

CHCS Webinar: The Use of Psychotropic Medications for Children Involved in Child Welfare

February 14, 2008
1:00-2:30 pm ET

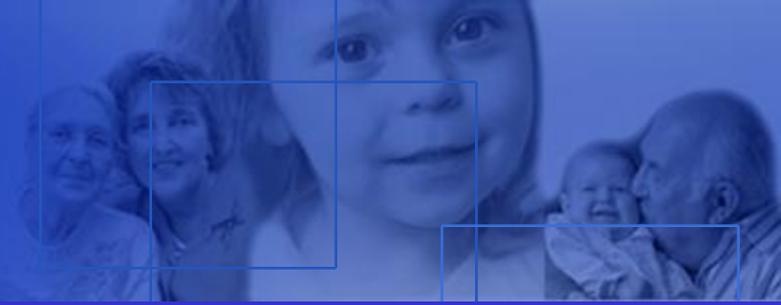
Kamala Allen, Center for Health Care Strategies
Peter S. Jensen, MD, The REACH Institute

Dial-In Number: 1 (866) 238-0826



Our Mission

To improve health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.



Our Priorities

Our work with state and federal agencies, Medicaid health plans, providers, and consumers focuses on:



Advancing Health Care Quality and
Cost-Effectiveness



Reducing Racial and Ethnic Disparities



Integrating Care for People with
Complex and Special Needs



CHCS and Children's Health

With support from the Annie E. Casey Foundation for its Children in Managed Care Program, CHCS is working with states, managed care organizations, and family/consumer based organizations to improve the quality of care and outcomes for children with complex physical and behavioral health needs.



Child Welfare Quality Improvement Collaborative

CHCS has partnered with ten managed care organizations to improve physical and behavioral outcomes for children involved in child welfare.

Participating MCOs are working to:

- Increase access to care,
- Improve coordination of physical and behavioral health care,
- Implement medical/behavioral health homes, including the use of electronic medical records, and
- Identify best practices in behavioral health pharmacy management.



Peter S. Jensen, MD

President, REACH Institute

Dr. Jensen is the president and founder of the REACH Institute, a national non-profit committed to ensuring that children, adolescents, and families have access to optimal care for behavioral and emotional disorders.

Dr. Jensen was recently Ruane Professor in Child Psychiatry at the Columbia University in New York, where he also served as the **founding director of the Center for the Advancement of Children's Mental Health.**

Prior to coming to New York, Dr. Jensen was Associate Director for child and adolescent research at National Institute of Mental Health (NIMH).



...Putting Science to Work

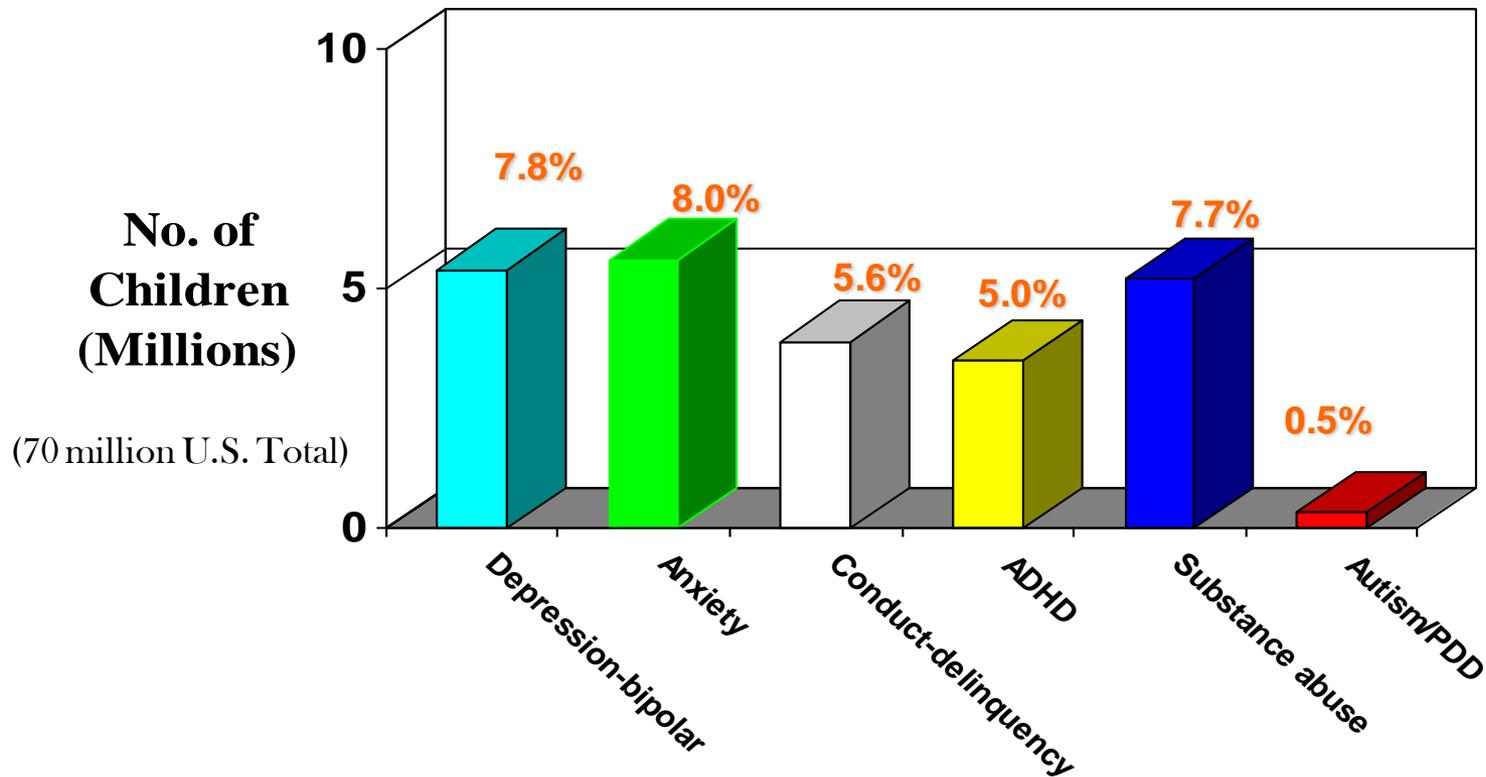
**Best Practices for Use of
Psychiatric Medications:
Applications to Child Welfare**

**The REsource for Advancing
Children's Health**

2008

Impact of Behavioral and Emotional Disorders on U.S. Children and Adolescents

13 million suffer from mental health problems



Gaps in Children's Mental Health Services

U.S. children and adolescents are in crisis due to unmet mental health needs

- **75%** of children do not get critical mental health services
- Unmet need highest among **minority youth**
- Schools not equipped to identify and manage these problems
- Families want mental health services from their children's doctors
- Most doctors lack the necessary **training** and **support**
- Parents often **blamed** as "the cause"



*Report of the Surgeon General's Conference on Children's Mental Health 2000



Risks of Not Meeting Children's Mental Health Needs

*If children's mental health needs go untreated, the **risks** are great:*

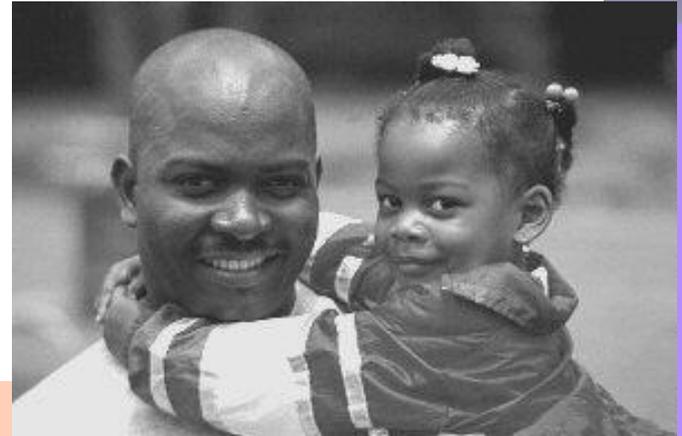
- ✓ Suicide
- ✓ School failure and dropout
- ✓ Injuries, hospitalization
- ✓ Chronic mental illness
- ✓ Drug and alcohol use
- ✓ Violence
- ✓ Divorce, family break-up
- ✓ Lifelong dependence on welfare



