

Briefing Paper

Subcommittee on Federal Financial
Management, Government Information, Federal
Services, and International Security

The Financial And Societal Costs Of Medicating America's Foster Children:

A Proposed Solution: Enforcement of Medicaid's Restriction of Covered Outpatient Drugs to Medically Accepted Indications

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PsychRights®

Law Project for
Psychiatric Rights, Inc.

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Executive Summary

The purpose of this briefing paper is to suggest that by enforcing Medicaid's coverage restriction of outpatient drugs to those that are for a "medically accepted indication," the vast majority of the problems associated with the administration of psychotropic drugs to children and youth in foster care would be eliminated.¹ As the US District Court said in *U.S. ex rel Rost v. Pfizer*:

Medicaid can only pay for drugs that are used for a "medically accepted indication," meaning one that is either approved by the FDA or "supported by citations" in one of three drug compendia, including DRUGDEX.²

Stated another way, "off-label" outpatient drug coverage is limited to indications for which there is recognized scientific support.³

Both the Department of Justice and the Inspector General of the Department of Health and Human Services (DHHS) agree, but the Centers for Medicare & Medicaid Services (CMS) has failed to enforce this statutory coverage restriction.

PsychRights believes the government should take the following three steps:

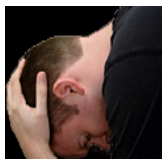
1. Announce that outpatient psychotropic drug prescriptions for use in children and youth that are not for medically accepted indications are not covered under Medicaid, and will no longer be reimbursed; except
2. Where abrupt withdrawal from drugs that are not for medically accepted indications can cause serious problems, then allow reimbursement for responsible tapering; and
3. Grant amnesty from False Claims Act liability for all past prescriptions that are not for medically accepted indications.

Absent that, private enforcement actions through the *qui tam* ("whistleblower") provisions of the False Claims Act against doctors prescribing psychotropic drugs to children and youth that are not for a medically accepted indication and pharmacies filling the prescriptions could accomplish the same thing, albeit, much more slowly. In such event, the Department of Justice should be supportive of such private, *qui tam* enforcement, rather than its current neutral, and in at least one instance, hostile position.

¹ It should be noted at the outset, however, that the problem of psychotropic drugs prescribed to children and youth on Medicaid extends to children and youth who have not been placed in foster care.

² 253 F.R.D. 11, 13-14 (D.Mass. 2008).

³ Attachment 1 is a chart identifying medically accepted indications for just over 50 of the most common psychotropic drugs prescribed to children and youth. Except for rare instances, such as the concurrent use of Lithium or Depakote with Abilify, for Acute Manic or Mixed Episodes of youth diagnosed with Bipolar 1 disorder, the use of more than one psychotropic drug at a time is not a medically accepted indication.



Medicaid Coverage of Outpatient Drugs Limited to Medically Accepted Indications

A. Statutory Provisions

42 USC 1396R-8(k)(3), provides, "The term 'covered outpatient drug' does not include . . . any . . . drug . . . used for a medical indication which is not a medically accepted indication." 42 USC 1396R-8(k)(6) then provides:

The term "medically accepted indication" means any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act [21 U.S.C.A. § 301 et seq.], or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in subsection (g)(1)(B)(i) of this section.

42 USC 1396R-8(g)(1)(B)(i) designates the compendia as:

- (I) American Hospital Formulary Service Drug Information;
- (II) United States Pharmacopeia-Drug Information (or its successor publications); and
- (III) the DRUGDEX Information System.

As succinctly stated by the court in *US ex rel Rost v. Pfizer*, 253 F.R.D. 11, 13-14 (D.Mass. 2008):

Medicaid can only pay for drugs that are used for a "medically accepted indication," meaning one that is either approved by the FDA or "supported by citations" in one of three drug compendia, including DRUGDEX. See 42 U.S.C. § 1396r8 (k)(3), (6); 42 U.S.C. § 1396r-8 (g)(1)(B)(I).⁴

B. Department of Justice Position

The Department of Justice concurs that outpatient drug prescriptions to Medicaid recipients that are not for a medically accepted indication are not covered and has

⁴ 42 U.S.C. § 1396r-8(d)(1)(B)(i) does provide "A State may exclude or otherwise restrict coverage of a covered outpatient drug if the prescribed use is not for a medically accepted indication," which taken in isolation does suggest that there is no such limitation unless a State makes the election. However, this is clearly incorrect in light of the entire statutory scheme. One possible interpretation is the states may pay for drugs that are not for a medically accepted indication even though Federal Financial Participation is not allowed.



recovered billions of dollars from drug companies for causing false claims by promoting such off-label prescribing by doctors.⁵

For example, in September of 2009, the Department of Justice issued a [news release](#) announcing a \$2.3 Billion settlement with Pfizer, stating, "[Pfizer] caused false claims to be submitted to government health care programs for uses that were not medically accepted indications and therefore not covered by those programs." Similarly, the Department of Justice's February 13, 2009, [Complaint in Intervention in U.S. ex rel Gobble v. Forest Laboratories](#),⁶ states that prescriptions presented to Medicaid that are not for medically accepted indications are false claims. *Ex rel Gobble*, resulted in a [Settlement Agreement](#) for \$149 million, and Forest agreed to pay an additional \$150 million fine in conjunction with pleading guilty to criminal conduct for causing false claims by promoting the use of the psychotropic drugs Celexa and Lexapro⁷ for use in children and youth when there were no medically accepted indication. As stated in paragraph 1 of the Settlement Agreement:

1. During the period January 1998 through December 2005, Forest knowingly caused false or fraudulent claims for Celexa and Lexapro to be submitted to the Federal Health Care Programs by promoting the sale and use of Celexa and Lexapro to physicians for pediatric uses (including by disseminating false and misleading information about the safety and efficacy of Celexa and Lexapro in treating pediatric patients), as set forth in the United States Complaint in Intervention, when those uses were not approved by the Food and Drug Administration ("FDA"), were not medically accepted indications (as defined by 42 U.S.C. § 1396r-8(k)(6)), and were not covered by Federal Health Care Programs [including Medicaid].

To the same effect is the settlement agreement in [U.S. ex rel Wetta v. AstraZeneca Pharmaceuticals](#),⁸

Similarly, in its September 24, 2010, [Statement of Interest in United States of America ex rel Polansky v. Pfizer, Inc.](#),⁹ citing to 42 U.S.C. § 1396r-8(k)(2), (3) and (6), the

⁵ For a description of \$7.9 Billion in False Claims Act recoveries from drug companies and how they are ineffective in stopping off-label prescribing, see, [Strategies and Practices in Off-Label Marketing of Pharmaceuticals: A Retrospective Analysis of Whistleblower Complaints](#), by Aaron S. Kesselheim, Michelle M. Mello, David M. Studdert, *PLoS Medicine*, April 2011, Vol. 8, Issue 4.

⁶ Case No. 03-cv-10395-NMG, District of Massachusetts, pp. 8-9, at ¶s 26-30; p. 10, ¶37; p. 31 ¶97; p. 32, ¶100.

⁷ And one non-psychotropic drug for any use.

⁸ Case No. 04-cv-3479-BMS, Eastern District of Pennsylvania, p.6.

⁹ EDNY, Case No. 1:04-cv-0074-ERK-ALC, pp 3-4.

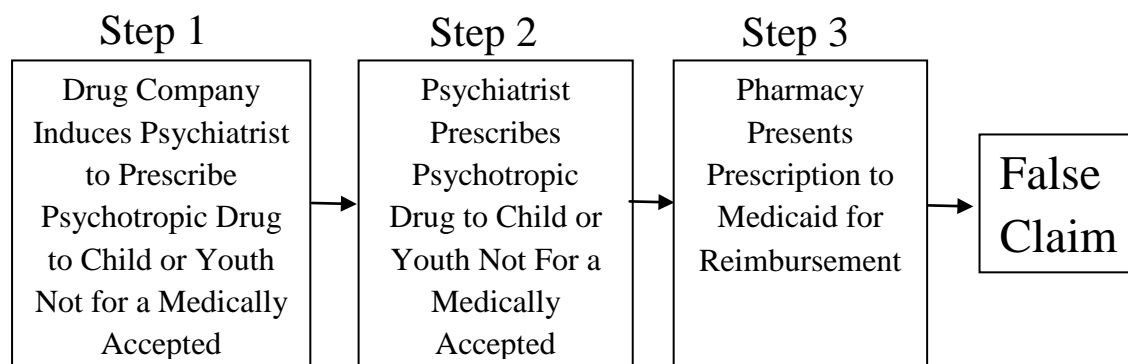


Department of Justice walks through the statutory provisions that "covered outpatient drug . . . does not include a drug . . . used for a medical indication which is not a medically accepted indication." *Polansky* involves the drug Lipitor and thus the Department of Justice at pp 7-8 said with respect to it:

Prescription claims for Lipitor would be "false" if they were prescribed for unapproved uses that were not supported by a citation in one of the statutorily-identified compendia.

The fraudulent scheme with respect to psychotropic drugs prescribed to children and youth on Medicaid can be depicted as follows:

Fraudulent Scheme

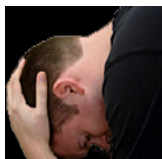


While recovering billions of dollars at Step 1 of the Fraudulent Scheme, the Department of Justice has consistently failed to address Steps 2 and 3. This vitiates the entire effort because doctors continue to issue prescriptions to children and youth that are not for a medically accepted indication.

C. DHHS Inspector General Position

This was implicitly recognized in the DHHS Inspector General's May, 2011, Report, [Medicare Atypical Antipsychotic Drug Claims For Elderly Nursing Home Residents](#), and particularly the accompanying [statement](#) in which he stated:

The drug companies have paid billions to resolve these civil and criminal liabilities under federal health and safety laws. But money can't make up for years of corporate campaigns that market drugs with questionable benefits and potentially deadly side effects. . . .



Doctors should base prescribing decisions on their best medical judgments, weighing scientific evidence and an especially careful analysis when they are prescribing drugs for off-label use.

Just as the drug companies have illegally promoted off-label use of psychotropic drugs on children and youth, they have illegally promoted off-label use of neuroleptics to Medicare patients in nursing homes.

Medicare carries the same drug coverage restriction to medically accepted indications:

Medicare requires that drugs be used for medically accepted indications supported by one or more of three compendia to be eligible for reimbursement.¹⁰

D. CMS Position?

In the Inspector General's Report, [Medicare Atypical Antipsychotic Drug Claims For Elderly Nursing Home Residents](#), CMS makes the statement that "prevention of [improper] payment [is] beyond our statutory authority."¹¹ This is a startling statement that, at a minimum cries out for justification. Technically, however, the statement was made with regard to Medicare, not Medicaid.

