Medications & Foster Youth: The Struggle—Why and Why Not

Sonoma County Fall 2012
Continuing Education

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Presentation Objectives

CASA Volunteers to increase understanding and skills related to advocating for youth who face psychiatric evaluation and treatment.

- Complexity of controversy
- Entities involved
- Psychiatric Evaluation process
- Challenges to Evals

- Heritability and Environmental influences of MI
- Common classes of Rx
- Side effects
- Medication monitoring

GAO 2011 Study

- Population compared: Foster/Non-Foster
- Rates of psychotropic prescriptions via claims filed to Medicaid in 2008
- 5 states: Florida, Massachusetts, Michigan, Oregon, and Texas

GAO 2011 Study Findings

- Found rates up to 4 times higher than in non-foster population
- Children receiving *greater than recommended doses*:

  Non-Foster = 0.16% to 0.56%

  Foster Care = 1.12% to 3.27%
- More children in foster care taking 5 or more medications than non-foster youth.

Specific Red Flags Identified

- Dosages exceeding usual recommended levels
- concomitant use of five or more psychotropic drugs
- prescriptions by a primary care provider lacking specialized training
- prescriptions for children of very young age

State:

Oregon (OR)

Medicaid amount paid for psychotropic medications prescribed to foster and nonfoster children during 2008:

$14,326,756

Percentage of children prescribed psychotropic medication age:	Foster children	Nonfoster children	Ratio of foster to nonfoster children
0–17 years old	19.7%	4.8%	4.1
13–17 years old	43.3%	12.0%	3.6
6–12 years old	23.4%	6.2%	3.8
0–5 years old	2.5%	0.6%	3.9

Note: Rates for foster and nonfoster children are comparable within the same state and the ratio of prescriptions to foster children to prescriptions to nonfoster children is comparable across states. However, prescription rates are not comparable across states because certain states covered more psychotropic drugs than other states. In addition, we excluded children whose prescriptions were not reported to CMS because they were covered by an HMO in the two states with both fee-for-service and HMO prescription coverage. Percentages and ratios are rounded to the nearest tenth, and therefore the reported ratio may be slightly different than the ratio of the rounded percentages.

Source: GAO analysis of state Medicaid and foster care data.

State:

Oregon (OR)

	Percentage of foster children	Percentage of nonfoster children
Children age 0–17 prescribed five (5) or more medications concomitantly	**0.13%**	**0.01%**
Children 0–17 with a dosage exceeding maximum guidelines based on FDA-approved labels	**1.12%**	**0.16%**
Children under 1 year old prescribed a psychotropic drug	**0.3%**	**0.1%**

Note: Rates for foster and nonfoster children are comparable within the same state and the ratio of prescriptions to foster children to prescriptions to nonfoster children is comparable across states. However, prescription rates are not comparable across states because certain states covered more psychotropic drugs than other states. In addition, we excluded children whose prescriptions were not reported to CMS because they were covered by an HMO in the two states with both fee-for-service and HMO prescription coverage.

Source: GAO analysis of state Medicaid and foster care data.

State:

Texas (TX)

Medicaid amount paid for psychotropic medications prescribed to foster and nonfoster children during 2008:

