DCF Psychotropic Medication Advisory Committee
Monthly Meeting Notes
December 2007
Riverview Hospital for Children and Youth
Middletown, CT

PRESENT: Janet Williams, MD, DCF Medical Director; Lesley Siegel, MD, DCF Regional Medical Director; Jacqueline Harris, MD, DCF Regional Medical Director; Joan Narad, MD, Associate Medical Director, RVH; M. Waqar Azeem, MD, RVH Medical Director; Milind Kale, MD, CJTS; John Pitegoff, MD; CCP Pediatrician; Brian Keyes, MD, NAFI: Aurele Kamm, APRN, CMCU Coordinator; Curtis Harmon, APRN, CMCU; MaryAnn D'Addario, DCF Director of Nursing; Irv Jennings, MD, FCA; Marian Cancelliere, APRN, Waterbury DCF; Tina Spokes, RN, Hartford, DCF; Tina Renneisen, APRN, Yale; Beth Muller APRN, UCHC, Charles Rich MD, Community Health Services; Naida Arcenas APRN, DMR; Blyse Soby RN DCF CQI; Carlos.A. Gonzolez M.D. IPP; Chris Malinowski APRN, Village for Families and Children; Patty Cables, APRN, Wheeler Clinic

1. Call to order: Janet Williams, MD called the meeting to order at 1:10 PM in the RVH AB Conference Room.
2. Set date/time of next meeting: The next meeting is scheduled for January 4**, 2008, 1:00 PM Riverview Hospital AB Conference Room.** Future meetings are as follows: February 1; March 7; April 4; May 2; June 6; July to be announced; August 1; September 5, October 3, November 7, and December 5, 2008.
3. Announcements:
   a. Dr. Williams was very pleased to announce that Joan Narad, MD, will begin the position of Regional Medical Director, Eastern Region on January 4, 2008.
   b. Dr. Williams announced that the RFP review committee will take place this month and a decision will be made by the DCF Commissioner in January. We will have a new pharmacy consulting group join us by February, 2008.
   c. Dr. Williams announced that Dr. Plant will attend the January meeting of PMAC to talk about medication use in less structured environments such as Star Homes and Therapeutic Group Homes.
   d. Dr Van Wattum is the new President of the CT Council for Child and Adolescent Psychiatry.
4. Minutes: The minutes of the November, 2007 meeting was accepted with minor changes.
5. Update- Review article on Melatonin in pediatric sleep disturbances: Committee members discussed there are no studies on the interaction of Melatonin with other psychotropic medications. It is unclear what is actually in the supplements. There was a study looking at brand names that determined 60-70% of brands have no active ingredients. Dr Siegel talked about a successful case in which Melatonin was prescribed for a 21/2 year old. There

is Good Housekeeping approval for safety used for a number of vitamins and supplements. It is believed that Melatonin is currently going through an FDA approval process. Riverview Hospital pharmacists currently dispense Melatonin.
Studies done outside of the United States use a special grade of Melatonin that is not often available within US. Patty Cables reported using Melatonin for patients with mixed results. Committee discussed new release of Rozeram, a hypnotic agent that targets same receptors. Dr Azeem has literature which he will supply. Rozaram increases Prolactin and in some cases has caused suicidal ideation. More information to follow.

6. Use of DDAVP Committee discussed notification that Desmopressin Acetate intranasal formulation has caused severe hyponatremia and seizures. Children are at risk for hyponatremia that can result in death. Therefore it is no longer indicated for the treatment of primary nocturnal enuresis and should not be used with patients who have a history of hyponatremia. Speculation that this product may be pulled off the market. Possibility of rapid absorption and bypass of liver metabolism. Desmopressin tablets have not been indicated as having the same level of risk. Dr Pitegoff stated that there have always been concerns of risk with DDAVP. He prefers behavior modification first and then 3-6 mo of treatment with DDAVP. He frequently takes children off of DDAVP after years of treatment. There was discussion about the advisability of Psychiatrists and Psychiatric APRNs prescribing DDAVP as opposed to allowing Pediatricians to manage. Most PMAC members refer to Pediatricians for medical work-up for enuresis, metabolic studies and prescribing of treatment for primary enuresis. There is often difficulty getting children to the laboratory. Preference for collaborating with a pediatric professional when treating primary enuresis. All in agreement that behavioral approach should be the first line. Naida Arcenas reported a case three years ago where the child died after treatment with DDAVP due to undiagnosed and untreated Diabetes. Everyone generally agreed that it is hard to treat children when laboratory studies are required but they are non-compliant with labs. Prescribers may need to discontinue meds.
7. Communications between institutions Discussion about the challenges for providers when children move between outpatient community and inpatient settings. Often community providers don't feel informed about med changes, diagnostic formulations and are then faced with maintaining these disputed changes as children return from inpatient stays. Suggestion was made to push communication between providers within 24-48hrs of admission and to negotiate differences of opinion. Other suggestions included community provider's involvement in hospital case conferencing, initiating DCF case conferencing and utilizing the Regional Medical Directors when differences aren't resolved. It was suggested that Karen Anderssen be invited to PMAC to discuss some of these issues.
8. DDS Program Review Committee Naida Arcenas reported on the role of the Program Review Committees in DDS and distributed written information. The system has been in place since 1987. The Program Review Committee

functions to ensure that psychiatric and behavioral services are used in accordance with current standards of medical practice. The use of all psychotropic medications and behavioral support plans must be reviewed and approved. DDS has many more nurses in the field compared to DCF. There are two Program Review Committees in each of three regions staffed by psychiatrists, behavioral professionals and parents. Requests to change meds always need consent. Consent can occur within hours where program review approval occurs within 6 weeks. Medication profiles follow the child and there are strict guidelines for off-label medication use. There is a comprehensive treatment approach and a long waiting list for regional DDS services. There is research ongoing on the use of psychotropic medications in patients with dysphasia-conducted by the DDS psychiatry department and looking at different groups of meds. There are plans to develop a new Autism Bureau within DDS. Suggestion was made to have the Director of current autism services come to speak with PMAC

9. CMCU Update The CMCU reached the 3 month mark of operation and is finding that the process is going more smoothly than at initiation. There have been approximately 850-900 requests that have been processed since October 1. There has been much positive feedback as well as constructive criticism. The group continues to look at numbers and trends. The Med-Link database is still under construction as DCF proposes to revamp the current medical profile.

Respectfully submitted,

Janet Williams MD