However, at the December 1, 2011, subcommittee hearing on The Financial And Societal Costs Of Medicating America's Foster Children, Bryan Samuels, Commissioner, Administration on Children, Youth and Families, testified that all DHHS could do is provide guidance to the states. This seems untrue as will be set forth below. In any event, Mr. Samuels does not technically represent CMS.

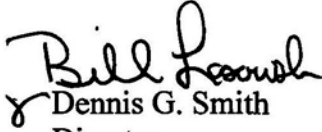
In 2007, there was a curious exchange of correspondence between the Utah Attorney General's Office and people at CMS. The correspondence was initiated by an [October 22, 2007 letter from the Utah Attorney General's Office](#) asking whether CMS interpreted the Medicaid statute as prohibiting Medicaid coverage of outpatient drugs that are not for a medically accepted indication. A [December 6, 2007, letter on CMS letterhead](#) responding to this question states, "(the Act) does not provide definitive policy on the coverage of Medicaid drugs for the uses you describe in your letter, nor have we addressed this issue in implementing Federal regulations." The letter is signed for the Director of the Centers for Medicaid and State Operations by someone else, as follows:

¹⁰ Page i of [Medicare Atypical Antipsychotic Drug Claims For Elderly Nursing Home Residents](#). Also see footnote 16, where the Inspector General's Report recites that the Medicare statute incorporates the Medicaid statute's prescription drug coverage restriction to medically accepted indications.

¹¹ Pages 21 & 39.



Sincerely,



Dennis G. Smith
Director

Incredulous with this response, in a [December 17, 2007, letter](#), the Utah Attorney General's Office wrote back:


With all due respect, I beg to differ and direct your attention to Section 1927(k)(3) regarding a specific exception to the definition of "covered outpatient drug." In pertinent part it states that the term "covered outpatient drug" (which would otherwise be eligible for Medicaid Federal Financial Participation) **does not include "a drug or biological used for a medical indication which is not a medically accepted indication."**

and:

I strongly encourage you to run this issue by your legal counsel and am confident that they will conclude that the clear, unambiguous definition of "covered outpatient drug" means that States are eligible for Federal Financial Participation with respect to drugs that are reimbursed only for "medically accepted indications," i.e., only for uses either approved by the FDA or "supported" in the specified compendia.

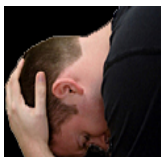
In response, without addressing the legal issues involved and without any indication CMS had consulted counsel, a [January 30, 2008, letter](#) was sent back re-affirming the previous letter. This letter was signed for the Director of the Center for Medicaid and State Operations, Disabled and Elderly Health Program Group as follows:

Sincerely,



for Gale P. Arden
Director

Thus, all four persons whose name appears on these two letters from CMS can claim the letter over their name was not written by him or her. This in itself doesn't prove any misconduct by any or of the four people whose names are associated with this CMS correspondence, but it certainly raises a serious question since the position espoused in



the letters is directly contrary to the position taken by the Department of Justice and the Inspector General of DHHS.

These letters were first brought to light by Ed Silverman of the Pharmed blog, in his September 15, 2008, post, [Antipsychotics & State Lawsuits: Stallard Explains](#). Because these letters are directly contrary to the position of the Department of Justice and the DHHS Inspector General, for the last six months Mr. Silverman has been trying to get CMS to say whether it takes the position that Medicaid coverage of outpatient drugs is not limited to medically accepted indications and has been unable to obtain an answer.

Frankly, the notion that Medicaid coverage of outpatient drugs is not limited to medically accepted indications seems outlandish since, as set forth above, it is contained in the very definition of covered outpatient drugs: "The term 'covered outpatient drug' does not include . . . any . . . drug . . . used for a medical indication which is not a medically accepted indication." 42 USC 1396r-8(k)(3). Boiled down, this position is that Medicaid coverage of outpatient drugs is not limited to covered outpatient drugs.

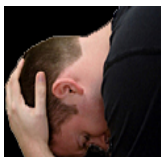
In any event, the Subcommittee might explore whether CMS truly takes the position that Medicaid coverage of outpatient drugs is not limited to medically accepted indications.

Enforcement

A. Government Enforcement Of Medicaid Outpatient Drug Coverage Restriction to Medically Accepted Indications for Psychotropic Drugs Prescribed to Children and Youth

The most straightforward approach to solving the problem of the inappropriate off-label administration of psychotropic drugs to children and youth in foster care is to enforce Medicaid's outpatient drug restriction to medically accepted indications. There are, however, two additional factors which PsychRights believes should be taken into account. The first is that abrupt withdrawal from some of these drugs can be extremely dangerous. The second is that the doctors who have prescribed psychotropic drugs to children and youth that are not for a medically accepted indication, and the pharmacies that were reimbursed for filling the prescriptions, are liable for substantial penalties under the False Claims Act. Therefore, it is recommended that the following approach be taken:

1. Announce that outpatient psychotropic drug prescriptions for use in children and youth that are not for medically accepted indications are not covered under Medicaid, and will no longer be reimbursed; except
2. Where abrupt withdrawal from drugs that are not for medically accepted indications can cause serious problems, then allow reimbursement for responsible tapering; and



3. Grant amnesty from False Claims Act liability for all past prescriptions that are not for medically accepted indications.

It is believed this will solve the bulk of the problem.

B. Prospective Drug Utilization Review

CMS has an apparently unused tool to achieve this. 42 USC §1396r-8 (g)(1)(A) requires the states to have a drug use review program (DUR) "designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud," and at 42 USC §1396r-8 (g)(2)(A)(i), requires a "prospective drug review . . . before each prescription is filled or delivered." 42 CFR §456.703 provides:

(a) General. Except as provided in Sec. Sec. 456.703 (b) and (c), the State plan must provide for a review of drug therapy before each prescription is filled or delivered to a recipient The State must provide pharmacies with detailed information as to what they must do to comply with prospective DUR requirements The pharmacies, in turn, must provide this information to their pharmacists. (emphasis added)

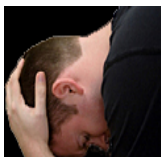
In other words, before each prescription is filled, it is required to be reviewed to determine eligibility for reimbursement by Medicaid. It does not appear this is being done, at least with respect to Medicaid's outpatient drug coverage restriction to medically accepted indications.

42 CFR §456.722 provides for this prospective review of prescriptions to occur through a computerized system, which must, under Part 11 of the State Medicaid Manual, include data elements sufficient to determine if the prescription is for a medically accepted indication. *See*, Addendum.

To summarize: 42 USC §1396r-8 (g)(2)(A) requires the states to have a prospective drug review program, and 42 CFR §456.705 requires such prospective review to verify eligibility before the prescription is filled. Under 42 CFR §456.722, the States' electronic claims management systems are required to collect the minimum data specified in Part 11 of the State Medicaid Manual, which includes data sufficient to determine whether the prescription is for a medically accepted indication.

C. False Claims Act

Another way to enforce the Medicaid restriction against psychotropic drugs given to children and youth that are not for a medically accepted indication is the False Claims Act, 31 USC §3729 *et seq.*, because the doctors writing these inappropriate prescriptions are causing false claims and the pharmacies filling them and obtaining reimbursement are presenting false claims (Steps 2 & 3 of the Fraudulent Scheme depicted above).



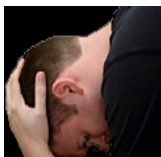
Since each offending prescription carries a minimum penalty of \$5,500 under 31 U.S.C. § 2729(a)(1)(G), it is expected that just a few enforcement actions would substantially curtail, if not eliminate, the practice.

This served as the impetus for [PsychRights' Medicaid Fraud Initiative Against Psychiatric Drugging of Children & Youth](#), drawing on the private *qui tam* enforcement mechanism provided in 31 U.S.C. § 3730. Thus far, there have been two cases unsealed in Alaska, one in Illinois and one in Wisconsin. On December 2, 2011, the 9th circuit denied rehearing of its non-precedential ruling affirming dismissal of the Alaska cases on the grounds that because the government knows about the fraud and isn't doing anything, private *qui tam* enforcement is not allowed, under what is known as the Public Disclosure Bar. 31 U.S.C. § 3730(e)(4). In other words, the 9th Circuit said, "If the government doesn't care about the fraud, why should we?" In July of this year, the Illinois case was dismissed because *the Department of Justice said the psychiatrist didn't have enough money to make it worthwhile*. The Wisconsin case is just getting started. PsychRights expect more cases to be filed, including in the 9th Circuit, since its ruling is explicitly not precedent and, PsychRights believes, wrongly decided.

If the Department of Justice changed its stance from hostility in these cases to at least one of neutrality it would be far easier to pursue these cases. Under 31 U.S.C. §3730(b)(2) the government can elect to intervene and take over the case, but even if it does, not the private party bringing the suit on behalf of the government can pursue the suit without the Department of Justice's participation. However, the Department of Justice has great discretion to have these cases dismissed and exercised that discretion in the Wisconsin case. The problem of dismissal under Public Disclosure Bar would be solved if the Department of Justice merely objected to dismissal in order to allow such suits to go forward.

Proven Alternatives to the Drugs

One of the justifications for giving psychotropic drugs to children and youth is that it is the only effective treatment for children and youth exhibiting serious behavioral problems. This is simply not true. Attachment 2 is Module 8 of the CriticalThinkRx Curriculum, [Evidence-Based Psychosocial Interventions for Childhood Problems](#) and associated [References](#), which goes through the scientific literature regarding proven effective psychosocial approaches. Attachment 3 is [Eliminating the Use of Psychotropic Medication in the Treatment of Children with Profound Emotional and Behavioral Issues](#), a description of the highly successful "Seneca" program in Northern California, where they successfully treated children and youth that were considered hopeless by other programs, and did so after getting them off the drugs.



Addendum

D. 42 CFR §456.722 Electronic claims management system.

(a) Point-of-sale system. Each Medicaid agency, at its option, may establish, as its principal (but not necessarily exclusive) means of processing claims for covered outpatient drugs, a point-of-sale electronic claims management (ECM) system to perform on-line, real-time (that is, immediate) eligibility verifications, claims data capture, adjudication of claims, and to assist pharmacists and other authorized persons (including dispensing physicians) in applying for and receiving payment. . . . If the State exercises this option and wishes to receive FFP for its ECM system, the system must meet the functional and additional procurement and system requirements in paragraphs (b) and (c) of this section.

