Psychotropic Medications - Use and Misuse

2006
Concerns were raised regarding the use of psychotropic medications in Texas foster children after the release of an Office of Inspector General (OIG) report in September 2004. Since then, the Texas Health and Human Services Commission (HHSC), the Department of State Health Services (DSHS), and the Department of Family and Protective Services (DFPS) have implemented a number of strategies to get a more detailed assessment of the problem and to assist providers in utilizing psychoactive medication appropriately. In February 2005, as part of the effort to assist providers, DSHS released best practice guidelines for healthcare providers entitled Psychotropic Medication Utilization Parameters for Foster Children. The guidelines were developed by a panel of child and adolescent psychiatrists, psychologists, guideline development specialists, and other mental health experts for use in the treatment of foster children who receive services through Texas Medicaid. The guidelines provide parameters for the appropriate use of psychotropic medication in foster children and also alert clinicians to seven criteria, or situations, that indicate a need for further review of a patient’s case. Since releasing the guidelines, State staff has worked with individual providers whose patients’ medication regimens fall outside the guidelines to encourage proper prescribing. This report outlines an additional analysis that has been done on prescribing psychoactive medication to Texas foster children for state fiscal year 2005 (September 1, 2004 through August 31, 2005). HHSC, DSHS and DFPS conducted this analysis because psychoactive medication prescribing to foster children continues to be higher on average than to other Medicaid children. The analysis is based on Medicaid prescription and medical claims data. It includes three of the largest psychoactive drug classes (stimulants, antidepressants and antipsychotics), along with all other drug classes classified as psychotropic medications in the 2006 DSHS Formulary (e.g. mood stabilizers, sedatives/hypnotics). The DSHS Formulary is included as Appendix B. The analysis focuses on children who received psychoactive medication for 60 or more days. Psychoactive medications initially are given on a trial basis to determine if the drug will be effective and well tolerated. Since Medicaid doctors typically write prescriptions for 30 days, one can’t tell from a single claim whether a child actually took the drug for 30 days or for just a few days. For this reason, the analysis focuses on children who received psychoactive medication for 60 or more days to indicate that the child was likely on the medication beyond an initial trial period. A full description of the methodology used in the analysis is included in the Methodology section at the end of this report. (Author abstract)
Dulcan, Mina K. Cummins, Thomas, M.D.
2006
American Psychiatric Pub.
Abstract unavailable.

Should you medicate your child's mind? a child psychiatrist makes sense of whether to give kids psychiatric medication.
Roberts, Elizabeth J., 1958-
2006
Marlowe & Co.
Abstract unavailable.

Multiple psychotropic medication use for youths: a two-state comparison.
dosReis, Susan. Zito, Julie M. Safer, Daniel J. Gardner, James F. Puccia, Karen B. Owens, Pamela L.
Johns Hopkins Medicine.
2005
Journal of Child and Adolescent Psychopharmacology
15 (1) p. 68-77
Available from: Mary Ann Liebert, Inc. publishers
140 Huguenot Street, 3rd Floor
New Rochelle, NY 10801-5215
Tel: 914-740-2100 1-800-M-LIEBERT
Available from: http://www.liebertpub.com/
The aim of this study was to compare multiple psychotropic use among youths enrolled in two U.S. mid-Atlantic state Medicaid and state Children's Health Insurance Programs (SCHIP). Administrative data were used to examine multiple psychotropic use among youths less than 20 years of age and who were continuously enrolled in Medicaid or SCHIP programs in two states during 1999. Multiple psychotropic use referred to multiclass combinations and was defined by the number of months of multiple use. Main outcome measures were the prevalence of multiple psychotropic use and months of multiple use. Demographic and clinical characteristics, mental health visits, and common combinations were examined according to months of multiple use. Among continuously enrolled youths, 21%-22% had at least one mental health-related visit, 8%-10% received a psychotropic medication, and 2%-3% received multiple psychotropic medications. Nearly one third (28%-30%) of youths with any psychotropic use received multiple medications, of which almost half was for 5-12 months. Multiclass use was more common in male, white, aged 10-14, disabled, and foster-care youths. Stimulants with antidepressants, antipsychotics, or alpha-agonists were the most common combinations. Multiple use occurred in nearly one third of youths with any psychotropic treatment. Additional research is needed to
investigate switching patterns and the effectiveness of combined pharmacotherapy. (Author abstract)