Families are Not Getting the Assistance They Need

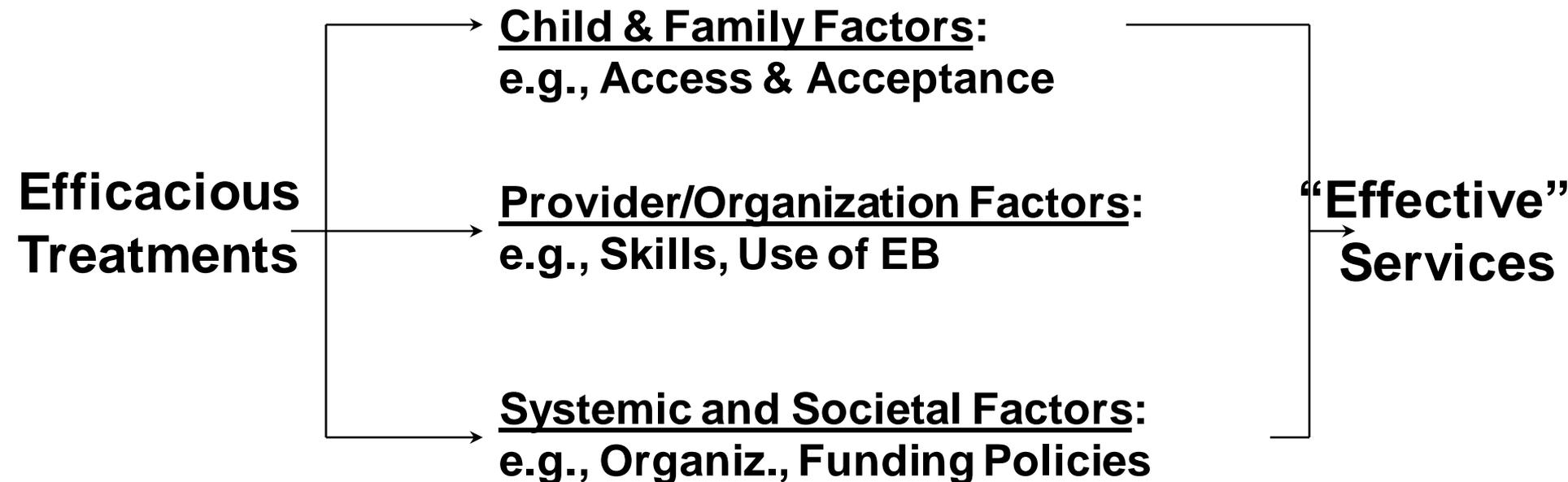
- Many proven treatments now available **but...**
 - ◆ Information is not getting to **families, health care providers** and **schools**
 - ◆ It takes anywhere from **10-20 years** for a proven intervention to reach a doctor who will use it to treat a child

- Information and assistance needs to be
 - ◆ **Family friendly**
 - ◆ **Guided by family input and experience**
 - ◆ **Science-based**
 - ◆ **Practical and hands-on**



Barriers vs. “Enhancers” to Delivery of Effective Services

Three Levels:

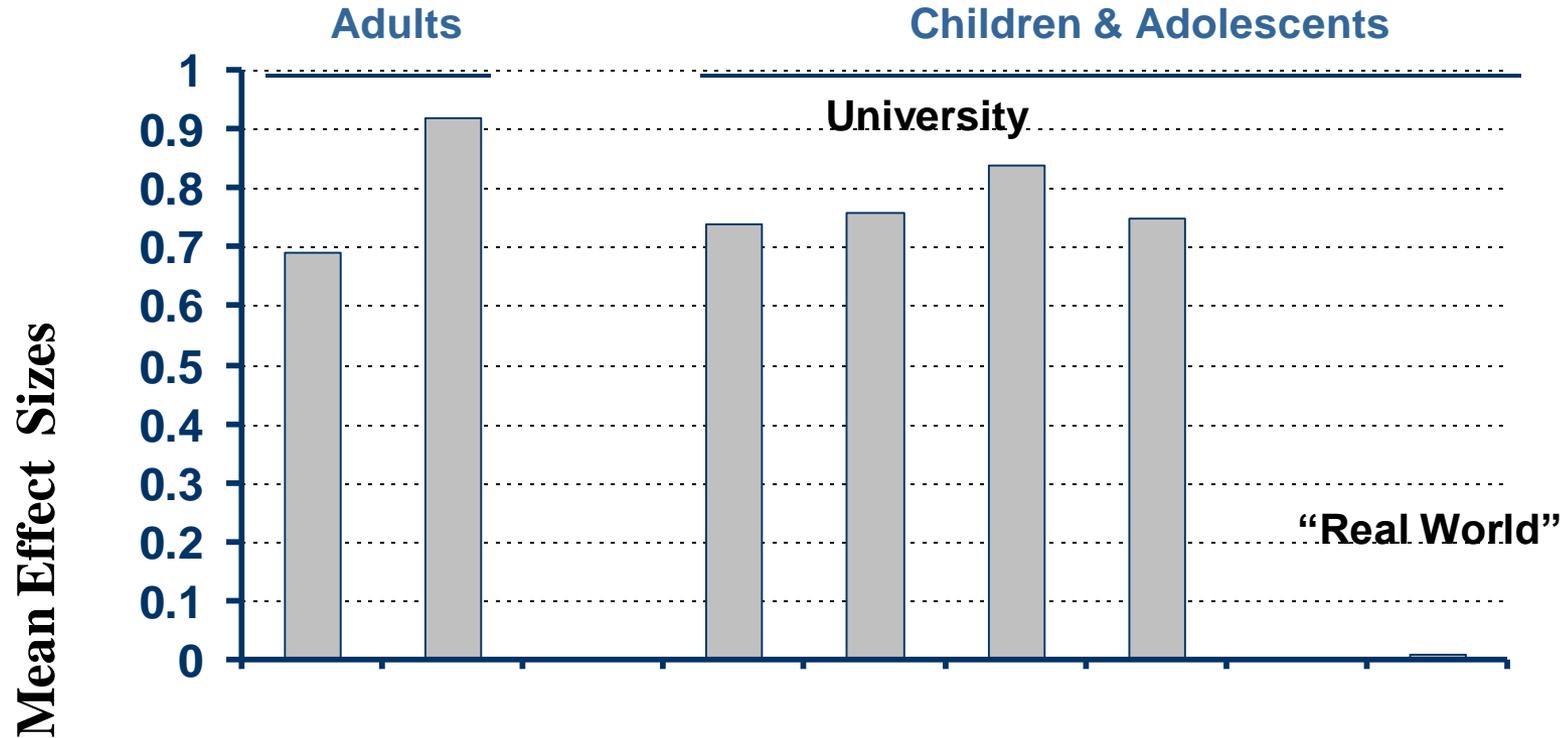


Science-based Plus Necessary “-abilities”

- **Palatable**
- **Affordable**
- **Transportable**
- **Trainable**
- **Adaptable, Flexible**
- **Evaluable**
- **Feasible**
- **Sustainable**

