count • Sexual dysfunction • Joint stiffness • Tardive dyskinesia 	Thought disorders such as schizophrenia and psychosis; symptoms such as hallucinations, delusions, impaired judgment, severe difficulty with social interaction, loose associations, and paranoia.

Table 2:

Psychotropic Medications (continued)

Medication Type	Subgroup	Common Medications	Typical Side Effects (not all inclusive)	Symptoms/ Issues Targeted
Antipsychotics	Atypical	<ul style="list-style-type: none"> • Aripiprazole (Abilify) • Clozapine (Clozaril) • Ziprasidone (Geodon) • Risperidone (Risperdal) • Quetiapine (Seroquel) • Olanzapine (Zyprexa) 	<ul style="list-style-type: none"> • Weight gain • Agitation • Sexual dysfunction • Tiredness • Lactation • Sleepiness • Heart problems • Stiffness 	Thought disorders such as schizophrenia and psychosis; symptoms such as hallucinations, delusions, impaired judgment, severe difficulty with social interaction, loose associations, and paranoia.
Anti-anxiety		<ul style="list-style-type: none"> • Lorazepam (Ativan) • Buspirone (BuSpar) • Prazepam (Centrax) • Propranolol (Inderal) • Clonazepam (Klonopin) • Escitalopram (Lexapro) • Chlordiazepoxide (Librium) • Oxazepam (Serax) • Atenolol (Tenormin) • Clorazepate (Tranxene) • Diazepam (Valium) • Alprazolam (Xanax) • Guanfacine (Tenex) • Diphenhydramine (Benadryl) • Catapres (Clonidine) • Hydroxyzine (Vistaril) 	<ul style="list-style-type: none"> • Confusion • Sleepiness • Agitation • Hallucinations • Fear • Psychosis • Rage • Memory impairment • Slurred speech • Lethargy • Spaciness • Disorientation • Suicidal ideation 	Symptoms including racing thoughts, feelings of overwhelming dread, rumination, excessive worry, excessive fear, tension, inability to sleep, inability to concentrate/ focus and irritability.
Attention Deficit/ Hyperactivity	Stimulants	<ul style="list-style-type: none"> • Amphetamine (Adderall) • Lisdexamfetamine (Vyvanse) • Dextroamphetamine (Adderal) • Pemoline (Cylert) • Dextroamphetamine (Dexedrine) • Methylphenidate (Ritalin and Concerta) • Dexmethylphenidate (Focalin) 	<ul style="list-style-type: none"> • Appetite disturbances • Weight loss • Agitation • Sleep disruptions • Insomnia • Rage • Disorganization • Compulsions • Obsessive thoughts • Forgetfulness • Nervous movements • Suicidal ideation 	Symptoms such as inability to focus, severe distractibility, inability to sit, fidgeting, irritability, impulsivity, excessive daydreaming, difficulty following directions/ listening, blurting out statements or words, and aggression.
	Non-Stimulants	<ul style="list-style-type: none"> • Guanfacine (Intuniv) • Atomoxetine HCL (Strattera) 	<ul style="list-style-type: none"> • Irritability • Sexual dysfunction • Suicidal ideation • Blood pressure issues 	
Anti-panic		<ul style="list-style-type: none"> • Clonazepam (Klonopin) • Paroxetine (Paxil) • Alprazolam (Xanax) • Sertraline (Zoloft) 	<ul style="list-style-type: none"> • Drowsiness • Lack of coordination • Suicidal ideation • Agitation • Disruption of feeling intensity 	Panic attacks with symptoms such as sudden fear, impending doom, or nervousness, physical symptoms such as sweating, rapid heartbeat, increased breathing, chest pains, and feeling as if one is dying. Symptoms are present without any actual threat present.