**Effect of Medicaid eligibility category on racial disparities in the use of psychotropic medications among youths.**
*Psychiatric services*  
56 (2) p. 157-163  
Available from: American Psychiatric Association  
1000 Wilson Boulevard, Suite 1825  
Arlington, VA 22209-3901  
Tel: 703-907-7300  
apa@psych.org  
Available from: http://www.psych.org/  
This study sought to determine the degree to which Medicaid eligibility categories modify disparities between black and white youths in the prevalence of psychotropic medication. Computerized claims for 189,486 youths aged two to 19 years who were continuously enrolled in a mid-Atlantic state Medicaid program for the year 2000 were analyzed to determine population-based annual prevalence of psychotropic medication by race or ethnicity and by whether the youths were eligible for Medicaid for reasons of family income, disability, or foster care placement. Logistic regression was used to assess the interaction of eligibility category and race. The mean annual prevalence of psychotropic medication for the population was 9.9 percent. The prevalence was 2.17 times higher for white youths than for black youths (16.5 percent compared with 7.6 percent). However, within eligibility categories, the white-to-black disparity was 3.8 among youths who were eligible for Medicaid because their family income was below the federal poverty level and 3.2 for youths enrolled in the State Children's Health Insurance Program. Medicaid eligibility categories had a profound impact on the racial disparity associated with the prevalence of psychotropic medications for youths. Eligibility category should be taken into account when ascertaining the role of access, undertreatment, and culture in disparities in mental health treatment. (Author abstract)

**Psychotropic medication for children and adolescents.**
Malkin, Michael. 2005  
Available from: National Association of Counsel for Children (NACC)  
1825 Marion Street, Suite 242  
Denver, CO 80218  
Tel: 1-888-828-NACC  
advocate@NACCchildlaw.org  
Available from: http://www.naccchildlaw.org
Mental disorders can be thought of as the consequence of both psychological and organic factors. Psychological factors are such events as emotional traumas at critical times in one's life. Organic factors are abnormalities in the structure or functioning of the brain which result from genetic control of the blueprint for the brain, interference with brain development (e.g., prenatal drug or viral effects) and interference with brain function from trauma, toxicity, infection, metabolic disorders, etc. These factors interact; organic impairment causes increased vulnerability to psychological stress, and psychological stress exacerbates organic impairment. There is good evidence that early childhood psychological stress can cause physical abnormalities in parts of the developing brain. And, physical impairment is often psychologically stressful. Some individuals with mental disorders have relatively pure problems in one or the other of these spheres, but most have problems in both, and proper treatment should reflect this complexity. In some cases, psychotherapy is less effective, if not impossible, without the use of psychotropic medication to correct underlying organic impairment, and, conversely, psychotherapy is generally an important adjunct to get the most benefit out of treatment with medication.

Psychotropic medications are tools for producing certain chemical and physiological effects in the central nervous system. As with other tools, their effects may be good or bad, depending on the intentions and skills of those who use them. The best general indicator of whether psychotropic medication is being properly used is whether the patient's mental functioning is better with the medication than without it. Usually, the answer to this is clear, but, sometimes, it is not simple to determine. Mental functioning has numerous components (e.g. thinking, emotions, control of behavior and impulses, perception, control of physiological processes such as sleeping and appetite etc.). Medications can have desirable effects on some aspects of mental functioning and undesirable effects on others as well as effects on bodily functions having nothing to do with the central nervous system. When the effects of medication are mixed (some desired, some undesired) how can it be determined if the sum is good or bad? Is a good night's sleep and relief of depressed mood worth putting up with a dry mouth and constipation? Is eliminating hallucinations worth the risk of developing uncontrollable movements? Is the ability to control assaultive impulses worth tolerating cognitive slowing and sedation? For a competent adult patient, this decision is up to the patient to make. For children or incompetent adults, the process of informed consent is more complex. Both the patient and the parent/guardian/judge have a role in it. (Author abstract)

http://www.naccchildlaw.org/pub/Psychmed_3-05.pdf

Psychotropic medication utilization parameters for foster children.
Texas Department of State Health Services.
2005
http://www.dshs.state.tx.us/mhprograms/PsychotropicMedicationUtilizationParametersFosterChildren.pdf
Abstract unavailable.