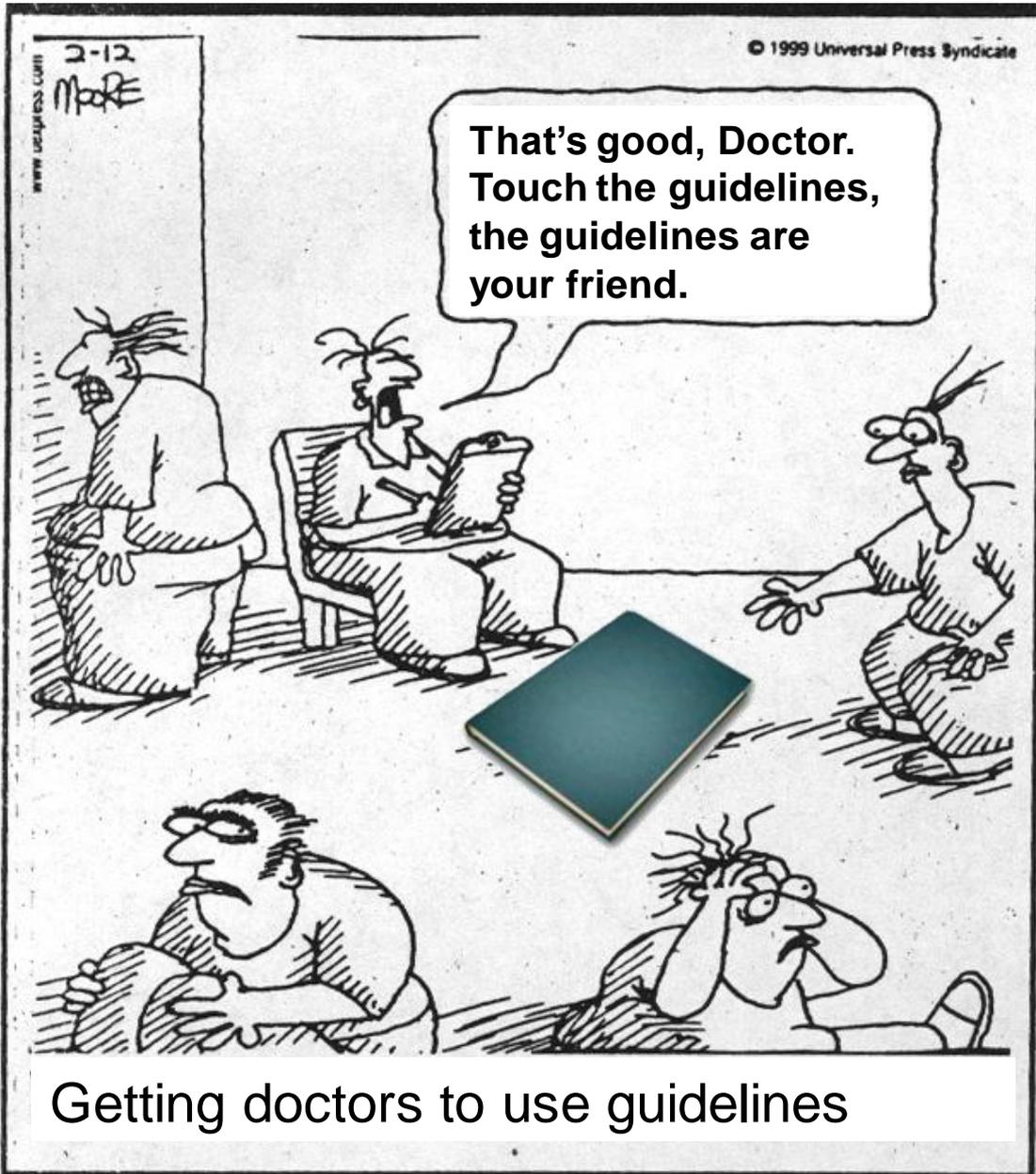


Effect Sizes of Psychotherapies



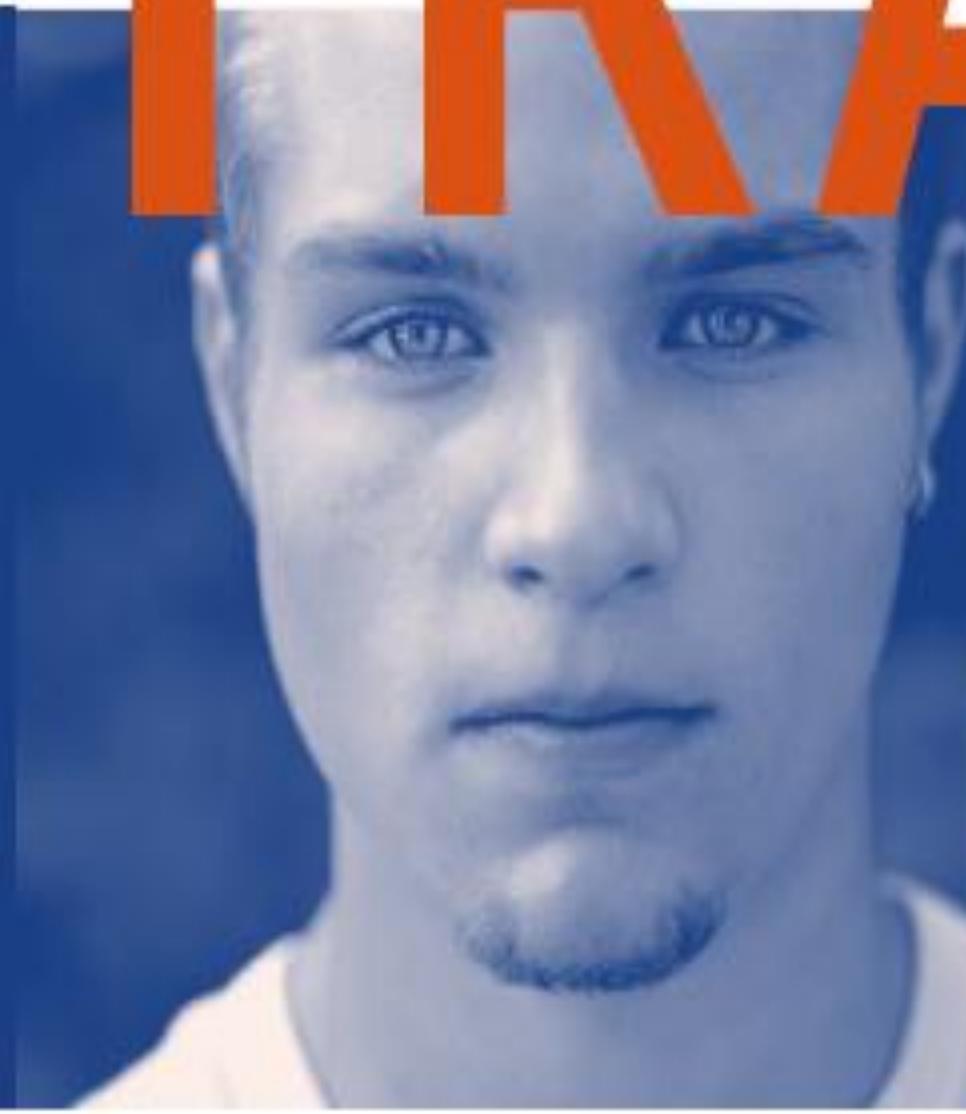
Weisz et al., 1995





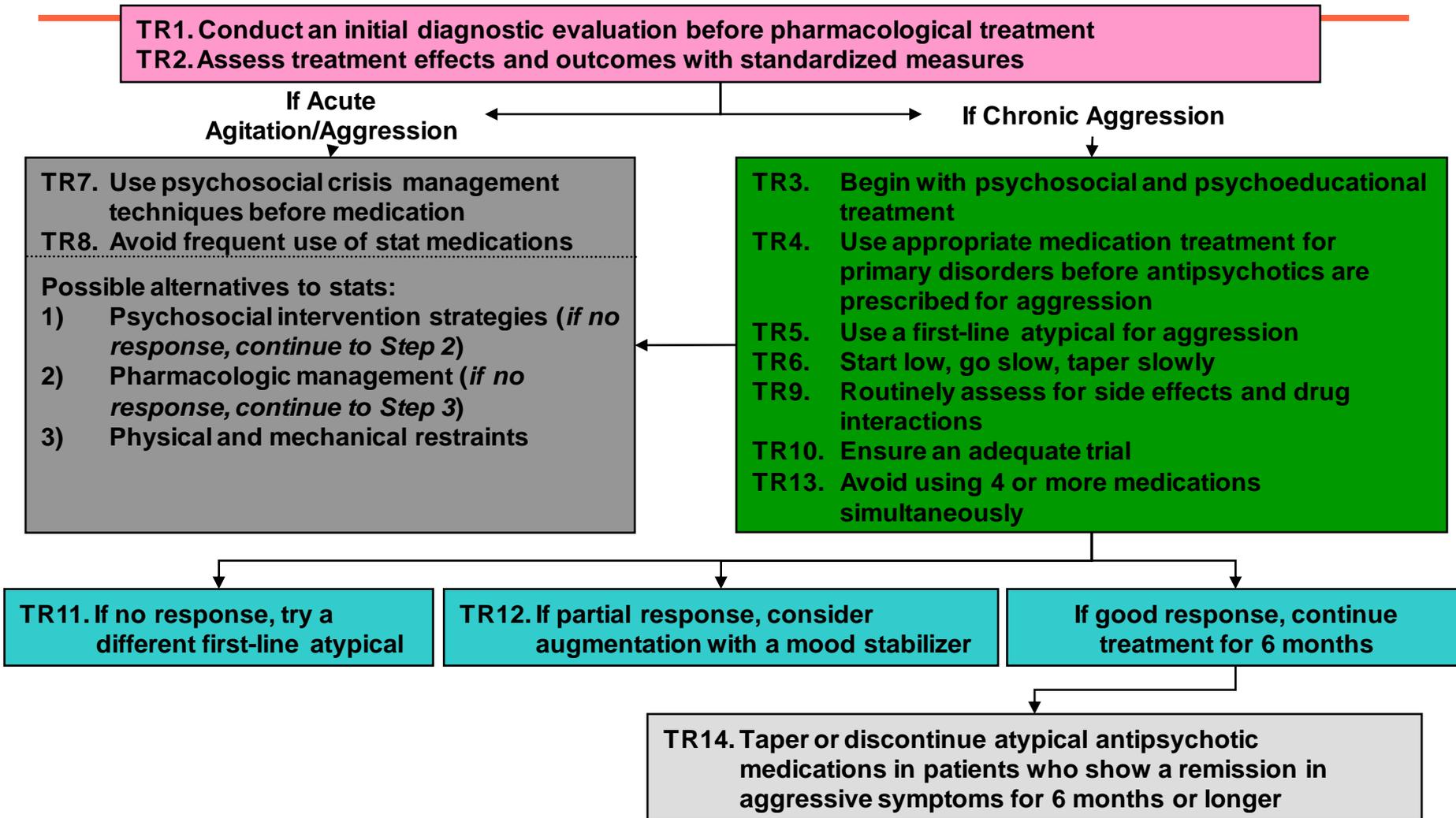
Getting doctors to use guidelines

TRAY



Treatment Recommendations
for the Use of Antipsychotics for
Aggressive Youth

Flow Chart Depicting the Systematic Application of the TRAY



Atypical Antipsychotics: Optimal Dosing/Titration Strategies for Children and Adolescents

Atypical Antipsychotics	Starting Daily-Dose	Titration Dose† q3-4 day (~Min. days to antipsychotic dose)	Usual Daily Dose Range in Aggression**		Usual Daily Dose Range in Psychosis	
			CHILD	ADOLESCENT	CHILD	ADOLESCENT
Aripiprazole	.25-5 mg	2.5-5 mg (7-10 days)	2.5-15 mg	5-15 mg	5-15 mg	5-30 mg
Clozapine	6.25-25 mg	1-2x starting dose (18-30 days)	150-300 mg	200-600 mg	150-300 mg	200-600 mg††
Olanzapine	2.5 mg for children 2.5-5 mg for adolescents	2.5 mg (10-15 days)	NDA	NDA	7.5-12.5 mg	12.5-20 mg
Quetiapine	12.5 mg for children 25 mg for adolescents	25-50 mg to 150 mg then 50-100 mg (18-30 days)	NDA	NDA	NDA	300-600 mg
Risperidone	0.25 mg for children 0.50 mg for adolescents	0.5-1 mg (10-15 days)	1.5-2 mg	2-4 mg	3-4 mg	3-6 mg
Ziprasidone	20 mg	20 mg for children 20-40 for adolescents (18-30 days)	NDA	NDA	NDA	NDA; (In adults, 160-180 mg)

NDA= no data available.

*There is little information to guide dosing strategies for aggression. However, for aggressive children treated with risperidone, doses are about half that of the usual antipsychotic dose.

**In treatment resistant schizophrenic adults, a serum clozapine level (of the parent compound) greater than 350mg/dl is generally required for efficacy.

Safety and Tolerability of Atypical Antipsychotics

	Anticholinergic	Elevated prolactin	EPS	Orthostasis	QTc Increase	Sedation	Weight Gain
Clozapine	++++	0/+	0/+	+++	+	++++	++++
Risperidone	+	++++	++	++	+	+	+++
