

TESTIMONY
House committee on Child Abuse and Neglect.
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[NECAAP]
28 February 2007

Mr Chairman, members of the committee. Thank you for taking the time to consider these difficult issues and for offering the time to speak to you today about matters of concern for all of us regarding medications and diagnosis for young children. My name is Don Condie, and I am the president of the New England Council for Child and Adolescent Psychiatry, the organization that represents more than 500 child psychiatrists in the New England area including almost 400 child psychiatrists in the Commonwealth of Massachusetts.

I have been a licensed physician in Massachusetts for almost 25 years and have worked extensively with children covered by MassHealth and involved with DSS. My training was at the Massachusetts Mental-Health Center, a state-funded program. I work now at Massachusetts General Hospital, and I serve as a psychiatric consultant for several schools in Massachusetts, including the Doctor Franklin Perkins School in Lancaster, Dearborn Academy in Arlington and Germaine Lawrence in Arlington.

I would like to address 3 major issues today:

- What scientific knowledge base is available to guide decisions about diagnosis and medications for very young children?
- What resources should be available to DSS and others who treat children to ensure that our best practices, based on this knowledge base, can be applied?
- What process is needed to ensure implementation of these best practices for children served by state agencies?

EXISTING KNOWLEDGE BASE

Several issues in the news over the last few months have caused concern for all of us who are entrusted with the care of children.

Your committee has heard considerable prior testimony from many sources about the still un-met mental health needs for children and families who come into contact with DSS.

Recent cases in Massachusetts have also raised the question of whether some diagnoses, in particular, ADHD and Childhood Onset Bipolar Disorder can be made reliably in very young children under the age of four. The answer to this question is not a simple one, and I hope you'll bear with me if I take a few minutes to outline the complexities.

Scientific research into the preschool age group has shown us that many disorders thought to be present only in later years can indeed be detected, at least in their early stages, at much younger ages.¹ Other research has suggested that there might be some protective effect of early treatment,² which could in fact soften the impact of certain major mental health illnesses and make them less severe when children become adults. These 2 lines of research have increasingly led to the diagnosis of very young children since earlier detection and treatment is thought to offer a better long-term outcome.

Because the brains of young children, and even adolescents are still developing, the use of medications in this age group remains a somewhat controversial issue, and while some treatment studies look promising there is no consensus yet about best practices.³ Evidence based medicine is the ideal for all disorders, but when research has not yet been done, or is not yet conclusive, treatment may still be required to relieve severe symptoms and families and doctors must weigh risks versus possible benefits.

Diagnosis and treatment are further complicated because a large proportion of families receiving MassHealth benefits have gone through significant traumatic events. One of the diagnostic possibilities that must be considered in this population is whether the effects of child abuse and neglect, or even symptoms of Post Traumatic Stress Disorder [PTSD] might explain some of the symptoms for which the child has been referred.

Other children in the DSS system have been through multiple foster homes, and perhaps multiple family placements prior to removal from a home. These children may suffer from a condition known as Reactive Attachment Disorder [RAD]. Symptoms of RAD may also be mistaken for early signs of ADHD or Bipolar Disorder. Simply put, children who have never had the benefit of consistent parenting do not develop the ability to soothe themselves and become aggressive and impulsive.

A child presenting with a history of severe behavioral symptoms at a young age might also have a developmental disorder such as Autism or Pervasive Developmental Disorder [PDD].

The overlap between symptoms of ADHD, Bipolar Disorder, PTSD, RAD and some types of PDD can be considerable, and only a comprehensive and time consuming evaluation can hope to tell them apart.

There are thus at least five major possibilities to be considered in any diagnostic evaluation of a very young child who might present with severe behavioral symptoms.

In summary then, a diagnosis of ADHD or Bipolar Disorder can be made, but it is rarely definitive in very young children. Much more research is needed for clarity in this area.

RESOURCE SHORTAGES

Child psychiatry has been classified as an underserved specialty for many years. Waiting times to be seen by a child psychiatrist can be months long.