(b) Functional requirements. The ECM system developed by the State must include at least the on-line, real-time capabilities specified in paragraphs (b)(1) through (3) of this section. . . .

(2) Claims data capture, including the following: . . .

(iii) Minimum data set (as defined in Part 11 of the State Medicaid Manual).

(3) Claims adjudication, including the following:

(i) Performing all edits and audits contained in the State's Medicaid Management Information System (MMIS) applicable to prescription drugs.

(ii) Notifying the pharmacist (or other authorized person, such as the dispensing physician) about the claim status.

(iii) Taking steps up to, but not including, payment of the claim.

Included in the data set of Part 11 of the State Medicaid Manual¹² are:

*6. Recipient's Date of Birth:

The date of birth of the recipient. . .

*61. Principal Diagnosis Code:

a. The diagnosis code for the principal condition requiring medical attention. . . .

¹² From http://www.cms.hhs.gov/manuals/downloads/P45_11.zip, downloaded on March 17, 2010.



62. Other Diagnosis Code:
a. The diagnosis code of any condition other than the principal condition which requires supplementary medical treatment. . . .
88. Drug Code:
Codes identifying particular drugs; e.g., National Drug Code, drug tables.
89. Diagnosis Code:
A table of codes identifying medical conditions; i.e., ICD-9-CM.
90. Drug Name:
The generally accepted nomenclature for a particular drug.
91. Drug Classification:
The therapeutic group in to which a drug is categorized.
92. Minimum Days Supply of Drugs:
The minimum units of a drug prescription eligible for payment.
93. Maximum Days Supply of Drug:
The maximum units of a drug prescription eligible for a particular drug. . . .
95. Diagnosis Name:
The generally **accepted** nomenclature for a diagnosis. Name is required only if not encoded by provider. (See Data Element No. 61.)

Attachments

1. [Medically Accepted Indications for Pediatric Use of Certain Psychotropic Medications.](#)
2. Module 8 of the CriticalThinkRx Curriculum. [Evidence-Based Psychosocial Interventions for Childhood Problems](#) and associated [References](#).
3. [Eliminating the Use of Psychotropic Medication in the Treatment of Children with Profound Emotional and Behavioral Issues](#)



Attachment 1

Medically Accepted Indications for Pediatric Use of Certain Psychotropic Medications by The Law Project for Psychiatric Rights (PsychRights)

Drug	Indication (diagnosis)	FDA Approval	DRUGDEX Support for Off-Label Use	DRUGDEX Recommendation Level
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Key:

White Background: Medically Accepted Indication

Orange Background: Pediatric Indication cited, but not supported by DRUGDEX

Red Background: No Pediatric FDA Approval or DRUGDEX citation

<u>Abilify</u> (Aripiprazole) - Antipsychotic				
	Autistic disorder-Psychomotor agitation	Yes (6-17)		
	Bipolar I Disorder - Adjunctive therapy with lithium or valproate for Acute Manic or Mixed Episodes	Yes (for 10 yrs old and up)		
	Bipolar I Disorder, monotherapy, Manic or Mixed Episodes	Yes (for 10-17 years old re acute therapy)		
	Schizophrenia	Yes (for 13-17 years old)		
<u>Adderall</u> (amphetamine/dextroamphetamine) - Central Nervous System Agent; CNS Stimulant				
	Attention Deficit Hyperactivity Disorder (ADHD)	Yes (for 3 years old and up re: [immediate-release] and 6 years old and up re: [extended-release] drug)		
	Narcolepsy	Yes (for 6 years old and up (immediate release only))		
<u>Ambien</u> (zolpidem) - nonbarbiturate Hypnotic				
	Insomnia, Short-term treatment	No		Class III
<u>Anafranil</u> (clomipramine) - Antidepressant; Antidepressant, Tricyclic; Central Nervous System Agent				
	Obsessive-Compulsive Disorder	Yes (for 10 years and up)		
	Depression	No		Class IIb
<u>Ativan</u> (lorazepam) - Antianxiety, Anticonvulsant, Benzodiazepine, Short or Intermediate Acting, Skeletal Muscle Relaxant.				
	Anxiety	Yes, oral only, 12 years and older		
	Chemotherapy-induced nausea and vomiting; Prophylaxis	No	Class IIa	
	Insomnia, due to anxiety or situational stress	Yes		
	Seizure	No	Class IIa	
	Status epilepticus	No	Class IIa	
	Premedication for anesthetic procedure	No		Class IIb
	Sedation	No		Class IIb
	Seizure, drug-induced; Prophylaxis	No		Class IIb
<u>Buspar</u> (buspirone) - Antianxiety, Azaspirodeconedione				
	Anxiety	No		Class III
	Autistic disorder	No		Class IIb
	Behavioral syndrome	No		Class IIb
	Pervasive developmental disorder	No		Class IIb
<u>Celexa</u> (citalopram) - Antidepressant, Serotonin Reuptake Inhibitor				
	Depression	No		None
	Obsessive-compulsive disorder	No		Class IIb
	Panic disorder	No		Class IIb
	posttraumatic stress disorder	No		Class IIb

Medically Accepted Indications for Pediatric Use of Certain Psychotropic Medications

by The Law Project for Psychiatric Rights (PsychRights)

Drug	Indication (diagnosis)	FDA Approval	DRUGDEX Support for Off-Label Use	DRUGDEX Recommendation Level
Clozaril (clozapine) – Antipsychotic; Dibenzodiazepine				
	Bipolar I Disorder	No		Class IIb
	Schizophrenia, Treatment Resistant	No		cited, with no recommendation level
Concerta (methylphenidate) - Amphetamine Related; Central Nervous System Agent; CNS Stimulant				
	Attention Deficit Hyperactivity Disorder (ADHD)	Yes (for 6 years old to 12 years old)		
	Attention Deficit Hyperactivity Disorder (ADHD)	Yes (for 6 years old and up) re ConcertaR		
	Autistic Disorder	No		Class IIb
	Impaired Cognition - inding related to coordination/ in coordination	No		Class IIb
	Schizophrenia	No		Class IIII
	Traumatic Brain Injury	No		Class IIb
Cymbalta (duloxetine) - Antidepressant; Central Nervous System Agent; Neuropathic Pain Agent; Serotonin/Norepinephrine Reuptake Inhibitor				
Dalmane (flurazepam) - Benzodiazepine, Long Acting, Hypnotic				
	Insomnia	Yes, 15 years and older		
Depakote/Depakene (valproate/valproic acid) – Anticonvulsant; Antimigraine; Valproic Acid (class)				
	Absence Seizure, Simple and Complex	Yes (10 years and older)		
	Complex Partial Epileptic Seizure	Yes (10 years and older)		
	Seizure, Multiple seizure types; Adjunct	Yes (10 years and older)		
	Bipolar I disorder, Maintenance	No		Class IIb
	Bipolar II disorder, Maintenance	No		Class IIb
	Chorea	No		Class IIb
	Febrile Seizure	No		Class IIb
	Mania	No		Class IIII
	Manic bipolar I disorder	No		Class IIb
	Mental Disorder - Mood Disorder	No		Class IIb
	Migraine; Prophylaxis	No		Class IIb
	Status epilepticus	No		Class IIb
	West syndrome	No		Class IIb
Desyrel (trazodone) - Antidepressant; Triazolopyridine				
	Migraine, Pediatric; Prophylaxis	No		Class III
Dexedrine (dextroamphetamine) - Amphetamine (class); CNS Stimulant				
	Attention Deficit Hyperactivity Disorder (ADHD)	Yes (for 3 years to 16 years old (immediate-release) and age 6 years to 16 years old (sustained-release))		
	Narcolepsy	Yes (for 6 years old and up)		
Effexor (venlafaxine) – Antidepressant; Antidepressant, Bicyclic; Phenethylamine (class); Serotonin/ Norepinephrine Reuptake Inhibitor				
	Attention Deficit Hyperactivity Disorder (ADHD)	No		Class IIb
	Generalized Anxiety Disorder	No		Class IIb
	Major Depressive Disorder	No		Class IIb
	Social Phobia	No		Class IIb
Focalin (dexamethylphenidate) - Amphetamine Related; CNS Stimulant				
	Attention Deficit Hyperactivity Disorder (ADHD)	Yes (for 6 years and older)		
Geodon (ziprasidone) - Antipsychotic; Benzisothiazoyl				

Medically Accepted Indications for Pediatric Use of Certain Psychotropic Medications

by

The Law Project for Psychiatric Rights (PsychRights)

Drug	Indication (diagnosis)	FDA Approval	DRUGDEX Support for Off-Label Use	DRUGDEX Recommendation Level
<u>Haldol</u> (haloperidol) - Antipsychotic; Butyrophenone; Dopamine Antagonist				
	Gilles de la Tourette's syndrome	Yes (for 3 years old and up)	It does not appear the injectible form (decanoate) is FDA approved for any pediatric use, nor is it supported by DRUGDEX for any indication.	
	Hyperactive Behavior, (Short-term treatment) after failure to respond to non-antipsychotic medication and psychotherapy	Yes (for 3 years old and up)		
	Problematic Behavior in Children (Severe), With failure to respond non-antipsychotic medication or psychotherapy	Yes (for 3 years old and up)		
	Psychotic Disorder	Yes (for 3 years old and up but ORAL formulations only)		
	Schizophrenia	Yes (for 3 years old and up but ORAL formulations only)		
	Agitation	No		Class IIb
	Migraine	No		Class III
<u>Invega</u> (paliperidone) - Antipsychotic; Benzisoxazole				
<u>Klonopin</u> (clonazepam) - antianxiety, Anticonvulsant, Bensodiazepine, Short or Intermediate Acting				
	Seizure	Yes, up to 10 years or up to 30 kg		
	Gilles de la Tourette's syndrome	No		Class IIb
	Hyperreflexia	No		Class IIb
	Nocturnal epilepsy	No		Class IIb
	Panic disorder	No		Class IIb
	Status epilepticus	No		Class IIb
<u>Lamictal</u> (lamotrigine) - Anticonvulsant; Phenyltriazine				
	Convulsions in the newborn, Intractable	No	Class IIa	
	Epilepsy, Refractory	No	Class IIa	
	Lennox-Gastaut syndrome; Adjunct	yes (2 years and older)		
	Partial seizure, Adjunct or monotherapy	yes (13 years and older, extended-release only; 2 years and older, chewable dispersible)		
	Tonic-clonic seizure, Primary generalized; Adjunct	yes (2 years and older)		
	Absence seizure; Adjunct	No		Class IIb
	Bipolar Disorder, Depressed Phase	No		Class IIb
	Infantile neuronal ceroid lipofuscinosis	No		Class IIb
	Juvenile myoclonic epilepsy	No		Class III
	Paroxysmal choreoathetosis, Paroxysmal	No		Class IIb
	Rett's disorder	No		Class IIb
	Status epilepticus	No		Class IIb
	West syndrome	No		Class IIb
<u>Lexapro</u> (escitalopram)- Antianxiety, Antidepressant, Serotonin Reuptake Inhibitor				
	Major Depressive Disorder	Yes (for 12 years old and up)		
<u>Limbitrol</u> (chlordiazepoxide/amitriptyline) - Tricyclic Antidepressant/Benzodiazepine Combination				
<u>Lunesta</u> (eszopiclone) - Nonbarbiturate Hypnotic				
<u>Luvox</u> (fluvoxamine) - Antidepressant; Central Nervous System Agent; Serotonin Reuptake Inhibitor				
	Obsessive-Compulsive Disorder	Yes (for 8 years old and up and immediate release formula only)		
	Asperger's Disorder	No		Class IIb

