THE TRAUMATIZED CHILD:

Indications, risks and benefits of psychotropic medication use.

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Financial Disclosures

- I have no financial relationships with any pharmaceutical research, manufacturing, or distribution companies.

Objectives

- Participants will have the opportunity to learn the basic neurobiology of trauma and the "end symptoms" of trauma which create disruption in the home and academic environments.
- Participants will have the opportunity to learn the risks and benefits of psychotropic medication use in children who have experienced trauma
- Participants will have the opportunity to participate in 3 case reviews of children who are on psychotropic medication and have histories of trauma exposure

In almost no circumstance should a child's sole treatment intervention be medication management for a behavioral or emotional concern when there is a history of trauma

-- One in four
-- 9.2% lifetime prevalence
-- Increased risk for chronic illness throughout the lifespan
-- Subthreshold population

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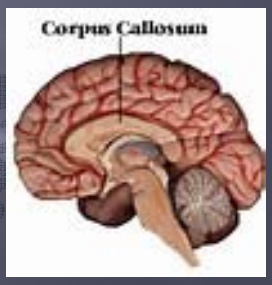
PTSD related to child abuse or domestic violence is associated with smaller cerebral volume and smaller corpora colossa



INTEGRATION

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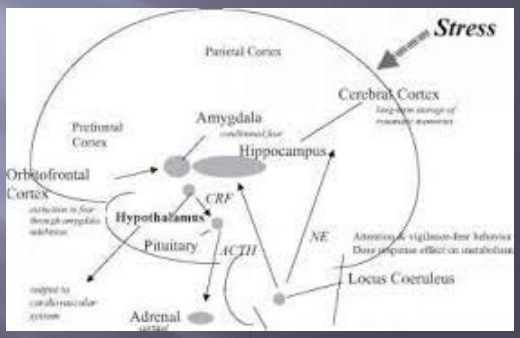

- lower academic achievement
- substance abuse
- conduct disorder
- depression
- suicidal attempts and self harm
- substance abuse
- psychiatric hospitalizations
- relationship difficulties

SEXUAL ABUSE

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DIAGNOSIS AND TREATMENT

American Academy of Child and Adolescent Psychiatry

MAKING A DIAGNOSIS

- Qualifying index traumatic event AND specific symptoms in relation to that traumatic experience.
- Extreme dysregulation of physical, affective, behavioral, cognition and/or interpersonal functioning

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PTSD Symptom Clusters: Reexperiencing

- As evidenced by at least one of the following:
  - recurrent and intrusive recollections, nightmares, or other sense of reliving the traumatic experience.
  - Repetitive play
  - Trauma specific reenactment
  - Trauma reminders lead to psychological or physiological distress.

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PTSD Symptom Clusters: Persistent Avoidance

- efforts to avoid trauma reminders including talking about the traumatic event or other trauma reminders
- inability to recall an important aspect of the trauma
- decreased interest of participation in previously enjoyed activities
- detachment or estrangement from others
- restricted affect
- a sense of a foreshortened future

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PTSD Symptom Clusters: Persistent Hyperarousal

- difficulty falling or staying asleep
- irritability or angry outbursts
- difficulty concentrating
- hypervigilance and increased startle reaction
- oppositional behavior
- regression in developmental skills
- new separation anxiety, and new fears not obviously related to the traumatic event.

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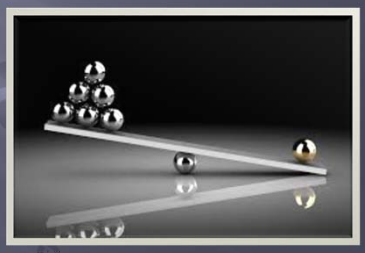
female gender
previous trauma exposure
greater exposure to index trauma
presence of a preexisting psychiatric disorder
parental psychopathology
lack of social support

parental support
lower levels of parental PTSD
resolution of other parental trauma related symptoms



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AACAP Practice Parameter: Psychotropic Medication Use in Children with PTSD

RECOMMENDATION 1: SCREENING

Psychiatric assessment of children and adolescents should routinely include questions about traumatic experiences and PTSD symptoms

RECOMMENDATION 2: EVALUATION IF INDICATED

- Parents or other caregivers should be included in this evaluation wherever possible. The proper assessment of PTSD requires relatively more diligence and educational interviewing than perhaps for any other disorder.

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RECOMMENDATION 3: CONSIDER DIFFERENTIALS

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RECOMMENDATION 4: COMPREHENSIVE TREATMENT

- education of a child and parent
- consultation with school personnel and PCP
- trauma focused psychotherapy
- pharmacology may be considered,
- treatment of mild PTSD should begin with therapy
- valid reasons for combining meds with therapies

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RECOMMENDATION 4: COMPREHENSIVE TREATMENT

Need for acute symptom reduction

Comorbid disorder (s)

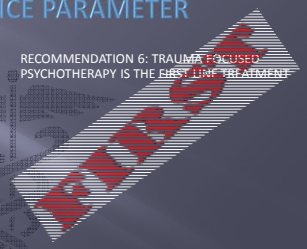
Partial or unsatisfactory response with potential for improved outcomes

AACAP PRACTICE PARAMETER

RECOMMENDATION 5: TREAT COMORBIDITIES

- commonly occurs in the presence of depressive disorder, ADHD, substance abuse, and other anxiety disorders.

RECOMMENDATION 6: TRAUMA FOCUSED PSYCHOTHERAPY IS THE FIRST LINE TREATMENT



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RECOMMENDATION 7: SSRIs can be considered for the treatment of children and adolescents with PTSD

- SSRIs are the only medications shown to effectively decrease symptoms in all three adult PTSD clusters.
- Limited research has been done on the pediatric population.

- citalopram or escitalopram
- fluoxetine
- sertraline
- Improvement of target symptoms of mood, cognition and sleep (some physical symptoms as well) within 4-6 weeks at therapeutic doses
- Dry mouth, headache, hyperarousal (pre-existing cyclical mood disorder), suicidal thoughts

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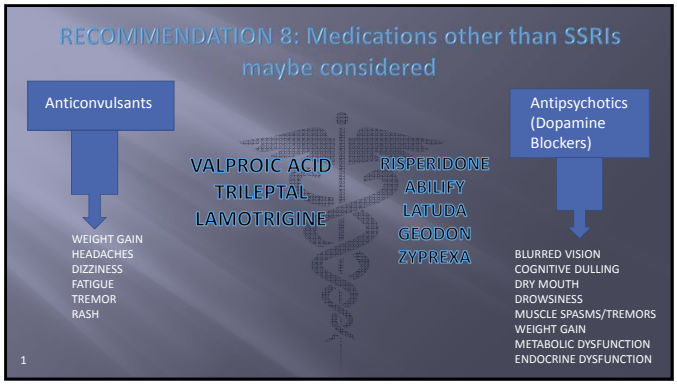
RECOMMENDATION 8: Medications other than SSRIs maybe considered
Anticonvulsants
VALPROIC ACID
TRILEPTAL
LAMOTRIGINE
WEIGHT GAIN
HEADACHES
DIZZINESS
FATIGUE
TREMOR
RASH
RISPERIDONE
ABILIFY
LATUDA
GEODON
ZYPREXA
Antipsychotics (Dopamine Blockers)
BLURRED VISION
COGNITIVE DULLING
DRY MOUTH
DROWSINESS
MUSCLE SPASMS/TREMORS
WEIGHT GAIN
METABOLIC DYSFUNCTION
ENDOCRINE DYSFUNCTION
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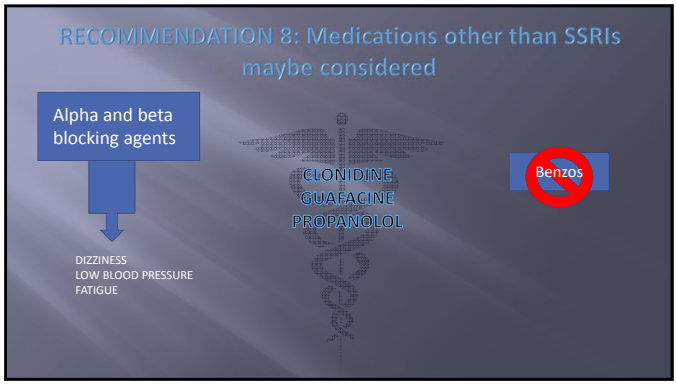
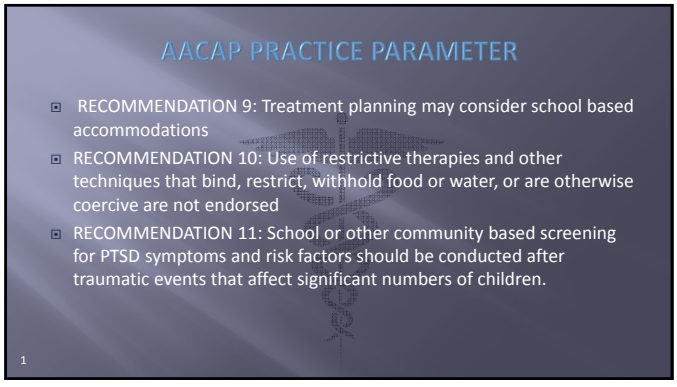

