February 09, 2019 — Most Common Medications & Diagnoses

Thanks so much to Dr. Hunter and Robert Latham for sharing their time and expertise with us. This is a complex subject and they gave us so many great pointers.

- When it comes to prescribing meds for children, we don't entirely trust the system to make the best decisions.
- Different states have different procedures for children in the system when meds are prescribed. Florida is a bit of a combination of all of them.

    - **The Department (DCF) doesn't have the authority to make the decision**. If a doctor determines that a child meets the criteria for meds, the 1st authorizing source is the biological parent (if there is no TPR).
    - Beside the parents, the GAL may know the child longer than everyone and know the most background and history.
    - The next decision maker is the Judge. (They hate these hearings). Try to negotiate to get a consensus on meds, if possible, prior to the hearing. In order to prescribe meds, you must have consent of #1--the parents; #2--a person with a court order; #3—DCF, which does NOT have blanket consent. They must come back to court each time a med changes or it's out of the dosage range originally approved
    - Case managers, GALS, and the child cannot consent.
    - If the department has custody, they have the authority to determine the provider--but the Court has the authority to veto. If you, the GAL, object to the medication, you can ask for a 2nd opinion or consultation.
    - If one med is being prescribed, you should call the med consult line. Since they don't know the child, they can only rely on information given to them by you. What you get is minimal, but you do get a "sanity check." They give you enough information to go back to the doctor and ask questions.
    - Be fearless and be persistent as GALS.
    - **The advice from Dr. Hunter and Robert is—if you have questions ask the doctor!!!!**

- **It is really important for you to talk to and build a relationship with the prescribing psychiatrist.**

    - Too often children are transported by a worker just assigned to a case, and parents are not available to provide the history. **Often the GAL is the only one who has a complete and accurate history to present. If you know your child is going to be evaluated by a psychiatrist, call them in advance to give them the most complete history.**

- **In order for a psychiatrist to make an appropriate diagnosis and prescribe the correct meds, they need information and history**.

    - Information gathering should be provided by someone who knows the child's history (medical, mental health, school). The Dr. should have as much information as possible, including input from the GAL and the foster parents
    - There is a fairly high psychopathology of children in foster care. Genetics are important.

- O Younger children may have developmental issues. Family background and pre-natal history are important considerations.
- o You must look at why kids come into the system. Serious abuse and neglect can cause mental health issues. You cannot ignore looking at those who have abused them as well—often children mimic the behaviors of the adults. Some mental health issues are genetic. We do know there are higher rates of psychiatric diagnoses and meds for children in the system.

- Doctors do NOT try to do damage to their patients!
- **Be aware- oftentimes when a child's placement changes, so do their doctors. Different doctors tend to prescribe different meds (even with the same diagnosis). Make sure you consult with any new doctors, especially if meds are changed.**
- **When a child is Baker-acted, the treating hospital calls the psychiatrist upon discharge to set up a follow-up appointment. The psychiatrist should also be contacted when the child is admitted! <u>If you are the GAL on a case when a child is Baker-acted, reach out to the psychiatrist upon admission!</u>**

- The psychiatrist is supposed to ask the child if they assent to meds. If the response is NO, the child is entitled to an attorney. **You must let your GAL attorney know so we can request that an AAL be appointed for the child.**
  - O The AAL will build up a case about why the judge should think differently or they will counsel the child on trying the meds.

- The psychiatrist should be in communication with the child's therapist.
- Kids on meds have been shown to have better outcomes than children just on psychotherapy with no meds.
- You need to ask how much experience the treating therapist has. Too often children with serious issues are being treated by therapists just out of school with new degrees.
- Every child does NOT have PTSD.
- Very often the children in the system have co-morbidity (trauma and another diagnosis). Severe trauma in younger children can result in relationship and bonding issues.
- The type and nature of the abuse experienced by the child interplays with the diagnosis and treatment.
- No meds will correct life circumstances. However, if a child is diagnosed with disturbing symptoms and meds can alleviate those symptoms, then meds are not always a bad thing.

<u>Common diagnosis and Medications of Children and Adolescents</u>

- **ADHD**
  - ADHD is a disruptive behavior disorder.
  - ADHD is the most common diagnosis of childhood. It affects more boys than girls. Onset is usually before age 6-7, but may become most obvious in primary school. It may also manifest later on.
  - Medication for ADHD is not curative, but does provide symptomatic relief—thus improving the quality of life.
  - The most common meds are stimulants and are either amphetamines (Dynavel, Adzenys, Adderall (XR), Dexedrine, Evekeo, Zenzedi, ProCentra or Vyvanse) or Methylphenidates (Aptensio, Ritalin, Concerta, Focalin, Metadate, Daytana or

Quillavent). Non-Stimulants (Intuniv, Kapvay, Strattera) and Off-Label (Wellbutrin, Provigil, desipramine Nortiptyline) These meds cause the brain to use the chemical dopamine more effectively, therefore, increasing concentration and focus.
    - Meds tend to work right away.
    - Most kids outgrow the hyper part as they get older.

- **Intellectual Disabilities, Autistic Spectrum Disorders**
    - Meds treat co-existing conditions or symptoms.

- **Disruptive, Impulse Control and Conduct Disorders, Oppositional Defiant Disorder**
    - There are NO meds.

- **Bipolar Disorders- Bipolar I, Bipolar II, Bipolar due to Medical Condition, Cyclothymia**
    - One of the most overused diagnosis in child welfare.
    - It is a diagnosis that is not always very accurate and is NOT a temper tantrum.
    - Meds (mood stablilizers) Lithium, Anti- Epileptic Drugs (Depakote, Tegretol, Lamictal) Off-Label (Neurontin, Trileptal, Topamax, Gabitril), Anti-Psychotics 2nd generation (Zyprexa, Risperdal, Seroquel, Geodon, Abilify, Latuda, Saphris) and Anti-Psychotics 1st generation (Haldo, multiple others).
    - Disruptive Mood Dysregulation Disorder – children are chronically irritable and difficult to control. Often treat the symptoms rather than the disorder and given bipolar meds.

- **Schizophrenia (rare until late adolescence)**
    - Antipsychotics as in bipolar

- **Depressive Disorders: Major Depressive Disorder, Persistent depressive Disorders**
    - SSRIs (Prozax, Zoloft, Lexapro, Celexa, Paxil), SNRIs (Effexor, Pristiq, Cymbalta, Fetzima), Others (Wellbutrin, Remeron, Brintellix, Viibryd)

- **Anxiety Disorders: Separation Anxiety Disorder, Panic Disorder, Agoraphobia, Generalized Anxiety Disorder, OCD,**
    - Meds: SSRIs, SNRIs Short term: Anti-histamines (Benadryl, Vistaril) Benzodiazepines (Ativan, Valium Xanax, Klonopin)

- A doctor can treat the diagnosis or the symptoms. Sometimes they need to treat both.
- Make sure a new MD gets old records and can speak to the previous doctor.
- **Communication is essential!**