Medically Accepted Indications for Pediatric Use of Certain Psychotropic Medications by The Law Project for Psychiatric Rights (PsychRights)

Drug	Indication (diagnosis)	FDA Approval	DRUGDEX Support for Off-Label Use	DRUGDEX Recommendation Level
Mellaril (thioridazine) - Antipsychotic; Phenothiazine; Piperidine	Schizophrenia, Refractory	Yes		
	Behavioral Syndrome	No		Class III
Moban (molindone) - antipsychotic, Dihydroindolone	Schizophrenia	Yes, 12 years and older		
	Aggressive behavior, In children	No		Class IIb
Neurontin (gabapentin) anticonvulsant	Partial seizure; Adjunct	Yes (3- 12 years old)		
	Complex Regional Pain Syndrome, Type 1	No		Class IIb
	Neuropathic Pain	No		Class IIb
	Partial Seizure	No		Class IIb
	Partial Seizure, Refractory	No		Class III
	Phantom Limb Syndrome	No		Class IIb
Orap (pimozide) - Antipsychotic; Diphenylbutylpiperidine; Dopamine Antagonist	Gilles de la Tourette's syndrome	Yes (12 years and older)		
	Anorexia Nervosa	No		Class III
Paxil (paroxetine) - Antidepressant; Central Nervous System Agent; Serotonin Reuptake Inhibitor	Panic disorder	No		Class IIb
	Trichotillomania	No		Class IIb
Pristiq (desvenlafaxine) Antidepressant, Serotonin/Norepinephrine Reuptake Inhibitor				
Prozac (fluoxetine) - Antidepressant; Central Nervous System Agent; Serotonin Reuptake Inhibitor	Major Depressive Disorder	Yes (for 8 years old and up)		
	Obsessive-Compulsive Disorder	Yes (for 7 years old and up)		
	Anxiety Disorder of Childhood	No		Class IIb
	Autistic disorder	No		None
	Bulimia nervosa	No		Class IIb
	Vasovagal syncope; Prophylaxis	No		Class III
Restoril (temazepam) - Antianxiety, Benzodiazepine, Short or Intermediate Acting, Hypnotic				
Ritalin (methylphenidate) - Amphetamine Related; Central Nervous System Agent; CNS Stimulant	Attention Deficit Hyperactivity Disorder (ADHD)	Yes (for 6 years to 12 years old)(extended release)		
	Attention Deficit Hyperactivity Disorder (ADHD)	Yes (for 6 years old and up)(immediate release)		
	Narcolepsy	Yes (for 6 years and up, and Ritalin(R) -SR only)		
	Autistic disorder	No		Class IIb
	Finding related to coordination / incoordination - Impaired cognition	No		Class IIb
	Schizophrenia	No		Class III
	Traumatic Brain Injury	No		Class IIb
Risperdal (risperidone) - Antipsychotic; Benzisoxazole	Autistic Disorder – Irritability	Yes (for 5 years old and up)		
	Bipolar I Disorder	Yes (for 10 years old and up)		
	Schizophrenia	Yes (for 13 years old and up, ORALLY)		
	Behavioral syndrome - Mental retardation	No		Class IIb
	Gilles de la Tourette's syndrome	No		Class IIb
	Pervasive developmental disorder	No		Class IIb

Medically Accepted Indications for Pediatric Use of Certain Psychotropic Medications by The Law Project for Psychiatric Rights (PsychRights)

Drug	Indication (diagnosis)	FDA Approval	DRUGDEX Support for Off-Label Use	DRUGDEX Recommendation Level
Rozerem (ramelteon) - Melatonin Receptor Agonist, Nonbarbiturate Hypnotic				
Seroquel (QUETIAPINE) - Antipsychotic; Dibenzothiazepine				
	Bipolar disorder, maintenance	Yes, 10-17 regular release only (12/4/09)		
	Manic bipolar I disorder	Yes, 10-17 regular release only (12/4/09)		
	Schizophrenia	Yes 13-17, regular release only (12/4/09)		
	Gilles de la Tourette's syndrome	No		Class IIb
Sinequan (doxepin) - Antianxiety Antidepressant; Antidepressant, Tricyclic; Antiulcer Dermatological Agent				
	Alcoholism - Anxiety – Depression	Yes (for 12 years old and up)		
	Anxiety – Depression	Yes (for 12 years old and up)		
	Anxiety - Depression - Psychoneurotic personality disorder	Yes (for 12 years old and up)		
	Pruritus (Moderate), Due to atopic dermatitis or lichen simplex chronicus	No		Class IIb
Sonata (zaleplon) - Nonbarbiturate Hypnotic				
Strattera (atomoxetine) - Central Nervous System Agent; Norepinephrine Reuptake Inhibitor				
	Attention Deficit Hyperactivity Disorder (ADHD)	Yes (for 6 years old and up)		
	Attention Deficit Hyperactivity Disorder (ADHD) - Social phobia	No		Class IIb
Symbyax (fluoxetine hydrochloride/olanzapine) - Antidepressant; Antipsychotic				
Tegretol (carbamazepine) - Anticonvulsant; Antimanic; Dibenzazepine Carboxamide; Neuropathic Pain Agent				
	Epilepsy, Partial, Generalized, and Mixed types	Yes		
	Apraxia			None
	Chorea			Class IIb
	Migraine; Prophylaxis			Class IIb
	Myokymia			Class IIb
	Neuropathy, General			Class IIb
	Schwartz-Jampel syndrome			Class IIb
Tofranil (imipramine) - Antidepressant; Antidepressant, Tricyclic; Urinary Enuresis Agent				
	Nocturnal enuresis	Yes (for 6 years old and up)		
	Attention Deficit Hyperactivity Disorder (ADHD), Predominantly Inattentive Type	No		Class III
	Depression	No		Class IIb
	Schizophrenia, Adjunct	No		Class III
	Separation Anxiety Disorder of Childhood	No		Class III
	Trichotillomania	No		Class IIb
	Urinary incontinence	No		Class IIb
Topamax (topiramate) - anticonvulsant, Fructopyranose Sulfamate				
	Lennox-Gastaut syndrome; Adjunct	Yes, 2 years and older		
	Partial seizure, Initial monotherapy	Yes, 10 years and older		
	Partial seizure; Adjunct	Yes, 10 years and older		
	Tonic-clonic seizure, Primary generalized; Adjunct	Yes, 2 to 16 years old		
	Tonic-clonic seizure, Primary generalized (initial monotherapy)	Yes, 10 years and older		
	Angelman syndrome	No		Class IIb
	Migraine; Prophylaxis	No		Class IIb

Medically Accepted Indications for Pediatric Use of Certain Psychotropic Medications

by The Law Project for Psychiatric Rights (PsychRights)

Drug	Indication (diagnosis)	FDA Approval	DRUGDEX Support for Off-Label Use	DRUGDEX Recommendation Level
	Status epilepticus	No		Class IIb
	West syndrome	No		Class IIb
<u>Tranxene</u> (clorazepate) - Antianxiety, Anticonvulsant, Benzodiazepine, Long Acting				
	Partial seizure; Adjunct	Yes, 9 years and older		
	Epilepsy	No		Class IIb
<u>Trileptal</u> (oxcarbazepine) - Anticonvulsant; Dibenzazepine Carboxamide				
	Partial Seizure, monotherapy	Yes (for 4 years old and up)		
	Partial seizure; Adjunct	Yes (for 2 years old and up)		
<u>Vyvanse</u> (lisdexamfetamine) - Amphetamine (class); CNS Stimulant				
	Attention Deficit Hyperactivity Disorder (ADHD)	Yes (for 6 years old to 12 years)		
<u>Wellbutrin</u> (bupropion) - Aminoketone, Antidepressant, Smoking Cessation Agent				
	Attention deficit hyperactivity disorder	No		None
<u>Xanax</u> (alprazolam) - Antianxiety, Benzodiazepine, Short or Intermediate Acting				
<u>Zoloft</u> (sertraline) - Antidepressant; Central Nervous System Agent; Serotonin Reuptake Inhibitor				
	Obsessive-Compulsive Disorder	Yes (6 years old and up)		
	Anorexia nervosa	No		Class III
	Generalized Anxiety Disorder	No		Class IIb
	Major Depressive Disorder	No		Class IIb
<u>Zyprexa</u> (olanzapine) - Antipsychotic; Thienobenzodiazepine				
	Bipolar 1, Disorder, Acute Mixed or Manic Episodes	Yes (ages 13-17), oral only, approved 12/4/09		
	Schizophrenia	Yes (ages 13-17), oral only, approved 12/4/09		
	Schizophrenia, Refractory	No		Class IIb
	Pervasive Developmental Disorder	No		Class IIb

RECOMMENDATION, EVIDENCE AND EFFICACY RATINGS

RESPONSE

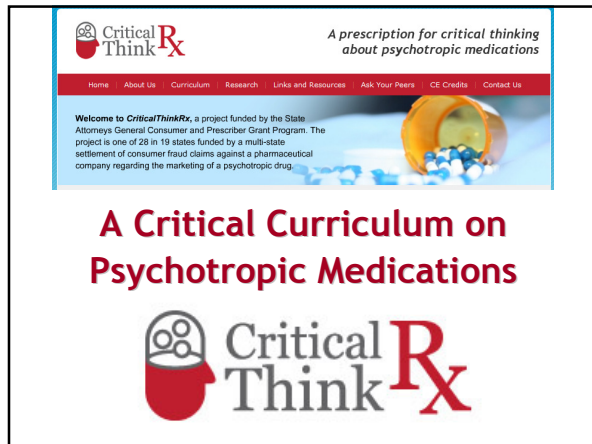
The Thomson Efficacy, Strength of Evidence and Strength of Recommendation definitions are outlined below:

