Psychotropic Medication Oversight in Foster Care

Children's Alliance Membership Meeting

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Definition

Psychotropic medications are drugs that target the brain and that are prescribed to treat symptoms of mental, emotional or behavioral disorders. Studies have found them to be effective for specific conditions.

Psychotropic medications include anti-anxiety medications, antipsychotics, antidepressants, mood stabilizers, stimulants, and sleep medications.

Introduction

It is estimated that 1 in 5 children in the U.S. will be diagnosed with a mental health disorder. Between 1995 and 2010 the use of psychotropic medications for treatment of mental health disorders in children has doubled in frequency.

Psychotropic polypharmacy (use of more than one medication at a time) has also increased substantially between 1996 and 2007.

**Merikangas et al., JAACAP 2010; Olfson et al, JAMA Psychiatry 2014; Comer et al., JAACAP, 2010.*

Introduction

Kentucky has one of the highest rates in the US of psychotropic medications prescribed to children.

- Benchmark Average Medicaid Children With Psychotropic Rx = 7%
- **Ky. Medicaid Children With Psychotropic Rx → 14%**

- Benchmark Average Foster Children with Psychotropic Rx = 26%
- **Ky. Foster Children with Psychotropic Rx → 42%**

** Source – Kentucky Medicaid Report*

National Trends in Pediatric Psychotropic Polypharmacy

- Office visits with multiclass psychotropic treatment increased from 14.3% to 20.2% from 1996-2007

Comer et al., JAACAP 2010.

- In children diagnosed with ADHD 13.4% receive 3 or more classes of medication

Winterstein et al., J Clin Psychiatry 2017

State Trends in Pediatric Psychotropic Polypharmacy

- 12.6% of all children enrolled in Medicaid received interclass polypharmacy between 2012-2015
- Predictors of interclass polypharmacy: (p value < 0.001)
  - Age 6 -11 years OR 1.58 (1.5, 1.67)
  - Foster Care OR 1.71 (1.58, 1.84)
  - Bipolar Disorder OR 2.24 (2.11, 2.38)
  - Total number of psychiatric diagnoses OR 1.8 (1.74, 1.85)
- CIFC receive more alpha-agonists or antidepressants but less stimulants

Lohr et al., J Managed Care Spec Pharm, 2018.