Medication Type	Subgroup	Common Medications	Typical Side Effects (not all inclusive)	Symptoms/ Issues Targeted
Anti-obsessive		<ul style="list-style-type: none"> • Clomipramine (anafranil) • Fluvoxamine (Luvox) • Paroxetine (Paxil) • Fluoxetine (Prozac) • Sertraline (Zoloft) 	<ul style="list-style-type: none"> • Agitation • Drowsiness • Sleep disruption • Appetite disturbances • Headache • Nervousness • Feeling emotionless • Suicidal ideation • Stomach upset • Fatigue • Sexual dysfunction 	Obsessive thoughts that are repetitive and unwanted (they can come in words or pictures and can be violent, sexual, or scary); extreme fear of something such as germs, dirt, or contamination; fears that doors are not locked or the oven was left on; impulsive thoughts of hurting someone or shouting bad things at people; or a fixation on a negative thought or event.
Mood Stabilizers		<ul style="list-style-type: none"> • Valproic acid (Depakene) • Depakote • Eskalith • Lithium (Lithobid) • Lithonate • Lithotabs • Lamotrigine (Lamictal) • Gabapentin (Neurontin) • Carbamazepine (Tegretol) • Topiramate (Topamax) 	<ul style="list-style-type: none"> • Weight gain • Tremors • Nausea • Appetite disturbances • Blurred vision • Dry mouth • Hives • Giddiness • Elimination disturbances • Seizures • Ringing in the ears 	Illnesses such as bipolar disorder for symptoms such as rapid mood shifts, periods of euphoria and periods of depression, paranoia, excessive sleep periods, excessive wake periods, and impulsivity.
Sleep Medications		<ul style="list-style-type: none"> • Zolpidem (Ambien) • Amobarbital (Amytal) • Lorazepam (Ativan) • Diphenhydramine (Benadryl) • Chloral Hydrate • Triazolam (Halcion) • Eszopiclone (Lunesta) • Phenobarbital • Estazolam (prosom) • Temazepam (Restoril) • Alprazolam (Xanax) 	<ul style="list-style-type: none"> • Sleepiness • Sleep walking • Dry mouth • Lack of coordination • Hallucinations 	Inability to sleep, insomnia, frequent night awakening, repetitive nightmares.
Alpha Agonists		<ul style="list-style-type: none"> • Guanfacine (Tenex or Intuniv) • Catapres (Clonidine) 	<ul style="list-style-type: none"> • Constipation • Dizziness • Drowsiness • Dry mouth 	Used in attention/hyperactivity disorders, to reduce anxiety, and to help regulate emotions.
Hormonal Agents		<ul style="list-style-type: none"> • Drospirenone and ethinyl estradiol (Yaz and Beyaz) 	<ul style="list-style-type: none"> • Blood clots (especially when smoking) • Water retention • Irritability 	Premenstrual dysphoric disorder including severe mood dysregulation.

Source: Adapted from National Alliance on Mental Illness. *Commonly Prescribed Psychotropic Medications*, available at www.nami.org.

Table 3: Common Symptoms of Mental Health Disturbances in Children

Various symptoms are often seen in the mental health disturbances of children and teens. These are symptoms that advocates and caregivers should be aware of to better understand what is atypical and a red flag for further evaluation. Symptoms can be brought about through different ways, illnesses can manifest differently in children, and multiple mental health issues may co-exist.

Behavioral

- Excessive crying
- Aggression
- Self-abuse, i.e., biting or hitting self, head banging
- Destruction of property
- Defiance/arguing
- Inability to manage behavior in a classroom
- Suicidal attempts
- Severe/frequent tantrums

Affective/Emotional

- Profound sadness
- Lack of eye contact
- No or few expressions of joy
- Lethargy
- Suicidal ideation

Biobehavioral

- Refusal to eat
- Sleep disruptions
- Exaggerated startle response
- Bedwetting
- Wetting/soiling pants
- Extreme distraction

Benefits of Psychotropic Medications

Medications make life easier for many children and adults everyday. Medications save lives, relieve pain, manage troublesome symptoms, and help people improve their ability to function in the world. These medications specifically target symptoms and issues associated with mental illness and mental health.

- **Thought disorders**, such as schizophrenia, can often be helped by medications such as risperidone (Risperdal), which promotes the ability to think more clearly and function at a higher level.
- **Mood disorders**, such as depression, can be helped with medications such as sertraline (Zoloft), which help regulate emotions and address basic issues like sleep and concentration.
- **Behavior disorders**, such as conduct disorder, can often be helped with anti-anxiety medications such as atenolol (Tenormin), to help manage aggressive outbursts.
- **Attention disorders**, such as attention deficit disorder, can be managed with medications such as amphetamines (Adderal) to improve focus, increase concentration ability, and decrease vulnerability to distraction.

Drawbacks of Psychotropic Medications

No medication comes without risk of side effects or other interferences in the body. Some antidepressants can reduce the ability to experience emotions, even pleasurable emotions, and can eliminate interest in sex.³

Behavior management medications often cause drowsiness and withdrawn behavior. Attention disorder medications can interfere with appetite or sleep and create additional problems for a child. Some psychotropic medications cause tics, nightmares, and even some of the same symptoms they aim to help, such as hearing voices. Some medications used to treat thought disorders can cause lifelong side effects that do not go away even when the medication is stopped. These side effects can include things like repetitively smacking one's lips or other odd movements.

Antipsychotic medications such as risperidone (Risperdal) or olanzapine (Zyprexa) as well as some of the mood stabilizing agents and antidepressants can cause weight gain to varying degrees. A few pounds can profoundly impact the developing child's self-esteem, performance, and relationships. Some medications are linked to obesity, even when used for only a few months. Not only does weight gain impact self confidence but it also places children and teens at risk for diabetes, heart disease, eating disorders, and a lack of compliance with treatment recommendations. Rapid weight gain also decreases the motivation to exercise, the desire to socialize, and the ability to engage in typical physical activities. Weight gain with psychotropic medications is a serious issue that needs to be taken into account.

