

Psychotropic Medication Oversight among Youth in Custody of State Child Welfare Systems



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Note. I have no financial conflicts to disclose

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Psychotropic Medication Use among Youth in Child Welfare Custody



“It [mental healthcare] is really important. If I don’t have the help that I need, then I won’t be able to get my medicine and stuff. I need my medicine. If I don’t have my medicine, I have real bad blow-ups I try to hurt people or hurt myself, or I destroy stuff. So I really need my medicine for that.”

-Youth formerly in foster care

(Leslie, Mackie, et al, 2011)

Psychotropic Medication Use among Youth in Child Welfare Custody



“They told me if it ever made me sleepy then they’ll take me off of the [antipsychotic medication]. Cause I’m a school person. I like to go to school. I like to learn and for the simple fact it was making me fall asleep in school I just felt like you’re just taking the fun out of my life because I love school, you’re just taking the one thing I love out of my life. And I would tell the doctor the medications is making me fall asleep in class and my teachers would tell them she’s falling asleep a lot in class and they still wouldn’t take me off the medications.”

-Youth formerly in foster care

(Leslie, Mackie, et al, 2011)

Learning Objectives:



Our objectives for this presentation are:

- 1) Summarize recent rates of mental health need and psychotropic medication use among youth in child welfare custody;
- 2) Describe five overarching components for psychotropic medication oversight for youth in foster care, prioritized by Health and Human Services (HHS), and variation across states; and
- 3) Provide resources, linked in these slides and available on thumb drives, for each of the five components prioritized by HHS.



**LEARNING
OBJECTIVE 1**

- **Summarize recent rates of mental health need and psychotropic medication use among youth in foster care;**

Mental Health Needs of Youth in Foster Care

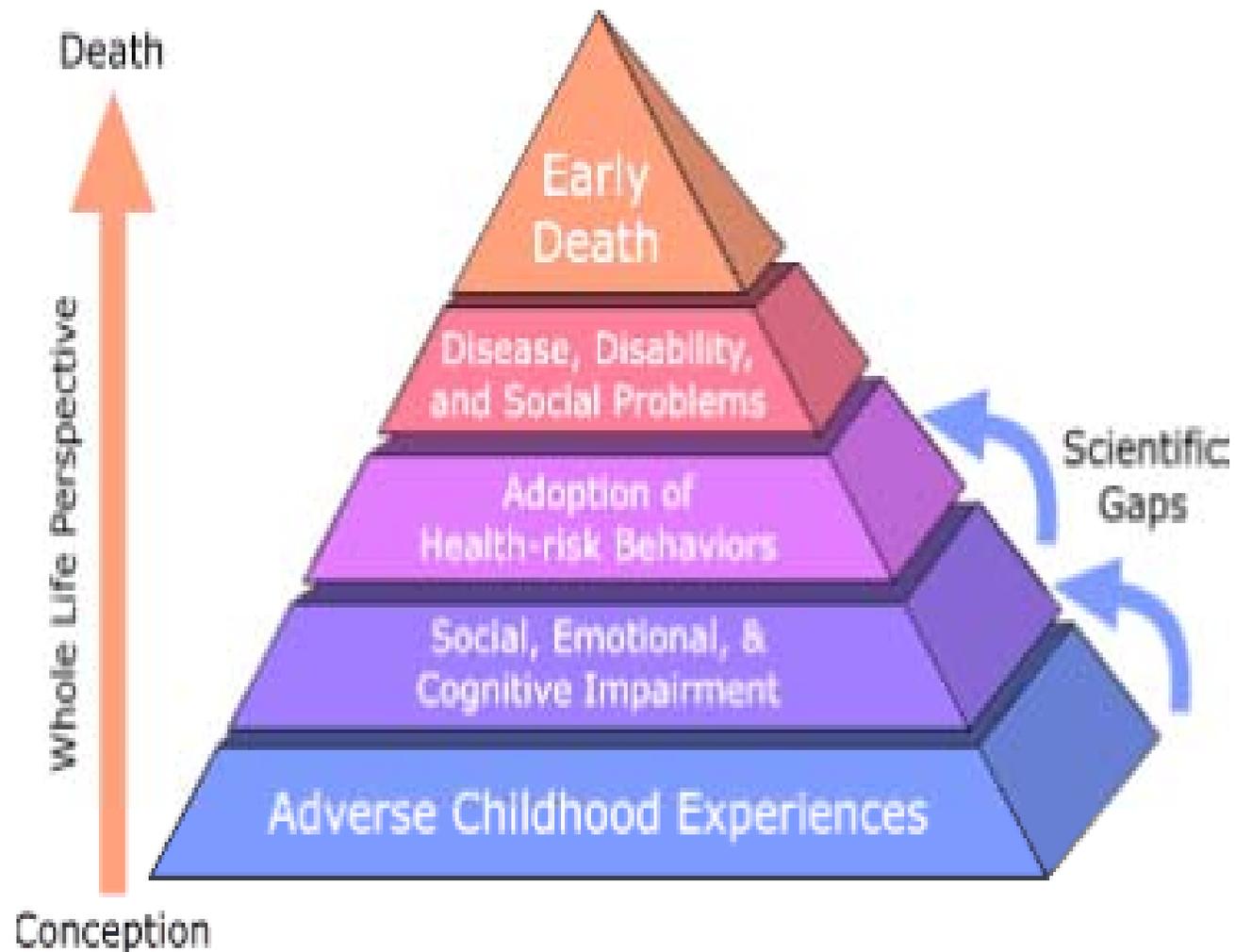


- Rates of emotional or behavioral disorders range from 50-80% of children in foster care (point prevalence rate) vs. 11-25% community-based rate.
- Rates of emotional or behavioral disorders correlate with histories of adverse childhood experiences including:
 - Abuse
 - Neglect
 - Domestic violence
 - Poverty
 - *In-utero* and environmental drug exposure
 - Genetic loading?

Lifelong Effects of Early Childhood Adversity and Toxic Stress

- The potential consequences of toxic stress in early childhood for the pathogenesis of adult disease are considerable.
- Behavioral level-evidence of strong link between early adversity > health threatening behaviors.
- Biological level- growing documentation of extent of cumulative stress over time and timing of specific environmental insults > structural and functional disruptions > physical and mental illness in adults.

(Shonkoff and Garner, Pediatrics Vol. 129, No. 1, January 2012)



<http://www.cestudy.org/aboutcestudy.php>

Alumni of Child Welfare Outcomes



Lifetime prevalence of mental health disorders among adults who experienced stays in foster care exceeds the incidence rate of the general population

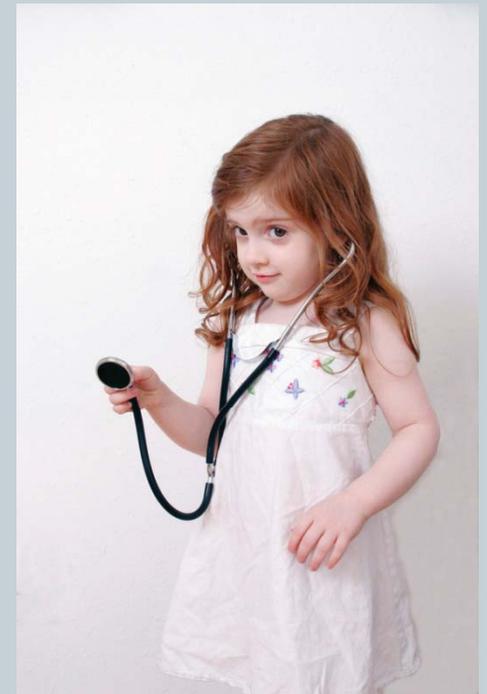
- PTSD 30% Alumni vs. 7.6% Gen Pop
- Major Depression 41.1% vs. 21% Gen Pop
- Panic disorder 21.1% vs. 4.8% Gen Pop
- GAD 19.1% vs. 7% Gen Pop
- Drug dependence 21% vs. 4.5% Gen Pop

(Northwest Alumni Study, Pecora et.al. 2005)

Psychotropic Medications for Youth



Over the last decade there has been an exponential increase in the use of psychotropic medications prescribed for emotional and behavioral disorders in children, particularly preschoolers.



Psychotropic Medications



- Also called psychiatric medications, they are defined by their function, helping to alleviate emotional or behavioral symptoms or conditions.
- Classes of psychotropic medications are also defined by their target symptoms:
 - Antipsychotic medications address psychotic symptoms but are also increasingly being used “off label” to treat aggression.
 - Mood stabilizers (ex. Lithium) are used to help stabilize mood swings typically associated with Bipolar disorder.
 - Stimulants are a class of medications used to treat ADHD

Safety and Efficacy



Research into the effects of these medications lags behind prescribing trends.

These trends and the lack of research to support current practice have important implications for our work with traumatized children.

Lack of Safety and Efficacy Studies of Psychotropic Medications for Children



Brain continues to develop through adolescence

Scientific knowledge is limited on long-term consequences of adding psychoactive medications to a developing brain



PROBLEM AREA	MEDICATION	SHORT-TERM EFFICACY	LONG-TERM EFFICACY	SHORT-TERM SAFETY#	LONG-TERM SAFETY#
Anxiety Disorders (including OCD*)	SSRIs (*FDA indications for OCD only) Benzodiazepines	A C	B C	A C	B C
ADHD	Stimulants* Atomoxetine* TCAs Alpha-2 Adrenergic Agonists*	A A A A	A B C B	A A A A	A A B B
Aggression in Autism	Atypical antipsychotics* (risperidone, aripiprazole)	A	B	A	B
Aggressive Conduct	Lithium Valproate Carbamazepine Atypical antipsychotics	B B C A	C C C B	B A C A	C A C B
Bipolar Disorder	Lithium* Valproate Carbamazepine Atypical antipsychotics*	B C C A	C C C C	B A B A	C A C B
Depression	SSRIs* (fluoxetine, escitalopram) TCAs Bupropion Venlafaxine	A C B C	A C C C	A B B C	B B C C
Schizophrenia (psychosis)	Antipsychotics*	A	C	A	C
Tourette's Disorder	Antipsychotics* (haloperidol, pimozide) Alpha-2 Adrenergic Agonists	A B	C C	C B	C C

SSRI = Selective Serotonin Reuptake Inhibitor TCA = Tricyclic Antidepressant

Updated: November 1, 2010

Reach Institute Tool



- Tool was developed by Peter Jensen and the Reach Institute
- FDA approved medications for a given indication are marked with an asterisk*
- **A** = Adequate data to inform prescribing practices. For efficacy and safety: ≥ 2 randomized controlled trials (RCTs) in youth; **long-term efficacy and safety are defined based on studies lasting 6 months or longer**. Please note, for efficacy, “A” means that the agent is better than a comparator (usually placebo). For safety, “A” doesn’t mean “safe”, it merely indicates that the risks have been characterized in 2 or more carefully executed studies.
- **B** = For short- and long-term efficacy and short-term safety: 1 RCT in youth or mixed results from ≥ 2 RCTs. For long-term safety, only 1 careful prospective study lasting 6 months or more, or mixed results from ≥ 2 longitudinal studies.
- **C** = No controlled evidence or negative studies; case reports and FDA reports of adverse events only.