Olanzapine	++	++	+	++	+	+++	++++
Quetiapine	+	0/+	0/+	++	+	++	++
Ziprasidone	+	+	+	+	++	+	0/+
Aripiprazole	0/+	0/+	+	+	0	+	0/+

Adapted from: Pappadopoulos EA, Jensen PS, Schur SB, et al (2002). *Schizophr Bull* 28:111-121.

TRAAAY: Pocket Reference Guide for Clinicians in Child and Adolescent Psychiatry (2004). NYS-OMH & CACMH

Evidence-Based Outpatient Treatment

WELL-ESTABLISHED

PROBABLY EFFICACIOUS

Depression

None

Self-Control (children)
Coping with Depression (adolescents)

ADHD

Behavioral Parent Training
Beh. Interventions in Classroom

Behavioral Management Training
Behavioral Modification in Classroom

Anxiety/PTSD

None

Cognitive-Behavioral (TF-CBT)

Phobia

Participant Modeling
Reinforced Practice

Imaginal & In Vivo Desensitization
Live and Filmed Modeling

Disruptive Behaviors (and/or IA)

Living with Children
Videotape Modeling

Preschool

Parent-Child Interaction Therapy

School Age

Parent Training Program
Time-Out Plus Signal Seat Treatment

Adolescent

Anger Coping Therapy
Problem Solving Skills Training
Anger Control Training w/Stress Inoculation
Functional Family Therapy
Multisystemic Therapy
Rational-Emotive Therapy

Evidence for Medications in Childhood Disorders

STRONG

ADHD **Stimulants, TCAs**

Imp Aggr **Stimulants, APs, &
Mood Stabilizers**

MODERATE

DEPRESSION **SSRIs**

AUTISM **Antipsychotics**

OCD **SSRIs, TCAs**

ANXIETY **SSRIs**

WEAK

BIPOLAR **Lithium**

TOURETTE'S **Antipsychotics**

Service-based/Systemic Interventions

STRONG EVIDENCE

**Multisystemic Therapy
Intens. Case Management
M-D Treatment Foster Care**

MODERATE EVIDENCE

**Family Education and
Support
Mentoring
Partial Hospitalization
Respite Care**

NEGATIVE, MIXED, or NO EVIDENCE

**Psychiatric Hospital (Inpatient)
Residential Treatment Center
Group Home
Crisis Intervention**

GuideLines for Adolescent Depression – Primary Care (GLAD-PC) Steering Committee & Liaisons

Steering Committee

Boris Birmaher, MD
Greg Clarke, PhD
Allen Dietrich, MD
Bernard Ewigman, MD
Sherry Glied, PhD,
Charles Homer, MD
Miriam Kaufman, MD
Stanley Kutcher, MD
James Perrin, MD
Brenda Reiss-Brennan, RN
Ruth E. K. Stein, MD
Angela Diaz, MD

John Campo, MD
Dave Davis, MD
Graham Emslie, MD
Eric Fombonne, MD
Kimberly Hoagwood, PhD
Danielle Laraque, MD
Kelly J. Kelleher, MD
Michael Malus, MD
Harold Pincus, MD
Diane Sacks, MD
Bruce Waslick, MD

Organizational Liaisons

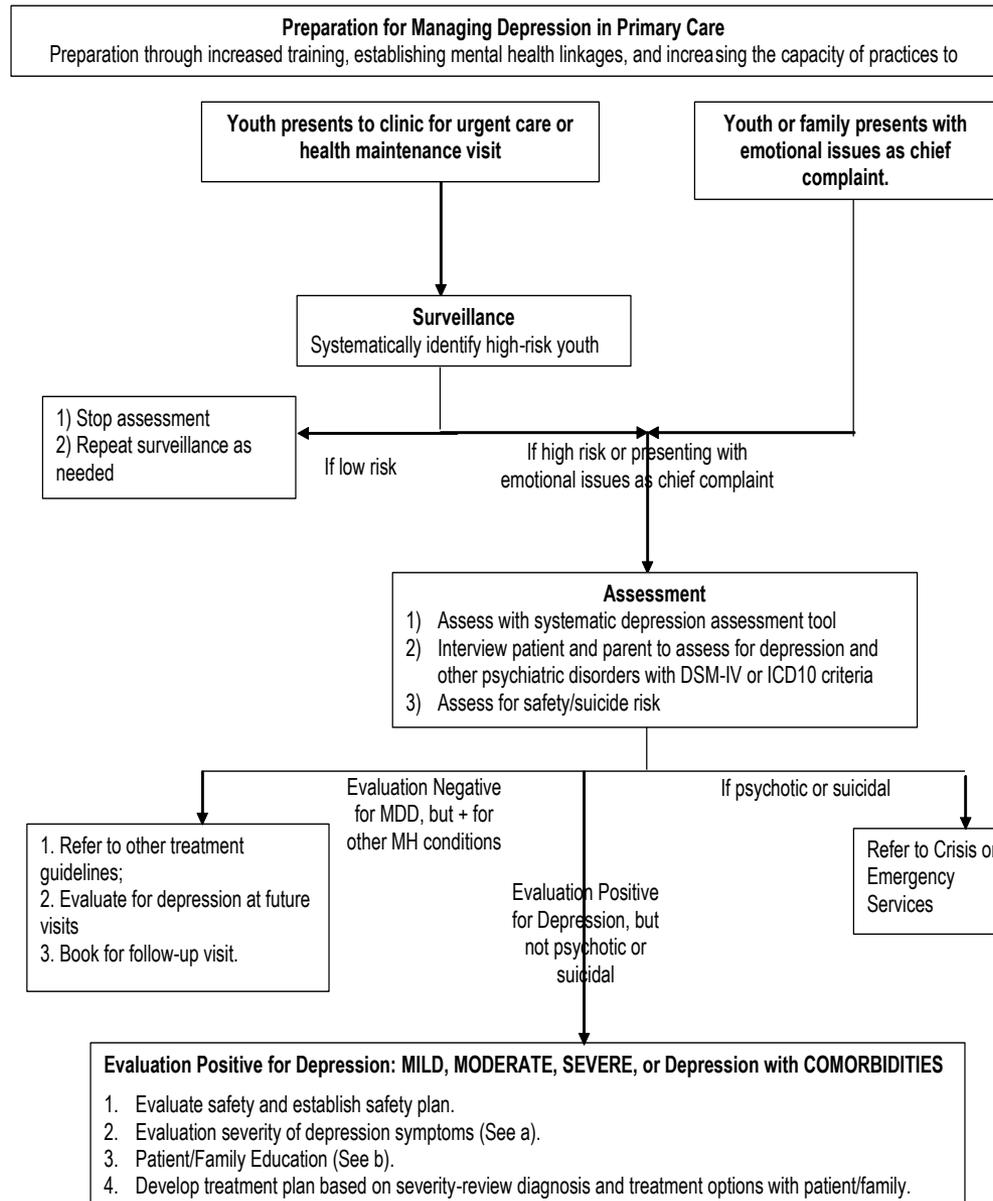
Darcy Gruttadaro (NAMI)
Sue Bergeson (DBSA)
Mike Faenza (NMHA)
Eric Fombonne (CPA, CACAP)
Ben Vitiello (NIMH)
James MacIntyre (AACAP)
Bruce Waslick (AMA)
Deborah Ebner (SAM)
Diane Sacks (CPS, AAP)
Michael Malus (CCFP)
Angela Diaz (AAP)
Judy Garber (APA)
Jim Perrin (AAP)
Kelly Kelleher (AAP)
David Fassler (APA)
Bernard Ewigman (AAFP)
Stanford Friedman (SDBP)
Sandra Spencer (FFCMH)
Vicky Wolfe (CPA)

Avoiding Polypharmacy

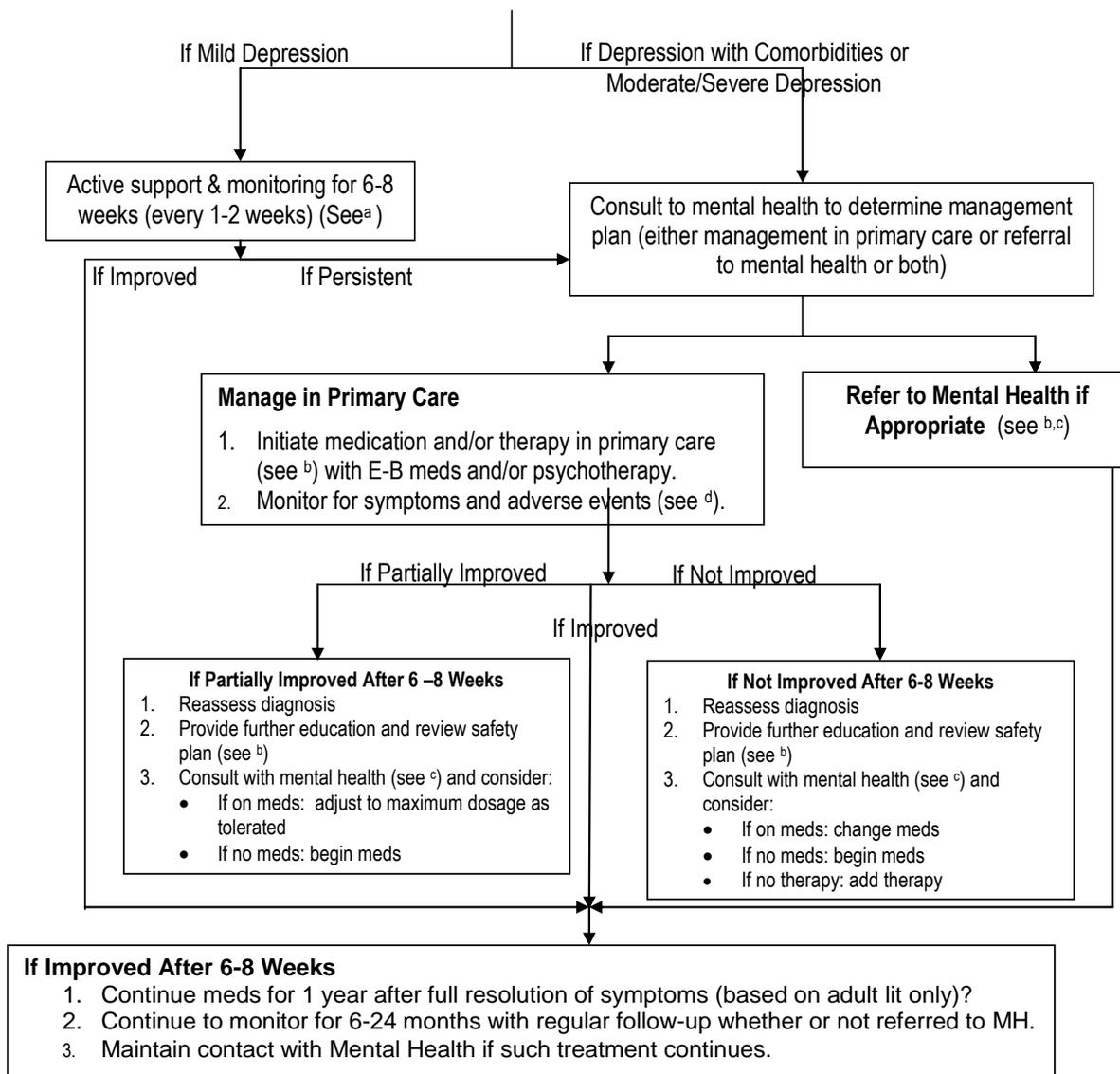
- Avoid using multiple medications simultaneously whenever possible
- Re-evaluate regimen of patient who does not experience decreased aggression while receiving multiple medications
- Consider tapering/discontinuing one or more medications if patient is on 4 medications without clear benefit