In children and adolescents, medications can sometimes be used to help diagnose mental health conditions. For example, when a child has a difficult time paying attention in class, is falling behind with school work, and is having severe tantrums involving aggression, diagnoses such as attention deficit hyperactivity disorder, post traumatic stress disorder, depression, or even bipolar disorder might be considered. A stimulant typically used to treat ADHD may be tried to see if the child responds well to the treatment and the symptoms come under control. The successful use of the medication helps to secure the ADHD diagnosis. If, however, a child is thought to be bipolar and is placed on aripiprazole (Abilify) or lithium with no effects or worsening of symptoms, the diagnosis of bipolar disorder may be ruled out and alternative diagnoses will be considered.

No medication comes without risk of side effects or other interferences in the body.

Psychotropic Medication Use in School-age Children and Adolescents in Foster Care

Little is known about how medications impact children and adolescents in the short or long term. Children are not just “mini adults”; they cannot just be given a smaller dose because they have smaller bodies. Children, well through adolescence, are growing, changing, and maturing on the outside as demonstrated by their growth and pubertal changes. They are also growing on the inside as their brains and nervous systems mature. Controlled research on medication use with children is rarely conducted since it carries too high a risk for the children. Therefore, most research is naturalistic or based on case studies, which often provide biased, inaccurate, or incomplete information on medication use.

Multiple studies and reports have found that children in foster care are vulnerable to inappropriate or excessive medication use. The issues vary but the underlying concern that children in care are more vulnerable to improper psychotropic medication use remains the same. In addition to being in foster or state care, other factors that increase the risk of inappropriate use of psychotropic medication among children and adolescents include:

- being a child or adolescent;⁴
- being poor;⁵
- living in group care;⁶
- being hospitalized in psychiatric inpatient units;⁷ and
- being incarcerated.⁸

Findings from state studies of psychotropic medication use among children in foster care include:

- A California study found that in children in foster care between the ages of 6 and 12, 16% had been on some form of psychotropic medication.⁹
- In a study of Utah’s foster care system, over 44% of children in foster care had been diagnosed with one or more mental health conditions. Of these, 35% were receiving psychotropic medications. Medication use also increased with the age of the children.¹⁰
- In Texas, a study of Medicaid children and adolescents found increases in antipsychotic use in children, specifically in children between ages 10 and 14.¹¹

Josh, age 5

Josh was on multiple medications while in foster care due to his severe acting out, including running into traffic, destructive tantrums, and aggression towards peers. His foster parents struggled with him from the beginning and had only wanted to accept his younger sister, who was two. When Josh was removed from this foster home and placed in a home where he was wanted by foster parents who took a great interest in him, all of his aggressive, impulsive behaviors disappeared. He continued to need only medication for his attention deficit disorder to help him concentrate in school. Josh and his younger sister were eventually adopted by this family where he continues to excel.

- Another Texas study found that children in foster care enrolled in Medicaid were three times as likely to receive psychotropic medication than other children enrolled in Medicaid. Of these, more than 40% received more than three psychotropic medications and over 15% were receiving at least four.¹² Other studies have found similar results.¹³
- A Minnesota study examined records of 473 children in foster care and found that 43% received some type of psychotropic medication.¹⁴ Of these, use was higher in males and older children; however use of these medications in children under age eight ranged up to 30%.
- A Connecticut study of children and adolescents enrolled in Medicaid revealed almost five percent were on psychotropic medications. About 14% of these children were on more than one psychotropic medication; these children were more likely to be male, older, and in state care.¹⁵

The medications prescribed reflect all psychotropic drug groups. Use of Selective Serotonin Reuptake Inhibitors (SSRIs) for depression, stimulants for attention/hyperactivity disorders, and antipsychotics have all increased. A review of youth enrolled in Medicaid in seven states revealed that although the rates of antipsychotic medications changed little for disorders such as schizophrenia or bipolar disorder, there was a vast increase in using them with other diagnoses such as conduct disorder, attention/hyperactivity disorders, and anxiety and depression disorders.¹⁶ This increase is of concern due to the potency of antipsychotic drugs and their high potential for side-effects. In addition, their impact on growth, development, and the immature neurological system is unknown.

Multiple studies and reports have found that children in foster care are vulnerable to inappropriate or excessive medication use.

Psychotropic Medication Use in Infants, Toddlers, and Preschoolers

Children under six years who are experiencing mental health disruptions are extremely vulnerable whether they are in foster care or not. These children are rapidly developing—physically, neurologically, emotionally, and psychologically.

A St. Louis sample of preschoolers with mood and disruptive behaviors, as well as those without symptoms, was recruited from primary care and day care sites.¹⁷ Seven percent of these children between age three and five had been prescribed psychotropic medication. Of those who met criteria for a DSM diagnosis, 12% were prescribed psychotropic medication. Medications included stimulants, mood stabilizers (lithium), antipsychotics, and anti-anxiety agents. Clonidine, an anti-anxiety agent and blood pressure medication is being increasingly used in children as young as two years old.¹⁸

Although rare, antipsychotic use is noted in children as young as one year of age.¹⁹ The use of antipsychotic medication is on the increase, however. Olfson and colleagues²⁰ found significant increases in the use of these high-potency medications between 1999-2001 and 2007. Of these children, only about 41% had a mental health assessment, about 43% saw a psychiatrist, and only 41% had a psychotherapy visit. The most common diagnoses these medications were prescribed for were attention deficit/hyperactivity disorder, disruptive behavioral disorder, pervasive developmental disorder, and mental retardation.