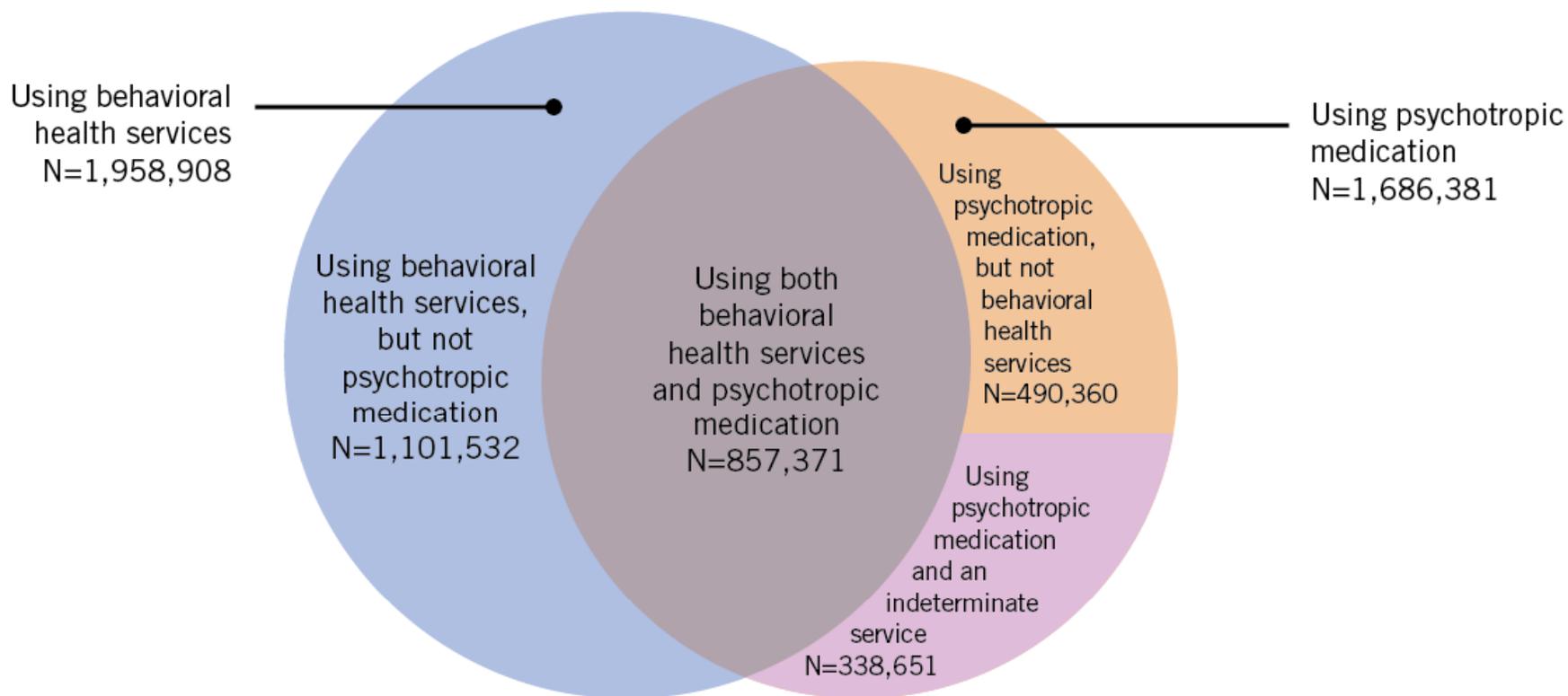
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Updated: November 1, 2010

In 2005, 2.8 million children in Medicaid used behavioral health care, and of those, 1.7 million used psychotropic medications.

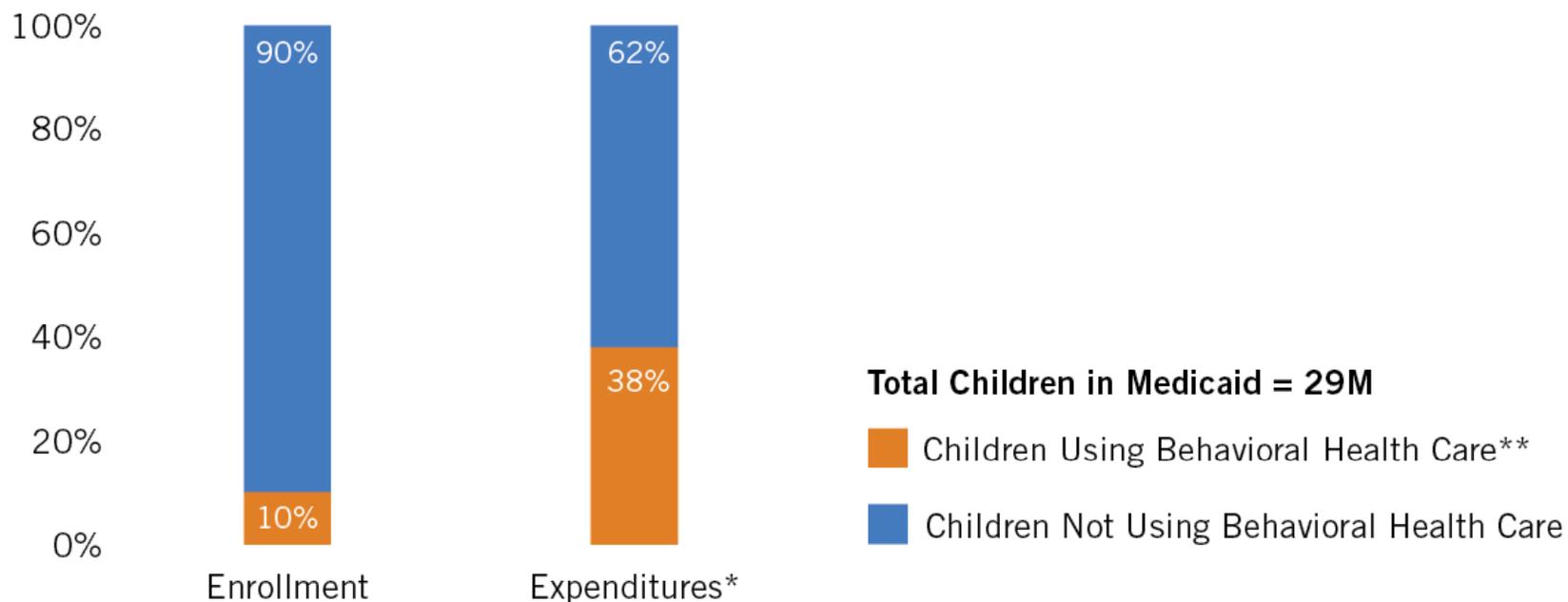
ALL CHILDREN IN MEDICAID USING BEHAVIORAL HEALTH CARE, 2005 (N=2,787,919)



Source: S. Pires, K. Grimes, T. Gilmer, K. Allen, & R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, December 2013.

Behavioral health accounts for a disproportionate share of Medicaid spending for children, given the relatively small number of children who use behavioral health care.

CHILDREN USING BEHAVIORAL HEALTH CARE AS A PROPORTION OF TOTAL MEDICAID ENROLLMENT AND EXPENDITURES



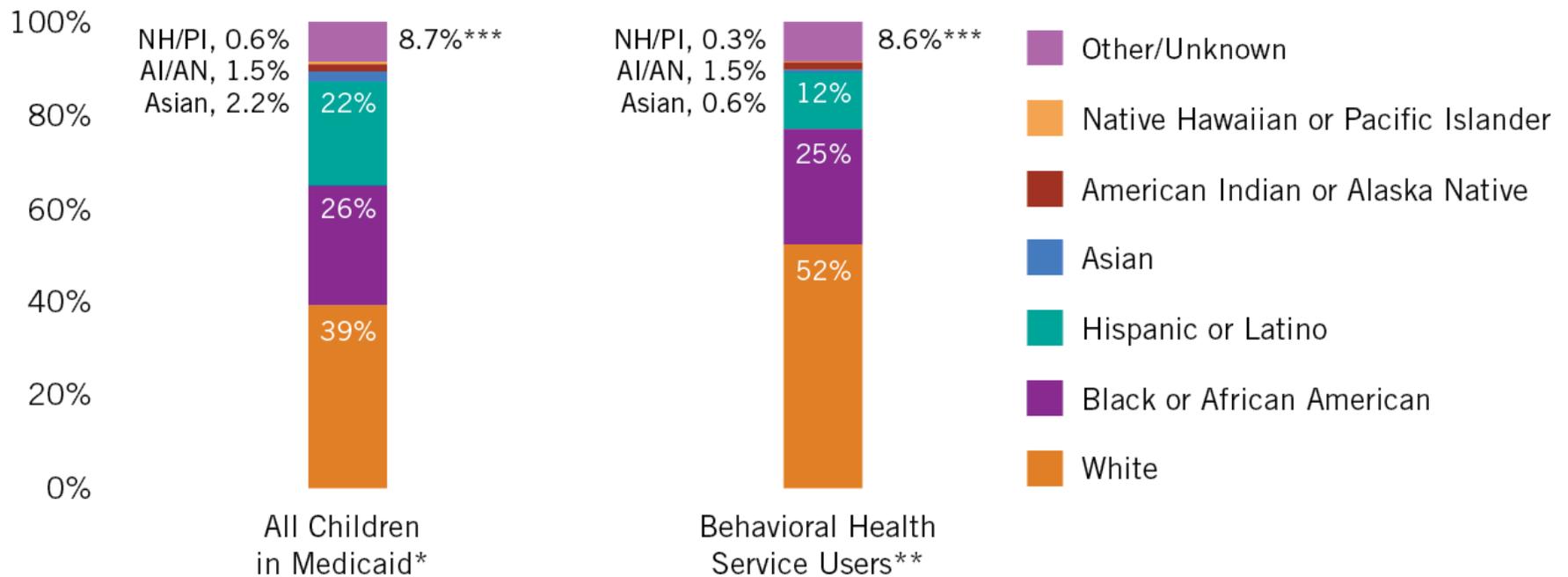
* Total combined expenditures for all children in Medicaid in 2005 from: Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations: Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services (HCFA 2082), Medicaid and Statistical Information System. 2008 Statistical Supplement.

** Children using behavioral health care in 2005, N= 2,787,919.

Source: S. Pires, K. Grimes, T. Gilmer, K. Allen & R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, December 2013.

Children in Medicaid from racially/ethnically diverse backgrounds are less likely than white children to use behavioral health services.