Antipsychotic Drugs: Side Effects

KENTUCKY
Cabinet for Health and Family Services

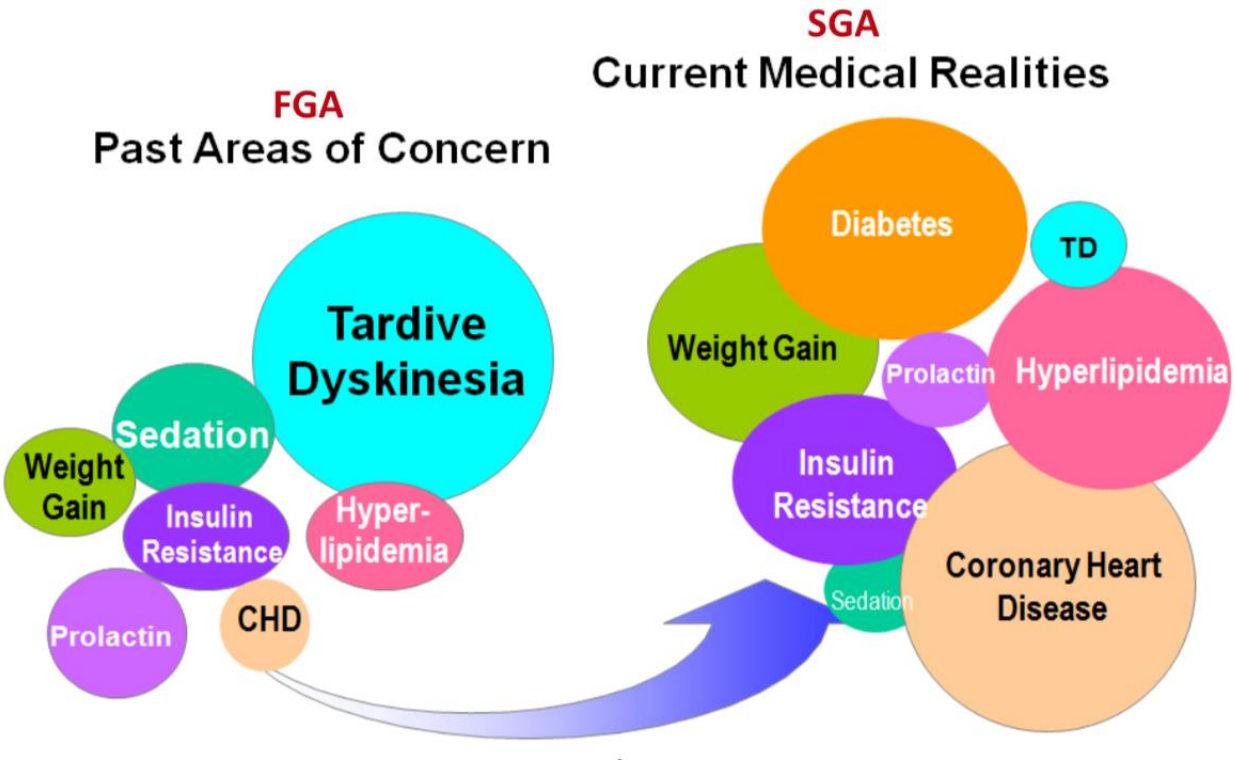
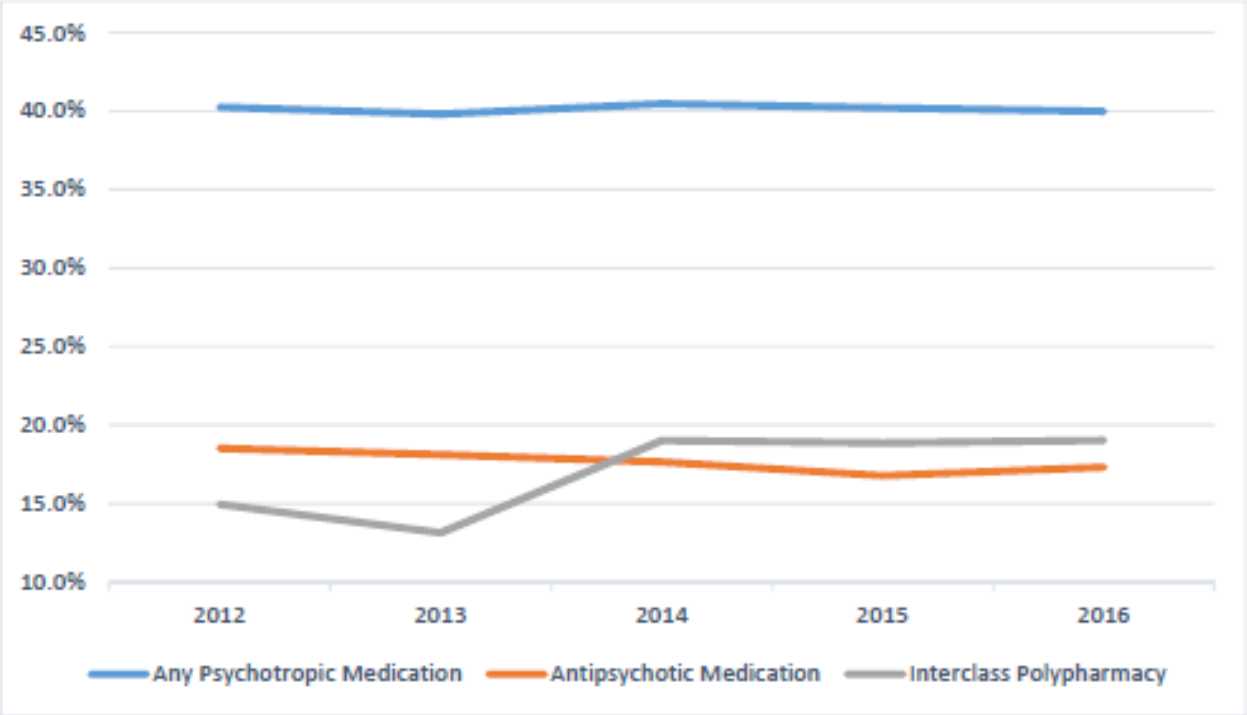
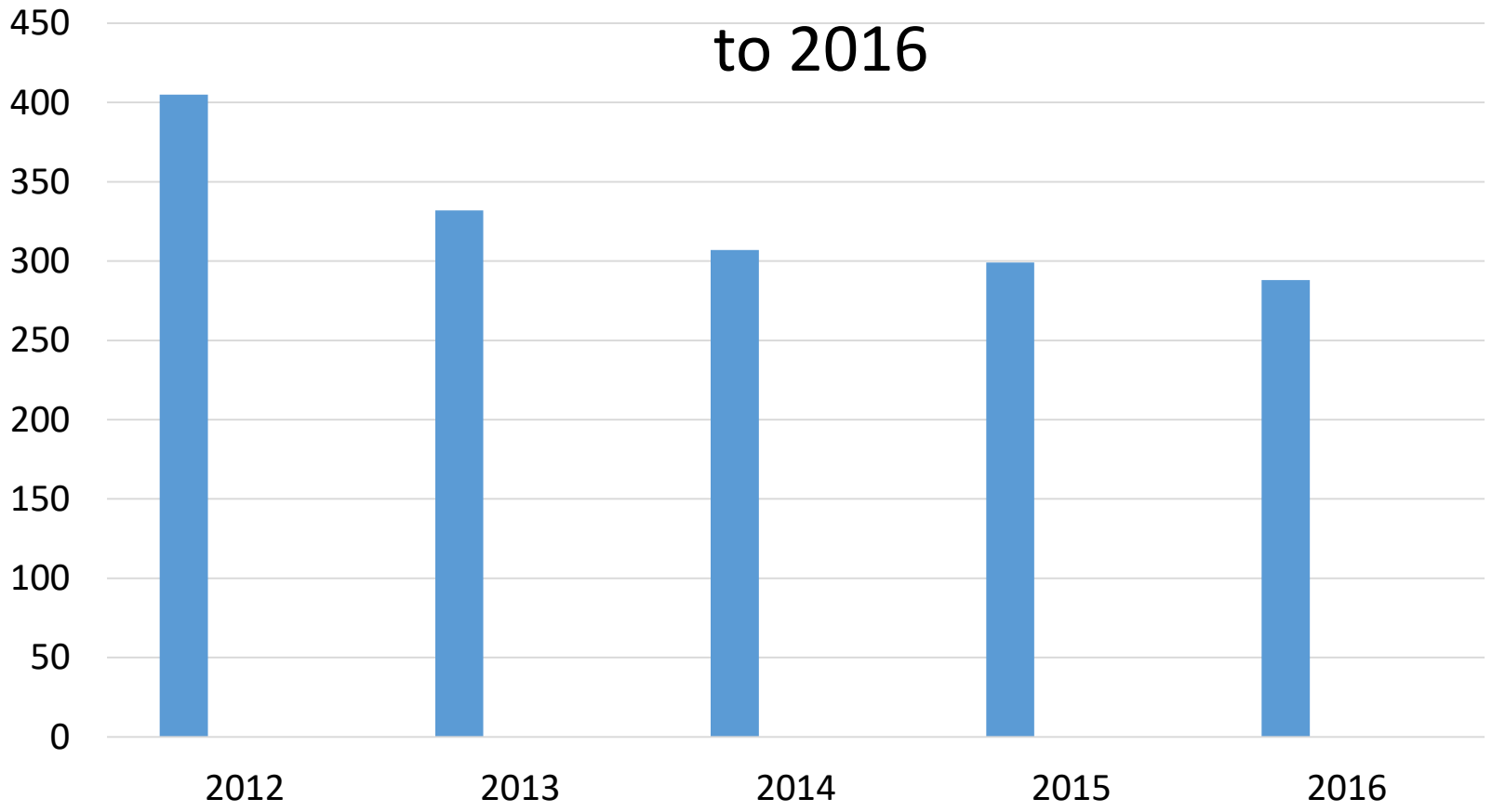