Crismon and Argo²¹ discuss several issues critical to this age group. They warn that even with growing data regarding very young children and psychotropic medication, the evidence remains scant and inconclusive. Constant care is needed to evaluate how the medication impacts the child's growth, development, functioning, and ability to relate. Gleason, et al,²² strongly recommend that before any medications are prescribed, available nonpharmaceutical interventions be tried, and if medication is started, that nonpharmaceutical interventions continue to be in place.

FDA-Approved Medications

According to the Food and Drug Administration (FDA), a medication must meet the following criteria to be approved for use in children and adolescents:

- an existing approval in adults for the same indication(s);
- one adequate and well-controlled trial in pediatric patients demonstrating efficacy;
- pharmacokinetic data to support dosing recommendations; and
- longer-term (six months) safety data in a sufficient number of patients to support safety.

Off-Label Use

Many medications used with children are often used “off label” meaning they are used to treat symptoms they were not originally FDA approved to treat. Forty-five percent of medications used to treat mental health disturbances in children and teens were deemed off label because they had not been approved by the FDA for use in children under age 18.²³ Providers often practice off-label use when there is no reliable data or evidence base for using various medications in children.²⁴ Using medications “off label” is legal and has proved to benefit many individuals; however concerns have been raised about risks of widespread off-label use and the understanding of off-label use by prescribers and patients.²⁵ More than 75% of psychotropic medication use in children and adolescents is thought to be off label.²⁶ In fact, only about 31% of psychotropic medications are FDA approved for use in children or adolescents.²⁷ For example, guanfacine was originally used to treat high blood pressure. Now it is often used in children for anxiety or attention deficits. Also, Lamictal, an antiseizure medication, is often used to treat depression or bipolar disorder.

Black Box Warning

The FDA places black box warning labels on prescription medications with a high potential for adverse effects. This is the strongest warning the FDA can impose. All antidepressant medications need to carry a black box warning that using the drug can increase the risk of suicidal tendencies and behaviors in children and adolescents.

Antidepressants called the SSRIs have received the most attention. Drugs in this group include citalopram (Celexa), escitalopram (Lexapro), fluoxetine (Prozac), fluvoxamine (Luvox), paroxetine (Paxil), and sertraline (Zoloft). A black box warning means medication providers should closely monitor any child or adolescent starting an antidepressant for changes in mood or behavior and an increase in suicidal thinking, suicidal planning, and suicidal attempts. The mechanisms behind this increase in suicidal tendencies are unclear. One hypothesis is the medication boosts energy before the individual can resolve or get a handle on the suicidal feelings or thoughts. In other words, the obstacle to making a suicide attempt may have been the lack of energy to actually make the attempt. With an increase in energy, the individual may then act on their impulses. Parents and caregivers should be prepared and warned of this possibility before consenting to use of the medication. Suicide is a real and potential threat to children and adolescents. It is the third leading cause of death for children aged 15-19 and the fourth leading cause of death for children 10-14 years old.²⁸ This initial threat is usually minimized within one-to-two months of medication use.

Only about 31% of psychotropic medications are FDA approved for use in children and adolescents.

Sherilyn, age 17

Sherilyn lived in foster care between the ages of 5 and 9, then was returned to her mother's care. When she was 11, her mother had her hospitalized for extreme behavioral outbursts, aggression, running away, impulsive behavior, truancy, and getting in trouble with the law for stealing and loitering. These behaviors continued in the hospital and Sherilyn was eventually diagnosed with bipolar disorder.

Sherilyn was placed in foster care again, and over the next three years she was placed on various and multiple medications including lithium, amphetamines, buspirone, clozapine, SSRIs, lorazepam, and resperidone. She often had some initial reprieve from her symptoms, but did not respond well to any of the medications. Her behaviors worsened, she began using drugs and alcohol, ran away, and began sexually acting out.

At 15, she entered treatment where she was taken off all her medications, kept safe and contained, and provided a new set of skills to manage herself and her life (dialectical behavioral therapy). Sherilyn finally felt cared for and safe enough to disclose to staff the ongoing sexual abuse she had experienced by her mother's boyfriend, who had raped her repeatedly and threatened her life and her mother's. Once she disclosed the abuse to the staff, and later her mother, her aggression stopped, she no longer had outbursts, and although she still struggled socially she was working through things and was medication free.

Sherilyn, now 17, is completing high school, working in a local grocery store, and experiencing healthy relationships with her foster parents.

Consent to Use of Psychotropic Medications

Any child placed on medication needs a caregiver's consent. For children in foster care, who has the authority to consent to the medication is a grey area. In some states, biological parents must consent. In others, it is the state or children's administration, the foster parent caring for the child, the court, or state designated panels or overseers.²⁹ For children placed in a group home, residential treatment center, or inpatient psychiatric setting, the physicians or staff may have consent to treat, which can include consent to medicate.