MEDICAID ENROLLMENT AND BEHAVIORAL HEALTH SERVICE USE BY RACE/ETHNICITY

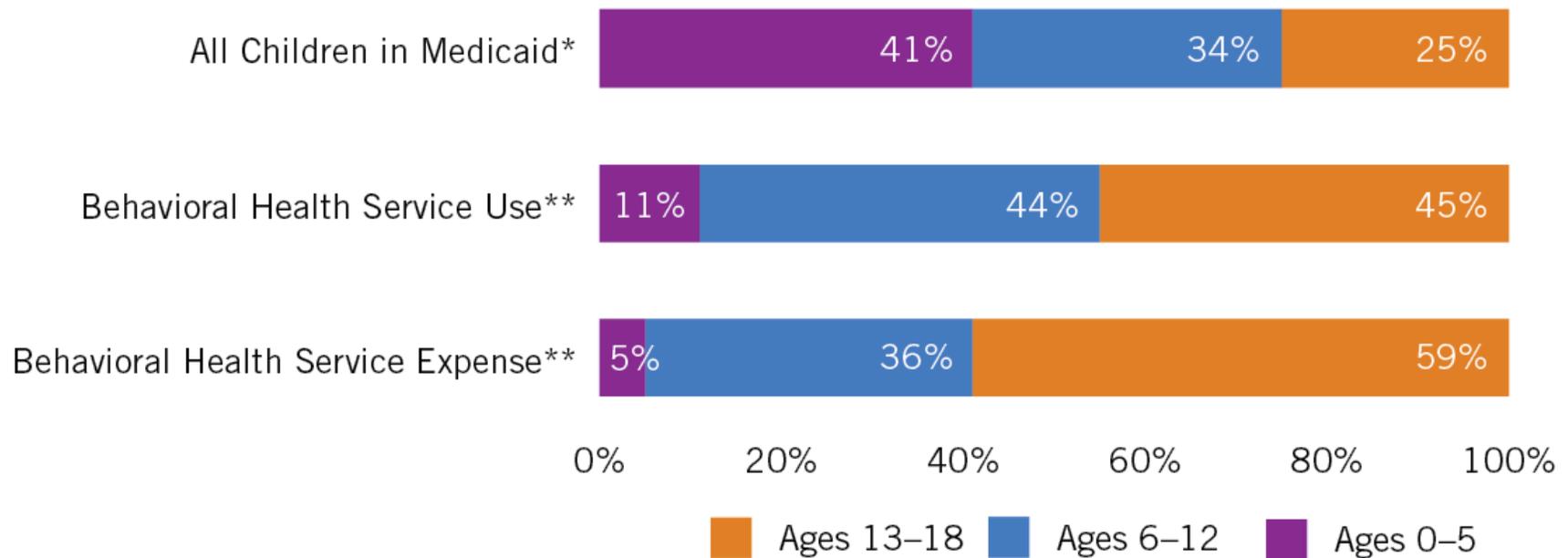


* All children in Medicaid in 2005, N = 29,050,305.
 ** Behavioral health service users in 2005, N = 1,958,908.
 *** Other category includes: 2.9%, Hispanic or Latino, plus one or more races; 0.3%, more than one race; and 5.6%, unknown.

Source: S. Pires, K. Grimes, T. Gilmer, K. Allen, & R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, December 2013.

Adolescents, ages 13–18, represent 25% of the overall Medicaid child population, but 45% of children in Medicaid using behavioral health services, and nearly 60% of total behavioral health expenditures.

MEDICAID ENROLLMENT, BEHAVIORAL HEALTH SERVICE USE AND EXPENSE BY AGE GROUP



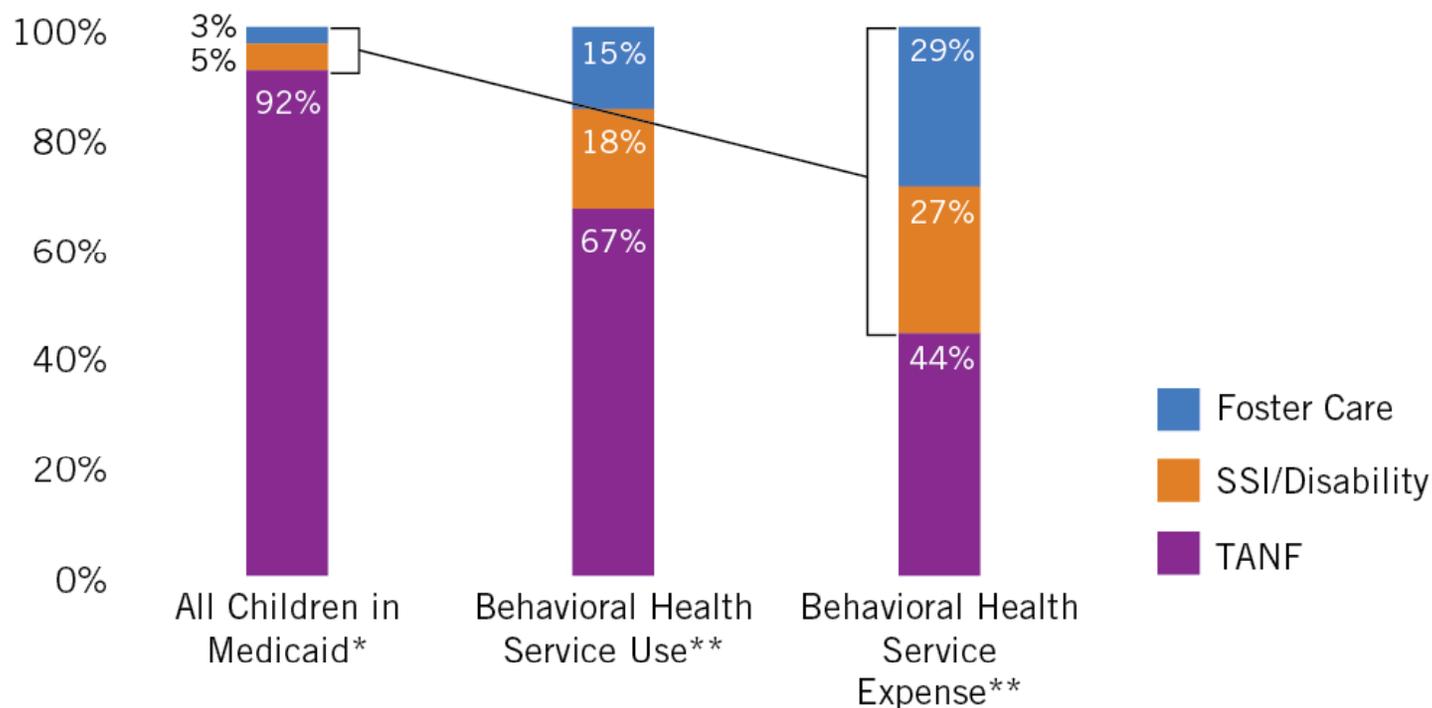
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Source: S. Pires, K. Grimes, T. Gilmer, K. Allen, & R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, December 2013.

Children in foster care and those with SSI/disability eligibility together represent only 8% of the Medicaid child population, but their care accounts for 56% of total behavioral health spending.

MEDICAID ENROLLMENT, BEHAVIORAL HEALTH SERVICE USE, AND EXPENSE BY AID CATEGORY



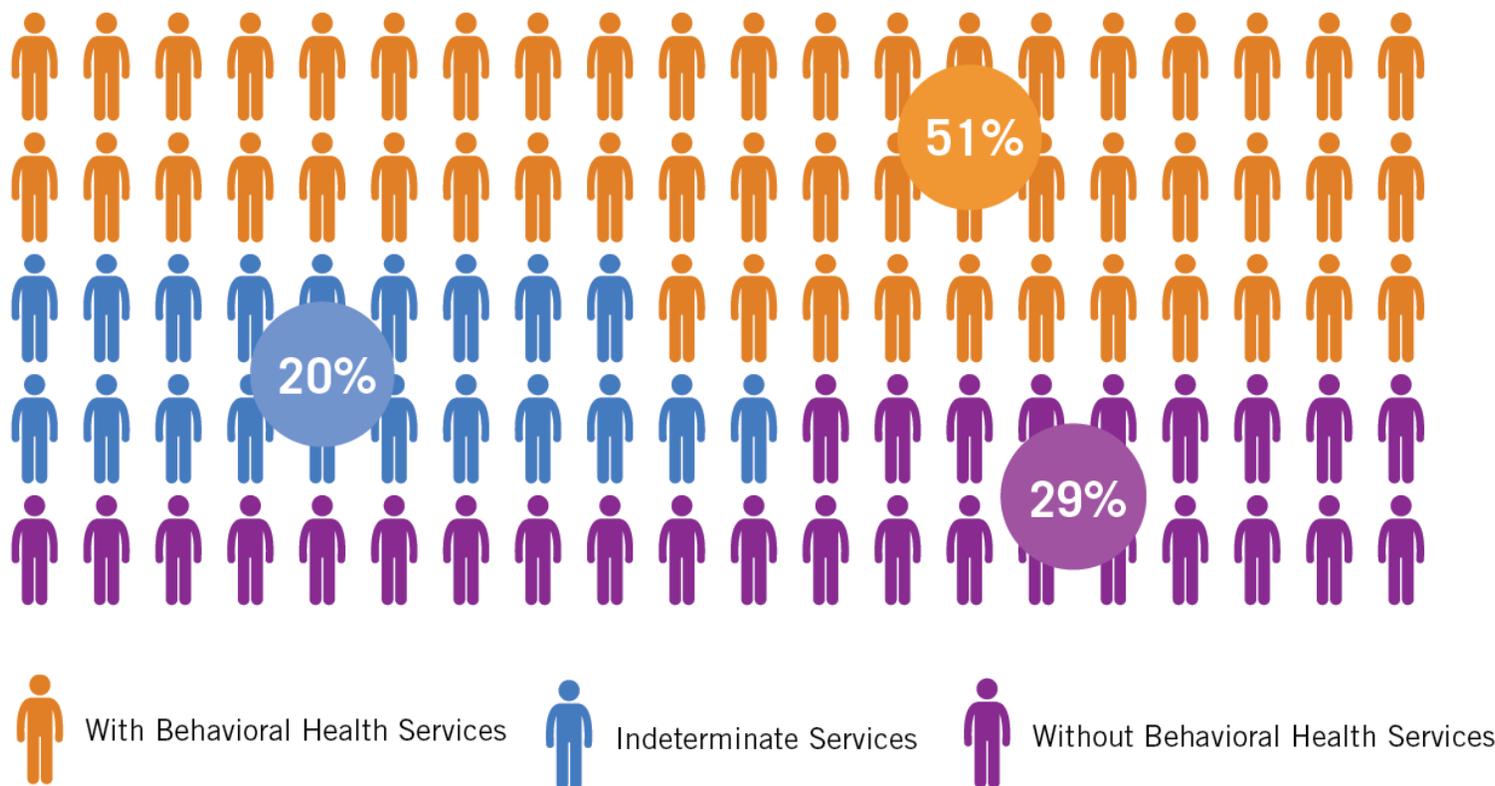
* All children in Medicaid in 2005, N=29,050,305.

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Source: S. Pires, K. Grimes, T. Gilmer, K. Allen, & R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, December 2013.

Children in Medicaid are frequently prescribed psychotropic medications, but only half of those getting medications receive accompanying behavioral health services.