Figure 13. Trends in Percentage of Foster Children with Medicaid Coverage: Psychotropic Medications, Antipsychotic Medications, and Interclass Polypharmacy, 2012-2016



UofL CAHRDS State-University Partnership Final Report 2018

Number of children with HLPP in 2012 who remain on ≥ 4 classes of medications to 2016



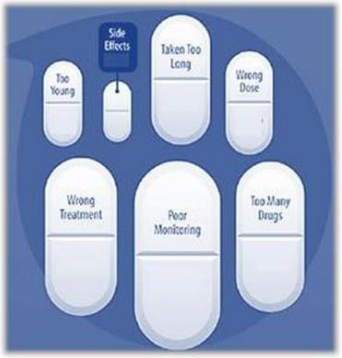
HLPP = High level polypharmacy or children on 4 or more classes of medications

N=405, or 3.61% of all children in foster care

Lohr et al. (2018)

Total Prescriptions by Class of Psychotropic Medication in HLPP

Medication Class	Counts	Percentage
Antipsychotics	9383	24.5
Antidepressants	8171	21.33
Stimulants	7145	18.65
Alpha-agonists	7058	18.43
Mood Stabilizers/anticonvulsants	4964	12.96
Benzodiazepines, Anxiolytics, hypnotics	949	2.48
Lithium	635	1.66



Do the Potential Benefits of Psychotropic Medications Outweigh the Potential Risks?

Many people have become concerned about the inappropriate use of psychotropic medications among youth in foster care for a number of reasons:

- Many youth in foster care who may need counseling and other trauma-focused mental health services do not receive these services.
- There are potentially serious short- and long-term side effects of many psychotropic medications.
- The medications have not been tested widely with children and youth.

After a positive screen conduct a thorough psychiatric assessment.

A comprehensive mental health assessment includes:

- A comprehensive assessment of the full range of psychiatric symptoms and disorders, as well as impairment from these symptoms and disorders.
- A full developmental assessment.
- A full medical history, including a sleep history.
- A relevant medical work-up, physical examination, and nutritional status evaluation.
- If relevant, an assessment of school functioning including academic, behavioral, and social aspects.
- An assessment of family psychiatric history which includes past and current history of parental psychiatric illnesses, substance abuse and treatment history of parents, parent figures (e.g., step-parent), siblings, and other relatives.
- An assessment of family structure and functioning, parent-child relationship and interaction.
- An assessment of environmental risk factors and stressors including any history of abuse (physical, sexual) or neglect, traumatic life events, domestic violence, economic instability, etc.

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Mental health interventions should start with psychosocial therapy first.

Level 1

Start with psychosocial treatment. Parental involvement is essential, with involvement of other caregivers or school-based interventions as needed.

- Provide a comprehensive treatment plan to treat target symptoms and monitor treatment progress. Monitor response to treatment using reliable and valid measures of changes in the target symptoms.
- In mild cases, attempt a course of at least 12 weeks of psychosocial interventions before considering medication.
- In moderate to severe cases, a higher level of intervention may be appropriate as the initial step.

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After which medications may be helpful.

Level 2

If medications are being considered, first reassess the diagnosis and diagnostic formulation. Weigh the risks and benefits of initiating treatment with psychotherapeutic medications.

If a decision is made to initiate medication:

- Initiate with monotherapy. Start low, go slow.
- Except in rare cases, use monotherapy.
- Continue psychosocial treatment during treatment with medication.
- Monitor for suicidality.
- Monitor for adverse effects of medications.
- The use of antipsychotics should be restricted to the diagnoses of schizophrenia (rare in children), mania/bipolar disorder, psychotic depression, drug induced psychosis, Tourette's syndrome and tic disorders, and in some cases, severe aggression as a target symptom.
- On rare occasions, antipsychotics may be used in obsessive compulsive disorder (OCD) after extensive cognitive behavioral therapy (CBT) or failure of two adequate selective serotonin reuptake inhibitor (SSRI) trials.
- Antipsychotics should not be used primarily to target ADHD symptoms or as sedatives in children.
- There may be instances where antipsychotics are used for parasuicidal and severe self-injurious behaviors.