Table 1. Strength Of Recommendation		
Class I	Recommended	The given test or treatment has been proven to be useful, and should be performed or administered.
Class IIa	Recommended, In Most Cases	The given test, or treatment is generally considered to be useful, and is indicated in most cases.
Class IIb	Recommended, In Some Cases	The given test, or treatment may be useful, and is indicated in some, but not most, cases.
Class III	Not Recommended	The given test, or treatment is not useful, and should be avoided.
Class Indeterminant	Evidence Inconclusive	

Table 2. Strength Of Evidence	
Category A	Category A evidence is based on data derived from: Meta-analyses of randomized controlled trials with homogeneity with regard to the directions and degrees of results between individual studies. Multiple, well-done randomized clinical trials involving large numbers of patients.
Category B	Category B evidence is based on data derived from: Meta-analyses of randomized controlled trials with conflicting conclusions with regard to the directions and degrees of results between individual studies. Randomized controlled trials that involved small numbers of patients or had significant methodological flaws (e.g., bias, drop-out rate, flawed analysis, etc.). Nonrandomized studies (e.g., cohort studies, case-control studies, observational studies).
Category C	Category C evidence is based on data derived from: Expert opinion or consensus, case reports or case series.
No Evidence	

Table 3. Efficacy		
Class I	Effective	Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective
Class IIa	Evidence Favors Efficacy	Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy.
Class IIb	Evidence is Inconclusive	Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion argues against efficacy.
Class III	Ineffective	Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is ineffective.

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A Critical Curriculum on Psychotropic Medications

A Critical Curriculum on Psychotropic Medications

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www.CriticalThinkRx.org

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Module 8

Alternatives to Medication: Evidence-Based Psychosocial Interventions

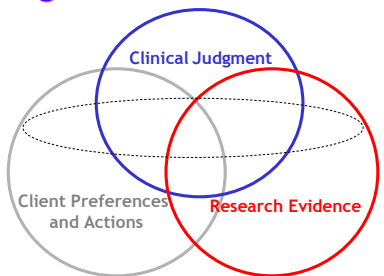


Part A

What is Evidence-Based Practice?



The integration of *best research evidence* with *clinical judgment* and *client values*



(Gambrell, 2006)

A philosophy *and* a process designed to unite research and practice in order to

maximize chances to help clients
minimize harm to clients (in the name of helping)



(Gambrill, 2006)

Deeply participatory

EBP is “anti-authoritarian”—it urges all involved to question claims about what is known *and unknown* about treatments

(Gambrill, 2006)

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EBP difficulties

- ☑ Threats to business-as-usual
- ☑ Limited training and supervision
- ☑ Concerns about cultural sensitivity
- ☑ Worries that “cook book” methods mask real-world complexity

(Barratt, 2003; Chorpita et al. 2007; Duncan & Miller, 2006)

9

An intervention should have *at least some* unbiased observations or tests supporting its usefulness with particular problems and clients

10

Some criteria for judging an intervention

- ☑ Sound theoretical basis
- ☑ Low risk for harm
- ☑ *Unbiased* research exists
- ☑ Therapist and client concur

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Available “evidence” no guarantee of usefulness

Published evidence is influenced by funding sources, researcher biases, and conventional wisdom

Statistically significant differences between treatment groups means simply that more clients in one group had some type of response (partial to complete)

(Hoagwood et al. 2001; Ingersoll & Rak, 2006)

12

However, on average, *all major therapies produce equivalent results.*

Clients' improvement may result from *factors common to every therapy*

(Elkins, 2007; Hubble, Duncan, & Miller, 1999)

13

Most improvement has little to do with therapy or technique

Factor	% improvement explained
Client + outside therapy factors	87
Client-therapist alliance	8
Therapist allegiance to model	4
Therapist technique	1

(Hubble, Duncan, & Miller, 1999; Wampold, 2001)

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Healthy skepticism

"We would do well ... to remain optimistically humble on the matter of evidence-based practices in mental health" by accepting that all assumptions are "provisional and reversible"

(Norcross, Beutler & Levant, 2006, p. 11)

15

A clinician's "rubric" for EBP

"Adhere when possible, adapt when necessary, assess along the way"

(Amaya-Jackson & DeRosa, 2007, p. 388)

16

Choosing proper interventions rests on

- ☑ a clear understanding of the problem from a person-in-situation perspective
- ☑ addressing the complexity of the problem
- ☑ a policy of "First, do no harm"



Part B

Deconstructing the Diagnosis:



What is this child's problem in behavioral terms?

Bio-psycho-social or bio-bio-bio?

- ✓ Complex problems in living reduced to “brain disorders”
- ✓ Complex life events reduced to “triggers”
- ✓ Medicalization of distress and disability leading to false hopes of “quick fix” via pills

(Read, 2005)

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We often ignore environmental influences on behavior

- ☑ Poor parenting, neglect, abuse
- ☑ Schools’ failure to motivate children
- ☑ Poverty, lack of access to resources
- ☑ Violence in media, society, neighborhood
- ☑ Culture’s emphasis on instant gratification
- ☑ Drug culture (“take,” not “talk”)
- ☑ Lack of tolerance for differences

(Bentley & Collins, 2006)

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Children’s distress: “Disorders” or complex adaptations to distressing life experiences?



*By seeing children as real persons
with their own view of their
situation, one ascribes a different
meaning to their behavior*

(Donovan & McIntyre, 1990)

21

“Understanding” rather than “diagnosing”

A developmental-contextual
approach views actions as
“communicative”: attempts
by individuals to cope, adapt,
struggle with their life
experiences



(Donovan & McIntyre, 1990)

22

Here’s a list of feelings and
behaviors from DSM-IV-TR
criteria of “disorders”
commonly diagnosed in
children

Note the similarities...

“Attention-Deficit/ Hyperactivity Disorder (ADHD)”

Feels:

- Angry, irritable, frustrated



Acts:

- Fidgets, squirms
- Easily distracted, forgetful (difficulty thinking, concentrating)
- Interrupts others (acts impulsively)
- Acts aggressively

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“Major Depressive Disorder”

Feels:

- Sad, empty
- Afraid, anxious
- Angry, irritable, frustrated



Acts:

- Eats, sleeps too little (or too much)
- Moves, speaks slowly
- Acts impulsively
- Acts aggressively
- Easily distracted (difficulty thinking, concentrating)

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“Anxiety Disorder”

Feels:

- Afraid, anxious
- Angry, irritable, frustrated



Acts:

- Cries, throws tantrums
- Freezes, clings
- Fidgets (psychomotor agitation)

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“Conduct Disorder”

Feels:

- Angry, irritable, frustrated, hostile



Acts:

- Bullies and threatens
- Fights
- Steals, lies
- Runs away
- Destroys property

27

“Oppositional Defiant Disorder”

Feels:

- Angry, irritable, frustrated, hostile



Acts:

- Disobedient
- Loses temper
- Argues with adults
- Annoys people
- Refuses to follow rules

28

“Bipolar Disorder”

Feels:

- Alternating sad and euphoric
- Alternating fearful and reckless
- Angry, irritable, frustrated

Acts:

- Easily distracted (difficulty thinking, concentrating)
- Moves, speaks fast (agitation)
- Acts impulsively
- Acts aggressively
- Does not sleep well

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“Psychotic Disorder”

Feels:

- Sad, empty
- Blunted feelings, expressionless
- Angry, irritable, frustrated
- Afraid, anxious

Acts:

- Apathetic
- Refuses to speak
- Dresses inappropriately
- Cries frequently
- Sees or hears things

30

“Post-Traumatic Stress Disorder”

Feels:

- Sad
- Afraid, anxious
- Angry, irritable, frustrated
- Helpless, guilty, shameful

Acts:

- Agitated, impulsive, re-enacts trauma
- Hypervigilant: distrustful, withdraws
- Dissociated: forgets and can't focus



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“Reactive Attachment Disorder”

Feels:

- Afraid, anxious
- Angry, irritable, frustrated

Acts:

- Watchful, frozen
- Avoids attachments
- Seeks approval or can't be comforted
- Disregards danger cues



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The common elements

Experiencing negative emotions
(sadness, fear, anger, irritability)

Difficulty controlling oneself
(impulsivity, aggression, inattention)

Seeing self and world negatively
(hopelessness, helplessness, shame, withdrawal)

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What are we medicating?

Negative emotions leading to disruptive actions—especially under stressful conditions that tax the child's adaptive capacities

(Schore, 1994, 2003)

34

Most commonly medicated

Impulsive aggression
“a key therapeutic target across multiple disorders”



(Jensen et al. 2007, p. 309)

35

DSM's scientific value seriously challenged in all disciplines

- ✓ internal inconsistency in the manual (rejects categorical approach in intro but then lists 300+ categories)
- ✓ overlap between categories leads to “co-morbidity”—with no increase in understanding
- ✓ persistent problems of unreliability, especially with children's diagnoses
- ✓ lack of fit between categories and empirically observed symptom clusters

(Caplan, 1995; Duncan et al. 2007; Maj, 2005; Kirk & Kutchins, 1992, 1994; Jacobs & Cohen, 2004; Mirowsky & Ross, 1990)

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More recent DSM critiques...