CHILDREN IN MEDICAID PRESCRIBED PSYCHOTROPIC MEDICATIONS WITH AND WITHOUT ACCOMPANYING BEHAVIORAL HEALTH SERVICES*

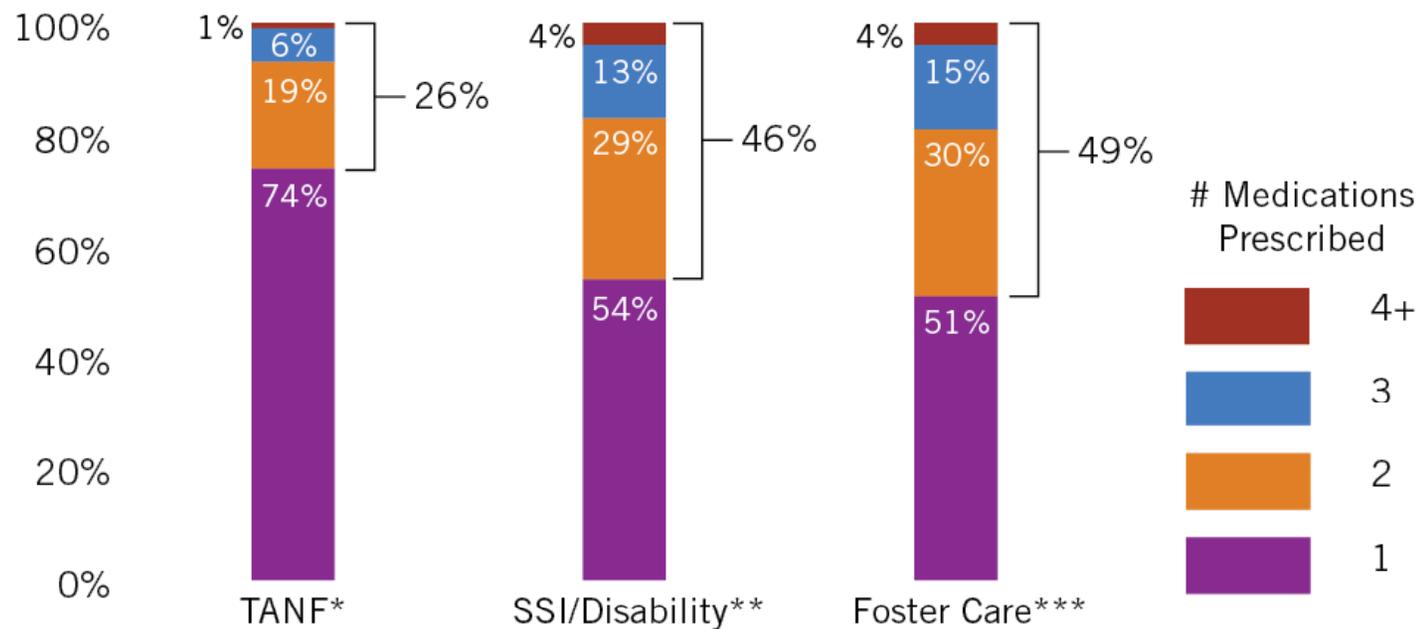


* Based on all children in Medicaid receiving psychotropic medications in 2005, N = 1,686,387.

Source: S. Pires, K. Grimes, T. Gilmer, K. Allen, & R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, December 2013.

Children in foster care who are prescribed psychotropic medications are more likely than children in other aid categories to receive multiple medications, with 49% prescribed 2 or more, and close to 20% prescribed 3 or more.

CONCURRENT PSYCHOTROPIC MEDICATION USE AMONG CHILDREN IN MEDICAID



*N=1,119,266 **N= 354,945 ***N= 212,176

Source: S. Pires, K. Grimes, T. Gilmer, K. Allen, & R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, 2013.

Antipsychotic prescribing rates in Child Welfare



- Rates of antipsychotic use increased from 8.9% in 2002 to 11.8% in 2007 (**range from 2.8% in HI to 21.7% in TX**). (Rubin, et. al. *Children and Youth Services Review*, 34(6), 2012)
- Use of antipsychotic medications is amongst the **fastest growing class of psychiatric medications**.
- Use in Medicaid-enrolled Children age 3-18 **grew 62% between 2002 and 2007**;
- ADHD is the most common diagnosis (39%, Bipolar 11%, ADHD and Bipolar 12%).

Rates in New Mexico: SGA



Trajectories of Second Generation Antipsychotics

State	2002 pop	2002 rate	2003	2004	2005	2006	2007	2007 rate	2007 pop	% change 2007– 2002
NM	3060	0.037	.	.	+	+	.	0.04 6	4489	24.32 %

(Rubin, et. al. *Children and Youth Services Review*, 34(6), 2012)

Rates in New Mexico: Polypharmacy



Trajectories of Polypharmacy*

State	2002 pop	2002 rate	2003	2004	2005	2006	2007	2007 rate	2007 pop	% change 2007– 2002
NM	3060	0.077	+	+	+	+	.	0.103	4489	34.9%

*Concurrent use of 3 or more classes of psychotropic medication during the year. Concurrent use was defined as overlapping use of ≥ 3 psychotropic classes 30 days or more. Psychotropic classes included stimulants, antidepressants, SGAs, sedative/hypnotics, anxiolytics, mood-stabilizers, and alpha agonists.

(Rubin, et. al. *Children and Youth Services Review*, 34(6), 2012)

Fostering Connections to Success and Increasing Adoptions Act of 2008



- **Public Law (P.L.) 110-351 requires states to:**
 - develop a plan for **ongoing oversight and coordination of health care services for children in foster care**, in coordination and consultation with the State title XIX (Medicaid) agency, pediatricians, and other experts in health care, as well as experts in and recipients of child welfare services.
 - The purpose of these requirements is to ensure that children in foster care receive high-quality, coordinated health care services, **including appropriate oversight of any needed prescription medicines.**

Child and Family Services Improvement and Innovation Act (P.L. 112-34)



- Whereas the law had previously required that the plan address “oversight of prescription medicines,” the new provision builds on this requirement by specifying that the plan must include an outline of “**protocols for the appropriate use and monitoring of psychotropic medications.**”
- With the amendments made by P.L. 112-34, it is **now a statutory requirement that oversight of psychotropic medications be explicitly addressed in the health care oversight and coordination plan.**

The following factors may play a role in the patterns of psychotropic medication use in foster children:



- **Insufficient State oversight and monitoring of psychotropic medication use;**
- **Gaps in coordination and continuity** of medical and mental health care across public health and social service systems involved with affected children and their families;
- **Provider shortages**, especially of board-eligible and board-certified child and adolescent psychiatrists, in some geographic areas (e.g., rural areas); and
- **Lack of access to effective non-pharmacological treatments** in outpatient settings.

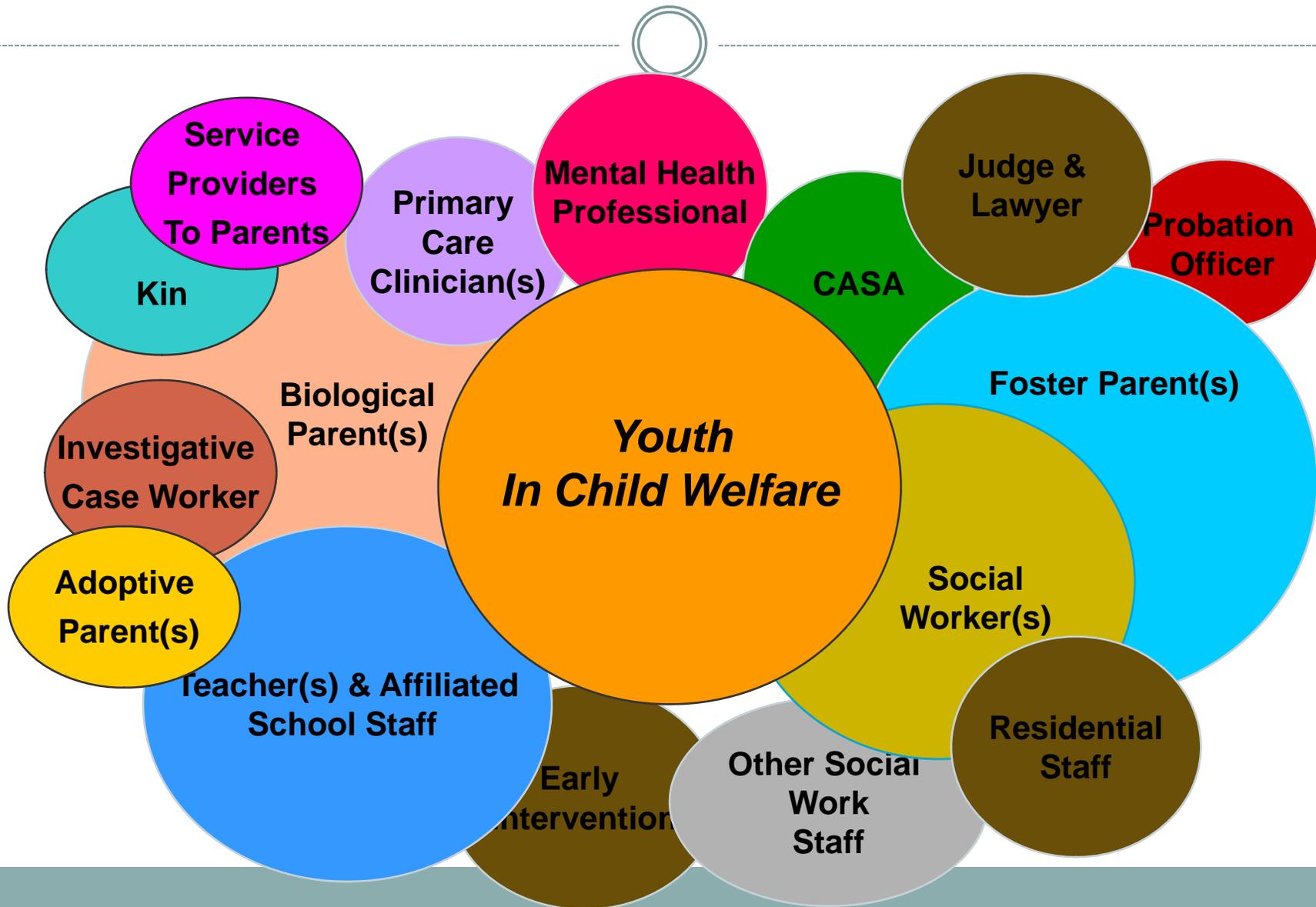
These concerns are highlighted across three Government Accountability Office (GAO) reports:

GAO. 2011. "HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions." Vol. GAO-12-270T. Washington, DC: United States GAO.

GAO. 2012. "Children's Mental Health: Concerns Remain About Appropriate Services for Children in Medicaid and Foster Care." Vol. GAO-13-15. Washington DC: United States GAO.

GAO. 20;14. "HHS Could Provide Additional Guidance to States Regarding Psychotropic Medications" Vol. GAO-14-651T. Washington, DC: United States GAO.