$194,952,105

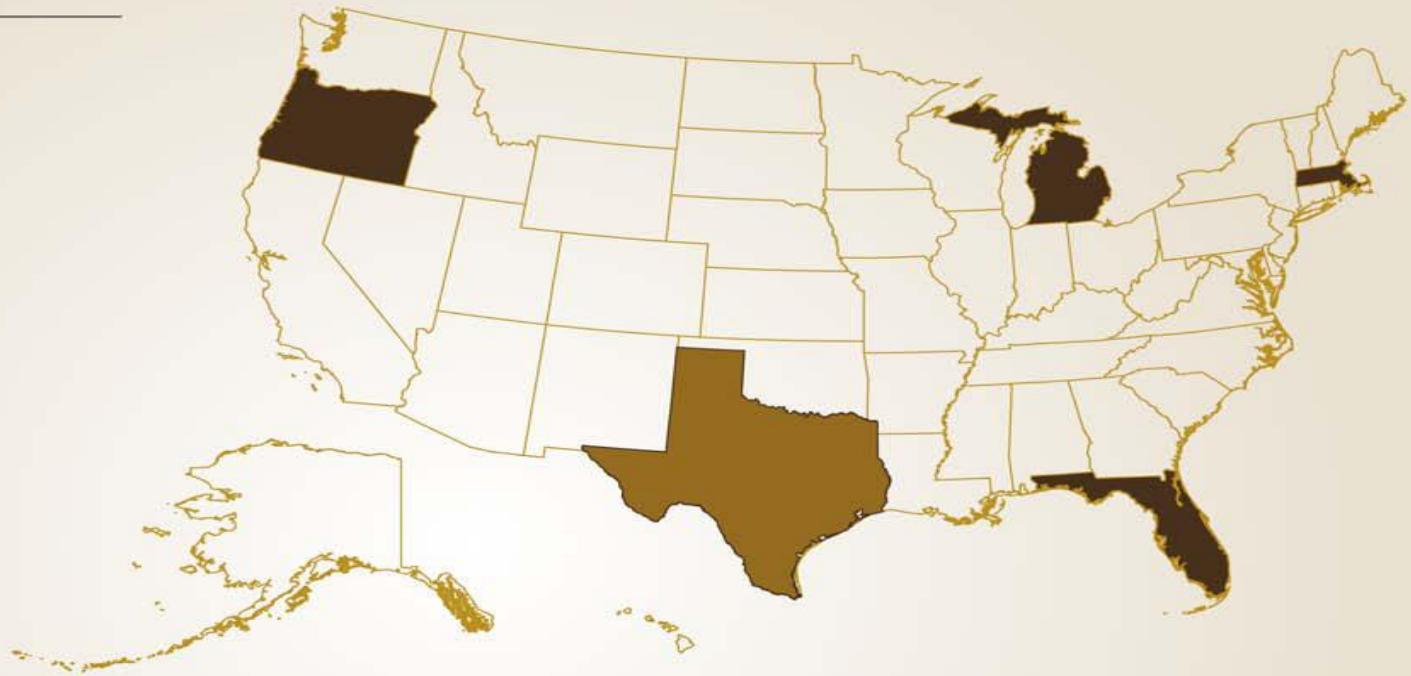
Percentage of children prescribed psychotropic medication age:	Foster children	Nonfoster children	Ratio of foster to nonfoster children
0–17 years old	32.2%	7.1%	4.5
13–17 years old	58.2%	11.4%	5.1
6–12 years old	45.8%	10.6%	4.3
0–5 years old	9.1%	3.1%	2.9

Note: Rates for foster and nonfoster children are comparable within the same state and the ratio of prescriptions to foster children to prescriptions to nonfoster children is comparable across states. However, prescription rates are not comparable across states because certain states covered more psychotropic drugs than other states. In addition, we excluded children whose prescriptions were not reported to CMS because they were covered by an HMO in the two states with both fee-for-service and HMO prescription coverage. Percentages and ratios are rounded to the nearest tenth, and therefore the reported ratio may be slightly different than the ratio of the rounded percentages.

Source: GAO analysis of state Medicaid and foster care data.

State:

Texas (TX)



	Percentage of foster children	Percentage of nonfoster children
Children age 0–17 prescribed five (5) or more medications concomitantly	1.05%	0.02%
Children 0–17 with a dosage exceeding maximum guidelines based on FDA-approved labels	3.27%	0.37%
Children under 1 year old prescribed a psychotropic drug	1.2%	1.0%

Note: Rates for foster and nonfoster children are comparable within the same state and the ratio of prescriptions to foster children to prescriptions to nonfoster children is comparable across states. However, prescription rates are not comparable across states because certain states covered more psychotropic drugs than other states. In addition, we excluded children whose prescriptions were not reported to CMS because they were covered by an HMO in the two states with both fee-for-service and HMO prescription coverage.

Source: GAO analysis of state Medicaid and foster care data.

Important Considerations

- Data did not include:
  - the non-Medicaid population
  - HMO/managed care population
  - Private fee for services
- May not necessarily be generalizable to Sonoma population

GAO 2011 Study Findings

Most Important and Useful finding was the identified lack of guidelines and support for better provision of care:

- monitoring
- evaluation
- second opinion
- collaboration between medical care providers and other members of treatment team

GAO 2011 Implications

- States must identify protocols for medication monitoring.
- Follow HHS-endorsed, nationwide guidelines for consent, oversight, consultation, and information sharing
- Improve consent (Who?)—assent?

But Foster Youth have more problems…

- About 30% of children in foster care have severe emotional, behavioral, or developmental problems. Physical health problems are also common.
- Children in foster care often struggle with the following issues:
  - blaming themselves and feeling guilty about removal from their birth parents
  - wishing to return to birth parents even if they were abused by them
  - feeling unwanted if awaiting adoption for a long time
  - feeling helpless about multiple changes in foster parents over time
  - having mixed emotions about attaching to foster parents
  - feeling insecure and uncertain about their future
  - reluctantly acknowledging positive feelings for foster parents

Greater prevalence of mental illness and *exposure to trauma*

- 57% of foster youth a 15x greater chance to have a diagnosis than non-foster medicaid recipients.
- 10% of national youth population have a diagnosed mental disorder [4]
- NAMI reports, ‘21%of children ages 9-17 have a diagnosable mental or addictive disorder that causes at least minimal impairment.’

Greater Prevalence through *Heritability Factors*

- Genetic mutations across chromosomes affect variety of aberrant expressions (especially across neurologic functions)
- Genetic predisposition for turning gene expression on
- How heritable is the mental illness
- Anticipation—earlier and earlier onset or increased severity in subsequent generations

Etiological Nature or Nurture

Higher rates of psychopathology in children in out of home placement

- Etiological influence of pre-placement environment/s
- Etiological influence of heredity
- Stressors of out of home placement
  - Fears
  - What is to happen next? Rapid change?
  - Anomie—peers/staff/parents