Clinical Assessment Flowchart



Clinical Management Flowchart



Children Enter Foster Care with MH Problems

- ◆ **44.6% of children entering new episode of foster care had CBCL *T* score > 60 (Leslie, Landsverk, et al, 2000)**
 - Of these, 41.5% received outpatient mental health service during an 18-month follow-up period. (San Diego)
- ◆ **80% of FC children assessed by a clinician had at least one psychiatric diagnosis. (Zima, Bussing, et al., 2000)**
 - Most common diagnoses were disruptive behavior disorders (41%), affective disorders (32%), anxiety disorders (20%), adjustment disorders (13%), and learning disorders (12%)
 - 47% of those diagnosed with psychiatric disorder had at least one co-morbid condition. (Los Angeles County)



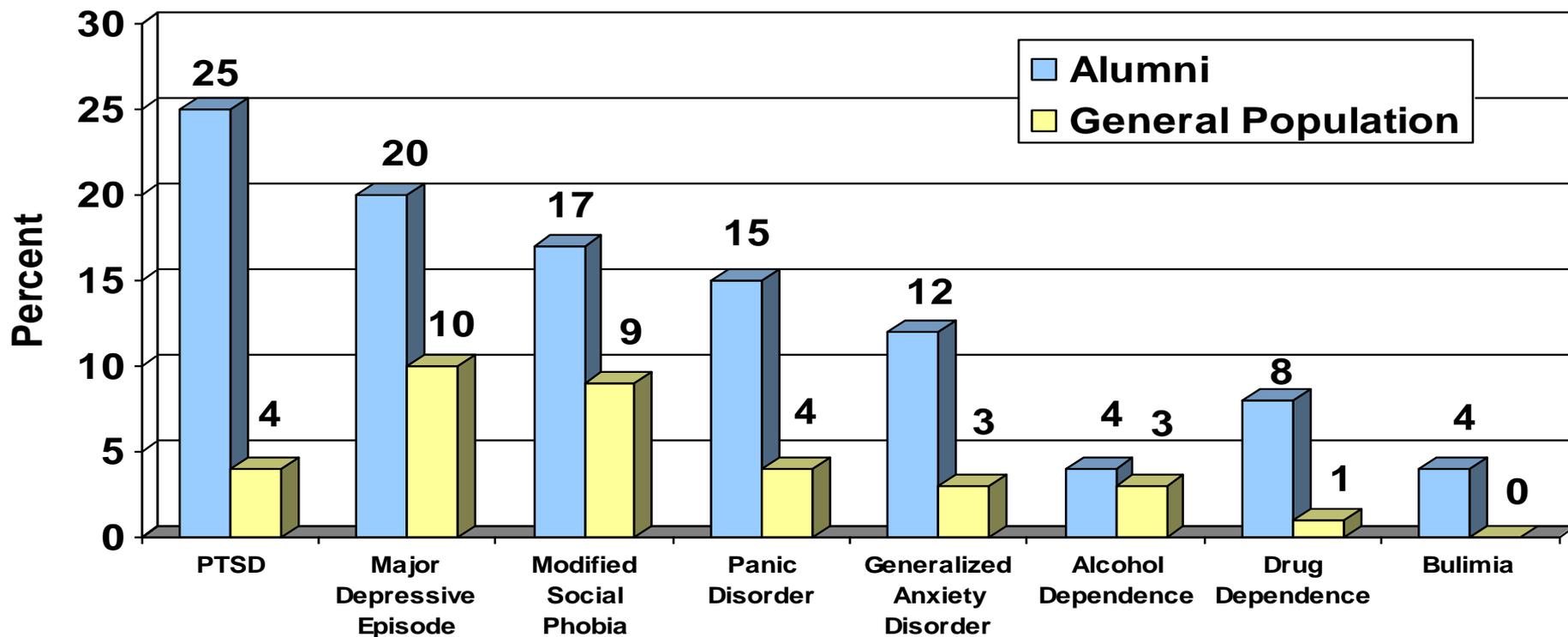
Rates for Lifetime Symptoms of Mental Health Disorders: NW Alumni Study

<i>Mental Health Outcomes</i>	<i>NW Alumni Study: % with symptoms - life-time</i>
Major depression episode	41.1
PTSD ^b	30.0
Modified social phobia	23.3
Panic syndrome	21.1
Drug dependence	21.0
Generalized anxiety disorder	19.1
Alcohol dependence	11.3
 <i>Sample Size</i>	 (479)

Source: Pecora et al. (2005). Northwest Foster Care Alumni Study report. www.casey.org

Too Many Young Adults Leave Care with Untreated Conditions

Twelve-Month Mental Health Diagnoses among Foster Care Alumni and the General Population



Mental Health Diagnosis

Source: Pecora, P. J., Kessler, R. C., Williams, J., O'Brien, K., Downs, A. C., English, D., White, J., Hiripi, E., White, C. R., Wiggins, T. & Holmes, K. (2005). *Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study*. Seattle, WA: Casey Family Programs. www.casey.org

Enhancing Mental Health for Youth in Foster Care: The Casey Foster Care Project

A collaborative project among:

Casey Family Programs

REACH Institute & Columbia CACMH

Harvard Medical School

NYC Administration for Children's Services (ACS)

The Annie E. Casey Foundation

Texas DSHS and Dept of Protective and Regulatory Services

North Shore Hospital System/LIJ

Nassau County Department of Social Services

SCO

Children's Village

DePelchin Children's Center

Edwin Gould

Family Support Systems Unlimited

Harlem Dowling

Casey Project Child Welfare Application

- **Parent/Family/Youth Level: Parent Facilitators**
 - ◆ **Parent Engagement and Self-Advocacy (working with birth and foster parents using parent advocates)**
 - ◆ **Youth Taking Charge (SPARCS modification, peer support, and mentoring)**
- **Clinician & Caseworker Level:**
 - **EB Assessments/Diagnosis**
 - **Brief Psychotherapy manuals and TA for anxiety, depression, trauma, and conduct problems**
 - **Pediatric psychopharmacology**
 - **Training of agency staff in parent engagement methods (PESA)**
- **Systems Level: leadership, commitment to E-B innovations, stakeholder buy-in, and ongoing consultation**

Guidelines for Managing Impulsive Aggression (IA) in Outpatient Settings Including Child Welfare

- **Consensus conference February 12-13, 2007, in Dallas**
 - ◆ **90 Participants: AACAP, AAP, family advocacy organizations, + reps from California, NY, & Texas, FDA, AHRQ, pediatricians, CAPs, scientists**
 - ◆ **Rutgers CERT, AE Casey, Casey Family Programs, Columbia University, & REACH Institute**
- **Guidelines for:**
 - **Psychopharmacology Interventions for IA**
 - **Modification of TRAY for outpatient settings, Peds, CAPs**
- **Publications & Products**
 - ◆ **2 papers in process (JAACAP or Pediatrics)**
 - ◆ **Toolkits on the web**

Guidelines for Managing IA in Outpatient Settings Including Child Welfare

ASSESSMENT & DIAGNOSIS

- Engage patient and parents during initial evaluation.
- Conduct a thorough initial evaluation and diagnostic work-up before initiating pharmacological treatment.
- Assess treatment effects and outcomes with standardized measures.
- For acute aggression, conduct a risk assessment and if necessary, consider referral to psychiatrist or emergency department evaluation.