Care (Dis-)Coordination



Setting the Context

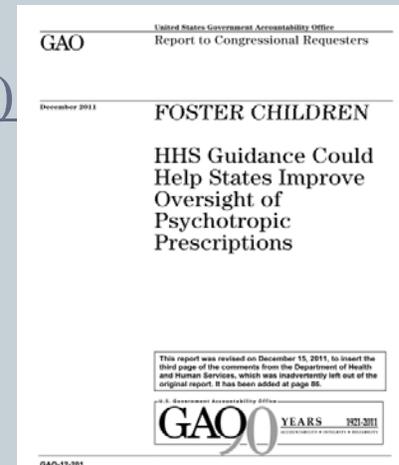


- **NPR:**
 - [Foster Kids Given Psychiatric Drugs at Higher Rates](#) (2011)

- **PBS:**
 - [The Watch List: The Medication of Foster Children](#) (2011)

- **ABC:**
 - [20/20: Overmedication in Foster Care](#) (2011)

- **GAO**
 - [HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions](#) (2011)
 - [Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care](#) (2012)
 - [HHS Could Provide Additional Guidance to States Regarding Psychotropic Medications](#) (2014)



Federal Policy Context



PL 105-89:

“The Adoption and Safe Families Act” of 1997

Included ‘well-being’ as an element of the mission for child welfare agencies

1997

PL 110-351: *Fostering Connections to Success and Increasing Adoptions Act of 2008*

Required plan for oversight and coordination of health and mental health services for children in foster care

2008

PL 112-34:

Child and Family Services Improvement and Innovation Act

Required protocol for psychotropic oversight by July 2012

2011

(Mackie et al, 2013)



**LEARNING
OBJECTIVES
2 and 3**

- Describe five overarching components for psychotropic medication oversight for youth in foster care, prioritized by Health and Human Services, and variation across states; and
- Provide resources, linked in these slides and available on the 3BI thumb drives, for each of the five components prioritized by HHS.

Information Memorandum (5 Components)



- 1. Screening, evaluation and treatment planning**
- 2. Shared decision-making and informed consent**
- 3. Medication monitoring**
- 4. Mental health expertise and consultation**
- 5. Information sharing**

(U.S. Department of Health and Human Services, 2012)

Tufts/ICH Research Team



- **3 national studies:**
 - 2009-2010 (Charles H. Hood Foundation)
 - ✦ Examine state policies and best practices and disseminate to child welfare agencies
 - 2011-2013 (William T. Grant Foundation)
 - ✦ Identify types of information states using to develop mental health oversight plans
 - 2012-14 (Agency for Health Research and Quality)
 - ✦ Document state approaches to monitoring psychotropic medication use in all 50 states, and DC.

Methods



- **Tools:** Semi-structured qualitative interviews and surveys to validate and update state data
- **Samples:** Key informants
 - Child welfare
 - Collaborators in youth-serving systems
- **Document review:** Policy and protocols available on child welfare website or provided by key informant
- **Analytic approach:** Coding consensus, co-occurrence, and comparison

Samples



- **2009-2010 (Charles H. Hood Foundation)**
 - **47 out of 50 states and DC (response rate: 94.1%)**
 - **Key informants, n=58**
 - **Governor's Office (n=1)**
 - **Medicaid (n=1)**
- **2011-12 (W.T. Grant Foundation)**
 - **51 out of 50 states and DC (response rate: 100%)**
 - **Key informants, n=72**
 - **State and county-administered child welfare agencies (n=58)**
 - **Medicaid (n=7)**
 - **Judiciary (n=2)**
 - **Contracted academic partners or consultants (n=5)**
- **2012-2013 (AHRQ)**
 - **46 of 50 states and DC (response rate: 90.2%)**

Federal Policy Context



PL 105-89:

“The Adoption and Safe Families Act of 1997

PL 110-351: *Fostering Connections to Success and Increasing Adoptions Act of 2008*

PL 112-34:

Child and Family Services Improvement and Innovation Act

2012

2013

1997

2008

2011

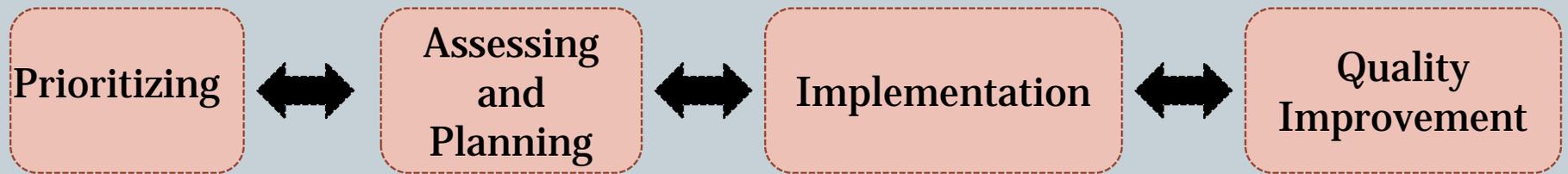
*Study 1:
Psychotropic Oversight Plans
(Mackie et al, 2012)*

*Studies 2 and 3:
Psychotropic Monitoring Mechanisms*

Implementation Stage



- For each component, states are at different stages of development:



Psychotropic Oversight Policies (2009-10)



Alaska



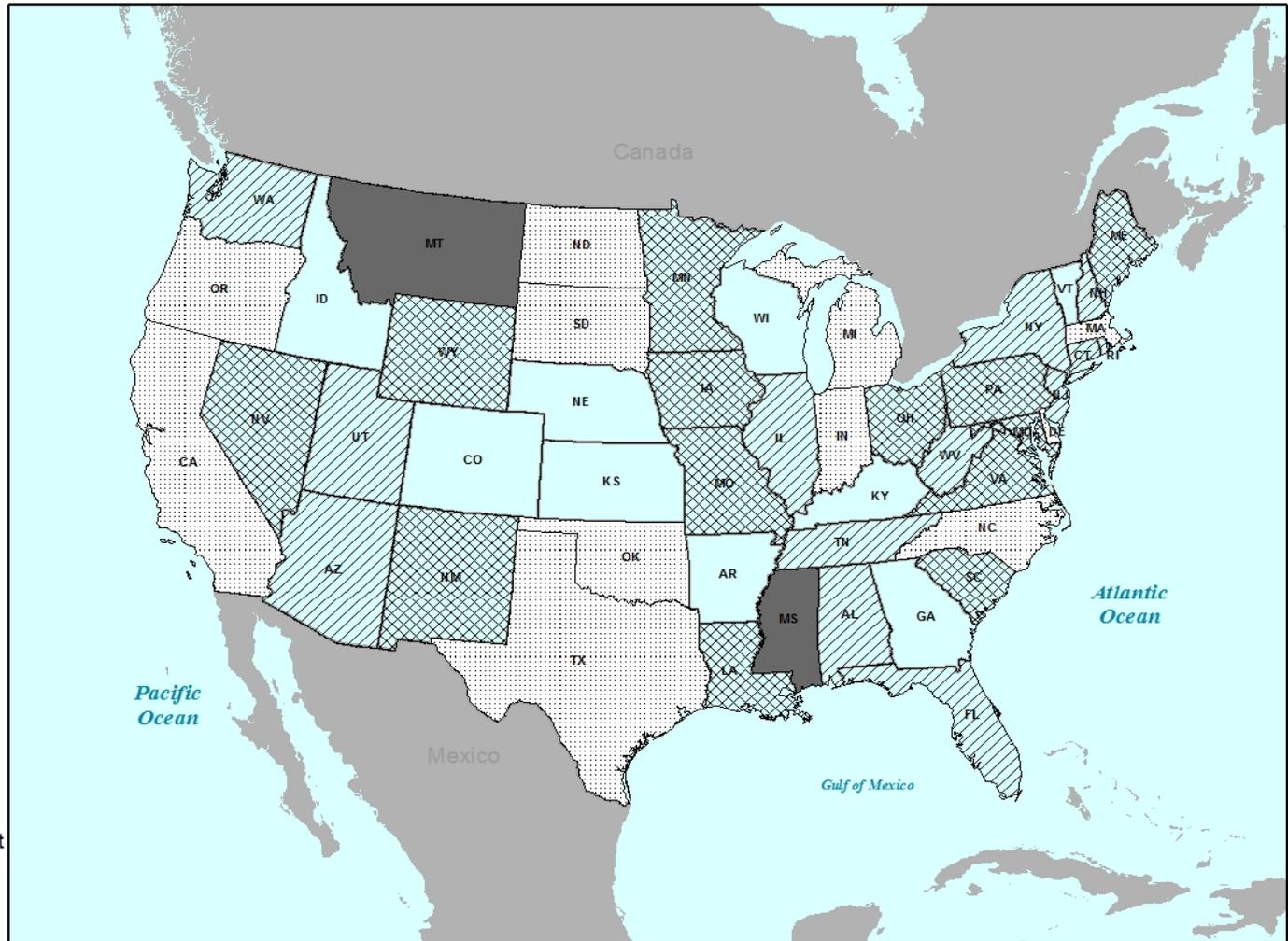
Hawaii



States

Policy Status

-  Evaluation Only
-  Oversight Only
-  Both Evaluation and Oversight
-  No Policy
-  no data



Component One



SCREENING, ASSESSMENT, AND TREATMENT PLANNING

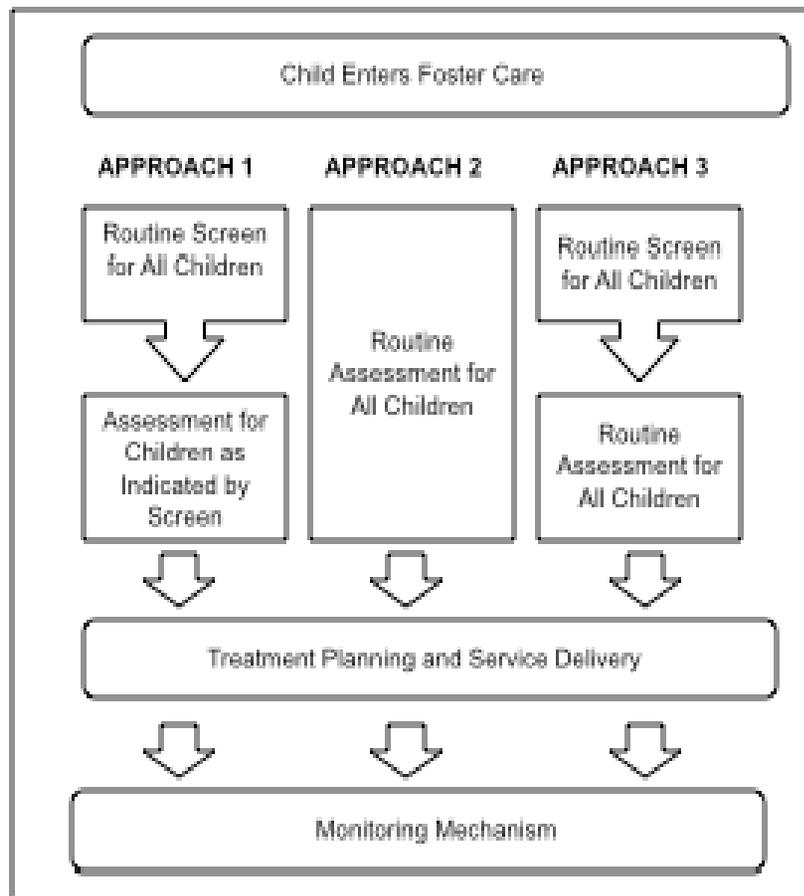
Component 1: Screening and Assessment



- Initial Health Screen (24-72 hours)
- Comprehensive Assessment (30-60 days)
- Sensitive to the unique needs and experiences of youth in child welfare custody
 - Trauma related to maltreatment and trauma secondary to removal from home and placement changes
 - *In-utero* environmental drug exposure
 - Genetic loading

