

House Committee on Child Abuse and Neglect

February 28, 2007

I. Introduction

Good morning Majority Leader Rogers and members of the Committee. Thank you for the opportunity to speak with you today. My name is Doctor David R. DeMaso. I am the Psychiatrist-in-Chief at Children's Hospital Boston and Professor of Psychiatry and Pediatrics at Harvard Medical School. I have been practicing child and adolescent psychiatry in Massachusetts for over 25 years.

II. Children's Hospital Boston

At Children's I oversee a large psychiatry program that includes a 16-bed child inpatient unit, a 14,000 visit per year outpatient service as well and a 24 hr-7 day per week psychiatry emergency room program that sees approximately 100 children per month. I manage one of the country's largest mental health consultation programs for hospitalized medical and surgical patients. Additionally I oversee a large school and community based prevention and treatment program intervening with over 3,400 children each year in the Boston community. As you might expect, this means we see many children and adolescents who have active DSS involvement.

At the hospital, we run mental health training program for 3 disciplines: social work, psychology, and psychiatry. We also oversee a research program focused on prevention and translating evidence based practice into the real world. Finally, we have a strong mental health advocacy and policy component that combines the efforts of the hospitals' government relations team and my department.

III. Focus of testimony

I know you may have questions about recent events in the news. However for patient confidentiality reasons and with Children's having some involvement, I will not be able to respond to questions related to the case or any hypothetical situations.

I would like to discuss four areas which may be helpful for you to consider in your deliberations regarding the use of medications in the management of children in the care of the Department of Social Service: 1) What we know about the safety and efficacy of psychopharmaceutical treatment; 2) what we still need to learn; 3) how we should seek to balance our clinical knowledge with appropriate safeguards; and 4) what can be done to enhance DSS's ability to operationalize an improved mental health system.

IV. What we know

- We know that one out of five children has a mental disorder and that one of 10 children has a disabling mental disorder.
- We know that children with mental disorders experience significant clinical distress and impaired function at home, at school, with friends, and in the community.
- We know that only one-fifth of children with mental disorders receive treatment.
- We know that most children who receive mental health services receive them only at school, where resources are inadequate to meet their needs.
- We know that children in the child welfare service sector have rates of mental disorders that are four to six times higher than children in the general population, reflecting their troubling histories of family disruption and exposure to traumatic events. These children

also have higher rates of severe disorders and more frequent co-occurring disorders, resulting in complex treatment needs.

- We know that there are safe and effective pharmacologic and non-pharmacologic treatments for children with mental disorders, including antidepressants for depression and anxiety, stimulants for impulse control problems and aggression, and antihypertensives for hyperarousal associated with trauma exposure.
- We know that withholding medications from children with severe mental disorders can result in increased suicide and other forms of self-injury, increased aggressive acts, increased substance experimentation and abuse, increased school failure and drop out, and increased family stress and disruption.
- We know that most clinicians will recommend and most parents will accept psychotropic medication for their children only when the benefits clearly outweigh the risks.
- We know that psychotropic medications generally are most effective when prescribed in combination with other treatments, such as individual and family therapy and linkage to other child-serving systems.
- We know that access to and reimbursement for mental health services are seriously inadequate in this state and nationwide.
- We know that this situation is untenable for children in the Commonwealth and their families, who deserve universal access to quality mental health care.

IV. What we still need to learn

- While we have good reasonable evidence about the safety and efficacy of psychopharmacologic interventions in broad populations, including children, we don't know enough about the outcome of both non-psychopharmacologic and psychopharmacologic interventions in the "real world, where children may have more than one disorder, families are stretched to their limits with limited access to quality care, and communities lack the resources needed to provide a safety net for problems created by poverty, homelessness, poor schools and violence..
- We need to better understand the interaction between multiple medications used simultaneously to address multiple severe symptoms.
- We need to better understand the interplay between the use of medications and the developmental changes children experience as they grow and mature.
- We also need to better understand the specific genes, brain structures, and brain chemistry profiles generating mental disorders, so as to improve our "targeting" of the use of psychotropic medications.