Conflict is common between interested parties; biological parents may disagree with foster parents on whether a child should be medicated. Having someone who knows the child's needs, what medications the child is taking, and how those medications impact the child is critical. In Illinois, where a Department of Guardian and Advocacy was established to oversee medication use by foster youth, reports indicate that mood disorder medications were prescribed to 240 children in foster care without state consent.³⁰ In Florida, following the suicide of a seven-year-old child in foster care who had been prescribed three different psychotropic medications, it was discovered over 3,000 children in foster care were found to be on medications without legal consent.³¹

While the age of consent for children is 18 nationally, states differ regarding the age of assent. Generally, the age of assent is 14, and means the child agrees or gives assent to be on medications. Mindful providers will want to discuss medications and their use with children of any age, in developmentally appropriate terms. Children should understand what to expect and be encouraged to describe how a medication makes them feel. Cooperation and understanding generally leads to better practice and more promising outcomes.

Multiple Medication Use

Children in foster care are often prescribed more than one psychotropic medication at the same time. A study of psychotropic medication use in children enrolled in Medicaid across five states found risk factors for the use of more than one antipsychotic medication, including:

- the diagnosis of schizophrenia,
- recent mental health hospitalization, and
- being male.³²

In a Connecticut study, almost five percent or almost 10,000 children and adolescents out of 196,000 were prescribed at least one psychotropic medication and of those receiving these medications almost 14% were on more than one psychotropic medication.³³ Risk factors included being in state custody, being male, being older, and being European American. The most common combinations of medications included an antidepressant and an antipsychotic, a stimulant and an antidepressant, and a stimulant along with an alpha agonist.

Similar risk factors found in another study included being male, showing social maladjustment, acting aggressively, and having severe emotional illness.³⁴ That study also found that about 20% of youth treated in community mental health centers received at least two psychotropic medications compared to over 40% of youth treated in an inpatient unit.

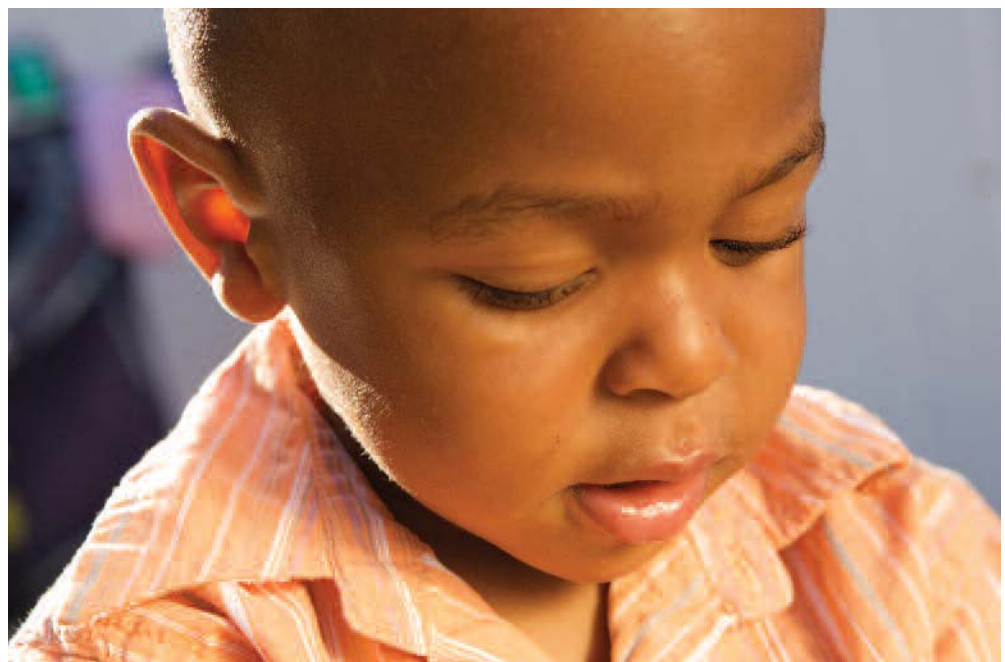
Having someone who knows the child's needs, what medications the child is taking, and how those medications impact the child is critical.

Frankie, age 8

Frankie is a sensitive, bright, articulate eight year old who has been in therapy since entering foster care at age six after the death of his grandmother, who was raising him. Frankie experienced emotional dysregulation meaning he could not control his outbursts at times. He would call names, disrupt the class, and clash with his peers, leaving him with few friends. He was unable to learn positive social skills and demonstrate them with his peers.

Frankie began to display highly sexualized behavior and talked about sexual things regularly. He became obsessed with thoughts about sex and one time he wrote the word “sex” about 50 times on a school paper during a test. He later said he did this to get it out of his head, but it did not work. Frankie also began displaying compulsive behaviors like checking the doors of the house at night and watching out his window in a hypervigilant state. At times, Frankie appeared frenzied, with a wild look in his eyes; he spoke rapidly and would be very tangential within his conversations.