When they are finally seen, children cannot come to the office and tell us directly about their own symptoms as adults might be expected to do. For this reason child psychiatrists are trained to rely upon information from the family and from collateral sources. Gathering collateral information is time consuming and usually not reimbursed by insurers. Considerable extra time is required in order to make phone calls, discuss standardized questionnaires which might be filed out by teachers and family, and contact others who treat the child, including pediatricians, therapists and anyone else who might be able to cast light on the child's behavior in different settings. It is very rare when severe symptoms are apparent during an office visit, even if that visit is extended to an hour or more.

For this reason, child psychiatrists, more than most other practitioners, must rely upon statements by the family about the child's symptoms at times when the child cannot be directly observed. Some parents are better than others at accurately reporting symptoms their child might have shown.

Children who come into contact with DSS usually do so because of some stresses within their family system. These difficulties can make it much harder for families to report accurately and for a child psychiatrist or pediatrician to obtain an accurate history of the child. If a child has gone into foster care, there may be very little information about who the child's pediatrician was, their last visit to the pediatrician, or any reliable history of their early development.

Even if resources specific for child psychiatry could be magically increased, the needs of children also involve special school placements, substance abuse issues for older children, treatment for parents, afterschool programs, and a host of other services that are in equally short supply. Attempts to fortify only one part of this complex web of services will not be effective unless other required services to children can also be accessed.

IMPLEMENTATION PROCESS

Recent accounts in the newspaper have suggested that the DSS is in the process of obtaining the services of child psychiatrist in order to review medication practices for many children in the DSS system. While this is a laudable goal, the devil is always in the details for any such plan.

Child psychiatry is a sub-specialty with a shortage of practitioners. Many attempts have been made to address difficulties in access to care, especially for the MassHealth population. One such program is the Massachusetts Child Psychiatry Access Project known as MCPAP. This program started at UMass to allow pediatricians to consult a child psychiatrist within 30 minutes if a child presents to a pediatrician's office with what appears to be a mental-health issue. In addition, follow-up is guaranteed for that child if the telephone consultation cannot resolve the questions. This model has been shown to work, but additional funding would be needed to allow DSS access to this existing system. Expanding an already existing program does offer efficiencies for resource utilization however.

DSS will still need an internal process to determine which cases they might wish to refer for a second opinion. Any panel of experts to whom DSS might refer cases should consist of board certified child psychiatrists, and ideally child psychiatrists familiar through long years of practice with the MassHealth population itself. Some states have identified Centers of Excellence for child psychiatry and offer consultation through these centers. Institutions that offer training to residents in child psychiatry are required to undergo rigorous certification to offer such training and are natural candidates for such a designation.

With regard to insurance issues, MBHP, the management company that oversees mental health care through MassHealth has a program to allow extra time for diagnostic visits in cases where more sessions might be required. Most private insurers do not offer such an extended evaluation process that could prove useful for such complex cases.

RECOMMENDATIONS.

- In order to allow for better coordination of mental health services for children NECAAP asks that the legislature review and pass H2144 and S187, an *Act Improving and Expanding Behavioral Health Services for Children in the Commonwealth*. This omnibus bill designates the Commissioner of Mental-Health as the leader for public policy around mental health issues and gives the Commissioner oversight of other public agencies efforts in this area. Centralizing such authority would help avoid duplication of services and programs at a time when resources are scarce.