- ✓ more behaviors now seen as “mental disorders” (from 106 in 1952 to 365 in 1994)
- ✓ political lobbying determines inclusion or exclusion of diagnoses
- ✓ all DSM task force members on mood and psychotic disorders tied to drug industry
- ✓ practitioners focus on diagnosis rather than client, losing client’s actual story
- ✓ still no “gold standard” validity—no specific bio-marker linked to *any* disorder

(Andreasen, 2006; Tucker 1998; Charney et al. 2005; Kutchins & Kirk, 1998)

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Critical list of DSM “accomplishments”

- ☑ increases people’s interest to classify psychosocial problems as medical disorders
- ☑ Helps justify more studies to see how many people can fit how many DSM categories (which often change)
- ☑ led to modest increase in diagnostic reliability since 1980
- ☑ now used by most practitioners in main schools of thought—mostly to obtain third-party reimbursement?
- ☑ brings financial revenues to the American Psychiatric Association from sales of DSMs and training materials
- ☑ strengthened psychiatry’s leadership in mental health system (as official definer of mental distress)

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Part C

Empirically-supported psychosocial interventions for children and adolescents



Focus: Trauma, Resilience and Child Welfare



Trauma and early loss

For thousands of children every year, loss and trauma due to disrupted attachments to biological parents result in foster care placements

(Jones Harden, 2004; Racussin et al. 2005)

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Additional, placement-related traumas

- ✓ Emotional disruption of out-of-home placement
- ✓ Adjusting to a foster care setting
- ✓ Relative instability of foster care
- ✓ High turnover of workers

(Jones Harden, 2004; Racussin et al. 2005)

42

Neurobiology of attachment



Brains develop in a *socially dependent manner*, through secure attachments and *consistent, competent* adults attuned to the needs of the child

(Schore, 1994, 2001, 2003; van der Kolk, 2003)

43

Child's "job": to form close, trusting attachments with caregivers



Adolescent's "job": to expand attachments using secure base with caregivers

(Gunnar et al. 2006; Mash & Barkeley, 2006; Moran, 2007; Wolfe & Mash, 2006)

44

Trauma, abuse, and neglect

- ☑ disrupt a child's ability to form secure attachments
- ☑ impair brain development and regulation
- ☑ make self-control difficult
- ☑ alter identity and sense of self

(Bowlby, 1988; Cook et al. 2005; Courtois, 2004; Creeden, 2004; Jones Harden, 2004; van der Kolk, 1994)

45

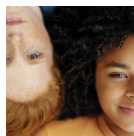
Resilience

The ability to function well despite living or having lived in adversity rests mainly on normal cognitive development and involvement from a caring, competent adult

(Agaibi & Wilson, 2005; Masten et al. 1990; Schofield & Beek, 2005)

46

- ✓ Risk and protective factors in the foster child, foster-families, agencies, and birth family interact to produce upward or downward spirals



- ✓ Understanding resilience helps create interventions that produce positive turning points in children's lives



(Schofield & Beek, 2005)

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Three key elements

1. Secure base: is child strengthening sense of security and able to use foster-parents as a secure base?
2. Sense of permanence: is placement stable and foster-parents offering family membership?
3. Social functioning: is child functioning well in school, with peers?

(Schofield & Beek, 2005)

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Treatment goals

- ✓ Enhance sense of personal control and self-efficacy
- ✓ Maintain adequate level of functioning
- ✓ Increase ability to master, rather than avoid, experiences that trigger intrusive re-experiencing, numbing, and hyper-arousal

(Ford et al. 2005; Kinniburgh et al. 2005)

49

What could help?

Activating child's internal reparative mechanisms through *dyadic interventions* and creating secure attachments

- dyadic therapy mobilizes the completion of interrupted biological and emotional developmental processes



(Amaya-Jackson & DeRosa, 2007; Courtois, 2004; Ford et al. 2005; Pearlman & Courtois, 2005)

50

A sensorimotor approach

Children's internal stimuli, can trigger dysregulated arousal, causing emotions to escalate

- Integration of cognitive, emotional and sensorimotor levels is crucial for recovery

(Ogden, 2006)

51

Why would this help?

Child develops the ability to take in, sort out, process, and interrelate information from the environment — leading to self-organization of internal states and self-control of behavior

(DeGangi, 2000; Kinniburgh et al. 2005; Schore, 2003; van der Kolk, 2006)

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How would this help?

By enhancing children's:



- ✓ social skills
- ✓ ability to understand and express feelings
- ✓ ability to cope with anger and distress
- ✓ ability to problem-solve and think helpful thoughts
- ✓ skills to self-direct and create goals

(Bloomquist, 1996; Kinniburgh et al. 2005)

53

Alternatives to medication

- ☑ Consistent, structured, supportive adult supervision
- ☑ Opportunities for self-expression and physical activity, to give children a sense of mastery over their minds and bodies



(DeGangi, 200; Faust & Katchen, 2004)

54

Helpful activities

- ☑ Teaching problem-solving and pro-social skills
- ☑ Modeling appropriate behaviors
- ☑ Teaching self-management
- ☑ Helping children learn to comply and follow rules



(DeGangi, 2000; Faust & Katchen, 2004)

55

Helpful interactions

- ☑ Desensitizing hyper-reactivity
- ☑ Promoting self-calming and modulation of arousal states
- ☑ Organizing sustained attention
- ☑ Facilitating organized, purposeful activity



(DeGangi, 2000)

Expected outcomes

Children learn to develop appropriate responses, self-organization and control, which in turns leads to



MASTERY AND SELF-ESTEEM

(Kinniburgh et al. 2005)

57

Many treatment alternatives

Symptom-focused: Behavioral, cognitive-behavioral, and interpersonal therapies, attachment-based therapies, trauma-focused therapies

System-focused: Treatment foster care (TFC), Multi-dimensional treatment foster care (MTFC)



(Farmer et al. 2004; Racussin et al. 2005)

Focus:
Dysregulated “moods”



**“Depression”
and “Anxiety”**



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The New York Times
Talk Therapy Pivotal for Depressed Youth



February 6, 2007
In Rigorous Test, Talk Therapy Works for Panic Disorder
By [BENEDICT CAREY](#)

61

Link to child maltreatment

Abuse leads to “hypervigilance” to threat, resulting in anxiety and hopelessness

Neglect results in dysregulated “moods”

(Greenwald, 2000; Lee & Hoaken, 2007)

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“Traumatized children tend to communicate what has happened to them ... by responding to the world as a dangerous place by activating neurobiologic systems geared for survival, even when objectively they are safe”

(van der Kolk, 2003, p. 309)

Therapy or no therapy?

Some 30-40% recover without intervention

Approximately 50% of treated patients improve within 8 weeks

A friendly sympathetic attitude and encouragement are key

(Roth & Fonagy, 1996)

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Consensus strongly favors cognitive-behavioral therapy (CBT) as first-line treatment above medications

(APA Working Group, 2006; March, 1995; Roth & Fonagy, 1996; Velting et al. 2004)

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Other effective interventions

1. Interpersonal psychotherapy
2. Psychodynamic psychotherapy
3. Exposure-based contingency management
4. Problem-solving and coping-skills training

(APA Working Group, 2006; Roth & Fonagy, 1996)

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Patient preference

When given a choice,
patients express a
preference for
psychosocial
interventions over
medications



(APA Working Group, 2006)

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“Bipolar Disorder” and “Schizophrenia”

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Very rare in children (~1%)

Diagnosis controversial:

- no laboratory “test”
- “symptoms” may be manifestations of ordinary developmental differences

(Birmaher, 2003; Birmaher & Axelson, 2006; Cepeda, 2007; Correll et al. 2005; Danielson et al. 2004; Irwin, 2004; Findling, Boorady & Sporn, 2007; Roth & Fonagy, 1996)

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High risk of over-diagnosis

NIMH Review: 95% of 1500 children
referred for high clinical suspicion of
childhood-onset schizophrenia did not meet
DSM criteria after careful inpatient
observation off all medications

*No evidence that they would have developed
psychosis if left untreated*

(Shaw & Rapoport, 2006)

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Link to child maltreatment

Child abuse and neglect considered
a causal factor for psychosis and
“schizophrenia”

- Content and severity of psychotic symptoms related to severity of past abuse

(Cepeda, 2007; Morrison et al. 2005; Read & Ross, 2003; Read et al. 2004, 2005)

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**Many children improve when
treated with family-based
psychosocial interventions,
even without medications**

- High rates of “relapse”
observed on medication

(Birmaher, 2003; Birmaher & Axelson, 2006; Cepeda, 2007; Correll et al. 2005; Danielson et al. 2004; Findling et al. 2007; Irwin, 2004; Roth & Fonagy, 1996)

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Effective psychosocial treatments

Child- and Family-Focused CBT
combined with interpersonal and
“social rhythm” therapy to stabilize
mood, activities and sleep

**Community support and social
acceptance** through day programs and
sports/cultural activities

(Findling et al. 2007)

73

Who recovers and why?

Psychiatric literature is mostly
silent about the characteristics
of people who fully recover
from psychosis and how and why
they do so

(Siebert, 2000)

74

Focus: Disruptive behaviors



Disruptive behaviors: the most frequent reason for referral of children to mental health services

(Brestan & Eyberg, 1998; Butler & Eyberg, 2006)

76

For disruptive behaviors and conduct “disorders”

☒ **Family-based behavioral
interventions**



(APA Working Group, 2006; Brestan & Eyberg, 1998;
Diamond & Josephson, 2005; Kazdin, 2005, 2000, 2000b;
Kazdin & Weisz, 2003; Thomas, 2006)

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The New York Times (2006, December 22)

TRIOUBLED CHILDREN
Parenting as Therapy for Child's Mental Disorders



TJ Van de Wals attention deficit problems have improved in response to parenting techniques, his mother Dawn, right, said.

78

Effective parenting: the most powerful way to reduce child and adolescent problem behaviors



(Caspe & Lopez, 2006; Johnson et al. 2005; Kumpfer et al. 2003) 79

Strongest evidence base

1. Parent management training (PMT)
2. Problem-solving skills training (PSST)
3. Brief strategic family therapy (BSFT)
4. Functional family therapy (FFT)

(Brestan & Eyberg, 1998; Butler & Eyberg, 2006; Farley et al. 2005; Kazdin, 2003; Kazdin & Whitley, 2003; Springer 2006; Thomas, 2006)

80

Goals of parent training

- ☑ Promote parent competencies & strengthen parent-child bonds
- ☑ Increase consistency, predictability & fairness of parents
- ☑ Produce behavior change in children



(Kazdin, 2003; McCart et al. 2006; Webster-Stratton & Reid, 2003) 81

“Problem” children or “problem” adults?