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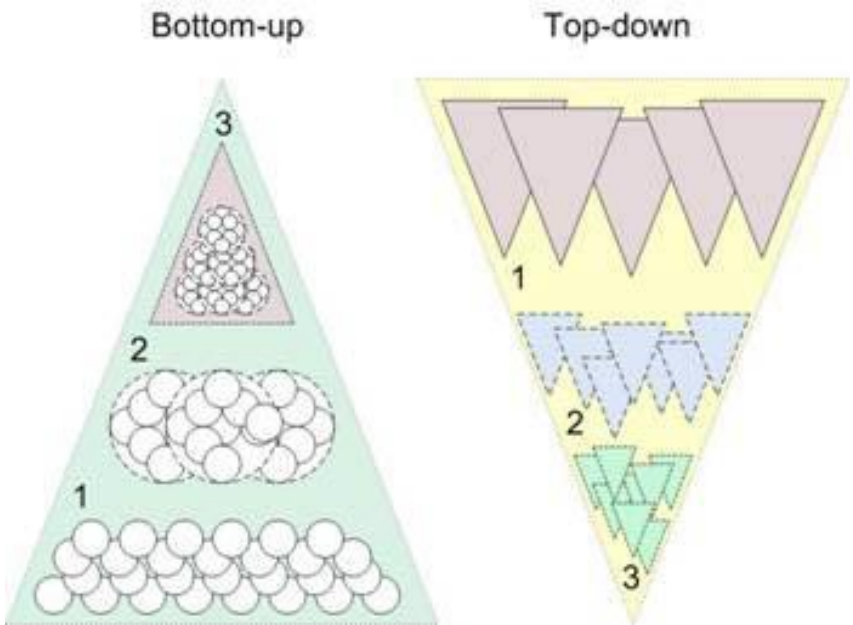
Pathophysiology of aggression
balance of systems

- Amygdala “bottom-up”
  - Embeds emotional significance in stimuli
  - More active in childhood/puberty
  - “hot cognitions”
- Pre-frontal cortex “top-down”
  - Integrates emotional and cognitive information
  - Executive function
  - “cold cognitions”



Approach to Aggression (Chronic, Impulsive)in Children and Adolescents Ages 6 to 17 Years Old

Level 1

Engage the child and family in taking an active role in implementing psychosocial strategies and help them to maintain consistency with psychosocial, psychoeducational, and other evidence-based treatments interventions:

- Parent Management Training (PMT), Parent-Child Interaction Therapy (PCIT), behavioral therapies such as ABA therapy, behavioral modification, and contingency management
- Multimodal interventions: Multisystemic therapy
- Cognitive Behavioral Therapy (anger management)
- Family therapy

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Approach to Aggression (Chronic, Impulsive)in Children and Adolescents Ages 6 to 17 Years Old

Level 2

If Level 1 interventions are not successful, re-assess:

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

- Always treat primary disorder fully first before addressing aggression with other pharmacologic agents.
- Treat comorbid ADHD per guidelines. Refer to page 18
- Treat comorbid Anxiety Disorders per guidelines. Refer to page 35.
- Treat comorbid Mood Disorders per guidelines. Refer to page 40 for Bipolar Disorder and page 52 for Major Depressive Disorder
- Treat comorbid Disruptive Mood Dysregulation Disorder per guidelines. Refer to page 45.
- Consider monotherapy with methylphenidate formulation, then amphetamine formulation or alpha-2 agonist, then atomoxetine.
- May want to consider combination therapy of stimulant with an alpha-2 agonist.
- For affective aggression, if benefits outweigh risks, consider starting with low-dose risperidone or aripiprazole (most robust evidence for use at the time of publication).

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Monitoring antipsychotic medications for side effects

Table 2.

