Medication in Residential Treatment:
Administration and Clinical Experiences

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ABSTRACT: This paper describes a clinical procedure for the administration of medication for children in residential treatment, utilizing seven well-defined steps. Clinical procedures for monitoring medication are outlined. Experiences with various drugs during a 3-year period are noted. The use of medication for symptom control and to enable the child to gain a feeling of mastery of his or her symptoms is emphasized as a primary goal of drug treatment.

In this paper, we report our procedures and clinical experiences in the use of psychotropic medication within a 38-bed residential treatment center during a 3-year period, 1973-1976, focusing particularly on the role of drugs in the child's struggle to develop inner controls.

This particular residential treatment center offers a well-coordinated, collaborative treatment program involving group living, on-ground school, and psychotherapy for children 5-15 years old. An integrated, pluralistic approach is utilized, including psychoanalytically oriented intensive individual psychotherapy, group and family therapy, and special education. Diagnoses include borderline psychoses, as well as character disorders and severe neurotic conflicts [1].

A common feature of these children was an inability to develop and maintain adequate internal controls. The causes for a given
child's apparent dyscontrol were varied and required careful delineation. So-called target symptoms, "hyperactivity," for example, are notoriously multiply determined; anxiety, depression, organicity, and psychosis may all give rise to hyperactivity. The purpose of making a differential diagnosis of the target symptom was to ensure the selection of the particular drug that would be most effective in helping the child. This process of selection was also influenced by a consideration of the aspects of the child's experience that seemed most affected by the symptom. For example, a drug might be employed (1) to help the child engage in a therapeutic relationship, (2) to facilitate attention and learning, (3) as an additional measure during the initial period of stress, (4) episodically at times of crises, and (5) on a maintenance basis for certain borderline psychotic children.

With these considerations in mind, we shall describe our clinical procedure and our experiences with a few selected drugs.

Clinical Procedure

The suggestion that a child might benefit from medication may be made by any staff member in the course of any of a variety of weekly meetings devoted to discussions of treatment. Frequently, the precipitant was a change noted in the child's usual behavior patterns, for example, inability to sustain attention and concentration in school, variation in sleep patterns, or manifestations of anxiety.

A misunderstanding that was often encountered in staff discussions of whether to employ a drug was the notion that it was being used to control the child: In fact, the purpose of using a drug was to help the child control himself or herself. The use of medication was never intended primarily or solely to make work easier for the staff members who dealt with the child. Because of the need to clarify such basic intentions, no medication was prescribed without full discussion on the part of the entire staff of the proposed medication and goals for its use, and its anticipated effects on the child. Further, since the child was the one who had to take the drug, the child too had to have as thorough an understanding of its effects and of the reasons for taking it. Therefore, the child's therapist and other staff members were encouraged to discuss these matters with the child. Last, no drug was given without the informed consent of the child's parent or guardian.

After the initial proposal, the following procedure was followed: