Use of Psychotropics among Children in Foster Care Webinar Series – Part 3: Collaborative Oversight and Monitoring Approaches: State Examples

Tuesday, February 28th at 3:30 PM (ET)

Call-in Number: 1-800-832-0736       Conference Room: 2884179

Please call: 202-687-0308 or email irvinema@georgetown.edu if you need any assistance during the call.
Setting the Stage: National Guidelines and State Approaches for Psychotropic Medication Oversight

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Director, ARCH, Tufts CTSI

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Research Associate, Tufts Medical Center
AHRQ Training Fellow, Brandeis University

Note. We have no financial conflicts to disclose

Webinar #3: February 28, 2012
Mental Health Needs of Youth in Foster Care

- Rates of emotional or behavioral disorders*
  - Foster Care: 37-80%
  - Community-Based: 11-25%

- Why?
  - Trauma associated with abuse/neglect
  - Domestic violence
  - Poverty
  - In-utero environmental drug exposure
  - Genetic loading
  - Trauma secondary to removal from home

Care (Dis-)Coordination

- Service Providers
- Primary Care Clinician(s)
- Mental Health Professional
- CASA
- Investigative Case Worker
- Kin
- Biological Parent(s)
- Adoptive Parent(s)
- Teacher(s) & Affiliated School Staff
- Early Intervention
- Youth In Child Welfare Custody
- Foster Parent(s)
- Social Worker(s)
- Residential Staff
- Judge & Lawyer
- Probation Officer
- Other Work Staff
Exacerbated by...

- Multiple placements (positive and negative effects) 
  *(Battistelli et al, 1996)*

- Reliance on Medicaid/public mental health providers; potential access issues 
  *(Iglehart, 2003)*

- Lack of a single designated and consistent individual (e.g., parent, worker, clinician) to monitor care 
  *(Battistelli et al, 1996)*
Medication Use among Youth in Foster Care

- Estimated rates of medication use*
  - Foster Care: 13-52%
  - General population: 4%
- In a national study, rates of medication use varied: 0%-40% (a 40-fold variation) across catchment areas (Leslie et al, 2011)

What Guidance is Available?

- Multi-State Study on Psychotropic Medication Oversight in Foster Care
- Professional Guidelines
- State Approaches
- Federal Inter-Agency Initiatives

Additional Resources:

Child Welfare Information Gateway*

*Hyper-links to resources will be available throughout this presentation.
Multi-State Study on Psychotropic Medication Oversight in Foster Care

- 47 States and District of Columbia (48/51)

- Thank you!

- Currently in field to update findings

- For more information, contact project manager: tmackie@tuftsmedicalcenter.org
<table>
<thead>
<tr>
<th>Sponsor/ Author</th>
<th>Guideline</th>
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</thead>
<tbody>
<tr>
<td>AACAP</td>
<td>Policy Statement on Psychiatric Care of Children in the Foster Care System</td>
</tr>
<tr>
<td>AACAP; and Child Welfare League of America (CWLA)</td>
<td>Policy Statement on Mental Health and Use of Alcohol and Other Drugs, Screening and Assessment of Children in Foster Care</td>
</tr>
<tr>
<td>American Academy of Pediatrics</td>
<td>Fostering Health: Health Care for Children and Adolescents in Foster Care</td>
</tr>
<tr>
<td>Jensen PJ, Romanelli LH, Pecora PJ, Ortiz A.</td>
<td>Mental Health Practice Guidelines for Child Welfare</td>
</tr>
</tbody>
</table>
State Approaches

- Illinois
  - Collaboration with University and other Youth-Serving Agencies

- Texas
  - Collaboration with contracted Managed Care Entity

Additional Resources: [Multi-State Study on Psychotropic Medication Oversight, Study Appendix](#)
Federal Inter-Agency Initiatives

- **Inter-Agency Collaboration**
  - HHS
  - ACF
  - SAMHSA
  - CMS
  - Joint-Agency

- **Further Assistance**
  - Webinars
    - Feature TX and IL
  - Technical Assistance
  - Information Memorandum
  - Child Welfare Summit
Component 1: Screening, evaluation and treatment planning.

COMPREHENSIVE AND COORDINATED SCREENING, ASSESSMENT, AND TREATMENT PLANNING MECHANISMS TO IDENTIFY CHILDREN’S MENTAL HEALTH AND TRAUMA-TREATMENT NEEDS
Screening and Evaluation

- 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
  - *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: Mental Health Screens and Assessments in U.S. (2009-2010)

- 73% Screen → Assessment
- 25% Assessment
- 2% Screen and Assessment
Component 1: Select an approach to mental health evaluation

- What type of approach will we use?
  - e.g., as needed, screen/assessment, assessment

- How will the approach address the unique needs for mental health evaluation of youth in child welfare custody, including trauma, \textit{in utero} exposures, and potential genetic loading?

- When will we do an evaluation (30-60 days)?

- Who will conduct the evaluation?

- What standardized “tool” will we use?

- 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

Resource: California Evidence Based Clearinghouse
Component 2: Shared decision-making.

INFORMED AND SHARED DECISION-MAKING (CONSENT AND ASSENT) AND METHODS FOR ONGOING COMMUNICATION WITH THE CHILD, CHILD WELFARE AGENCY, MENTAL HEALTH PROVIDER(S), AND HIS/HER CAREGIVER
Component 2: Informed Consent

External Agencies

Internal to Child Welfare Agency

- Clinical Encounter Participants (Prescriber, Foster Parent, Youth)
- Child Welfare Worker
- Child Welfare Administrator
- Child Welfare Unit with Mental Health Expertise
- Expert Review Unit (University, Other)
- Court System

IL: Authorized Agent
Component 2: Informed Consent

Internal to Child Welfare Agency

- Clinical Encounter Participants (Prescriber, Foster Parent, Youth)
- Child Welfare Worker
- Child Welfare Administrator
- Child Welfare Unit with Mental Health Expertise

External Agencies

- Expert Review Unit (University, Other)
- Court System

TX: “Medical Consenter”
Component 2: Shared decision-making

- How will we...
  - Engage youth
    - Consent/Assent
    - Handbook
  - Engage foster and kin caregivers
  - Engage biological parents, whenever appropriate
  - Use information systems to support decision-making

Resource: NRCPFC: Handbooks for Youth in Foster Care

Handbook under review, Children’s Bureau/ ACF
Component 3: Medication monitoring.

EFFECTIVE OVERSIGHT PROCEDURES THAT INCLUDE MONITORING OF USAGE AT BOTH THE CLIENT AND POPULATION LEVEL
## Component 3: Medication Monitoring Approaches

<table>
<thead>
<tr>
<th>Prospective</th>
<th>Retrospective</th>
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</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>Court Hearings</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>Drug Utilization Review</td>
</tr>
<tr>
<td>Mandatory Second Opinion</td>
<td>Data Trends</td>
</tr>
</tbody>
</table>

- **Emphasis of Illinois Approach**
- **Emphasis of Texas Approach**
Component 3: Dimensions of Medication Monitoring

- Variety of data sources
  - SACWIS
  - Medicaid
  - Mental health
  - Managed care plans

- Real time vs. periodic extraction

- Merged databases
Component 3: Routine Process for Medication Monitoring

- How will we monitor prescription patterns for:
  - Individual children
  - Overall system

- Possibly through:
  - Periodic audits
  - Team reviews
  - Court hearings (required component)
  - SACWIS reports
  - Medicaid/mental health data reports
  - Child and Family Services Review
Component 3: Monitor Trends

- What sort of tracking system will we use?
  - “It is tedious to develop a policy but not really that hard. The hard part is implementation and tracking. Need to have people with specific skills to track and interpret the data.”

- How will we access systems data and accurately track trends in collaboration with:
  - Medicaid
  - Mental health providers
  - Managed care plans
Component 3: Outliers

What “outlier” practices will we focus on?

- Too many:
  - Child taking 3+ medications at a time
  - Prescribing 2+ meds in same class >30 days
  - Polypharmacy before monopharmacy

- Too young:
  - Psychotropic medications in children <5 years

- Too much:
  - Dosage exceeds recommendations

- Antipsychotic meds >2 years and no diagnosis of schizophrenia, bipolar disorder, or psychosis

- No documentation of risk/benefit discussion or informed consent paperwork

Note: See Webinar 2 for additional details.
Component 4: Mental health expertise and consultation.

AVAILABILITY OF CONSULTATION BY A BC/BE* CHILD AND ADOLESCENT PSYCHIATRIST AND/OR OTHER TRAINED MENTAL HEALTH PROVIDERS (AT BOTH THE SYSTEM AND INDIVIDUAL CASE LEVEL)

*BC/BE refers to Board-certified/Board-eligible
Component 4: Access to Professional Guidance

Medical & Mental Health Director in State Child Welfare Agencies
n=47

- Medical Director (8.5%)
- Mental Health Director (25.5%)
- Both (25.5%)
- Neither (40.4%)
Component 4: Mental Health Expertise

- 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
Component 5: Information sharing.

MECHANISMS FOR PROVIDING ACCURATE AND UP-TO-DATE INFORMATION RELATED TO PSYCHOTROPICS TO CLINICIANS, CHILD WELFARE STAFF, AND CONSUMERS (E.G., YOUTH, FAMILY MEMBERS, FOSTER PARENTS, AND ADVOCATES)
Component 5: Challenges & Solutions

- 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*.
  - Acquire additional expertise in child welfare agency
## Component 5: Up-to-date Professional Guidelines

<table>
<thead>
<tr>
<th>Sponsor/Author</th>
<th>Publication</th>
</tr>
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<tbody>
<tr>
<td>NIMH</td>
<td>Mental Health Medications</td>
</tr>
<tr>
<td>NIMH</td>
<td>Treatment of Children with Mental Illness</td>
</tr>
<tr>
<td>NIMH</td>
<td>Treatment of Children with Mental Disorders</td>
</tr>
<tr>
<td>NAMI</td>
<td>NAMI Policy Research Institute Task Force Report: Children and Psychotropic Medications</td>
</tr>
<tr>
<td>AACAP</td>
<td>Psychiatric Medications for Children and Adolescents: Part I – How Medications are Used</td>
</tr>
<tr>
<td>AACAP</td>
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</tr>
</tbody>
</table>
Questions?

- For more information on the *Multi-State Study on Psychotropic Medication Oversight in Foster Care* please see the Executive Summaries for the respective studies.

- For additional information about our work, including our current study, please contact:
  
  Laurel K. Leslie  
  ([lleslie@tuftsmedicalcenter.org](mailto:lleslie@tuftsmedicalcenter.org))

  Tom Mackie  
  ([tmackie@tuftsmedicalcenter.org](mailto:tmackie@tuftsmedicalcenter.org)).


Psychotropic Medication for Children in Texas Foster Care

Administration for Children, Youth, and Families Webinar Series: “Use of Psychotropics Among Children in Foster Care”
February 28, 2012

James A. Rogers, MD
Medical Director
Significant Events Leading to Reform

• In April 2004, the state Comptroller released a report critical of foster care in Texas.

• In February 2005, DFPS released the best practice guidelines: *Psychotropic Medication Utilization Parameters for Foster Children*.

• In September 2005, Senate Bill 6 implements reforms including placing all children in foster care under a single managed care organization, as well as requirements related to medical consent and the monitoring of psychotropic medications.

• In April 2008, a single MCO (*STAR Health*) began for 27,000 children and young adults in foster care in Texas.
Medical Consent

• Court authorizes DFPS or an individual to consent to medical care

• If DFPS is authorized, DFPS must designate an individual

• Medical consenter must complete training on informed consent

• Medical consenter must participate in each medical appointment of child

• Court may authorize a 16 or 17 year old youth to consent to his or her own medical care
Judicial Review of Medical Care

• DFPS must provide Summary of Medical Care in court reports for each hearing under TFC Chapter 263

• The Summary of Medical Care includes details about medications, including psychotropic medications

• Judges can order a review of the child’s psychotropic medication regimen by STAR Health
Residential Child Care Licensing
Minimum Standards

Revised in 2007 to add heightened requirements for foster care providers concerning psychotropic medications:

- Training on psychotropic medications
- A minimum of quarterly visits with the prescribing physician to assess child’s progress and presence of side effects
- Monitoring, documenting and contacting the prescribing physician about side effects or adverse reactions
Features of STAR Health

- Medical home model (PCP)
- Expedited enrollment
- Coordination of physical and behavioral health (Service Management Teams)
- Provision of preventive care (Texas Health Steps)
- Broad network of providers
- 24/7 nursing and behavioral help-line
- Medical advisory committees to monitor the provision of the healthcare
- Health Passport for continuity of care
Health Passport

- Operational on April 1, 2008 for access by state staff, network providers and medical consenters
- Secure, web-based electronic health record (EHR) system
- Accessed at www.fostercaretx.com (follow the link to “sign-up”)
- Provides access by authorized users according to their role
- Initially populated with two years of Medicaid and CHIP claims history and pharmacy data
- When the child leaves foster care, the Passport is available in electronic or printed formats to:
  - child’s legal guardian, managing conservator, or parent
  - child if at least 18 years of age or an emancipated minor
Health Passport Features

- **Demographics:** Displays personal contact information of the child’s physicians and other individuals involved in the child’s care
- **Visit History:** Displays claim-based record of each visit to a health care provider with date of service, diagnosis, and any procedures performed
- **Medications:** Displays claims-based record on all prescriptions filled
- **Immunizations:** Displays a comprehensive list of a child’s immunizations
- **Lab Results:** Displays results of lab tests performed, if available
- **Electronic Documentation:** Providers can document Texas Health Steps, dental, and behavioral health assessments within the Passport
- **Vital Signs:** Providers can record vital signs at the point of care
- **Allergies:** Providers can record allergies at the point of care. Passport automatically checks for possible negative medication interactions
Psychotropic Medication Monitoring

• In February 2005, DFPS released the *Psychotropic Medication Utilization Parameters for Foster Children*, which were updated in June 2007 and most recently in December 2010. The current version can be found at: http://www.dfps.state.tx.us/Child_PROtection Medical_Services/guide-psychotropic.asp

• These Parameters use eight criteria to indicate a need for further review of the child’s medication regimen.
Criteria for Review of the Medication Regimen

1. Absence of a thorough assessment of DSM-IV diagnosis in the child’s medical record.
2. Five (5) or more psychotropic medications prescribed concomitantly.
3. Prescribing of:
   - Two (2) or more antidepressants at the same time
   - Two (2) or more antipsychotic medications at the same time
   - Two (2) or more stimulant medications at the same time
   - Three (3) or more mood stabilizer medications at the same time
Review Criteria (Continued)

4. The prescribed psychotropic medication is not consistent with appropriate care for the patient’s diagnosed mental disorder or with documented target symptoms.

5. Multiple psychotropic medications for a given mental disorder are prescribed before utilizing a single medication.

6. The psychotropic medication dose exceeds usually recommended doses.
7. Psychotropic medications are prescribed for children of very young age, including children receiving the following medications with an age of:
   - Antidepressants: Less than four (4) years of age
   - Antipsychotics: Less than four (4) years of age
   - Psychostimulants: Less than three (3) years of age

8. Prescribing by a primary care provider for a diagnosis other than the following (unless recommended by a psychiatrist consultant):
   - Attention Deficit Hyperactive Disorder (ADHD)
   - Uncomplicated anxiety disorders
   - Uncomplicated depression
Psychotropic Medication Utilization Review (PMUR) Process

- **Health screenings** - STAR Health Service Managers conduct phone interviews with caretakers to identify those children who have medication regimens which appear to be outside of the Psychotropic Medication Utilization Parameters prescribing criteria.

- **Automated pharmacy claims screening** – STAR Health also conducts a real time automated screening program utilizing pharmacy claims information from vendor drug to identify foster children who have medication regimens which may fall outside the prescribing criteria.

- **External request** – CPS Nurse specialists, CPS caseworkers, CASA volunteers, foster parents, attorneys or Child Placing Agencies can request a medication review.

- **Court request** – Family court judges can request a review to answer questions about a foster child’s medication regimen.

*Update on the Use of Psychoactive Medication in Texas Foster Children Fiscal Year 2002-2011* can be found at:

http://www.hhsc.state.tx.us/medicaid/OCC/Psychoactive_Medications.html
Psychotropic Medication for Children in Texas Foster Care

Fiscal Years 2002-2011

Percentage of Children in Foster Care

- Psychotropic Meds 60 days+
- Class polypharmacy
- Five or more Meds polypharmacy

36% Decrease since 2004

68% Decrease since 2004

70% Decrease since 2004
Oversight of Psychotropic Medications in Foster Children: The Illinois Model

Michael W. Naylor, M.D.
University of Illinois at Chicago
Director, Clinical Services in Psychopharmacology
Clinical Services in Psychopharmacology

• Historical context
  – DCFS challenged by federal courts, DOJ & ACLU
    • inadequate casework
    • chaotic and dangerous placements
    • substandard care
  – Illinois violating constitutional rights of children
Clinical Services in Psychopharmacology

• Historical context
  – *Chicago Tribune* 1995 editorial series:
    • DCFS called “the worst child welfare system in America…” and “a cruel, indifferent bureaucracy that harms kids.”
    • “system of shame”
Clinical Services in Psychopharmacology

• Historical context
  – Federal court-approved consent decree 
    \((B.H. \text{ v} \ Suter, \ 1991)\)
    • DCFS & ACLU agree to collaborate on system reform plan
Clinical Services In Psychopharmacology

• DCFS recognized need for quality assurance vis-a-vis psychototropic medications
• Rule 325
• Contracted with UIC in 1992 to provide independent medication review
DCFS Rule 325

Administration of psychotropic medications to children for whom DCFS is legally responsible
DCFS Rule 325

• Challenge
  – provide informed consent
  – provide safe and effective care
  – delivered in timely manner
  – protect rights of foster children
  – provide longitudinal oversight
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
Clinical Services In Psychopharmacology

• Objectives:
  – provide independent review for all psychotropic medication requests
  – monitor utilization of psychotropic medications
  – provide consultation on particularly complicated cases
Objectives:

- notify the Guardian where provider patterns warrant review
- conduct training for DCFS, foster parents and childcare providers on psychotropic medications
- disseminate information regarding new pharmaceutical developments and alerts
The Illinois Model

Evaluation and Treatment Planning
Evaluation and Treatment Planning

• Integrated Assessment
• Revised DCFS Rule 325
  – Guidelines for the Utilization of Psychotropic Medications for Children in Foster Care
Evaluation and Treatment Planning

• “The prescription of psychotropic medications is just one component of a comprehensive treatment plan that includes psychosocial and behavioral interventions.”

• “All children must receive a diagnostic assessment prior to starting a psychotropic medication.”
The Illinois Model

Consent
Clinical Services In Psychopharmacology

• Concept
  – DCFS is the legal guardian for ~ 15,300 youth
  – The Office of the Guardian is responsible for providing consent for medical and psychiatric treatment
Psychotropic Medication Request Form

- Demographic information
  - name
  - DCFS ID Number
  - date of birth
  - sex
  - race
  - weight and height
  - placement
  - physician’s name and specialty
Psychotropic Medication Request Form

• Clinical information
  – diagnosis, medical and psychiatric
  – current medications and dosage
  – laboratory tests
  – requested medication
    • dosage and frequency
  – symptoms/rationale
Psychotropic Medication Request Form

- Medication request
  - type of request
  - medication requested including dose, range and duration
  - symptoms supporting medication request
  - rationale for polypharmacy and non-first-line medications
## Psychotropic Medication Request Form

**Child’s Name:**

**DCFS ID# (Sistema):**

**Male** □  **Female** □

**Date of Birth:**

**If 18 or older, include either consent from youth or continued guardianship court order:**

**Ethnicity:**

**Placement type:**
- Foster Home □  Residential □  Hospital □  Family of Origin □  Shelter □  DOC □  Other □

**Facility or Agency Name:**

**Contact Person:**

**Phone:**

**Fax:**

**Prescriber:**

**Specialty:**

**Phone**

**Fax:**

**Psychiatric Diagnoses (include r/o):**

**Medical Diagnoses:**

<table>
<thead>
<tr>
<th>Current Psychotropic Medications</th>
<th>No Current Meds</th>
<th>Current weight</th>
<th>Current height</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Include all current meds &amp; dosages, meds on without consent and those being renewed to be discontinued</em></td>
<td><em>to be discontinued</em></td>
<td><em>Date wt. and int. last taken</em></td>
<td></td>
</tr>
</tbody>
</table>

**Tests to be Monitored:**
- FBS □  HgA1C □
- Lipids □  Na □
- K+ □  Mg++ □
- EKG □  VPA level □
- L/C02 level □  CBZ level □
- LFT’s □  TFT’s □
- Kidney □  Other □

**Will Monitor:**
- Adequate Growth □
- Excessive Wt. Gain □
- AIMS/DISCUS □

**Other current medical medications, over the counter and supplements:**

**Medication Request (all fields required for processing):**

**Type of request:**
- New □  Increase □  Renewal (consent to expire) □  Resume (prior trial) □  New ward, current med □  One Time Order □
- Emergency med (for acute r/s) □  On med or dosage w/o consent; Prescriber who started med □  Date started □

**Medication:**

**Dosage:**

**Times Given:**

**Range:**

**Form:**

**Duration:**

**Symptoms/behaviors for this medication (do not list diagnoses, acute = current; remitted = controlled on medication):**

**This Medication is to treat acute symptoms; list current symptoms:**

**Addiction rationale for co-pharmacy, non-first-line medications, polypharmacy and other significant clinical information i.e. explanation of the treatment plan or history, alternative treatments (required for children <8), etiology of sleep disturbance. List all current adverse/side effects:**

**Side effects for all medications:**

**YES**

**Does child object:**

**YES**

**Reviewed with child:**

**Number of completed by:**

**Name**

**Phone**

**Fax**

**pages:**
Consent Process

Prescribing Clinician

DCFS Authorized Agent

UIC Research Team

UIC Psychiatric Nurse

UIC Psychiatric Nurse

UIC Psychiatric Consultant MD
Completed Consultations

DCFS Psychotropic Consultation Requests

Monthly Total

Clinical Services in Psychopharmacology

- Consultant recommendations:
  - approved
  - denied
  - modified
  - reviewed (emergency medications only)
UIC Consultation Team Recommendations

CSP Recommendations

- Approved: 75.0%
- Denied: 0.3%
- Incomplete: 8.3%
- Modified: 18.3%
- Reviewed: 2.1%

Total: 100.0%
The Illinois Model

Oversight Procedure
Clinical Services in Psychopharmacology

• Informal oversight
  – feeds back through the Office of the Guardian or to the CSP program
    • Administrative Case Reviews
    • GAL, Office of the Public Guardian
    • Regional nurse
Clinical Services in Psychopharmacology

- Formal oversight
  - case-specific
    - independent medication review
    - watch list – high risk children
    - record review
Clinical Services in Psychopharmacology

• Formal oversight
  – system-wide
    • CSP consent database (1998 – present)
    • Medicaid payment database (1998 – 2008)
    • watch list – high risk prescribers
    • emergency medication use
Clinical Services in Psychopharmacology

• Formal oversight (cont.)
  – system-wide
    • quarterly reports
      – timeliness
        » error rates
      – medications without consent
      – denials
Clinical Services in Psychopharmacology

- Formal oversight
  - system-wide
    - quarterly reports
      - children ≤ 4 years
      - polypharmacy
      - co-pharmacy
      - high-risk preschoolers
# Children on Two or More Antipsychotics

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Gender</th>
<th>4th Qtr Children meeting criteria</th>
<th>4th Qtr Total in Demographic Category</th>
<th>% 4th Qtr</th>
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<tr>
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<td><strong>26</strong></td>
<td><strong>1989</strong></td>
<td><strong>2%</strong></td>
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</table>
The Illinois Model

Consultation
Clinical Services in Psychopharmacology

- Consultations
  - clinician requested
  - caseworker
  - regional nurse
  - Guardian
  - GAL, judges
  - CSP requested
Clinical Services in Psychopharmacology

• Consultations
  – MD:MD
  – review of consent history
  – chart review
  – face to face
The Illinois Model

Information Sharing
Clinical Services in Psychopharmacology

• Information sharing
  – clinical
    • medication history
  – educational
    • foster parents
    • care providers, Authorized Agents
    • caseworkers
    • post-adoption workers
# Medication History

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Medication History</th>
</tr>
</thead>
<tbody>
<tr>
<td>John</td>
<td>11/23/1996</td>
<td>Methylphenidate</td>
</tr>
</tbody>
</table>

<table>
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<th>Date</th>
<th>Weight</th>
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<th>Current Medication</th>
<th>Dosage</th>
<th>Recommendation</th>
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Clinical Services in Psychopharmacology

• Information sharing
  – DCFS Prescribers Listserv
    • FDA warnings
    • policy changes
  – website
    • [http://www.psych.uic.edu/csp](http://www.psych.uic.edu/csp)
    • clinicians
    • foster parents, care providers
    • educational materials
    • clinical resources
The Illinois Model

Projects
Current Projects

• Diagnosis of bipolar disorder in foster children
• Impact of consultation on utilization of fluoxetine
• Second generation antipsychotics (SGA) and weight gain in foster children
• Identification of high risk preschoolers
Rate of Diagnosis of Bipolar Disorder
Impact of Consultation

![Graph showing the impact of consultation on % Requests over months. The graph includes lines for Paroxetine Warning, CSP Intervention, Black Box Warning, Paroxetine, Fluoxetine, and Other SSRIs.](image)
## SGAs and Weight Gain

<table>
<thead>
<tr>
<th>Medication (n)</th>
<th>Weight (S.D.)</th>
<th>Δ weight (S.E.)</th>
<th>Z-score (S.D.)</th>
<th>Δ Z-score (S.E.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone (654)</td>
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</tr>
<tr>
<td>Baseline</td>
<td>92.5 (43.0)</td>
<td>25.1 (1.02)</td>
<td>0.32 (1.09)</td>
<td>0.64 (0.03)</td>
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<tr>
<td>Peak</td>
<td>117.6 (52.4)</td>
<td>0.96 (1.07)</td>
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<tr>
<td>Olanzapine (168)</td>
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</tr>
<tr>
<td>Baseline</td>
<td>95.9 (40.4)</td>
<td>29.8 (2.1)</td>
<td>0.27 (1.02)</td>
<td>0.88 (0.07)</td>
</tr>
<tr>
<td>Peak</td>
<td>125.7 (49.4)</td>
<td>1.15 (0.85)</td>
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<tr>
<td>Quetiapine (282)</td>
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<tr>
<td>Baseline</td>
<td>119.1 (47.5)</td>
<td>21.4 (1.49)</td>
<td>0.73 (1.06)</td>
<td>0.46 (0.04)</td>
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<tr>
<td>Peak</td>
<td>140.5 (51.9)</td>
<td>1.19 (1.04)</td>
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<td>Aripiprazole (158)</td>
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<tr>
<td>Baseline</td>
<td>123.3 (48.2)</td>
<td>19.5 (1.77)</td>
<td>0.83 (1.21)</td>
<td>0.42 (0.06)</td>
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<tr>
<td>Peak</td>
<td>142.8 (54.0)</td>
<td>1.25 (1.02)</td>
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<tr>
<td>Ziprasidone (125)</td>
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<tr>
<td>Baseline</td>
<td>136.6 (51.8)</td>
<td>16.81 (2.04)</td>
<td>1.10 (1.09)</td>
<td>0.23 (0.06)</td>
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<tr>
<td>Peak</td>
<td>153.4 (53.7)</td>
<td>1.33 (1.05)</td>
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1 - p < 0.0001; 2 - p = 0.0002
SGAs and Weight Gain

<table>
<thead>
<tr>
<th></th>
<th>Z-score (S.D.)</th>
<th>Δ Z-score (S.E.)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>0.66 (0.86)</td>
<td>0.12 (0.04)</td>
<td>0.003</td>
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<tr>
<td>Male</td>
<td>0.54 (0.97)</td>
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<tr>
<td>Residential</td>
<td>0.71 (0.92)</td>
<td>0.23 (0.04)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Foster Care</td>
<td>0.48 (0.96)</td>
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Impact of the Clinical Services in Psychopharmacology

- The CSP can:
  - assess statewide diagnostic patterns
  - monitor rate of utilization of psychotropic medications
  - identify adverse effects of medications
  - implement evidence-informed consent strategies
  - assess impact of changes in consent strategies on prescriber behaviors
Closing Comments
Bryan Samuels
Commissioner
Administration on Children, Youth and Families
Suggested Components of a Comprehensive Oversight and Monitoring Plan

1. Screening, Assessment, and Treatment Planning
2. Shared Decision-making
3. Medication Monitoring (Client and System Level)
4. Mental Health Expertise and Consultation (Client and System Level)
5. Information Sharing (Training/Education and Use of Data)
Q & A

Remember to submit questions in the Q&A pod. We will attempt to address unanswered questions following the webinar and post responses with the archived recording.

TA Needs Survey:
https://www.surveymonkey.com/s/CW_Survey