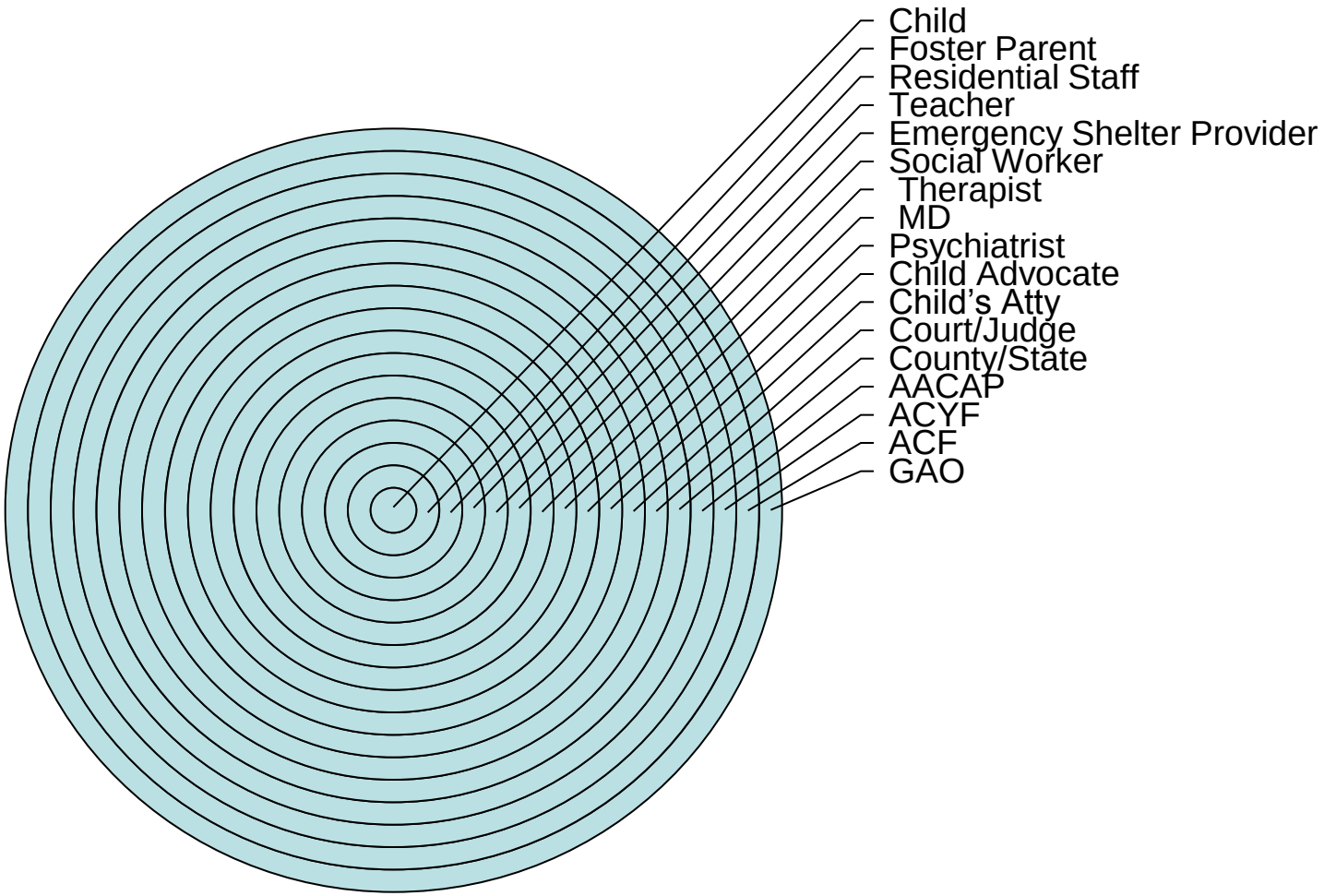
Why we medicate

Medications decrease anxiety, agitation, and aberrant thoughts, decreasing incidents:

- acting out, hurting self or others, and then blaming self, become stigmatized, and giving up on themselves and others,
- thus promoting an ***identity*** as victim-abuser, and pathological, sociopath

- Behaviors—
  - Throwing chairs through windows, gross destruction of property (self and others)
  - Attacking other children/adults
  - Sabotage/contamination
  - Hurting animals
  - Stealing/hoarding
  - Self-harm
  - Suicide attempts
  - Sexual Acting Out

The Struggle



So, in examining our biases and current understanding, ***"Why* Not *medicate foster youth?"***

- Risky and difficult side effects—who is monitoring/tracking
- Power of radical acceptance and objectivity
- Grief work, therapy, adjustment, and therapeutic interventions
- Unstudied effects of medications on development
- Treating a behavior not an organic/chemical imbalance (debatable)
- The real solution is human powered—consistent and expected, loving kindness, compassion, and care

Advocate Solutions

- Assist child to self-monitor and keep track of symptoms and side-effects
- Encourage child interest and participation
- Assist treatment team and communicate your observations
- Encourage child to communicate his/her observations
- Hold responsible parties accountable through report and communications with child's team

Advocacy Entails

- Understanding psychiatric evaluations and follow-up procedures
- Assessing and identify limitations
- Being solution-focused
- Organizing data, observations, narratives, and facts
- Developing relationships and communicating (that will serve communication needs)
- Translating to and for child (prepare)
- Increasing objectivity

Triggers for Psychiatric Evaluation

- Standard Evaluation at Entry
- Evaluation at Crisis
- Evaluation after medical consult
- Routine Evaluation

Data Points in the Psychiatric Evaluation

Patient hx:

- *Developmental milestones*
- *Insults*
- *Exposures*
- *Hx of current sxs*
- *Hx of past tx*

Current Assessment of:

- *Functional*
- *Health Bxs*
- *Social-Relational*
- *Cognitive (process and content), Attention*
- *Mood & Affect*
- *Psychomotor*

Data Points in the Psychiatric Evaluation

- Family Hx
  - Extended family mental/medical illnesses
  - Pregnancy Hx (medical and psychosocial)
  - Housing at pregnancy, birth, beyond
  - Parental Education and Work (exposure)
  - Caregiving hx (if parents were at work)
  - Socio-economic status, resources, nutrition

Evaluation Part II

- Records Review
  - Medical
  - Psychological
  - psychiatric
- Family / Collateral
- Academic
- Current Caregiver