(AAP District II Task Force on Health Care for Children, 2001; AACAP/CWLA, 2002; Jensen et al, 2009)

Component 1: State Approaches



	n (%)
Approach 1	35 (73)
Approach 2	12 (25)
Approach 3	1 (2)

Component 1: Self-Reflection (2)



At the systems-level:

- Is a **standardized** “tool” employed (trauma-informed and evidence-based)?
- How will the **cost** be reimbursed to recruit appropriate clinicians?
 - e.g., foster care-risk adjustment
- Are there **available services** once needs are identified?
- Can we **track** receipt of services?
 - e.g., information system

Component 1: Self Reflection (1)



At the practice-level:

- Before initiating pharmacotherapy, was an evaluation of physical and mental health employed and medical history obtained?
- What **type of mental health evaluation** was provided?
 - e.g., as needed, screen/assessment, assessment
- Does the approach address the **unique needs** for mental health evaluation of youth in child welfare custody, including trauma, *in utero* exposures, and potential genetic loading?
- **When** was the screen (24-72 hours) and assessment (30-60 days) conducted?
- **Who** conducted the evaluation?

Component 1: Guidelines



Sponsor/ Author	Guideline
American Academy of Child and Adolescent Psychiatry (AACAP)	<u>Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline</u>
AACAP	<u>Policy Statement on Psychiatric Care of Children in the Foster Care System</u>
AACAP; and Child Welfare League of America (CWLA)	<u>Policy Statement on Mental Health and Use of Alcohol and Other Drugs, Screening and Assessment of Children in Foster Care</u>
American Academy of Pediatrics	<u>Fostering Health: Health Care for Children and Adolescents in Foster Care</u>
Jensen PJ, Romanelli LH, Pecora PJ, Ortiz A.	<u>Mental Health Practice Guidelines for Child Welfare</u>

Component 1: Resources



Sponsor/ Author	Resource
AAP	<u>Trauma toolbox for primary care</u>
California Evidence Based Clearinghouse	<u>Searchable database of program information for child welfare professionals</u> , including at minimum: CEBC rating and peer-reviewed articles for programs that can be used by
Agency for Healthcare Research and Quality	<u>Systematic Evidence Review of Interventions Addressing Child Exposure to Trauma: Maltreatment</u>

Component Two



SHARED DECISION- MAKING AND INFORMED CONSENT

Component 2: Definitions



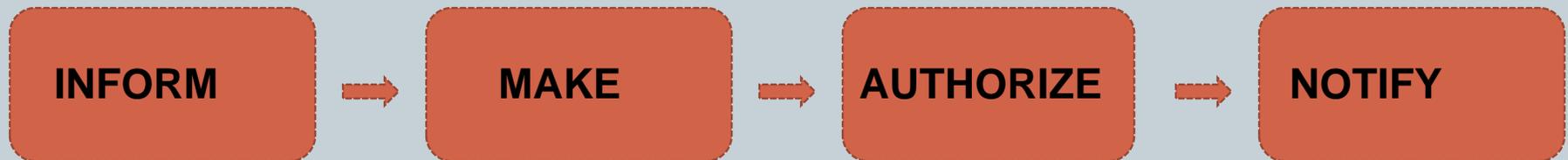
- **Consent:** The process of a:
 - Clinician providing information to the child, family, and state-assigned decision maker about the treatment options, targeted symptoms, and course of treatment; and
 - State-assigned decision-maker provides an informed decision regarding which treatments are in the best interest of the child.
(Romanelli et al, 2009)
- **Assent:** A 3-part process that includes the youth:
 - Understanding (to the best of his/her developmental abilities) treatment options,
 - Voluntarily choosing to undergo treatment options, and
 - Communicating this choice.
(Bartholome, 1995)

Component 2: Consent and Child Welfare



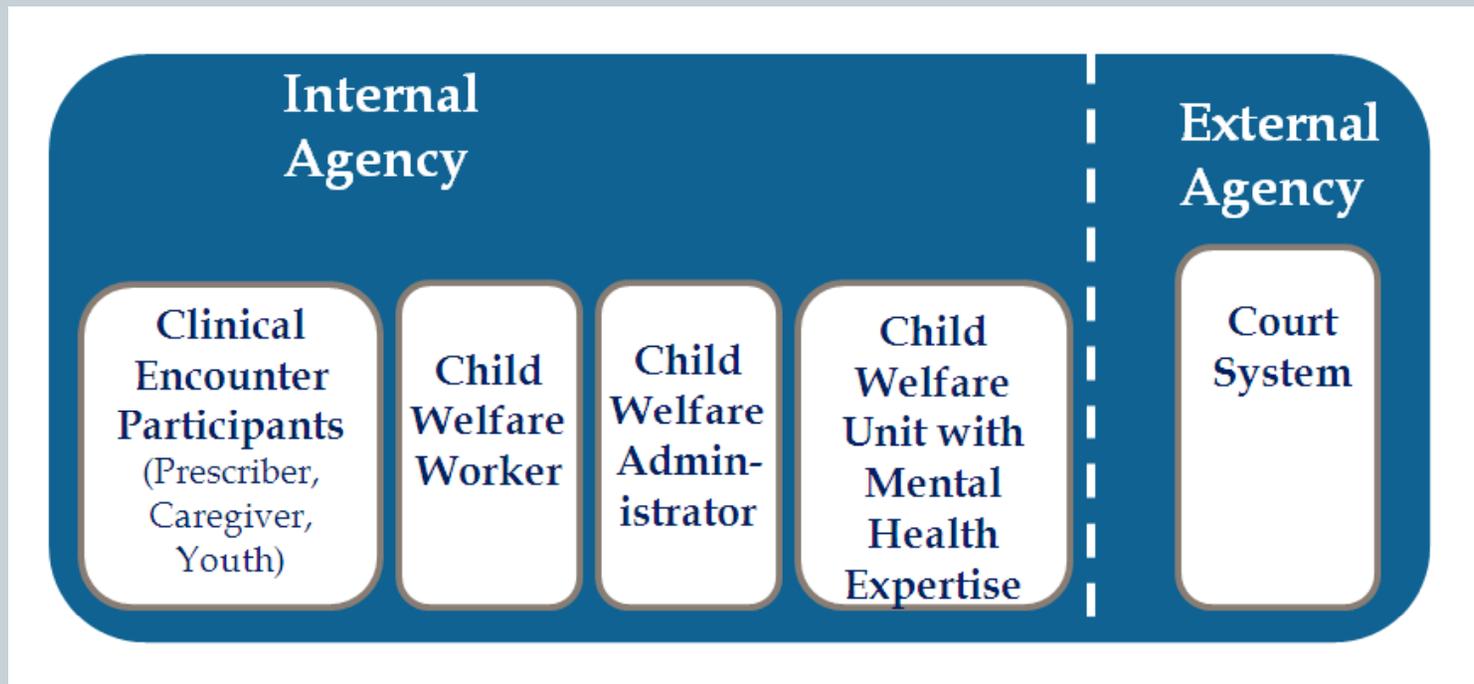
- Child welfare agency, acting as *in loco parentis* or “in place of the parent,” assumes legal responsibilities and functions of the parent when child enters custody
- **Informed consent and shared decision-making:**
 - A process, both at time of initiation and ongoing, by which the child welfare agency or its designee consents to the use of mental health services, including psychotropic medications, for children in custody.

Component 2: Process



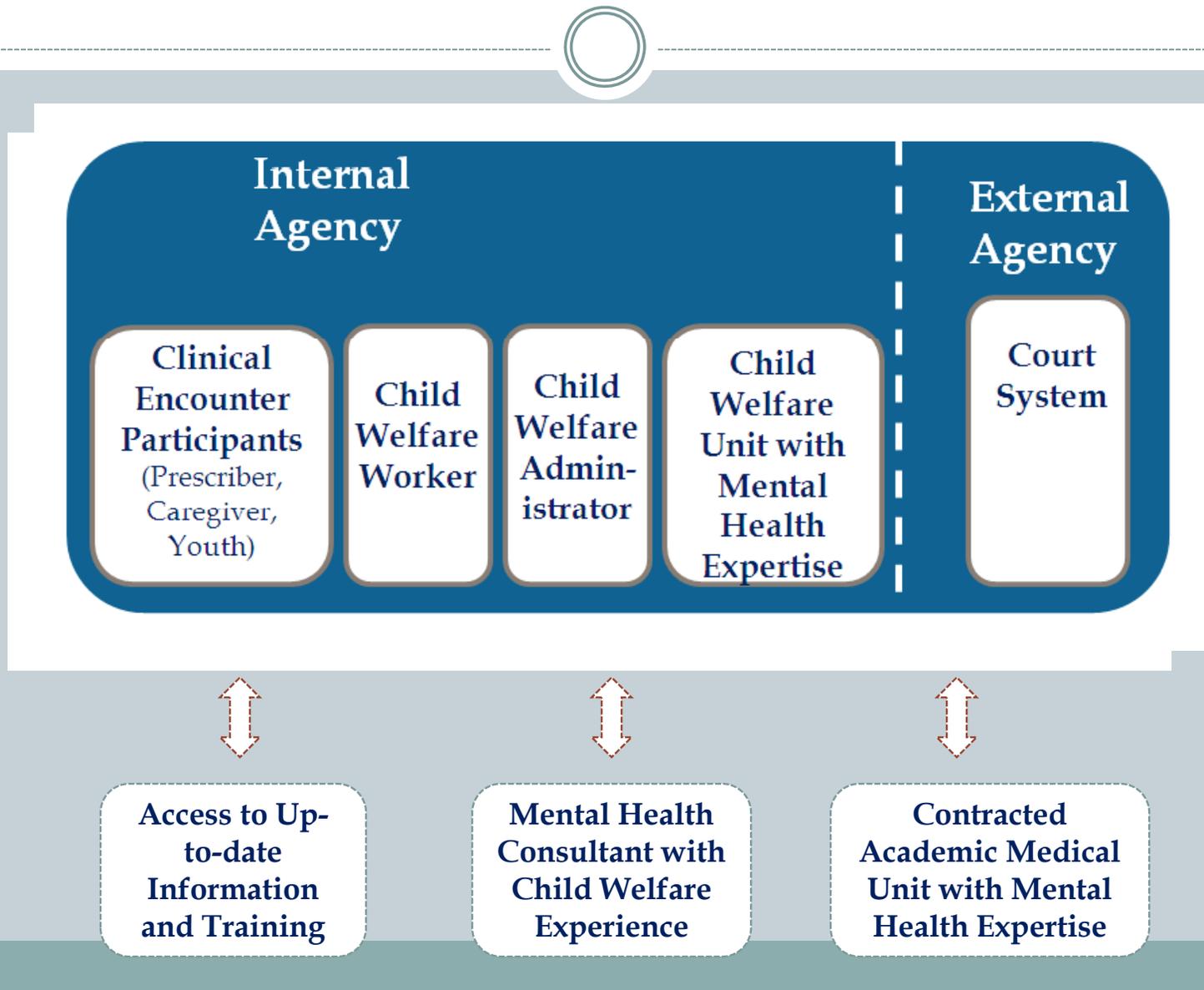
(Leslie, Mackie, et al, 2010)

Component 2: *Who Makes the Decision to Consent*



(Leslie, Mackie, et al, 2010)

Component 2: What additional resources are available?