Coercive parenting was the only factor linked to children’s failure to improve their conduct after family treatment

(Webster-Stratton, Reid & Hammond, 2001)

82

Maltreatment consistently linked to aggressive behaviors

- ☑ History of trauma virtually *universal* in youth with conduct “disorders”

(Greenwald, 2000; Lee & Hoaken, 2007)

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Children in foster care

- ✓ have socio-emotional problems **3 to 10 times more often** than other kids
- ✓ Coercive interactions only result in escalation of aggressive behaviors



(Nilsen, 2007)

84

Parent-training in child welfare

*Promising programs exist to
train biological and foster
parents*

Goal is to break the cycle of
coercive parenting and child
oppositional behavior

(Barth et al. 2005; Nilsen, 2007)

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“ADHD”

Large evidence base exists for
behavioral interventions, incl.
parent training, social skills
training, and school-based
services

- Results equivalent to stimulant
medications without the health
risks



(APA Working Group; Chronis et al. 2004, 2006)

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Focus: Mentoring



Children's development
depends upon reciprocal
activity with others with
whom they have a strong
and lasting bond



(Jones Harden, 2004; Rhodes et al. 2006)

Mentorship

A relatively long-term, non-expert
relationship between a child and
non-parental adult, based on
acceptance and support, aiming to
foster the child's potential, where
change is a desired but not
predetermined goal

(Dallos & Comley-Ross, 2005; Rhodes et al. 2006)

Significant effects

Meta-analysis of 55 studies
found significant effects of
mentoring programs

- Community-based programs more
effective than school-based
programs

(DuBois & Silverthorn, 2005)

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Mentoring in foster care

Survey of 29 programs found mentoring provides a bridge to employment and higher education, helps with transitional problem-solving

(Mech, Pryde & Rycraft, 1995)

91

Common factors for success

- ☑ Frequent contacts
- ☑ Emotional closeness (attunement)
- ☑ Longer duration
- ☑ Structured activities
- ☑ Ongoing training for mentors

(DuBois & Silverthorn, 2005; Gilligan, 1999; Rhodes et al. 2006)

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Mentors enhance resilience

Sensitive mentoring increased self-esteem and well-being, reduced aggression and opened new relationships beyond care system

- *prevents negative outcomes as youth leave foster care*

(DuBois & Silverthorn, 2005; Gilligan, 1999; Lemon et al. 2006; Legault et al. 2005; Rhodes et al. 1999, 2006; Schofield & Beek, 2005)

93

Reduces violence

“Having someone to count on when needed” softened the impact of trauma and reduced likelihood of youth engaging in violent offenses

(Maschi, 2006)

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Part D

Conclusions and Recommendations



Medicalized approach to distress and disability pathologizes children's behaviors and ignores the context of their experiences

- “Understanding” rather than “diagnosing” changes the meaning of those behaviors and can lead to more helpful interventions

96

Abuse, neglect and trauma disrupt secure attachment and impair the child's ability to self-regulate

- "Repair" occurs through the formation of secure attachments, rather than by medication



Irritability, impulsivity and aggression appear in criteria for most DSM diagnostic labels used on children

- We are medicating children's negative emotions and immature self-control

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Growing consensus

Just Say 'No' to Drugs as a First Treatment for Child Problems

(Duncan, Sparks, Murphy, & Miller, 2007)

99

Attempt psychosocial interventions *before* initiating medication

Ample evidence supports their use as effective first-line options for children's behavioral problems, *with no apparent risk of medical harm*

100

Fundamental issues of efficacy and safety of psychotropic medications in children remain unresolved

Therefore, medicating children should be avoided



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A Critical Curriculum on Psychotropic Medications

Module 8

The End



www.CriticalThinkRx.org

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Attachment 3

Eliminating the Use of Psychotropic Medication in the Treatment of Children with Profound Emotional and Behavioral Issues

Introduction

Two decades ago, Seneca Center created its intensive residential treatment program to serve children who exhibit the most serious emotional and behavioral issues. From its inception, the program adopted a “no reject, no eject” intake/discharge policy based upon a philosophy of unconditional care. As a result, the children referred to the program during the last 20 years have represented some of the most challenging young people residing in Northern California. Most have been failed by numerous foster homes and other group care and residential treatment programs. In many cases, the children have been in and out of psychiatric inpatient care prior to their placement with Seneca.

Throughout the operating history of Seneca’s intensive residential treatment program, the prevailing assumption in the larger mental health provider community has remained the same: the children targeted by our program cannot be treated successfully without using psychotropic medication. Twenty years later we now know, beyond any doubt, that it is possible to take these children from the most chaotic backgrounds and help them to succeed without pharmacological interventions. Indeed, the experience of Seneca’s residential program raises serious questions about the popular practice of utilizing psychotropic medication to treat traumatized children with serious behavior disorders.

Ironically, the actual act of removing the medications has turned out to be crucial to the successful treatment of the children in our care. First of all, we have found that children who are not medicated are much more readily available for engagement with adult caregivers. Second, removing these medications gives children a very powerful message that we have faith in their capacity to learn how to regulate themselves. As a result, it does not take long for these children to realize that Seneca staff will live up to their commitment to provide unconditional care for them, addressing behaviors that previously would have led to placement disruption.

The elimination of pharmacological interventions in our treatment model sends a powerful message not only to the children, but to program staff as well: they are capable of having a profound impact on these children's lives by (1) supporting them to feel safe and (2) helping them to tap into their (often unrecognized) strengths, interests and creativity. Staff morale is increased, moreover, when they know that their interpersonal interactions with the children, *not the use of psychotropic medications*, are the most important element in enabling these young people to reclaim their lives.

Overview of Seneca's Residential Treatment Program

Seneca's residential treatment program currently consists of four houses, each providing care and treatment for six children. The base staffing pattern for each group home includes three bachelor's level counselors during non-school hours. When the children are asleep, there is one awake overnight counselor at each house, with a floating counselor available to respond to a crisis. Assigned to each house are a clinician and house manager who, with the direct care counselors, comprise the treatment team. The clinician provides individual therapy to each of the six children in the group home. The house manager provides regular individual supervision to the direct-care counselors. Together, the therapist and house manager oversee the therapeutic milieu, as well as implementation of each child's individualized treatment plan. House staff meet weekly to discuss the progress of each child. During this meeting, the team members discuss the emotional, social, and developmental needs of each child, as well as individual strategies and interventions to address those needs.

Most, if not all, of the children placed in the residential program attend school at Seneca's nonpublic school/day treatment program located in San Leandro. In this enriched school setting, the children benefit from intensive special education and mental health services. All the children attend Seneca's after-school program as well, where they participate in a variety of structured group activities such as science and nature projects, arts and crafts, music appreciation, and sports games.

Direct-care counselors understand that it is their responsibility to provide the children with a safe and nurturing experience of outstanding care and positive regard. Each child, from the beginning of his/her placement in the residential program, receives the strong message that he/she will not be discharged from the program due to challenging behaviors. Rather, residential staff will do whatever it takes to support the child to feel safe and begin the process of making sustained therapeutic progress.

Treatment Philosophy

Very early in the agency's history, Seneca staff learned that the needs of children with chaotic family and/or placement histories are most effectively addressed through supportive interactions with caregivers. In particular, we soon refined and distilled our experience into a treatment model that incorporates three essential elements: safety, predictability, and engagement.

The core service principles of safety, predictability and engagement permeate every aspect of Seneca's residential treatment program. What children first discover when they come into our care is that program staff intervene immediately with any unsafe behaviors. Much of this engagement takes place through carefully planned behavioral interventions that are predictable and lead to clear choices for the children. Another level of safety involves the close supervision of children's contact with previous caretakers who, in the past, may have led the children to fear they would be returned to an unsafe environment.

In addition to promoting safety and predictability for the children, Seneca staff strive to engage the children in healthy, constructive relationships. It is this engagement that "cements" together all the components of the treatment model and leads a child to start believing that he/she can influence his/her own behavior and environment. Residential program staff provide what has often been missing from a child's interaction with previous caretakers, including the ability to accurately reflect the child's states of mind, to connect with the child's "better instincts," to set clear limits, and to acknowledge and encourage the child's interests and strengths.

Description of Children Served by the Residential Program

Typically, Seneca's residential treatment program has been utilized by county placing agencies as a "last resort" for children whose behavior has not responded to the highest levels of previous care (including psychiatric hospitalization). Some children have experienced as many as 30 changes in placement prior to entering Seneca's program. In addition to numerous failed stays in foster homes and other residential treatment facilities, many of the children have experienced multiple psychiatric hospitalizations and have extensive medication histories. It is the agency's policy to reevaluate the use of psychotropic medications at intake into a Seneca residence and to develop a plan for the discontinuation of those medications at the earliest point possible.

During its first 11 years of operation, the residential program provided only long-term care. In 1997, Seneca entered into a contract with Alameda County Social Services to utilize one of the residential program's six-bed group homes to provide short-term stabilization and evaluation services. This program (located at the agency's Los Reyes House) was specifically developed to evaluate foster children identified by the county as needing higher levels of care. The overarching goal of both the short-term and long-term residential treatment programs is to discharge children to less restrictive environments (and when possible, the most family-like setting possible). At Los Reyes House, however, program staff are more immediately involved in researching and identifying the next placement for each child, including working closely with Alameda County Social Services to achieve a successful long-term placement for the child.

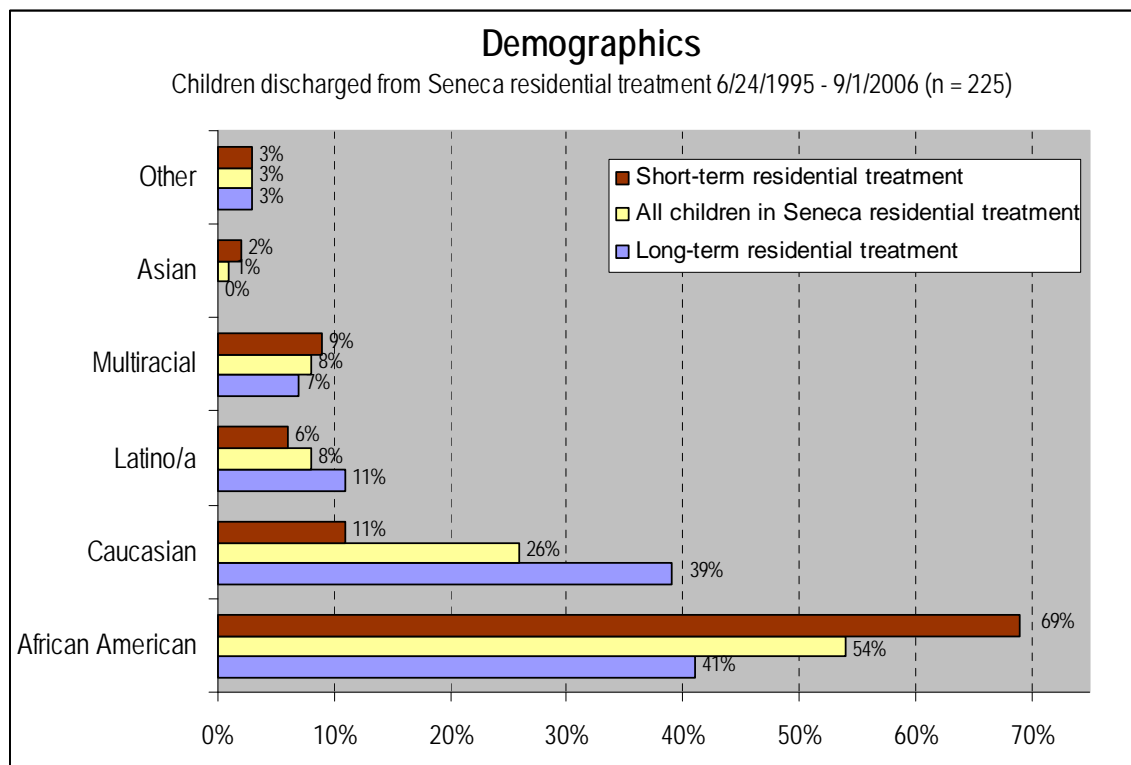
To help us to describe the experiences of children served by the residential program, Seneca staff and two UC Berkeley School of Social Welfare MSW students recently conducted a chart review of every child discharged from the program during the last 11 years, with specific attention paid to collecting medication use, psychiatric evaluation, and post-discharge placement data.¹ Since June 1995, a total of 225 children have been discharged from the program after a stay of at least 30 days. Information about children's placement histories, experiences of abuse, psychiatric diagnoses, and medications was obtained by reviewing information available in individual Table

¹ This evaluation includes children who were discharged between 6/24/1995 and 9/1/2006 who were admitted to a Seneca Residential Treatment Program for at least 30 days.

of Life Events and Psychiatric Intake documents. Post-discharge placement information was available for 180 children (80%), obtained through both electronic records and therapist reports. Following is a summary of the results of the chart review study, which provides an illuminating overview of client child characteristics and placement histories.