Medication of children and youth in foster care.
Green, Diane L. Hawkins, Wesley. Hawkins, Michelle.
This study examined the type and frequency of prescribed medication of foster care youth in a south Florida county during April, 2001. Using file reviews and structured interviews with targeted case managers, it was found that 23% of the total sample (n=722) were currently using medication. Most frequent medications prescribed were Risperdal, Clonidine, Adderall, and Ritalin. The majority of subjects had multiple prescriptions (57%) with no one pattern found for multiple prescribed drugs. The most frequent behaviors and symptoms found for those prescribed medication were sadness, delinquency history, and argumentative behavior. Approximately three-fourths of the youth had medications monitored, while the most frequent schedule of monitoring was monthly. The foster care placement was most likely to monitor medication while a psychiatrist did almost all prescribing. The most frequent placement was therapeutic foster home while the most frequent Diagnostic and Statistical Manual diagnoses were Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, Major Depression, and Bi-Polar Disorder. One most striking finding for mental health was that those currently on medication were much more likely to have been Baker Acted (Florida law that provides a reasonable process for involuntarily committing those whose conduct makes them dangerous to themselves or others) than non-medication foster care youth. Finally, few barriers to services were found for the medication sample in receiving medication services.

Psychotropic medication use in a national probability sample of children in the child welfare system.
Raghavan, Ramesh. Zima, Bonnie T. Andersen, Ronald M. Leibowitz, Arleen A. Schuster, Mark A.
University of California.
2005
Journal of child and adolescent psychopharmacology
15 p. 97-106
Publication Information: New Rochelle, NY: Mary Ann Liebert, Inc.
Available from: Technology Partner - Atypon Systems, Inc.
140 Huguenot Street
New Rochelle, NY 10801-5215
The aim of this study was to estimate the point prevalence of psychotropic medication use, and to describe relationships between child-level characteristics, provider type, and medication use among children in the child welfare system. The National Survey of Child and Adolescent Well-Being is the first nationally representative study of children coming into contact with the child welfare system. We used data from its baseline and 12-month follow-up waves, and conducted weighted bivariate analyses on a sample of 3114 children and adolescents, 87% of whom were residing in-home. Overall, 13.5% of children in child welfare were taking psychotropic medications in 2001-2002. Older age, male gender, Caucasian race/ethnicity, history of physical abuse, public insurance, and borderline scores on the internalizing and externalizing subscales of the Child Behavior Checklist were associated with higher proportions of medication use. African-American and Latino ethnicities, and a history of neglect, were associated with lower proportions of medication use. These national estimates suggest that children in child welfare settings are receiving psychotropic medications at a rate between 2 and 3 times that of children treated in the community. This suggests a need to further understand the prescribing of psychotropic medications for child welfare children. (Author abstract)

**Psychotropic medication for children and adolescents.**
Malkin, Michael.
2005
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1825 Marion Street, Suite 242
Denver, CO 80218
Tel: 1-888-828-NACC
advocate@NACCchildlaw.org
Available from: http://www.naccchildlaw.org
Mental disorders can be thought of as the consequence of both psychological and organic factors. Psychological factors are such events as emotional traumas at critical times in one's life. Organic factors are abnormalities in the structure or functioning of the brain which result from genetic control of the blueprint for the brain, interference with brain development (e.g., prenatal drug or viral effects) and interference with brain function from trauma, toxicity, infection, metabolic disorders, etc. These factors interact; organic impairment causes increased vulnerability to psychological stress, and psychological stress exacerbates organic impairment. There is good evidence that early childhood psychological stress can cause physical abnormalities in parts of the developing brain. And, physical impairment is often psychologically stressful. Some individuals with mental disorders have relatively pure problems in one or the other of these spheres, but most have problems in both, and proper treatment should reflect this complexity. In some cases, psychotherapy is less effective, if not impossible, without the use of psychotropic medication to correct underlying organic impairment, and, conversely, psychotherapy is generally an important adjunct to get the most benefit out of treatment with medication.
Psychotropic medications are tools for producing certain chemical and physiological effects in the central nervous system. As with other tools, their effects may be good or bad, depending on the intentions and skills of those who use them. The best general indicator of whether psychotropic medication is being properly used is whether the patient’s mental functioning is better with the medication than without it. Usually, the answer to this is clear, but, sometimes, it is not simple to determine. Mental functioning has numerous components (e.g. thinking, emotions, control of behavior and impulses, perception, control of physiological processes such as sleeping and appetite etc.). Medications can have desirable effects on some aspects of mental functioning and undesirable effects on others as well as effects on bodily functions having nothing to do with the central nervous system. When the effects of medication are mixed (some desired, some undesired) how can it be determined if the sum is good or bad? Is a good night’s sleep and relief of depressed mood worth putting up with a dry mouth and constipation? Is eliminating hallucinations worth the risk of developing uncontrollable movements? Is the ability to control assaultive impulses worth tolerating cognitive slowing and sedation? For a competent adult patient, this decision is up to the patient to make. For children or incompetent adults, the process of informed consent is more complex. Both the patient and the parent/guardian/judge have a role in it. (Author abstract)