American Diabetes Association/American Psychiatric Association Guidelines for Metabolic Monitoring in Recipients of Antipsychotic Medications							
	Monitoring Frequency						
Parameter	**Baseline**	**Week 4**	**Week 8**	**Week 12**	**Quarterly**	**Annually**	**Every 5 years**
Medical history*	X					X	
Weight (BMI)	X	X	X	X	X		
Waist circumference	X					X	
Blood pressure	X			X		X	
Fasting glucose or hemoglobin A1c	X			X		X	
Fasting lipids (HDL, LDL, triglycerides, total cholesterol)	X			X			X

**Notes*: Medical history includes personal and family history of obesity, diabetes, hypertension, and cardiovascular disease. More frequent assessments may be warranted based on clinical status.*

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Concerning medication practices

- No comprehensive evaluation of DSM-5 diagnoses
- 4 or more psychotropic medications prescribed at the same time
- The use of 2 or more medications from the same class
  - Antipsychotic medication, antidepressants, mood stabilizers, stimulants, alpha agonists
- Use of 2 or more medications before a rational trial of one medication
- High dosage above FDA recommended levels
- Use of psychotropic medication in a child less than 6 years of age
- Use of antipsychotic medications without checking glucose or lipids every year

Texas Dept. of Family and Protective Services, 2016

Antipsychotic medications should rarely be used in children < 6 years of age

- One instance = high levels of aggression in a child with a diagnosis of autism
  - FDA approved medications for Autism
    - Risperidone to age 5, Aripiprazole to age 6
- Before using an antipsychotic medication in a child < 6 years of age:
  - developmentally appropriate, trauma-informed comprehensive psychiatric assessment
  - evaluation of parental psychopathology and treatment needs, as well as family functioning.
  - psychosocial treatments first
- Low doses
  - Risperidone < 2 mg per day
  - Aripiprazole < 7.5 mg per day

Other concerning medication practices related to the age of the child

- Prescription of an antidepressant to a child less than six (6) years of age
- Prescription of a stimulant medication to a child less than five (5) years of age
- Prescription of an alpha agonist to a child less than six (5) years of age
- Prescription of lithium to a child less than eight (8) years of age
- Use of an antidepressant and an antipsychotic medication in a child less than nine (9) years of age
- Use of a mood stabilizer and an antipsychotic medication in a child less than nine (9) years of age
- Use of two (2) or more hypnotics in a child less than twelve (12) years of age

Concerning medication practices related to antipsychotic medications

- Any APM in a child less than eight (8) years of age
- Use of APM without first line psychosocial therapy
- Use of quetiapine at 25 mg or 50 mg only at night
- Use of any long-acting antipsychotic medication
- Lack of a blood glucose or lipid panel (cholesterol) within the last year

Deprescribing can be a practice

Identify medications that could be ceased or reduced. Start with medications:

1. Without a clear indication
2. If after assessment, it remains unclear what symptoms the medication was targeting
3. With the least evidence of efficacy for the symptoms or diagnoses the medication is prescribed to treat
4. That were ineffective for the symptoms targeted, or if the symptoms originally targeted have resolved
5. That are prescribed outside of guidelines recommending their use
6. With insufficient benefit to justify harms
7. With the greatest risk of future adverse effects
8. That are part of a prescribing cascade, when side effects of drugs were misdiagnosed and treated as symptoms of another disorder; or when the drug was prescribed to counter the adverse effects of another drug

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What is Informed Consent?

- Informed consent is a process in which doctors or other specialists provide information about possible treatment options to youth and the people responsible for making health decisions for those youth (parents, guardians, child welfare administrators/ supervisors, courts, or others).

- This information should include treatment benefits, risks and factors that might support or interfere with treatment effectiveness.

Questions for Informed Consent

- What diagnosis or symptoms is medication being prescribed for?
- What is the name of the medication? Is it known by other names? Is a generic version available?
- How, when and how long should this medication be taken?
- Are there any laboratory tests that need to be done before beginning the medication or on an ongoing basis?
- When and how should the person stop taking the medication?
- How long will it take before we see improvements in emotions or symptoms?