Frankie was discovered to have sleep apnea, but even with treatment his symptoms did not abate. Medications were discussed, including putting him on an antipsychotic, which raised concerns. Instead, Frankie was started on a low dose of sertraline (Zoloft—an FDA approved medication in the treatment of childhood obsessive compulsive disorder). Within two weeks, Frankie was more emotionally regulated and this also seemed to allow him the organizational abilities to disclose sexual abuse by his older foster sibling’s sister who visited occasionally. Frankie was able to successfully manage the investigation, engaged even more thoughtfully in therapy, relaxed with his peers, and got back on track in school. He was stabilized on 50 mg. of sertraline and no longer shows any of his frenzied behavior, obsessive-compulsive symptoms, or preoccupation with sex.



Side Effects of Psychotropic Medication

Side effects of psychotropic medication vary widely. Physical symptoms can include stomach upset, vomiting, acid reflux, and diarrhea. Agitation, nervousness, and irritability can be common. Sleep disturbances can include insomnia, bed-wetting, middle-of-the-night awakening, and nightmares. Some medications can actually cause paranoia, hallucinations, or intrusive thoughts. SSRIs can cause “activation” or an increase in agitation in preschool children.³⁵ Appetite disturbances are common, including appetite loss in stimulant medications and increased appetite in antipsychotics. Weight gain is one of the most disturbing side effects of antipsychotics, such as Seroquel.³⁶

When a Child Should Be Placed on Psychotropic Medication

Medication can be important to successfully treat a child or teen dealing with a mental illness. Medication can be helpful when a child is disturbed or overwhelmed by his or her own behavior and has not been able to learn to manage the symptoms through other means. A medication trial might help control the interfering symptoms and increase self-esteem and functional ability.

Children who are self-abusive, impulsive, or aggressive to others may need medication to help them manage their impulses and aggression. Children and teens who hear voices or have visual hallucinations may require medication to alleviate these symptoms. Medications can also support physiologic regulation that often gets out of sync with mood disorders and trauma; in other words, medication can help stabilize sleep patterns, appetite, and concentration.

Medication use can be helpful and is often instrumental in treating mental health issues in children and teens. The concerns lie in what medications are being used, if they are being well monitored, and if they are the right ones for the child based on symptoms, age, functional ability, and improvement.

A medication trial might help control the interfering symptoms and increase self-esteem and functional ability.

Recommendations for Best Practice

The American Academy of Child & Adolescent Psychiatry³⁷ makes the following recommendations for the use of psychotropic medication with children and teens:

1. Before initiating pharmacotherapy, a psychiatric evaluation is completed.

Understand the child as fully as possible. A psychiatric evaluation should include a family background, therapies already tried, current medications, the child's ability to function in multiple places, i.e., home, school, social circles, and mental health status. This information provides a baseline for starting any kind of treatment.

2. Before starting pharmacotherapy, a medical history is obtained, and a medical evaluation is considered when appropriate.

A medical history is critical to understanding any health issues that could relate to the child's symptoms. For example, a history of a head injury might relate to the development of aggressive behavior, or a seizure disorder history might relate to a decreased ability to focus. A medical evaluation would help establish baselines on such issues as growth (height and weight), cardiac function, and elimination patterns (particularly important in diagnosing encopresis and enuresis).

3. The prescriber is advised to communicate with other professionals involved with the child to obtain collateral history and set the stage for monitoring outcome and side effects during the medication trial.

Children act differently depending on their environments; their behaviors and emotional states can vary with different caregivers or other people. For example, a child can function well at school and thrive in a structured environment, but act out at home due to the presence of domestic violence. Gathering baseline information will help understand the impact of the medication over time.

4. The prescriber develops a psychosocial and psychopharmacological treatment plan based on the best available evidence.

A treatment plan is important to think through all necessary potential treatments as well as medication options. The evidence supporting these choices should be addressed as well.

5. The prescriber develops a plan to monitor the patient, short and long term.

Short-term monitoring helps to assess for any developments or increases in suicidal ideation as well as initial side effects, such as stomachaches or drowsiness. Long-term monitoring helps assess the continued impact and potential changes over time.

6. Prescribers should be cautious when implementing a treatment plan that cannot be appropriately monitored.

Treatment plans should be followed and evaluated over time. Treatment modalities or requirements that cannot be monitored should be reconsidered.

7. Prescriber provides feedback about the diagnosis and educates the patient and family about the child's disorder, and the treatment and monitoring plan.

The patient and caregivers should be kept updated and educated about the diagnosis, what it means, the treatment of the disorder, and the monitoring of the treatment plans.

8. Complete and document the assent of the child and the consent of the caregivers before initiating medication treatment and at important points during treatment.

Assent and consent needs to be given before treatment starts. Both children and caregivers should be given easy-to-understand information and have the risks and benefits of medication explained to them.

9. The assent and consent discussion focuses on the risks and benefits of the proposed and alternative treatments.

The risks and benefits of medication and of alternative treatments, such as psychotherapy, should be discussed.

