The Illinois DCFS Psychotropic Medication Consent Program

Opportunities to Improve Quality of Mental Health Care in the Child Welfare System

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University of Illinois at Chicago

Disclosures of Potential Conflicts

<table>
<thead>
<tr>
<th>Source</th>
<th>Research Funding</th>
<th>Advisory Committee</th>
<th>Employee</th>
<th>Speaker or Consultant</th>
<th>Books, Reviews, Planning</th>
<th>In kind (equipment or services)</th>
<th>Stock or Options</th>
<th>Honorarium or expenses for presentation</th>
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<tr>
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Disclosures

- Off-label uses of psychotropic medications may be discussed

Kudos

- Alice Gutierrez
- Sandra George
- Nina Deichl
- Stacey Lens-Crowley
- Stephanie Gallardo
- David Griffin
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- Jean Madigan

- Pravin Karuppaiah
- Catherine Francis

- Consultants
  - Elizabeth Charney, MD
  - Sucheta Connolly, MD
  - Diane Misch, MD
  - Fedra Najar, MD
  - Kathleen Kelley, MD

Children in Child Welfare

- Compared to other Medicaid-eligible youth, foster children:
  - have higher rates of emotional, behavioral and psychiatric disorders
  - use MH services at a significantly higher rate
  - are prescribed psychotropic medications at a higher rate
GAO Study

- Study design
  - Medicaid fee-for-service pharmacy claims for psychotropic medications
  - CY 2008
  - FL, MD, MA, MI, OR, TX
  - FC vs. NFC

- Study design
  - indicators of potentially risky practices were analyzed
    - > 5 psychotropic medications
    - prescriptions exceeding dosage guidelines
    - prescription to children < 1 year

- Study design
  - adherence to the AACAP Best Principles Guidelines was assessed:
    - Consent
    - Oversight
    - Consultation
    - Information Sharing

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<tr>
<th>State</th>
<th>Foster (FC)</th>
<th>Nonfoster (NFC)</th>
<th>FC/NFC Ratio</th>
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<td>4.1</td>
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<tr>
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<td>7.1</td>
<td>4.5</td>
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<th>Foster (FC)</th>
<th>Nonfoster (NFC)</th>
<th>FC/NFC Ratio</th>
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<tr>
<td>OR</td>
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<tr>
<td>TX</td>
<td>3.27</td>
<td>0.37</td>
<td>8.8</td>
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Recommendation for Executive Action

To improve the comprehensiveness of oversight of psychotropic drugs prescribed to foster children, we recommend that the Secretary of HHS evaluate our findings and consider endorsing guidance to state Medicaid and child welfare agencies on best practices for monitoring psychotropic drug prescriptions for foster children, including guidance that addresses, at minimum, informed consent, oversight, consultation, and information sharing.

Centralized DCFS Psychotropic Medication Consent Program

Two components
- Centralized Psychotropic Medication Consent Line
  - DCFS
  - Authorized Agent
- Clinical Services in Psychopharmacology
  - University of Illinois at Chicago

Psychopharmacology Expert Panel

- 6/8–9/2006
- Develop general practice guidelines
- Consultant - Peter S. Jensen, M.D.
- Facilitators
  - James McCracken, M.D.
  - Mark A. Riddle, M.D.
  - Mina K. Dulcan, M.D.
  - Mani Pavuluri, M.D.
- Panel participants
  - top 10 prescribing child psychiatrists for foster children
  - representatives from:
    - Department of Children and Family Services
    - Child Welfare Advisory Committee – High End Treatment
    - Cook County Office of the Public Guardian
    - Head, Child and Adolescent Psychiatry, Department of Mental Health
    - Department of Healthcare and Family Services Pharmacy Services
    - Professional Organizations
      - Illinois Council of Child and Adolescent Psychiatry
      - Illinois Psychiatric Society
      - Illinois Chapter of the American Academy of Pediatrics
DCFS Medication Guidelines

- All state wards under age 18 years must have consent from the DCFS Guardian prior to starting a psychotropic medication.
- All children and adolescents must receive a diagnostic assessment prior to starting a psychotropic medication.
- The prescription of psychotropic medications is just one component of a comprehensive treatment plan that includes psychosocial and behavioral interventions.
- Prescribing clinicians should communicate with other clinicians involved in the child’s care, particularly other prescribers.

- Prescription of a psychotropic medication should be based on research showing it to be safe and effective for the disorder being treated. Medications that have been approved by the FDA for the treatment of a specific disorder in children or adolescents meet this requirement by definition and should be used preferentially over non-FDA approved medications.
- Medications prescribed should be appropriate to the patient’s diagnosis and target symptoms.
- Existing medication algorithms should be consulted when making the decision about which medication to use for a specific disorder.

- The decision to utilize polypharmacy or co-pharmacy should be based on a solid clinical rationale and accepted medical practice:
- Monotherapeutic options should be exhausted before considering polypharmacy or co-pharmacy.
- When polypharmacy is necessary, the fewest medications should be used as possible.
- Medications should be started and titrated one at a time.