Comprehensive Psychiatric Evaluation

- Description of present problems and symptoms
- Information about health, illness and treatment (both physical and psychiatric), including current medications
- Parent and family health and psychiatric histories
- Information about the child's development
- Information about school and friends
- Information about family relationships
- Interview of the child or adolescent
- Interview of parents/guardians

Difficulties in Data Gathering

- Missing info
- Reporter/ed—can the info be trusted?
- Lack of participation and/or interest reporters, providers, child
- Acute distress or emergency—complicates thorough data gathering
- Lack of follow-up/through

Issues of Consent/Assent

- Tracking and obtaining consent from parents, social workers, medical rights
- Establishing wardship
- When a parent dissents
- Providing time to obtain informed consent
- Providing the time to gain informed assent
- Asserting need for change in tx plan
- Medication monitoring

Issues of Consent and Assent in Foster Youth Population

Table 4: State Consent Laws and Policies Compared with AACAP's Best Principles Guidelines

Guideline		FL	MD	MA	MI	OR	TX
Minimal	Identify the parties empowered to consent for psychotropic drug treatment for youth in state custody in a timely fashion						
Minimal	Establish a mechanism to obtain assent for psychotropic medication management from minors when possible						
Recommended	Obtain simply written psycho-educational materials and medication information sheets to facilitate the consent process						
Ideal	Establish training requirements for child welfare, court personnel and/or foster parents to help them become more effective advocates for children in their custody[1]						

Beyond Consent/Assent

- Struggle for adherence to protocol
- Struggle for communication about concerns
- Obtaining skilled medication monitoring/support
- Addressing emerging questions
- Self-monitoring of effects and side-effects
- Tracking and reporting symptom reduction

Psychotropic Medication Classes

- Hypnotics
- Sedatives
- Anxiolytics
- Anti-depressants
- Mood Stabilizers
- Anti-psychotics
- Stimulants
- Allergy Rx

- Improve sleep
- Commonly prescribed off label to tranquilize
- Decrease anxiety/tranquilize
- Boost mood/energy
- Prevent swings/manic
- Thought content/process
- Improve attention
- Address allergic responses-off label sedative

Hypnotics, Anxiolytics, and Sedatives

- Address sleep, anxiety, and over-stimulation, over-arousal (physiological over-reactivity as seen in ASD/PTSD)
- Other uses: alcohol/substance withdraw
- Types:
  - SSRIs (also used as antidepressants)
  - Benzodiazepines
  - Anxiolytics
  - Antihistamines

Anti-anxiety

SSRIs

citlopram (Celexa)

escitalopram(Lexapro)

floxetine (Prozac)

fluvoxamine (Lexapro)

sertraline (Zoloft)

Antihistamines

hydroxyzine hcl (Atarax)

hydroxyzine pamoate (Vistaril)

Benzos

lorazapam (Ativan)

clonazapam (Klonopin)

diazapam (Valium)

alprazolam (Xanax)

oxazepam (Serax)

chlordiazepoxide (Librium)

Other Anti-anxiety

buspirone (Buspar)

Sleep promoting medications

- Commonly prescribed
  - trazodone (Desyrel)
  - diphenhydramine (Benadryl)

- Sensitization—children become more excited rather than sleepy can happen with antihistamines used for sleep.

Antidepressants

Tricyclics

- Amytriptyline (Elavil)
- Desipramine (Norpramin)
- Doxepin (Sinequan)
- Imipramine (Tofranil)
- Nortriptyline (Pamelor)

SSRIs

- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Fluvoxamine (Luvox)
- Sertraline (Zoloft)

Others

- Bupropion (Wellbutrin)
- Mirtazepine (Remeron)
- Trazadone (Desyrel)

Mood Stabilizers

Anticonvulsants

- Divalproex (Depakote)
- Carbamazepine (Tegretol)
- Lamotrigine (Lamictal)

Other

- Lithium (Eskalith)
- Atypical Antipsychotics

Side-effects of anticonvulsants

weight gain, nausea, sedation, tremor, liver problems, slower blood clotting

Side-effects of Lamotrogine

rash, headache, dizziness

Side-effects of Lithium

weight gain, tremor, nausea, thyroid problems

Antipsychotics

Traditional

Haloperidol- (Haldol)