V. How we should balance clinical knowledge with appropriate safeguards

I think it is best to start with our ultimate objectives and work from there towards our clinical model. We want kids to be kids. We want our kids to function optimally in the world – in their families, with their peers, in their schools and in their neighborhoods.

- We do want to work closely with parents and families. Families or caretakers are critical to the decision making around the mental health treatment plan. They *must be involved* in the decision to treat with medication.
- We do want collaborative relationships between caretakers, pediatricians, case workers, teachers and well trained prescribers (child and adolescent psychiatrists, psychiatrists,

pediatricians, and psychiatric nurses) who work with children and adolescents with mental disorders.

- We do want to create a thoughtful and problem focused treatment plan for children with mental disorders that seeks to understand the child from biological, social, psychological, and developmental perspectives.
- In terms of treatment in general and medication in particular, we want to start with a thorough psychiatric assessment of a child and his or her family. This involves:
 - Interviewing the child and his or her parents regarding symptom presentation plus medical, social, academic, developmental, and trauma histories;
 - Obtaining critical information from other professionals who know the child: pediatrician, teachers, therapists, after school program staff;
 - Reviewing outside school and/or psychological testing;
 - Reviewing previous non-pharmacologic and pharmacologic treatment with an emphasis on what was helpful and what was not.
 - Identifying the child's and family's strengths in addition to their vulnerabilities.
- We do want to look for target symptoms that respond to medications – depression, anxiety, mood lability, inattention, agitation, psychosis, insomnia, and pain. Medications are more symptom specific than they are diagnosis specific.
- We do want and need to treat with medications when there is:
 - Inadequate response to non-pharmacologic treatment;
 - Significant impairment in daily functioning that has not abated with more conservative measures;
 - So much impairment that children cannot effectively participate in therapy.
 - A substantial risk of danger to self or others.
- We do want and must have a program of close monitoring and follow-up for the target symptoms and side effects once the decision is made to begin the treatment with medication,
- We do want families/caretakers to understand the specific reason the child is being treated with medication, how to administer medication safely, what side effects to watch for, and what side effects to report, and when.
- We do want an ongoing process of re-assessment of medication at regular intervals. In this way medications that do not offer clear benefits to the child can be discontinued in a timely manner.
- We do want an ongoing process to monitor for reoccurrence of illness after medication discontinuation.

VI. What can be done to enhance DSS's capacity?

- The above outlines good psychiatric assessment and management approaches, but leads to the question of access, which has been so problematic for many of children in the Commonwealth. This is likely even more true for youngsters involved with DSS.
- I think the recent appointment of a psychiatric consultant to DSS, combined with recommendations you have previously heard from my colleagues about improving the agency's internal and consultative medical capacity, would be important first steps.
- However, I would argue that with respect to mental health resources, we need to go farther. This is one of the primary reasons why we at Children's have been so involved

in pushing the Children's Mental Health Campaign and supporting the legislation of Representative Balsler and Senator Tolman.

- *An Act Improving and Expanding Behavioral Health Services for Children* (HB1872) in the Commonwealth is designed to identify children early and put the supports in place to help children function.
- The bill includes the following:
 - It creates multi-agency teams to improve case management of children with complex needs;
 - It proposes increased identification and early intervention by promoting pediatric provider screening and school mental health consultative services while providing reimbursement for collateral behavioral health services;
 - It recognizes the critical need for understanding the prevalence, cost, types and effectiveness of mental health services among children served by state agencies and proposes the creation of a Behavioral health Research and Evaluation Council.

VII. Conclusion

- This Act contains elements of "What can be done." I encourage your support.
- We have the opportunity to develop a responsive mental health system where we can intervene on behalf of our children.
- We want to be able to intervene with both non-pharmacologic and pharmacologic services in a timely and helpful manner.
- We do not want to diminish the appropriate use of these effective treatments, leading to unnecessary suffering, impairment, and possible loss of life.