RECOMMENDATION 8: Medications other than SSRIs maybe considered
Alpha and beta blocking agents
CLONIDINE
GUAFACINE
PROPANOLOL
DIZZINESS
LOW BLOOD PRESSURE
FATIGUE
Benzos


AACAP PRACTICE PARAMETER
RECOMMENDATION 9: Treatment planning may consider school based accommodations
RECOMMENDATION 10: Use of restrictive therapies and other techniques that bind, restrict, withhold food or water, or are otherwise coercive are not endorsed
RECOMMENDATION 11: School or other community based screening for PTSD symptoms and risk factors should be conducted after traumatic events that affect significant numbers of children.
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BEYOND THE PRACTICE PARAMETERS

Racism, demographics and insurance barriers

Many treatment models lack regard for alternative medical approaches, focus on individuals rather than communities or families, limit focus from strength based approaches, biased assessment techniques

BARRIERS TO CARE

- Racial/ethnic groups having reduced access to effective prevention services and treatment.
- 1 in 5 children with mental health concerns receive care. Despite 10-20 % of children having emotional/behavioral disturbances.
- Children from minority racial/ethnic groups are less likely to receive both private and public services
- Racially biased diagnoses are well documented
- Disparities in the choice of psychotropic medications are also noted between races

2

BARRIERS TO CARE

- Poverty
- Insurance and access to services
- Medicaid has helped somewhat
- Racism on the individual, institutional and social levels
  - Providers and their interpersonal skills have an effect and have been shown in research to differ depending on race.
  - Interpretation of behavior
  - Referrals

The system and demographics collide

- Medicaid eligibility categories in themselves had a profound influence on psychotropic medication patterns
- Race/ethnicity was significantly associated with number of medications consumed with larger percentages of white adolescents taking two or more psychotropic medications.
- The increased use of psychotropic medications and decreased use of psychotherapy in outpatient settings
- Challenges in access to and quality of Medicaid services

2

Foster care and its effects on psychotropic medication use

37-52% vs. 4%

- High rates of emotional and behavioral problems/May be more likely to be prescribed psychotropic medications.
- 2-3 fold increase – especially Medicaid enrollees
- Rx combinations of psychotropic medications has also appreciably increased during this time The mean age of kids on meds was 10 years.
- (c) History of physical abuse, public insurance, score > 60 on either subscale of the CBCL
- (-) AA/Latina; History of neglect; Uninsured

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State Level Oversight

- Youth should receive screening upon placement and a subsequent comprehensive mental health assessment by a professional. Others have argued all youth should receive a full assessment.
- Guidelines also recommend a clear mechanism for achieving psychotropic medication oversight
- 23 states endorsed a state policy/guidelines regarding mental health evaluation.
- Use of three or more psychotropic medications among youth with autism in foster care varied from 5% to nearly 50% across 28 states (5).