Component 2: Self Reflection



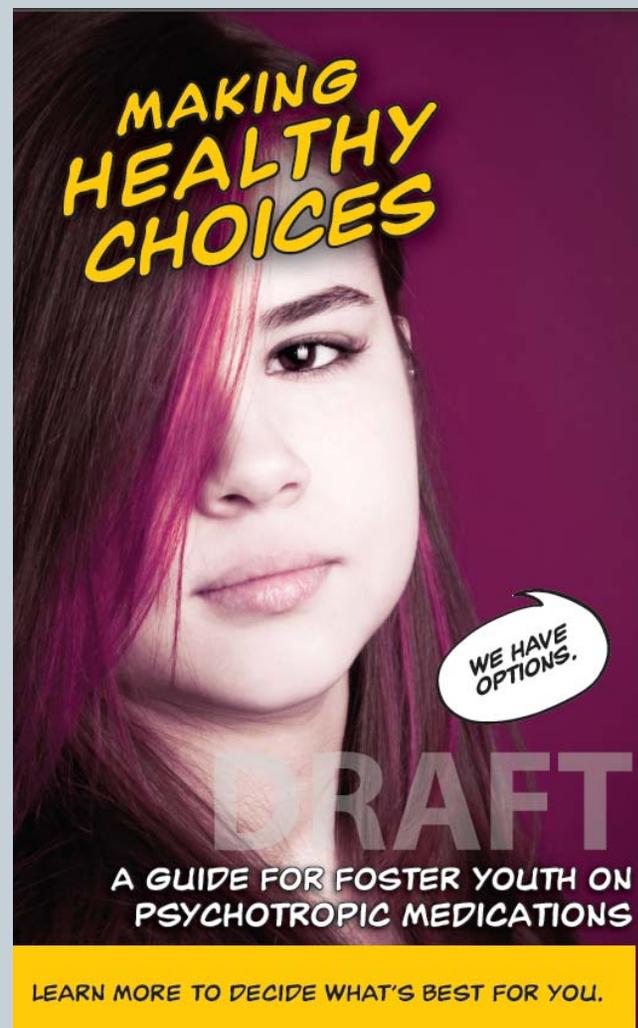
At the systems level:

- How can we ensure meaningful informed consent and shared decision-making?
- What are the policy/legal considerations specific to our state that need to be considered?

At the practice level:

- Whether or not at the age of consent/assent, how does the youth feel about taking this medication?
 - ✦ Consent/assent
 - ✦ Handbook (<http://www.nrcyd.ou.edu/publication-db/documents/psychmedyouthguide.pdf>)
- Who informs, makes, authorizes prior to the child starting this medication?
 - Authorized consentor
 - Role of foster and kin caregivers and biological parents, whenever appropriate
- Is a second opinion warranted in this case?
- Who is notified of decision to start psychotropic medication use?

Resource: NRCPCF: [Handbooks for Youth in Foster Care](#)



Component 2: Resources



Sponsor/ Author	Resource
California	Foster Youth Help
Maine	Youth in Care Bill of Rights
New York	A Medical Guide for Youth in Foster Care
Oregon	Foster Care Questions
Center for Health Care Strategies	Resources to Educate Youth, Families, Child Welfare Staff, and Providers about Psychotropic Medications
Child Welfare Information Gateway	Use of Psychotropic Medications
Patient Information Handouts	e.g., Dulcan, MK & Lizarralde, C. <i>Helping Parents, Youth and Teachers Understand Medications for Behavioral and Emotional Problems: A Resource Book of Medication Information Handouts</i> (3 rd Edition)

Component Three



MEDICATION MONITORING AT THE CLIENT AND POPULATION-LEVEL

Component 3: Medication Monitoring (2012-13)



- **Multi-level**
 - **Client:** Care coordination within and external to medical system, facilitate transitions and medical history, and identify red flag criteria to examine specific safety concerns
 - **Provider:** Provider feedback as QI tool, issued to the provider or hospital
 - **Population:** Needs assessment, policy-planning, monitoring problems and trends

