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Foster youth and psychotropic treatment: Where next?

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ABSTRACT

Foster care children are prescribed psychotropic medications at rates significantly higher than same-aged peers. Concerns about the safety of psychoactive chemicals on developing bodies and potential misuses with foster care populations have led to varied and complex responses by the media, lawmakers, and researchers. First, we look at how foster youth are prescribed psychoactive substances, including polypharmacy (sometimes called concomitant prescription), and at the mounting and major responses by federal and state governments. Second, we consider a recent parameter published by the American Academy of Child and Adolescent Psychiatry. Third, we consider how foster care settings, what we call open systems, complicate parameter implementation, creating potential gaps among researcher, prescriber, foster caregivers, and youth medication explanatory models of treatment experience. And finally, to address gaps among researcher, prescriber, and patient explanatory models, we propose the use of arbitrage, a conceptual framework and process for the integration of competing and sometimes incommensurable explanatory models, knowledge and practice claims.

1. Introduction

While the use of psychotropics to treat pediatric illnesses has increased since the 1990s (Mojtabai & Olfson, 2008, 2010; Olfson, 2009; Olfson, Marcus, & Weissman, 2002; Safer, Zito, & Dos Reis, 2003; Walkup et al., 2009; Zito et al., 2003; Zito, Safer et al., 2007), it is estimated that only one-third of medications have product label indications for use with youth (Malone, Sheikh, & Zito, 1999; Roberts, Rodriguez, Murphy, & Crescenzi, 2003). And some have estimated that the 463,000 children in foster care settings are 2 to 3 times more likely to be prescribed psychotropics (dosReis, Zito, Safer, & Soeken, 2001; Raghavan et al., 2005; Zima, Bussing, Crecelius, Kaufman, & Belin, 1999a,b). In 2009, Crystal and colleagues found stark differences between children covered by Medicaid and those on private insurance: they were prescribed four times more antipsychotics. They are also more likely to receive drugs for less severe conditions than their middleclass counterparts. And more than 4% of those ages 6 to 17 in Medicaid fee-for-service programs received antipsychotic drugs, compared with less than 1% of those privately insured (Crystal, Olfson, Huang, Pincus, & Gerhard, 2009). Deleterious side effects, specific to children and adolescents at critical stages of development, as well as gaps in research demonstrating the safety (Correll, 2008; Costa, Steardo, & Cuomo, 2004; DeVeaugh-Geiss et al., 2006; Greenhill, Vitiello, & Riddle, 2003; Jensen et al., 1999; Luby et al., 2006; Olfson, Crystal, Huang, & Gerhard, 2010; Safer & Zito, 2006; Zima et al., 1999a; Zito, Socolar, Eilers, Crystal, & Lexchin, 2007; Zito, Safer et al., 2008) of psychotropic agents suggest the need for careful, research-informed prescription and monitoring practices in what we have called the medication grid (Longhofer, Floersch, & Jenkins, 2003). In this paper the medication grid and explanatory models (Baer, Weller, de Alba García, & Salcedo Rocha, 2008; Daley & Weisner, 2003; Garro, 1988, 2000; Kleinman, 1988; Kirmayer, 2001; White, 2005) are used to explore two knowledge gaps (Longhofer & Floersch, 2004) in the administration of psychiatric medication to youth in foster care. The first is a gap between research and practice. The second is within practice: gaps in desire, interpretation, attitude, and belief among manifold individuals involved in various social fields of medication management (Longhofer & Floersch, 2010).

First, we look at how foster youth are prescribed psychoactive substances, including polypharmacy (sometimes called concomitant prescription), and at the mounting and major responses by federal and state governments. Second, we consider a recent parameter published by the American Academy of Child and Adolescent Psychiatry (AACAP), which offers guidelines on decision-making for prescribers of psychotropic medications to all children, irrespective of their social environments (Walkup et al., 2009).

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Third, we consider how foster care settings, what we call open systems,[1] complicate the monitoring of and adherence to medication, creating potential gaps between psychopharmacological knowledge and its application in open systems (i.e., schools, neighborhoods, residential treatment centers, foster families). Gaps exist when there is divergence between the academic/research field, especially clinical trials, which typically valorize controlled studies that seek overarching trends, and the open and fluid practice fields[2] in the day-to-day lives and routines of foster youth and families dominated by the idiosyncratic caregiving combinations and characteristics of clients, child welfare systems, and prescribers. It is here that we find especially useful the medication grid and explanatory models to identify the elements of a medication experience that make psychotropic treatment in foster care settings meaningful, exceptionally difficult, and sometimes troubling. The medication grid is used to map the myriad ways others engage patients in five elements of medication experience: 1) diagnosis; 2) prescription, 3) access to medication, 4) monitoring, and 5) reporting. Grid participants (including the medicated) co-construct meanings of medication effects on daily living; these dynamic interactions are various and sometimes overlapping, competing, or contradictory prescriber, parent, and youth explanatory models and narrative constructions of the *medication* treatment experience. These models convey information based upon "processes of attention, interpretation, labeling, and social presentation" (Kirmayer, 2005, 833). Practitioners, patients, and family members may use different explanatory models: in their labeling of the disorder; in their understandings of the cause, seriousness, and course of illness and medication treatment affects in/on the body and mind; anxieties about the illness and medication; and different expectations about preferred or ideal treatments and hoped-for outcomes. Models may refer to specific symptoms, syndromes, or disorders or to broader categories. Practitioner, family and social network and patient models may also deploy varying theories of the body, brain, mind, self and identity. What we call medication explanatory models (MEM) may refer to three illness and treatment questions: 1) what problem (i.e., behavioral, emotional, and cognitive) does medication solve?; 2) what are the actual effects (moment to moment), including side effects?, and 3) what is the future outlook on medication? (Floersch, Longhofer, Kranke, & Townsend, 2010; Floersch et al., 2009). Moreover, the central process of co-constructing explanatory models is associated with how various participants identify the emotional, behavioral, and cognitive effects of medication and construct meaningful narratives around them (Garro, 2000).[3] Together the medication grid and explanatory models point to the significance of invested adults co-constructing with adolescents meaningful understandings that give shape to the attitudes toward and beliefs about medication treatment and adherence (Longhofer & Floersch, 2010).