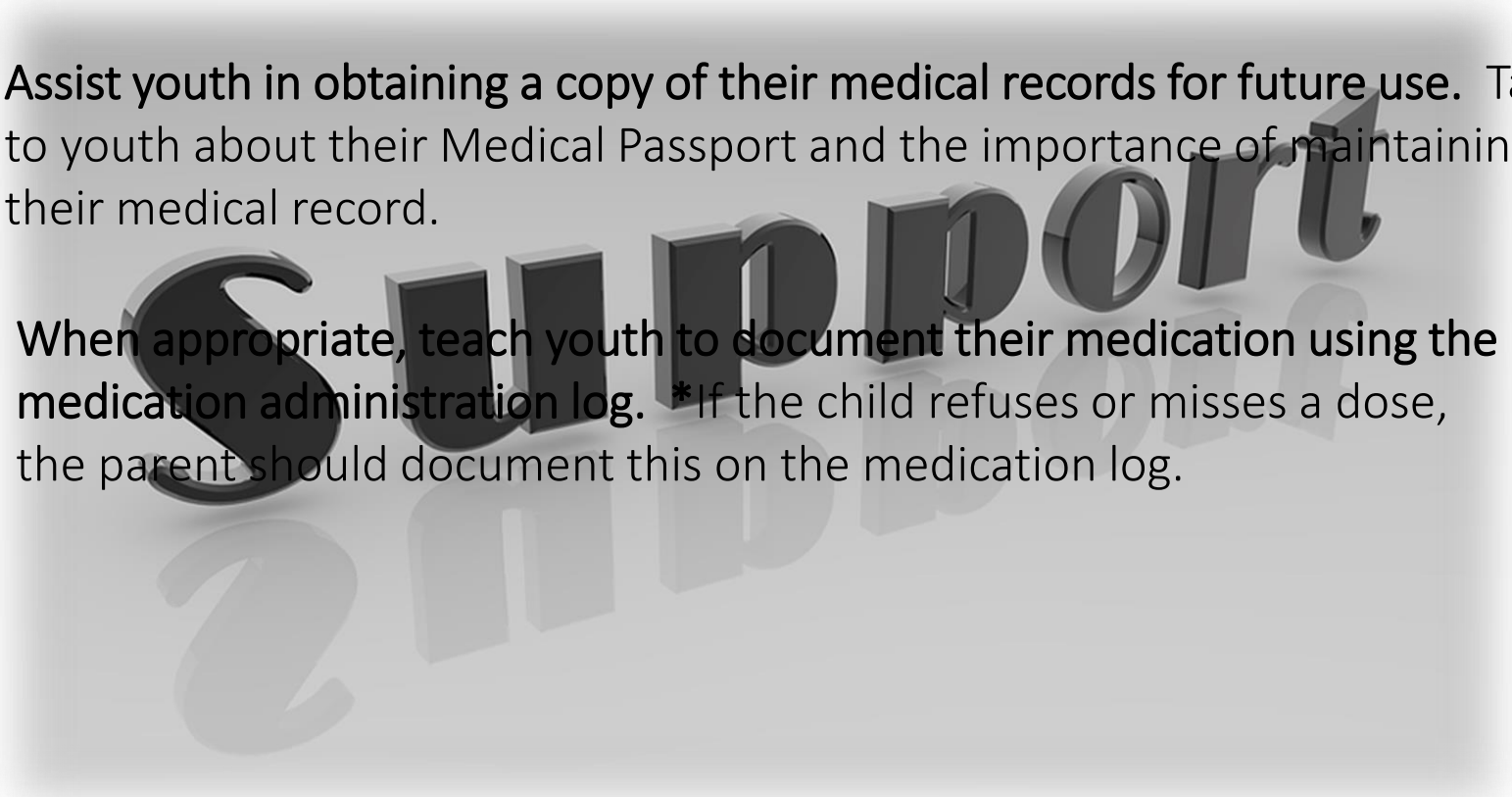
Questions for Informed Consent

Discuss Side Effects

- Is there written information available about potential side effects?
- What side effects should I keep in mind? Can they be prevented?
- What should I do if the young person experiences these side effects?
- Will the medication interact with other medications (prescriptions or over-the-counter medication) the person currently takes?
- What should the person do if a dose is missed?

How can You Support Youth in Taking Medication Safely?

You can play an important role in helping make sure that medicine is taken safely and that any concerns are addressed.



- **Assist youth in obtaining a copy of their medical records for future use.** Talk to youth about their Medical Passport and the importance of maintaining their medical record.

- **When appropriate, teach youth to document their medication using the medication administration log.** *If the child refuses or misses a dose, the parent should document this on the medication log.