INITIAL MANAGEMENT & TREATMENT PLANNING

- Provide psychoeducation for patients and their families and set realistic expectations about treatment.
- Partner with the patient and family in developing an acceptable treatment plan.
- Help the family establish community and social supports.



PSYCHOSOCIAL/MEDICATION TREATMENTS

Psychosocial Interventions:

- Provide or assist the family in obtaining evidence-based parent and child skills training.
- Engage child and family in maintaining consistent psychosocial strategies.

Medication Treatment:

- Initial medication treatment should target the underlying disorder(s).
- When available, follow evidence-based guidelines for primary disorder.

CONTINUED....

Guidelines for Managing IA in Outpatient Settings Including Child Welfare



PSYCHOSOCIAL/MEDICATION TREATMENTS

Medication Treatment (Continued):

- Consider adding a second generation antipsychotic if severe aggression persists following an adequate trial of an appropriate treatment for underlying disorder (including psychosocial treatments).
- If no response, try a different second generation antipsychotic medication.
- If partial response, consider augmentation with a mood stabilizer.
- Avoid using more than 2 psychotropic medications simultaneously.
- Use recommended titration schedule and deliver an adequate medication trial before changing or adding medication.

Side Effects Assessment and Management

- Conduct side effects and metabolic assessments and laboratory tests that are clinically relevant, comprehensive, and based on established guidelines.
- Provide accessible information to parents and families about identifying and managing side effects.



If favorable response, continue treatment for 6 months.



Taper or discontinue medications in patients who show a remission in aggressive symptoms for 6 months or longer.



If good response, continue treatment for 6 months.



Taper or discontinue medications in patients who show a remission in aggressive symptoms for 6 months or longer.

Guidelines For Best Practices for Mental Health in Child Welfare (including meds)

- **Consensus conference October 9-10th, 2007**
 - ◆ 80 Participants, federal agencies, AACAP, family advocacy organizations, states MH & CW
 - ◆ AE Casey, Casey Family Programs, REACH Institute
- **Guidelines for:**
 - **EB Screening & Assessment**
 - **Psychosocial Interventions**
 - **Psychopharmacology Interventions**
 - **Support and Empowerment**
 - Youth
 - Parents (birth and foster, and kinship)
- **Publications & Products**
 - ◆ 2 papers in CWLA journal
 - ◆ Book of EB reviews in each area
 - ◆ How-to handbook for agencies
 - ◆ Toolkits on the web

Guidelines For Best Practices for Mental Health in Child Welfare

- **Psychopharmacotherapy Recommendations I**
 - ◆ **Informed consent must be established when a clinician prescribes psychotropic medications. Information must be given to child, family (bio-parent, foster parent, or caregiver), and the caseworker/state-assigned decision maker about the treatment options (both medication and non-medication options), risks/benefits of medication, target symptoms, and course of treatment.**
 - ◆ **Child welfare agencies must ensure consistent access to, and document, prescribed psychotropic medications, child's response, side effects, risks/benefits of meds, timeframes for response. Documentation should follow child throughout his or her stay in care.**

Guidelines For Best Practices for Mental Health in Child Welfare

➤ Psychopharmacotherapy Recommendations II

- ◆ Prescribers should have ongoing communication with the child and caregivers to monitor response, side effects, etc. Prescriber should discuss with the child and family medication adherence and any medication changes in the context of a collaborative relationship.
- ◆ Reliable and valid clinical rating scales should be used to quantify the response of the child's target symptoms to medication.



Guidelines For Best Practices for Mental Health in Child Welfare

- **Psychopharmacotherapy Recommendations III**
 - ◆ **During the initial 3 months on medication, visits should be at least monthly if the child's condition is unstable. If stabilized, follow-up be quarterly basis or more frequently if required. If youth's condition becomes unstable, prescriber should be contacted immediately.**
 - ◆ **Agencies must ensure that caseworkers receive training in common child mental health disorders, effective treatment options, & child and adolescent development.**
 - ◆ **Children and families should receive ongoing information on MH problems, effective treatment options, and how to manage one's life.**

Guidelines For Best Practices for Mental Health in Child Welfare

➤ Psychopharmacotherapy Recommendations IV

- ◆ In advance of youth leaving care, agencies should ensure an adequate clinical transition plan, including the identification of future prescribers and sources of payment.
- ◆ Agencies should support and monitor MH needs and access to medications and other MH services for birth families.
- ◆ The agency should periodically conduct reviews of patterns of psychotropic medication use within its caseload, on an aggregate- and provider-specific basis, and take necessary action in response to findings of such reviews.



Mental Health & Child Welfare Services Reform: Strategic Issues

- **Leadership, trust, engagement, and therapeutic alliance factors critical at all levels of “the system”**
- **Begin with the end in mind: establish and ensure necessary “abilities” at all 3 levels**
- **Enemy of the good is the perfect: raise the floor, not the ceiling**
- **Win-win strategies**
- **“Buy-in” -- partnership, not ownership**
- **Establish Consensus**
 - **February 12-13 Consensus Conference in Texas**
 - **October 9-10 Consensus Conference in Washington, DC**

Mental Health Services Reform: Strategic Issues

Training, TA, & Time

Training, TA, & Time

Training, TA, & Time

*Accelerating this
process:*

**The REsource for Advancing
Children's Health:**

The REACH Institute

The REACH Institute

~ *Putting Science to Work* ~

The Institute was established in the **spring of 2006** to **accelerate** the acceptance and effective use of proven interventions that foster children's emotional and behavioral health.

REACH fills a unique role by:

- Promoting a **family-oriented** approach to mental health care
- Developing **partnerships** with parents, pediatricians, schools, and others to apply best practices and proven interventions
- Providing **“hands-on” assistance** to partners
- Focusing on **Key Disorder Areas**



Training in What?