Chlorpromazine-(Thorazine)

Atypical

Aripiprazole- (Abilify)

Clozapine- (Clozaril)

Olanzapine-(Zyprexa)

Quetiapine- (Seroquel)

Risperidone- (Risperdall)

Ziprasidone- (Geodon)

Traditional side-effects

Tremor, muscle spasm, abnormal movement, stiffness, blurred vision, constipation

Atypical side-effects

Low white blood count, diabetes, lipid abnormalities, weight gain and other metabolic effects

Stimulants for ADHD

Guanfacine (Tenex or Intuniv)—anti-hypertensives used off-label

Clonadine (Catapres)

Methylphenidate (Concerta, Metadate, Daytrana, Methylin, Ritalin)

Dextroamphetamine sulfate (Dexedrine)

Lisdexamfetamine dimesylate (Vyvanse)

Buprion (Wellbutrin)

Atomoxetine (Strattera)

Side-effects:

- Decreased appetite/weight loss
- Sleep problems
- Jitteriness
- Headaches
- Dry mouth
- Dysphoria-feeling that something is wrong, sad, worried
- Increased heart rate
- Dizziness

Medication Monitoring Guidelines

- 3 month minimum for maintenance, more frequently at initiation of new RX
- RXs dependent on continuation with clear labs—require more frequent monitoring especially at initiation
- Regular routine re-evaluation with titration and discontinuation goals

Factors that should trigger additional investigation…

- Dosages exceeding usual recommended levels
- prescriptions for children of very young age
- concomitant use of five or more psychotropic drugs
- prescriptions by a primary care provider lacking specialized training

Challenges to Advocacy

- Confidentiality
- HIPPA
- Communication
- Difference of opinion—CASAs see youth in supportive 1:1 environment; devoid of some of the stressors in competitive environments, unscaffolded by single adult focused on his/her needs

Thank you for your attention and questions.

Feel free to contact your CASA Volunteer Supervisor for further questions and comments. References, if not formatted prior to the presentation are provided on the Sonoma County CASA website.

Additional tables for further interest follow.

Presentation References: Medication and Foster Youth: The Struggle, Why and Why Not (p.1 of 3)

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Table 7: State Information-sharing Laws and Policies Compared with AACAP's Best Principles Guidelines

Guideline		FL	MD	MA	MI	OR	TX
Ideal	Create a website to provide ready access for clinicians, foster parents, and other caregivers to pertinent policies and procedures governing psychotropic medication management	■		■		■	■
Ideal	Website includes psycho-educational materials	■		■		■	■
Ideal	Website includes consent forms	■				■	
Ideal	Website includes adverse effect rating forms						
Ideal	Website includes reports on prescription patterns for psychotropic medications						■
Ideal	Website includes links to helpful, accurate, and ethical websites about child and adolescent psychiatric diagnoses and psychotropic medications	■					■

■ Fully implemented

▨ Partially implemented

□ Not implemented

FL Florida
MD Maryland
MA Massachusetts
MI Michigan
OR Oregon
TX Texas

Source: GAO analysis of information collected through interviews with, and various documentation provided by, the selected states' Medicaid and Foster Care officials, and the AACAP's best principles guideline.

Guideline		FL	MD	MA	MI	OR	TX
Minimal	Establish guidelines for the use of psychotropic medications for children in state custody						
Ideal	Oversight program includes an advisory committee to oversee a medication formulary and provide medication monitoring guidelines to practitioners who treat children in the child welfare system[1]						
Ideal	Oversight program monitors the rate and types of psychotropic medication usage and the rate of adverse reactions among youth in state custody						
Ideal	Oversight program establishes a process to review non-standard, unusual, and/or experimental psychiatric interventions with children who are in state custody						
Ideal	Oversight program collects and analyzes data and makes quarterly reports to the state or county child welfare agency regarding the rates and types of psychotropic medication use. Make this data available to clinicians in the state to improve the quality of care provided						
Ideal	Maintain an ongoing record of diagnoses, height and weight, allergies, medical history, ongoing medical problem list, psychotropic medications, and adverse medication reactions that are easily available to treating clinicians 24 hours a day						