Component 3: Medication Monitoring

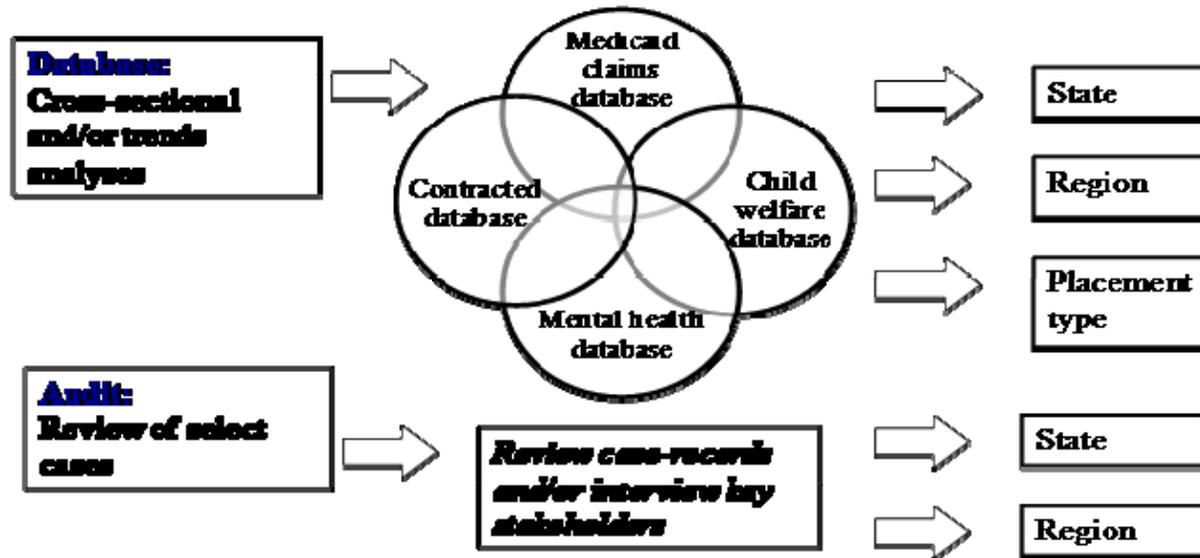


- **Multi-purpose**
 - Descriptive
 - Consultative
 - Evaluative

Component 3: Descriptive



Typology of Population-level Monitoring



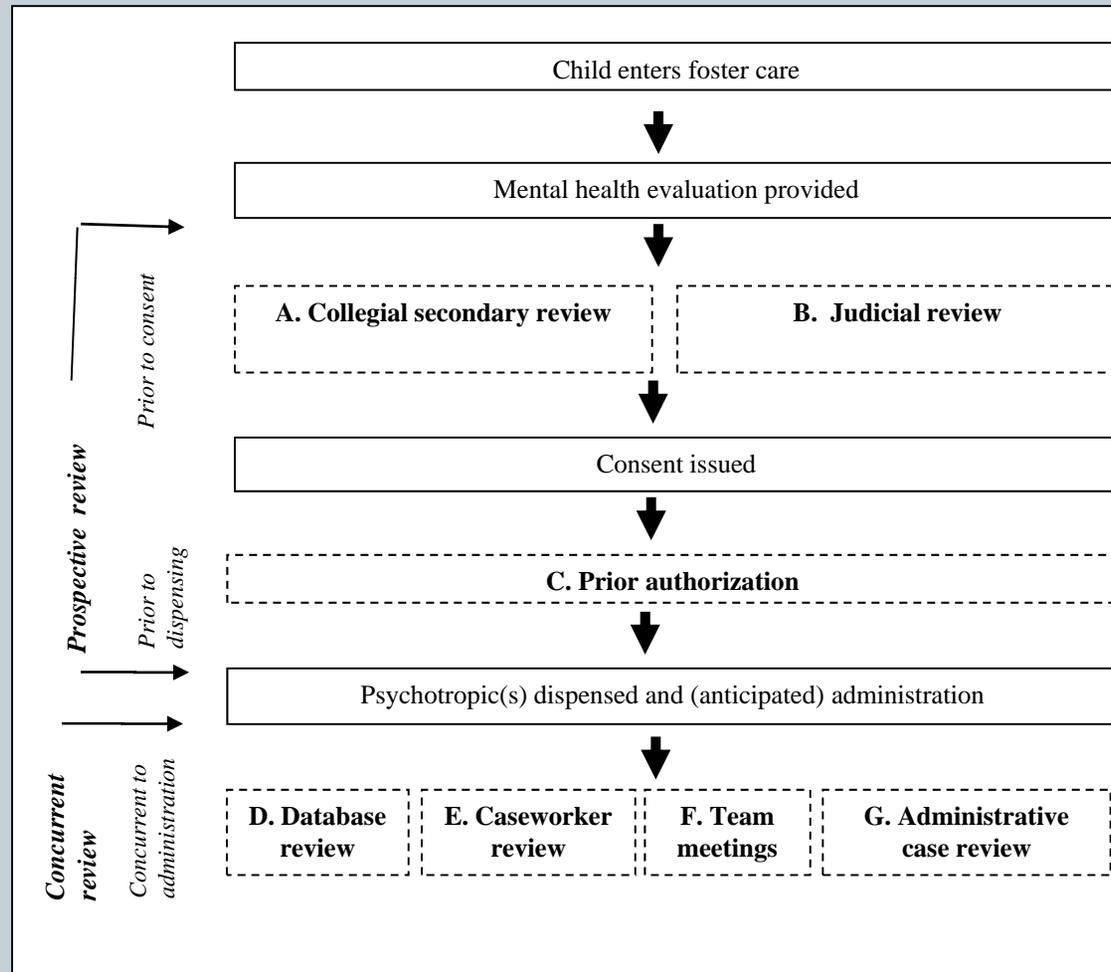
Component 3: Consultative



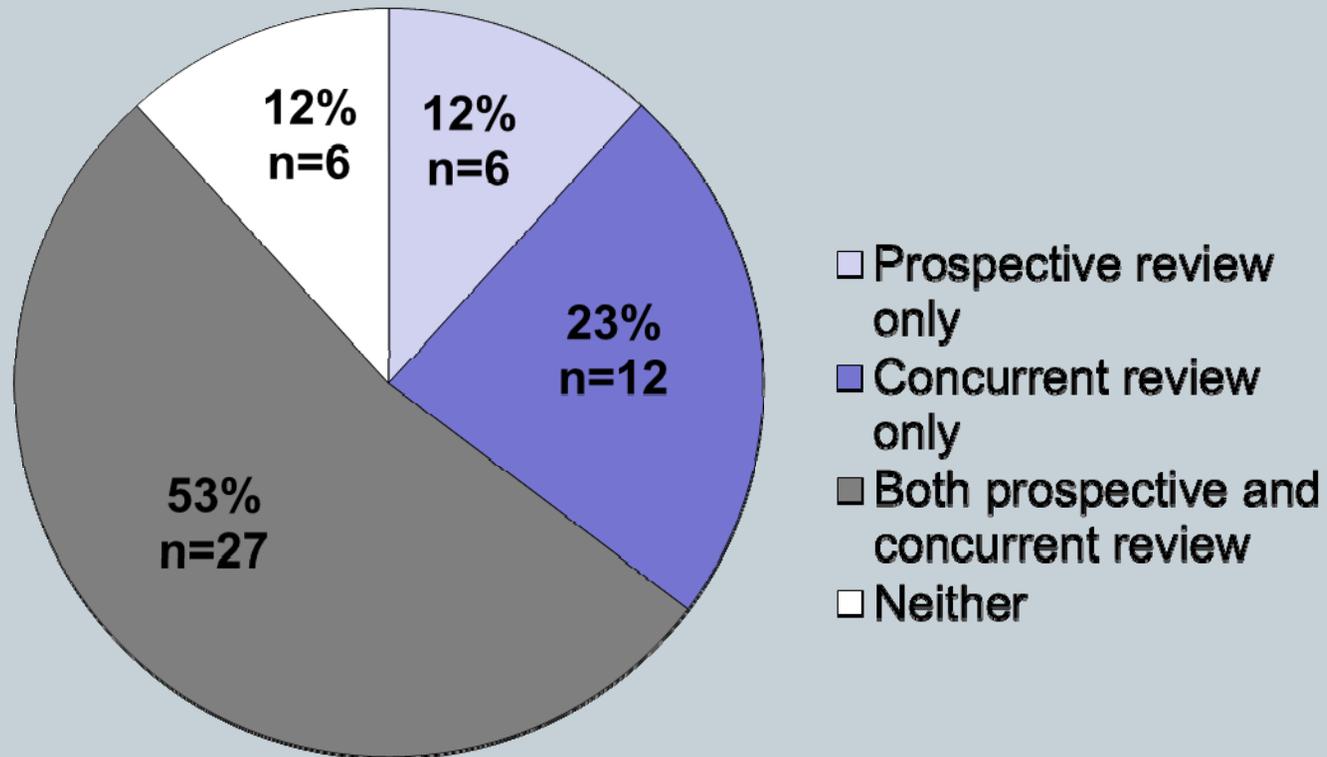
- **Cyber-medicine: On-line consultation**
- **Tele-medicine: Telephone consultation lines**
- **Co-located Consultation: In-person consultation**

Component 3

Taxonomy of Psychotropic Monitoring Mechanisms



Paper 1: State Approaches, N=51



Child-level Monitoring Mechanisms, n=103



	Collegial Secondary Review, n=14	Judicial Review, n=3	Prior Auth- ORIZATION, n=25	Concurrent Database Review n=34	Case- worker n=1	Team Review n=16	Admin- istrative Case Reviews n=10	Total n=103
Child Welfare, n (%)	12 (85.7)			12 (35.3)	1 (100)	15 (93.8)		40 (38.8)
Judiciary, n (%)		3 (100)					10 (100)	13 (12.6)
Behavioral Health, n (%)			2 (8.0)			1 (6.3)		1 (1.0)
Medicaid FFS, n (%)			17 (68.0)	13 (38.2)				39 (37.9)
Medicaid MC, n (%)			6 (24.0)	4 (11.8)				10 (9.7)
Other, n (%)	2 (14.3)			5 (14.7)				9 (8.7)

Paper 1: Rise in State-level Psychotropic Monitoring



- **Of the three most frequently employed monitoring mechanisms, implementation indicated an increase:**
 - Collegial Secondary Review: Nine of the 14 states (64%) implemented since January 2011.
 - Prior Authorization: Twelve of the 21 states (57%) implemented since January 2011.
 - Concurrent Database Review: Fourteen of 25 states (56.0%) implemented since 2011.

Component 3: Self-Reflection



At the systems-level:

Descriptive

- What do we want to measure regarding psychotropic oversight and for what purpose?
- What data will be used and will linking data be necessary?
- What analyses do we want to distribute to what stakeholders?
(State leaders? Clinicians? Case Managers? Parents? Youth?)
- What legal/policy barriers may exist to linking or disseminating data?

Consultative

- What stakeholders are in need of additional mental health expertise to ensure optimal psychotropic medication use?
- How can we provide a consultation service to support these individuals?

Evaluative

- What criteria/expectation/goal are you going to monitor (e.g., red flags)?
- How can key stakeholders be engaged in developing monitoring plans?

Component 3: Self-Reflection



At the provider level (based on our research and the [AACAP practice parameters](#)):

Descriptive

- What are the general trends in use of psychotropic medications among the population I serve?
- Are there concerning prescribing patterns for this population?

Consultative

- What systems are available for mental health consultations?
- Who can access these consultations?

Evaluative

- How will our practice-level system monitor the ongoing use of these medications?
- How often will the child or adolescent be seen?
- What are the possible side effects of this medication and how will they be identified and handled?
- What state or county systems, if any, evaluate optimal psychotropic medication use for youth populations that I work with?



Component 3: Resources



Sponsor/ Author	Resource
Arizona	<u>Psychotropic Medication Use Among Children in Foster Care in Arizona</u>
California	<u>Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges</u>
Government Accountability Office	<u>HHS Guidance Could Help States Improve Oversight of Psychotropic Prescription</u>
Medicaid Medical Directors Learning Network (MMDLN)/Rutgers CERTs	<u>Antipsychotic Medication Use Among Medicaid Children and Adolescents: Report and Resource Guide from 16 State Study</u>
National Committee for Quality Assurance	<u>Antipsychotic Medication Measures for Medicaid and CHIP</u>
Texas	<u>Psychotropic Medication Utilization Parameters</u>
Washington	<u>Partnership Access Line</u>

Component 4: Mental Health Expertise



- **Mental health expertise**
 - Child and Adolescent Psychiatrist
 - Pediatrician
 - Pharmacist
 - Psychiatric Nurse Practitioner
 - Registered Nurse

Component 4: Mental Health Expertise

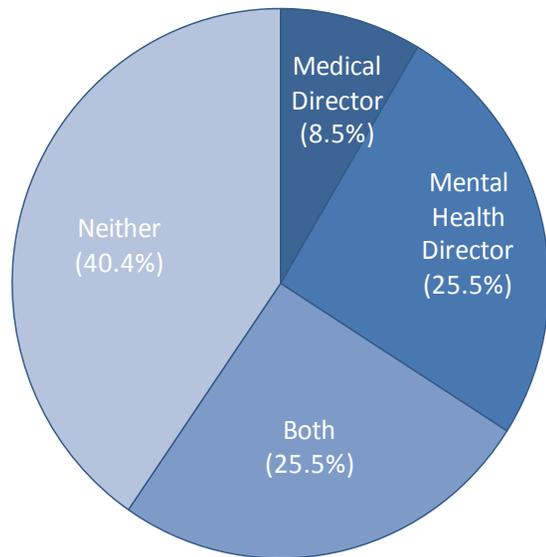


- **Mental health expertise may be available as:**
 - Hired staff within the Agency
 - ✦ (e.g., Medical and Mental Health Directors)
 - Staff at partnering State Agencies; or
 - Consultants external to the State system
 - ✦ Formal and informal arrangements

Component 4: Medical and Mental Health Directors

**Medical & Mental Health Director
in State Child Welfare Agencies**

n=47



Mental Health Expertise	n (%)
Medical Director	4 (8.5)
Mental Health Director	12 (25.5)
Both	12 (25.5)
Neither	19 (40.5)

(Leslie, Mackie, et al, 2010)

Component 4: Self-Reflection



At the system level:

- What skill set do we need in our system?
- Will we house expertise within child welfare, other public sector systems, or “contract-out”?
- How will we provide mental health expertise at the individual child level?
 - As-needed basis?
 - PRN consultation available?
 - Routine, required reviews?
 - ✦ Selected psychotropic medications/populations
 - ✦ All psychotropic medication/populations

At the practice level:

- Do you have mental health expertise available in cases where a second opinion is warranted?
- Do you have criteria for identifying cases in which a second opinion is considered appropriate?

Component 4: Resources



Sponsor/ Author	Publication or Tool to Support Mental Health Experts
AAP	<u>Advocacy Guide: Training Modules</u>
AACAP	<u>State Advocacy Manual</u>
AACAP	<u>State Advocacy Toolkit</u>
AACAP	<u>Understanding Your State Legislature</u>
AACAP	<u>Advocating for Children and Adolescents with Mental Illnesses</u>

Component 5: Information Sharing



- **Information Sharing:**

As stated in the information memorandum, disseminating accurate and up-to-date information and educational materials related to mental health and trauma-related interventions (including information about psychotropic's) to clinicians, child welfare staff, and consumers (e.g., youth, family members, foster parents, and advocates)

Component 5: Self-Reflection



Systems- and Practice-level

- Where can we get accurate, up-to-date information?
 - Consult available professional guidelines
 - ✦ Example: AACAP Policy Statement on Psychiatric Care of Children in the Foster Care System. See Appendix in *Tufts Study Report*.
 - Consult Child Welfare Information Gateway
 - Acquire additional expertise in child welfare agency

Component 5: Resources



Sponsor/Author	Publication
NIMH	<u>Mental Health Medications</u>
NIMH	<u>Treatment of Children with Mental Illness</u>
NIMH	<u>Treatment of Children with Mental Disorders</u>
NAMI	<u>NAMI Policy Research Institute Task Force Report: Children and Psychotropic Medications</u>
AACAP	<u>Psychiatric Medications for Children and Adolescents: Part I – How Medications are Used</u>
AACAP	<u>Psychiatric Medications for Children and Adolescents: Part II – Types of Medications</u>

Questions?



- For more information on the *Multi-State Study on Psychotropic Medication Oversight in Foster Care*, please link [here](#).
- For more information on a state evaluation of an approach to monitor antipsychotic medications conducted for the Office of the Child Advocate in the Commonwealth of Massachusetts, please link [here](#).
- To be in touch with me, please contact:

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