- **Parent/Family Level: Parent Facilitators**
- **Clinician Level: Increasing positive and/or proven practices, reducing potentially harmful, unnecessary/expensive practices**
 - **Brief Psychotherapy manuals and training on treatment for anxiety, depression, trauma, and conduct problems**
 - **Pediatric Psychopharmacology Mini-fellowship**
 - **Engagement training**
 - **EB Assessments/Diagnosis**
 - **Integrated approaches: MST, MDTFC**
- **Systems Level: consultation & reorganization**



REACH Approach: A 4-step process

Step 1

Identify and Validate

- Identify key problem areas
- Obtain consensus & commitment on the latest, most effective interventions derived from rigorous research

Step 2

Adapt

- Make interventions “user-,” “patient-” and “family-friendly”
- They can be readily applied by patients, families, and health care professionals

Step 4

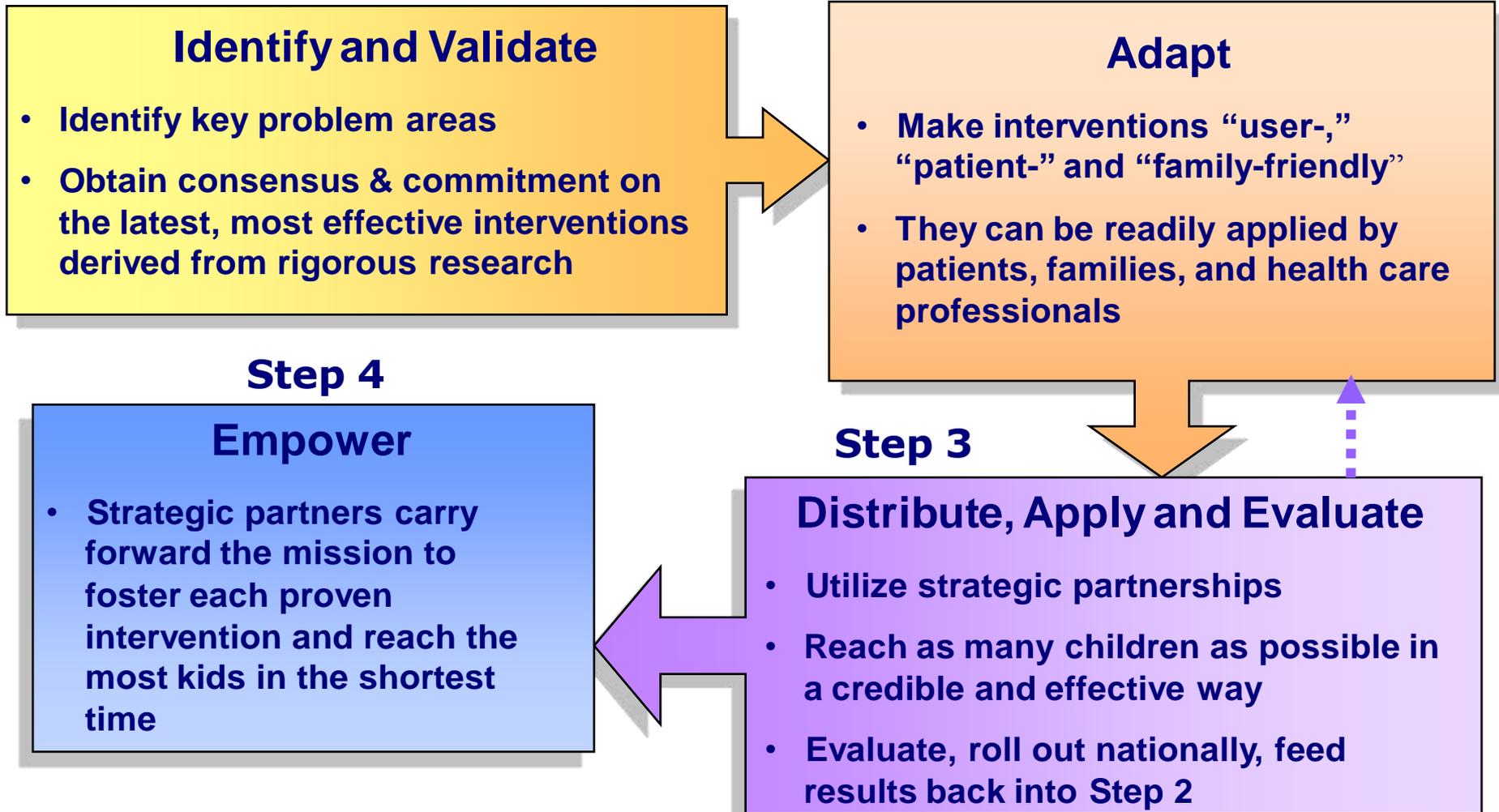
Empower

- Strategic partners carry forward the mission to foster each proven intervention and reach the most kids in the shortest time

Step 3

Distribute, Apply and Evaluate

- Utilize strategic partnerships
- Reach as many children as possible in a credible and effective way
- Evaluate, roll out nationally, feed results back into Step 2



Parents: Empowerment Programs

Develop methods for increasing parent “empowerment” and health care involvement.

- Parents and center staff have developed a **model program** to help parents in **owning and guiding** their children’s mental health care
 - ◆ Teach skills necessary to develop parent-provider partnerships
 - ◆ Provide up-to-date information about mental health disorders
- Program being implemented in New York City, Utah, and California
 - ◆ Needs expansion and distribution nation-wide



Parents: Empowerment Programs (cont.)

Reaching parents through strategic partners:

- CHADD (Children and Adults with Attention Deficit Disorder)
- National Alliance for the Mentally Ill (NAMI)
- The Federation of Families for Children's Mental Health
- Mental Health America
- Depression-Bipolar Support Association



Primary Care Providers: “Best Practices”

Partner with pediatricians and family doctors to identify and implement “Best Practices.”

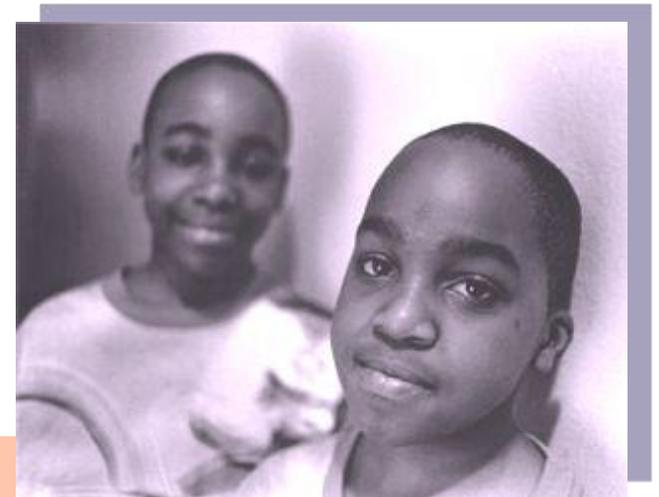
- Deliver **family-centered**, effective care
- Assist pediatricians and family practitioners to manage **youth depression** and **suicide risk**
- Help doctors in managing treating **ADHD and Depression**, and **avoiding over-diagnosis**
- Help doctors get the right information to patients and families
- Pediatric Psychopharmacology Program –
 - ◆ A “Mini-Fellowship”



Teachers and Schools: “Best Practices”

Partner with teachers and school leaders to:

- **Identify youth depression** and **suicide risk**
- Improve learning and achievement
- Promote emotional health of all kids through school-wide programs
- Make mental health services available to kids *where they are*
- *Early Identification & Screening programs*



Child Welfare: Best Practices

- *Parent/Family/Youth Level: Parent Facilitators*
 - ◆ **Parent Engagement and Self-Advocacy (PESA)** (working with birth and foster parents using parent advocates)
 - ◆ **Youth Taking Charge** (SPARCS modification, peer support, and mentoring)
- *Clinician & Caseworker Level:*
 - EB Assessments/Diagnosis
 - Brief Psychotherapy manuals and TA for anxiety, depression, trauma, and conduct problems
 - *Pediatric psychopharmacology*
 - Training of agency staff in parent engagement methods (PESA)
- *Systems Level:* leadership, commitment to E-B innovations, stakeholder buy-in, and ongoing consultation



REACH Training Programs

Reaching providers through strategic partners:

- American Academy of Pediatrics
- American Academy of Child & Adolescent Psychiatry
- Society of Developmental & Behavioral Pediatrics
- Child Welfare League of America
- Foster Family Treatment Association
- National Association of Pediatric Nurse Practitioners
- Key Scientists formed into working partners
- State Policy Makers
- Child Welfare and Health Care Agencies



**But the story is just
beginning ...**

The REACH Institute
REsource for Advancing Children's Health



Question and Answer