Client Demographic Information

- 118 children were discharged from the long-term residential treatment program, and 107 were discharged from the short-term residential program during the period covered by the chart review study.
- 71% of the residents were male; 29% were female.
- 10% of children discharged from long-term residential treatment and 3% of children discharged from short-term residential treatment were readmitted after a previous discharge.



Placement History

- Children admitted to long-term Seneca residential treatment programs had previously experienced an average of 9.7 placements, with the number of past placements ranging from 0 to 30.
- In comparison, children admitted to Los Reyes house had experienced an average of 7.2 previous placements, with number of past placements ranging from one to 16.

Length of Stay

- Children placed in Seneca's long-term residential treatment program were served for an average of 26 months, with some children staying for as little as one month and one staying for 60 months.
- Children admitted to Los Reyes House were served for an average of 5 months, with lengths of stay ranging from one to 11 months.

Post-Discharge Placement²

- Of the 118 children discharged from the long-term residential treatment program:
 - 58% were placed in another residential/group home setting
 - 18% were reunified with a biological family member
 - 17% were placed in a foster home
 - 6% were placed in Intensive Treatment Foster Care
 - 1% transitioned to a Seneca Community Treatment Facility
- Since the inception of the short-term stabilization and evaluation program, 107 children have been assessed by Seneca staff to assist Alameda County Social Services in determining the best subsequent placement. While several of these children required placement in Seneca's long-term residential treatment program, 78% of the children evaluated at Los Reyes were able to be transitioned to a lower level group home program. The other children were transitioned to a foster home or reunified with family, as follows:
 - 10% were placed in a foster home
 - 8% returned home to an adoptive or biological family member

² Based upon available discharge data.

- 4% were placed in Intensive Treatment Foster Care

Client Diagnostic Issues

The children admitted to Seneca's short or long-term residential programs arrive with a wide variety of previous diagnoses. Bipolar Disorder, in particular, has become an increasingly common diagnosis in recent years. A few children are reported to be hearing voices and given a diagnosis of psychosis (a diagnosis that, in our experience, has always proved to be wrong, with the voices being symptoms of dissociation). The other common diagnoses include hyperactivity (ADHD) and depression.

Previous Axis 1 Diagnoses for Children Admitted to Long-Term Residential Treatment

- Post-Traumatic Stress Disorder – 42%
- ADD/ADHD – 32%
- Depression/Depressive Disorders – 26%
- Oppositional Defiant Disorder – 17%
- Dysthymic Disorder – 9%
- Conduct Disorder – 7%
- Bipolar Disorder – 5%
- Adjustment Disorder – 3%

Previous Axis 1 Diagnoses for Children Admitted to Short-Term Residential Treatment

- Post-Traumatic Stress Disorder – 45%
- ADD/ADHD – 35%
- Depressive Disorder – 21%
- Dysthymic Disorder – 17%
- Oppositional Defiant Disorder – 15%
- Bipolar Disorder – 14%
- Conduct Disorder – 10%
- Adjustment Disorder – 7%

In order to receive Medi-Cal funding for treating these children, Seneca residential program clinicians must provide them with diagnoses according to the prevailing nomenclature: DSM-IV. As a result, most of the children receive a diagnosis of Post-Traumatic Stress Disorder (PTSD). Those who have had serious abuse and neglect in their earliest years often receive a diagnosis of

Complex PTSD, a diagnosis that is not yet part of the current DSM but one well established by clinicians working with this population.

Over time, however, Seneca residential clinicians have found that the process of attaching a diagnosis to a child is of dubious value in designing an effective treatment plan, particularly since many of these diagnoses infer genetic biological disorders that are most commonly treated with psychotropic medications. In our experience, children cannot be understood without a clear history of their relationships and the conditions that influenced their upbringing. Our approach is not to ask “what is wrong with this child?”, but rather, “what happened to this child?” Most importantly, we seek to determine the sustained patterns of relationship to which the child has been exposed prior to coming to Seneca?

In order to minimize the labeling of children, Seneca has developed a computerized Table of Life Events that creates a detailed chronology of each child’s life. It includes all the information we can assemble - sometimes as much as a hundred pages of prior evaluations, court reports and hospitalizations will be distilled into one document of four to five pages. The Table of Life Events document is usually quite effective at dispelling any simplistic notions regarding “what is wrong” with the child and returns us to the larger historical and cultural context of the child’s life and development. This, in turn, encourages us to address the real issues in the child’s life as opposed to “treating” a DSM IV description of his/her symptoms and behavior. Such a chronology also makes clear what has “worked” and “not worked” in past attempts at treatment.

Typical factors that have affected the lives of children placed in Seneca’s residential program include the following:

- Physical, sexual and emotional abuse, as well as severe neglect.
- Witnessing of violence between caretakers.
- Growing up with parents who could not set limits and/or who were terrified to intervene in a child’s behavior. (Children who become “out of control” with such caretakers are often labeled as bipolar).
- Growing up in homes where one or both of the parents were heavily involved in alcoholism and drug abuse.

- Living in homes where the mother engages in relationships with a series of men who abuse her and the children. Most often the woman in these situations is not able to protect either herself or her children.

The earlier these factors occur in a child's life, the more seriously they undermine the security of his/her attachments, and the more ingrained are the child's patterns of negative interaction with peers and adult caregivers.

Histories of Abuse and Neglect

- Children admitted to Los Reyes House have an average of 5.6 referrals to Child Protective Services (CPS) documented in the Table of Life Events, compared to 5.5 documented referrals for children admitted to long-term residential treatment.
 - Among children in long-term residential treatment, documented child abuse referrals ranged from 0 to 26.
 - Among children at Los Reyes House, previous documented child abuse referrals ranged from 1 to 18.
- 80% of all children admitted to Seneca residential treatment were given a primary Axis 1 diagnosis of Post-Traumatic Stress Disorder at the Seneca psychiatric intake. Histories of abuse and neglect are further reflected in Axis 1 diagnoses.¹

	<u>Long-term residential</u>	<u>Short-term residential</u>
Neglect	15%	14%
Physical Abuse	20%	30%
Sexual Abuse	22%	25%

Observations Regarding the Use of Psychotropic Medication

The vast majority of children placed in Seneca's residential program have a history of treatment with psychotropic medication. In virtually every case, the children were medicated to control their behavior, but these medications ultimately ended up being ineffective. A typical pattern involves the prescription of psychotropic medication followed by some reduction in acting-out behaviors. However, subsequent negative behaviors lead to the addition of yet another medication, with the pattern repeating itself one or more times. As a result, some children enter

Seneca's residential program with as many as seven different psychotropic medications, progressively added over time while the child continued to display symptoms.

Medication History of Children Placed in Seneca's Residential Treatment Program

- 76% of the children admitted to long-term residential treatment were on at least one psychotropic medication, compared to 53% of children admitted to the short-term Los Reyes Program. Nearly 92% of the children entering Seneca's long-term residential program had some history of psychotropic medication treatment, regardless of whether they were being actively treated with medication(s) at the time of admission.
 - Of the 28 children admitted with no medications, 19 had a previous history of treatment with psychotropic medications.
- 52% of children admitted to long-term Seneca residential treatment had been prescribed two or more psychotropic medications, compared to 35% of children admitted to the Los Reyes Program.
- 15% of children admitted to long-term Seneca residential treatment had been prescribed four or more psychotropic medications, compared to 7% of children admitted to the Los Reyes Program.

The policy of Seneca's residential treatment program is (and has been) to evaluate all past medication use prior to a child's admission. Once the child enters our care, the medications are carefully reduced and eventually stopped. Seneca has had the opportunity to test the viability of its no-medication treatment approach for almost 19 years, working with the some of the most challenging children in California—including several sent to us directly from Metropolitan State Hospital.

Impact on Residential Program Staff, Client Children and Family Members

Removing the option of using psychotropic medication in treatment planning and delivery has had the following impacts on residential program staff, children and family members:

We find that staff have a greater sense of personal connection to the children when they are not relying on medication. Instead of calling for another medication to control a symptom, they are more likely to observe variations in behavior and attend to the situations and antecedents that are affecting that behavior. Needless to say, all these factors contribute to better treatment outcomes.

Seneca's stance towards medication gives us specific advantages in working with the children themselves. It tells them that we do not need, and they do not need, an agent of external control in order to establish the conditions for their success. Most children respond very positively to this message, seeing it as further evidence that we are determined to engage them no matter how difficult their behavior has been in the past. Occasionally, we meet children who are convinced that they will be incapable of functioning if they do not have continuing access to their medications. In these cases, we include them as collaborators in tracking their own progress. Over time, they learn that they have the power to manage their own behavior and to participate positively in the larger world.

At times we see parents who are heavily invested in the use of psychotropic medication for their child. Often, past evaluations have determined that the child suffers from a biochemical disease that cannot possibly be treated without the use pharmacological intervention. We find that such parental views can be modified over time through their ongoing engagement with the program, observation of their child's progress over time, and discovering that they themselves can play a much more active role in helping their children.

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