- In order to be effective, medication trials must be adequate in terms of dosage and duration.
- If a child does not respond to the medication trial despite adequate dosage and duration the prescribing clinician should assess patient compliance, re-assess the diagnosis, rule-out the presence of co-morbid conditions and evaluate the influence of psychosocial stressors.
- PRN medications are prohibited.

CSP Database

- Placement data (SACWIS)
- Contact information
- HFS medication payment data
- HFS payments for procedure codes
- Psychotropic medication consent data
- Emergency medication utilization
Predictors of Placement Disruption

- Placement disruption:
  - severs key relational ties
  - interferes with academic achievement
  - disrupts continuity of medical care

Early identification of children at risk for placement disruption may represent an opportunity for prevention.

Study Objective
- To determine whether data from a psychotropic medication consent and oversight program for foster children could identify preschool children at risk for placement disruption.

Methods
- Sample
  - 309 foster children
  - born between 01/01/2006 and 12/31/2011
  - placement data missing for 54 subjects
- Outcome variable
  - placement disruption
  - > 2 placement changes after entering care
  - first placement considered as placement 0

Methods
- Independent variables:
  - psychiatric hospitalization
  - polypharmacy
  - physical abuse
  - sexual abuse
  - mood disorder
  - post-traumatic stress disorder (PTSD)
  - psychiatric symptoms: aggression, self-harm, suicidal symptoms, homicidal symptoms, psychosis/hallucinations

Methods
- Statistical analyses
  - logistic regression was used to identify the risk factors for placement disruption.
  - sensitivity and specificities were calculated for various combinations of risk factors to identify the best predictor combination.
### Predictors of Placement Disruption

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Odds Ratio (OR)</th>
<th>95% Confidence Interval</th>
<th>p-value</th>
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<td>Polypharmacy</td>
<td>1.93</td>
<td>1.1-3.5</td>
<td>0.03</td>
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<tr>
<td>Physical Abuse</td>
<td>2.7</td>
<td>1.3-5.3</td>
<td>.005</td>
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<tr>
<td>Psychiatric Hospitalization</td>
<td>2.5</td>
<td>1.2-5.3</td>
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<tr>
<td>Sexual Abuse</td>
<td>1.87</td>
<td>1.3-3.5</td>
<td>.05</td>
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</table>

**Findings:**
- best predictor combination – polypharmacy + psychiatric hospitalization
  - sensitivity – 50.7%
  - specificity – 70.2%
  - positive likelihood ratio – 1.701
  - negative likelihood ratio – 0.702

**Policy changes:**
- identify pre-school age children at risk for placement disruption using psychotropic medication oversight data
- refer children at high risk to DCFS Clinical for further review and referral for more intensive intervention

**Continuity Care Clinic**
- All children under 6 being considered for a psychotropic medication
- Guidelines for Prescribing Psychotropic Medication to Children Under 6 Years

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**Guidelines for Prescribing Psychotropic Medication to Children Under 6 Years**

1. **Assessment:**
   - Evaluate the child's mental health needs through a comprehensive assessment.
   - Consider the child's overall health and development.

2. **Diagnosis:**
   - Make a diagnosis based on the assessment results.
   - Ensure the diagnosis meets the criteria for the specific disorder.

3. **Efficacy:**
   - Consider the evidence for the effectiveness of psychotropic medications in children.
   - Evaluate the potential benefits and risks of different medications.

4. **Dose:**
   - Start with a low dose and gradually increase as needed.
   - Monitor for adverse effects and adjust the dose accordingly.

5. **Duration:**
   - Consider the duration of treatment based on the child's condition and progress.
   - Monitor for signs of medication overuse and withdrawal symptoms.

6. **Side Effects:**
   - Monitor for common side effects and potential interactions.
   - Have a plan for managing side effects.

7. **Patient Education:**
   - Educate the child and family about the medication and its importance.
   - Provide ongoing support and encouragement.

8. **Monitoring and Follow-Up:**
   - Regularly review the child's progress and adjust treatment as needed.
   - Encourage open communication and feedback from the child and family.

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**Prescribing Psychotropic Medication to Children Under 6 Years**

1. **Assessment:**
   - Conduct a comprehensive assessment of the child's needs.
   - Consider the child's overall health and development.

2. **Diagnosis:**
   - Diagnose the child's condition based on the assessment results.
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<tr>
<th>Region</th>
<th>Prevalence</th>
<th>Goals</th>
<th>Evidence</th>
<th>Implementation Challenges</th>
<th>Risks</th>
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<td>Reduce incidence</td>
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**Guidelines for Hand/Eye/Neck/Ear Impairments in Children Under 6 Years**

- **Prevalence**
  - North America: High
  - Europe: Low
  - Asia: Mixed

- **Goals**
  - Reduce incidence
  - Increase access to care
  - Enhance healthcare infrastructure

- **Evidence**
  - ... (details not visible)

- **Implementation Challenges**
  - ... (details not visible)

- **Risks**
  - ... (details not visible)