10. Implement medication trials using an adequate dose and for an adequate treatment period.

If medications are tried, the dosage needs to reach therapeutic levels and the medication needs to be tried for an adequate period to reach a therapeutic stage. Some medications work quickly, and leave the system quickly. Other medications need to reach certain levels to work well, and then those levels need to remain stable. For example, Zoloft is often used to treat obsessive-compulsive disorder with doses as high as 200 mg./day. With depression, the basic dose is 50 mg./day. Lithium is a medication that needs to reach a therapeutic level and be kept stable to be effective.

11. The prescriber reassesses the patient if the child does not respond to the initial medication trial as expected.

Finding the right or best medication might take time; some children do better on one medication than another, just like adults. At times, several medications might be tried before the best medication for that individual is found. For example, certain stimulant medications can have no effect on some children but work extremely well in others. The same phenomena

A medical history is critical to understanding any health issues that could relate to the child's symptoms.

can happen with antidepressants. The underlying reasons for specific symptoms may differ from person to person and the medications used to treat those symptoms can differ as well.

12. The prescriber needs a clear rationale for using medication combinations.

Combining medications increases the risk to the child; understanding what is needed and what medications compliment one another is key. For example, combining an antidepressant for depression and a stimulant for ADHD might be warranted. Placing a child on two antidepressants at the same time or two antipsychotics does not make sense in most cases.

13. Discontinuing medication in children requires a specific plan.

Most medications should not be stopped abruptly. They should be tapered off. Discontinuing medication should be part of a plan within the overall treatment goals.



Medication and the Pregnant Teen

Pregnancy heightens concern over the impact of any medication use. For the pregnant teen several issues need to be considered.

1. Teens who are already on medication when they become pregnant need to be discussing their medication use with their health care providers.
2. Some psychotropic medications require a tapering off; suddenly stopping some medications can lead to serious medical issues.
3. Some psychotropic medications, like lithium, may need to be “temporarily” stopped or reduced during the first trimester when the baby’s organs are being formed.
4. Research shows that the relative risk to the developing baby is minimal with many of the SSRI antidepressants and when depression remains successfully treated it can better support early bonding and higher quality mother-child interactions after birth.
5. Untreated depression can negatively affect the developing baby due to the common symptoms of depression, including interruptions in the mother’s nutritional intake, sleep disruptions, increased stress exposure, isolation, lack of exercise, and interference with normal prenatal bonding and preparation.
6. Pregnant teens with history of psychotic symptoms need to be closely monitored regarding their symptoms and their medications; untreated psychosis can have a profound negative effect on the pregnancy and on the baby after birth.
7. During pregnancy, medication dosages often need to be increased to maintain effective treatment.
8. No medications are considered completely safe during pregnancy; risks and benefits need to be evaluated on a case-by-case basis.
9. All medications pass into breast milk, however most are minute amounts and are thought to be able to be safely used, again risks and benefits need to be evaluated.
10. Some newborns can go through brief periods of “withdrawal” immediately after birth, these symptoms generally resolve within the first few days after birth and are not associated with any long-term consequences.

Finding the right or best medication might take time; some children do better on one medication than another, just like adults.



Questions Judges and Attorneys Should Ask

Judges and attorneys should consider the following questions when considering the best interests of or advocating for a child or teen in care. Children and teens have little, if any, power over their lives when they enter care. They generally lack the knowledge to understand what they need medically, regardless of the type of treatment needed. Asking the following questions will help identify their needs and determine which recommended treatments are in their best interests.

- **What is this medication needed for?**

What kind of symptoms is this child experiencing? Are these symptoms interfering with the child's ability to function? Are these problems an issue in multiple environments?

- **Were you able to obtain an accurate medical, behavioral, and psychological history from parents and past providers?**

Children in foster care do not always have a consistent caregiver who can be a reliable historian for what a child has experienced or what kinds of symptoms they are dealing with. Parents who are in conflict with their child may exaggerate symptoms or blame the child when they are really at the root of the presenting issues. Other parents may not have been around their children enough to provide accurate information. Parents and other caregivers can also become so frustrated by a child's behaviors that they exaggerate the child's symptoms to gain added support and sympathy. It is important to explore the source of the information about the child.

- **What else has been tried?**

Has counseling been provided? Has it been consistent? Has the child had a psychiatric evaluation? Has the child had a medical examination?

- **What other modes of treatment or intervention will also be provided?**

Medications should never be the sole mode of treatment for mental health disorders. Counseling should be provided to help children learn to manage or minimize their symptoms. Children often need to learn new skills, such as anger management or problem solving, to help them interact with others more successfully. Some children need to talk about their trauma or their grief to make sense of and resolve it; medication will not do this for them. Additional types of treatment may include Play Therapy, Social Skills Group, Parent-Child Interactive Therapy (PCIT), Dialectic Behavioral Therapy (DBT), Cognitive Behavioral Therapy (CBT), Child-Parent Psychotherapy, Parent Coaching, and Anger Management Groups.