4

State Level Oversight

VARIATION

- Evaluations only on subpopulations
- 2: policies only about certain types of medications
- 7: multiple meds

CONSISTENCIES

- Policy included evaluation on all youth (about 50%)
- Addressed consent (about 75%)
- Correlation with "urban" land
- Presence of a medical and mental health director were 5 times more likely than those without to have a policy on evaluation and psychotropic medication

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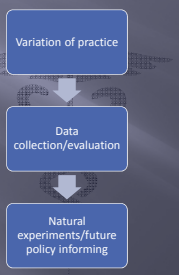
State Level Oversight



Facing foster care in Alaska

- 2008 Policy Agenda: FFCA members called for decreased use of psychotropic medication for Alaska's foster youth.
- Pathologizing a normal response to grief
- FFCA members have also complained about side-effects
- The youth and alumni of FFCA would like to see that the prescription of psychotropic medications for Alaska's foster children and youth is decreased and reviewed more closely

3

WHAT THE YOUTH HAVE TO SAY

- Trust building opportunities
- Freedom/personal time
- Family Relationships/connections/visits
- Mentors
- Having good listeners, get to know us, talk/vent, acknowledgement and praise
- Supporting dreams/hopes
- Non-judgmental relationships
- Effective communication with social workers and GAL's
- Permanent connection/stable home
- Not relishing diagnosis/medication (cut out the unnecessary)
- Preparation for the real world
- Extra time with peers
- Keeping siblings together
- Listen to what we have to say
- Pay attention to our needs
- If meds are absolutely necessary inform us what there for and what the side effects are

3

Case Study #1: A life of institutions

- Came to me by way of group home. Did not know what her meds were for or what she was on.
- Full scale IQ 69 with low average processing speed
- Strengths: No high risk sexual behavior, no substance abuse, no legal issues

Initial Medical Regimen

- Melatonin 3mg QHS
- Naltrexone 50mg QD
- Wellbutrin XL 150mg daily
- Oxcarbazepine 600mg twice daily
- Olanzapine 5mg PRN every 4-6 hours
- Desmopressin 0.2 mg 2 PO QHS
- Amantadine HCL 100 mg 2 BID
- Cyclobenzaprine 10mg every 12 hours
- Adderall XR 30mg daily
- Adderall 20mg daily
- Benztropine 0.5 mg 1 twice daily
- Fluoxetine 20mg 3 daily

Progress

- D/C Fluoxetine
- D/C Adderall
- Doing well in a foster placement (private)

Goals

- Identify long term placement, encourage self care

Case Study #2: Where will he go?

- Referred by pediatrician for med management in early 2015
- Severe emotional and behavioral regulation issues
- He did not have an IEP/504 plan at school until advocacy in early 2015
- There remains a lack of clear placement for this child

Initially
- Abilify 10mg daily
- Intuniv 1mg nightly

After hospitalization
- Add Adderall XR 20mg daily

Currently
- Per patient request, d/c Intuniv
- He remains on Adderall XR and Abilify, and he would like to taper off

Case Study #3: A SUCCESS STORY

- Initial contact through FASD team
- Significant trauma history
- Continued with my office for med management

Initial Regimen
- Abilify 2mg once daily
- Melatonin 3mg nightly

Two Months into Med Mgmt
- Add Concerta 18mg daily
- Back and forth with GAL on placement

Now
- Loving, structured, sober home that is a family placement
- No medication

CONCLUDING THOUGHTS

- WE MUST REMAIN VIGILENT AND ACTIVE WITHIN THE POLICY MAKING ARMS OF OUR ORGANIZATIONS, COMMUNITIES AND STATE. WE MUST ADVOCATE FOR EVIDENCED BASED, FISCALLY RESPONSIBLE TREATMENT OF CHILDREN WITH TRAUMA HISTORIES. THIS MEANS MORE THERAPY AND EVIDENCED BASED PSYCHOTROPIC MEDICATION USE.

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