And finally, to address gaps (Arnd-Caddigan & Pozzuto, 2008; Aram & Salipante, 2003; Longhofer & Floersch, 2004) among researcher, prescriber, and patient explanatory models, we propose the use of arbitrage (Van De Ven & Johnson, 2006), a conceptual framework and process for the integration of competing and sometimes incommensurable explanatory models, knowledge and practice claims (Boyer, 1990; Huff, 2000; Pettigrew, 2001; Starkey & Madan, 2001; Tranfield & Starkey, 1998). Arbitrage serves not to reconcile but to recognize differences so that practice can be improved and choices can be made by those unwilling or unable (practitioners and clients) to participate in a practice model or share understandings of medication events (Bellefeuille & Ricks, 2010). The production of knowledge about medication events, we argue, must occur through arbitrage, i.e., through the use of comparison of different explanatory models and perspectives on medication practice. And it is by identifying those features of medication events and experience (i.e., client, family, and practitioner) that appear invariant, or convergent (Azevedo, 1997), across explanatory models that we can learn something about the true complexities of medicating events among vulnerable youth. As with all parties to medicating children (Longhofer & Floersch, 2010), including foster youth, there are often inconsistent and contradictory perspectives about the causes of illness, rival narrative constructions of medication (Floersch et al., 2010; Groleau, Kirmayer, & Young, 2006; Stern, & Kirmayer, 2004) events, and wide-ranging understandings of both the intended and unintended effects (biological, social and psychological) of medication and the desired outcomes (Longhofer & Floersch, 2010). However, we will argue that multiple and sometimes competing explanatory models, or "pluralistic perspectives should not be dismissed as noise, error, or outliers…" (Van de Ven, 2007: 15) and that knowledge produced through arbitrage can be used to integrate the realities of direct practice with foster children and the many and complex players in their medication grids (Longhofer et al., 2003). It is through this type of engagement, in collaboration and negotiation with foster children and their myriad caregivers that researchers and practitioners can jointly engage in practice-relevant research and research-relevant practice.

2. Psychotropic medication in foster care settings

It is widely known that youth in foster care are at increased risk for mental illnesses and emotional and behavioral disturbances (Burns, Phillips, & Wagner, 2004; dosReis et al., 2001; Farmer et al., 2010; Harman, Childs, & Kelleher, 2000; McIntyre & Keesler, 1986; Pecora, 2010; Shin, 2005; Trupin, Tarico, Low, Jemelka, & McClellan, 1993) and use mental health services at a rate 10 times higher than those from community samples (Leslie, Landsverk, & Ezzet-Lofstrom, 2000; McMillen et al., 2004). One study of foster alumni enrolled in the Casey Family Programs (between 1966 and 1998) found that over 90% experienced some form of maltreatment and 50.6% had been diagnosed with a psychological disorder sometime during childhood (Pecora et al., 2003). Substantiated abuse and neglect, as well as losses of family, transitions between multiple placements and shifts in caregivers, combine to magnify the effects of mental health difficulties (Barber, Delfabbro, & Cooper, 2001; Fanshel, Finch, & Grundy, 1989; Fernandez, 1999; Newton, Litrownik, & Landsverk, 2000; Palmer, 1996). In addition, foster youth enter in-patient settings at younger ages and are more likely to return than same-aged peers; and while in-patient they are more likely to display externalizing behaviors requiring restraint (Persi & Sisson, 2008). And the length of time in care is strongly related to the likelihood of multiple placements: more

[1] Critical realism (Bhaskar, 1998; Collier, 1994; Sayer, 1992) looks at the ways that systems are isolated or connected to other or larger systems. Closed systems, where they exist (mostly in experimental situations or laboratories) are defined by the degree of their isolation (i.e., closure). In open systems, interaction with other systems are continuous and inevitable. And while it is possible to model a closed system (i.e., using particular methods or statistical techniques) of the body/brain/mind, in the real world these systems are in a constant state of interaction with the outside world (i.e., the relational world of family, school, neighborhood, caregivers). Moreover, not only are all parts of the foster care system interconnected to a greater or lesser degree; they are also embedded in and connected with every aspect of social life. It is quite clear that a child in foster care is rooted in what we are calling open systems of caregiving.

[2] Pierre Bourdieu used the concept of field (Bourdieu & Wacquant, 1992: 101–102) to describe the relations among spaces and the relational struggles over capital and positions among agents in space (e.g., medical fields, academic fields, foster care fields, psychiatric fields, social work fields). Bourdieu described fields as games (Bourdieu, 1990, 1998). Psychiatric, foster care systems or social work fields, thus, are not unlike games where participants accept basic rules and agree on what is worth fighting for. Playing in the foster care field with psychiatric medication, for example, produces mental states whereby participants accept the efforts, limitations and possibilities that set up competition in the game. Bourdieu calls this *illusio;* by this he means that while participants engage in play, they forget their status as players.

[3] In her work on medically unexplained symptoms, Risør (2009) has described four explanatory idioms: 1) the symptomatic; 2) the personal; 3) the social; and 4) the moral.