Medications should never be the sole mode of treatment for mental health disorders.

- **Who will monitor the ongoing use of this medication?**

- **How often will this child be seen?**

Successful medication management includes regular follow-ups. Especially when first started, medications often need to be adjusted for proper dosage or better timing. The development of side effects needs to be monitored. In children, medications often need to be slowly introduced over several weeks; the incremental adjustments will need to be monitored. Medication changes and ending a medication often require tapering as well. About 20% of people have some type of difficulty with the first psychotropic they are prescribed and will need to work with their mental health provider to find a better treatment option. It is important to consider who will take the child to appointments on a regular basis so a consistent adult is also well informed of the medications being used.

- **What are the possible side effects of this medication and how will they be handled?**

Some medications carry transient side effects, such as stomach upset or initial drowsiness. These often disappear over the first few days on the medication or they can be minimized by taking the medication at night rather than in the morning. Other side effects, such as vomiting, confusion, or inability to sleep, may mean this medication will not work with this child or that the child needs additional medication to balance the effects. Some side effects are seen weeks or even months after a medication is introduced. Some antipsychotics lead to rapid weight gain while some stimulants used to treat attention disorders lead to significant weight loss—these issues can impact overall health and can add to self esteem and other mental well-being problems.

- **What evidence supports the use of this medication with children?**

What do we know about how this medication works in children? Are there safety warnings that go along with this medication? What evidence do we have that it will not harm the child? Is this medication well tolerated in children?

- **Will this child be able to comply with the prescribed medication?**

Is there someone available who can assure the child has regular access to the medication and that it is being given as directed? Is this medication easy to use? For example, is it a once-a-day dose versus a four-times-a-day dose? Is the type of medication right for this child? For example, is there a liquid form available for a child who cannot swallow pills? Will additional lab tests be needed to start or sustain use of this medication? For example, will the child need a baseline EKG to assess for cardiac functioning or will the child require regular blood tests to assess medication levels. Can the patient afford the drug? If a patient cannot afford a medication, he or she will not be able to take it. Is it covered under Medicaid? Medicaid often has rules for what kinds of medications it will cover; alternative medications can

often be prescribed, but sometimes a very specific drug may be needed for certain symptoms.

- **Does the child agree with taking this medication?**

Despite the age of consent, how does this child feel about being on this medication? Has it been discussed with the child? Has the child been told what to expect? Is someone talking regularly with the child about how it feels while on this medication?

- **Who has given permission to begin this child on medication?**

Who should be giving permission? The parent? The foster parent? The prescriber? The child's advocate? The child? The social worker? Do the people involved in this child's life know of this medication and understand the risks and benefits? Have they been taught how to properly administer and monitor this medication?

- **What other medications is this child on? Can this medication be safely combined with the current medication?**

Is the child already on medications for other things such as asthma or acid reflux? Can this new medication be safely used with the current medications? Who has assessed this? Does the prescriber of the psychotropic medication know what the child is already on? What over-the-counter medications, vitamins, or naturopathic medications is the child taking?

- **How will this medication help improve this child's functioning?**

What challenges is the child struggling with that should change with this medication? Will this make life easier for this child?

- **What are the risks versus benefits of using this medication? What are the risks versus benefits of not using the medication?**

It is critical to understand the risks of any medication and of any other intervention or therapy. Equally important is understanding the benefits of using the medication or other therapies. The benefits need to outweigh the risks. Both the patient and the caregivers need to fully understand the risks and benefits as well.

- **Is a second opinion warranted in this case?**

Cases involving children on multiple medications, young children under six, and the use of atypical medications should always be reviewed by other practitioners. Children who have been difficult to treat or who have tried various medications previously may require a second opinion.

Despite the age of consent, how does this child feel about being on this medication? Has it been discussed with the child?

Conclusion

Medications improve lives and end the suffering millions of people experience daily. Psychotropic medications also return people to more optimal levels of functioning and eliminate distressing symptoms. Psychotropic medication use in children and adolescents has increased over the past decade. Many medications used today are safer, have fewer side effects, and are more effective than medications used 15 years ago. However, little research has studied the long-term effects of these medications or their effects on children and adolescents. Despite this lack of knowledge, psychotropic medications are used to treat and manage behavioral, emotional, and psychological symptoms experienced by children and teens.

Children in foster care or in other state care appear especially vulnerable to medication use. Concerns continue to be raised over adequate monitoring, second opinions, use of multiple medications at once, consent for the use of medications with children in care, and providing other necessary treatments such as counseling. Evidence shows individuals experience greater improvement when medication is combined with counseling than without.

The risks and benefits of treating a child with and without medication need to be examined with each medication considered. Children should be on the least-potent medication and the lowest possible dose, and for the shortest amount of time. Their developmental progress across all domains should be considered and protected. Psychotropic medications should be supportive and helpful and never place a child at risk of harm.

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740 15th Street NW
Washington, DC 20005
phone 202.662.1720
fax 202.662.1755
americanbar.org/child