- Implementation of a consult system for second opinions that can be accessed by DSS, should be a priority. This system should also allow access by pediatricians, therapists, teachers, and families, so that the process of accessing child psychiatry consultation does not go through only one channel.
- Programs such as MCPAP should serve as a model for implementation of any consultation services that DSS might require. The success of this existing model would be undercut however, if a lack of new resources to carry out additional consultations led to unfunded mandates to provide additional time from a system that is already at capacity.
- All mental health insurance coverage in the Commonwealth should include provisions for extended diagnostic evaluations in complex cases and reimbursement for these visits should be mandated. This offers another mechanism for extensive evaluations of children when complex cases are identified.
- DSS should be provided with all necessary in-house clinical expertise, including board certified child psychiatrist time, but also including the requirement that all DSS supervisors attain MSW degrees, and that regular training of DSS line staff include how and when to access consultation.
- DMH, which has a network of child psychiatrists specifically to review complex cases, should be provided additional resources to allow for more extensive consultation with DSS offices and avoid duplication of services.

Thank you for your time today and the opportunity to address these issues with you.

¹ Luby, J. and A. Belden "Defining and validating bipolar disorder in the preschool period." Dev Psychopathol.

The clinical characteristics and adaptive functioning of preschoolers who met DSM-IV criteria for bipolar disorder versus psychiatric and healthy comparison groups were investigated. A community-based sample of 303 preschoolers (3-6 years of age) and their caregivers was ascertained. Diagnostic classification based on parent report of mania symptoms was made using an age-appropriate psychiatric interview. Results indicated that 26 preschoolers met DSM-IV criteria for bipolar disorder who could be identified based the presence of 13 core age-adjusted mania items. These children could be clearly differentiated from children in two psychiatric groups (DSM-IV disruptive disorders, and major depressive disorder) and a "healthy" comparison group based on a specific symptom constellation. Findings indicated

that preschoolers in the bipolar group were significantly more ($p < .05$) impaired than the two psychiatric and healthy groups based on independent measures. Further, even after controlling for comorbid attention-deficit/hyperactivity disorder (81% comorbidity rate), the bipolar group remained significantly ($p < .05$) more impaired in multiple domains compared to preschoolers with DSM-IV disruptive disorders and healthy controls. Findings suggested that children as young as 3 years can manifest DSM-IV bipolar disorder when age adjusted symptom descriptions are employed, and that these children can be distinguished from healthy and disruptive disordered preschoolers. Recommendations for future research in this area that integrates developmental and mental health models are made.

² Cui, J., L. Shao, et al. "Role of glutathione in neuroprotective effects of mood stabilizing drugs lithium and valproate." Neuroscience.

Mood stabilizing drugs lithium and valproate are the most commonly used treatments for bipolar disorder. Previous studies in our laboratory indicate that chronic treatment with lithium and valproate inhibits oxidative damage in primary cultured rat cerebral cortical cells. Glutathione, as the major antioxidant in the brain, plays a key role in defending against oxidative damage. The purpose of this study was to determine the role of glutathione in the neuroprotective effects of lithium and valproate against oxidative damage. We found that chronic treatment with lithium and valproate inhibited reactive oxygen metabolite H₂O₂-induced cell death in primary cultured rat cerebral cortical cells, while buthionine sulfoximine, an inhibitor of glutathione rate-limiting synthesis enzyme glutamate-cysteine ligase, reduced the neuroprotective effect of lithium and valproate against H₂O₂-induced cell death. Further, we found that chronic treatment with lithium and valproate increased glutathione levels in primary cultured rat cerebral cortical cells and that the effects of lithium and valproate on glutathione levels were dose-dependent in human neuroblastoma SH-SY5Y cells. Chronic treatment with lithium and valproate also increased the expression of glutamate-cysteine ligase in both rat cerebral cortical cells and SH-SY5Y cells. In addition, chronic treatment with other mood stabilizing drugs lamotrigine and carbamazepine, but not antidepressants desipramine and fluoxetine, increased both glutathione levels and the expression of glutamate-cysteine ligase in SH-SY5Y cells. These results suggest that glutathione plays an important role in the neuroprotective effects of lithium and valproate, and that glutathione may be a common target for mood stabilizing drugs.

³ Pavuluri, M. N., P. G. Janicak, et al. **2002** "Topiramate plus risperidone for controlling weight gain and symptoms in preschool mania." J Child Adolesc Psychopharmacol.