http://www.naccchildlaw.org/pub/Psychmed_3-05.pdf

National Conference of State Legislatures.
2005
Available from: National Conference of State Legislatures
444 North Capitol Street NW Suite 515
Washington, DC  20001
Tel: 202-624-5400
info@ncsl.org
Available from: http://www.ncsl.org
State law is an important part of the foundation of each state’s response to child maltreatment. It also provides the legal framework for state legislators’ oversight of the child welfare agencies that are charged with protecting children’s safety and meeting their permanency and well-being needs. The National Conference of State Legislatures (NCSL) highlights state child welfare legislation through its State Child Welfare Legislation reports. This report documents significant state legislation enacted during calendar year 2004. A number of legislative trends that began in previous years continued in 2004. These included new laws to address children’s exposure to methamphetamine, to improve educational services to children in the child welfare system, to expedite permanency for foster children, to support foster parents and kinship caregivers, to assist youth who are aging out of care, and to promote collaboration among agencies that serve children and families. A few areas received an unusual amount of legislative attention in 2004. Perhaps the most notable is a move to ensure that parents’ rights are protected when child welfare agencies investigate. Many of these laws were passed to comply with recent amendments
to the federal Child Abuse Prevention and Treatment Act, which require that subjects of protective investigations be informed of the allegations against them and that child protective services (CPS) staff be trained in their legal duties to protect the legal rights and safety of children and families. State legislation in 2004 also addressed the prescription of psychotropic medication to children in custody, family involvement in case planning, and innovations in foster care, such as whole family placements and "dedicated" family homes. Descriptions of significant state legislation appear below by issue area in alphabetical order. The appendix contains both citations and summaries of the laws discussed here. (Author abstract)

Evidence-based therapies in child and adolescent psychiatry.

Special report
McClellan, Jon.
CME, Inc. (Irvine, Calif.)
2005
Psychiatric times
22 html pages 1-8
Available from: CME
2801 McGaw Avenue
Irvine, CA 92614
Tel: 800-993-2632 949-250-1008
customer.service@cmellc.com.
Available from: http://www.psychiatrictimes.com
Consumer, professional, legislative and regulatory organizations are increasingly calling for the development and adoption of evidence-based therapies, based on demands for quality services and expectations that outpouring of dollars and time are rewarded by beneficial outcomes. In child and adolescent mental health, growing public concerns over safety, in particular with psychotropic medications, and the recognition that psychiatric impairment is a major factor within other social service systems has further fueled the demand for empirically based interventions. Randomized, controlled trials (RCTs) with adequate sample sizes and defined study populations are the standard for characterizing an intervention as evidence-based (Cochrane Collaboration, 2002). A listing of all RCTs in child and adolescent psychiatry is beyond the scope of this commentary (for a review, see McClellan and Werry [2003]). This review will outline interventions with the best research support. Fortunately, although the literature remains limited, the number of well-conducted studies is increasing. (Author abstract)
http://www.psychiatrictimes.com/showArticle.jhtml?articleId=171201534

Mental health medications for children: a primer.
Guilford practical intervention in the schools series.
Brown, Ronald T. Carpenter, Laura Arnstein. Simerly, Emily.
2005
Guilford Press
This primer is designed specifically for school psychologists and other members of the school-based treatment team, as well as child clinical psychologists. The book provides information on psychotropic medications that are frequently prescribed to manage children's behavior and enhance learning and academic performance. Effective guidelines are outlined for monitoring medication use, documenting beneficial effects as well as adverse side effects, and facilitating collaboration among health care providers, teachers, and parents. Reproducible appendices include tools for managing these essential tasks. (Author abstract)

2004
Denver, CO : National Association of Counsel for Children
National Association of Counsel for Children
1825 Marion Street, Suite 242
Denver, CO   80218
Tel: 1-888-828-NACC 303.864.5320
advocate@NACCchildlaw.org
Available from: http://naccchildlaw.org
The manual is 422 pages and includes 26 articles covering a wide range of children's legal issues including: Interviewing Children with Disabilities; Youth with Sexual Behavioral Problems; Educational Advocacy; The Child as a Witness; Maintaining Sibling Bonds; Creating Youth Peer Courts; Confidentiality of Juvenile Mental Health Records; Psychotropic Medication; and more.

Use of psychotropic medications by youths in therapeutic foster care and group homes.
Duke University Medical Center.
2004
Psychiatric services
55 (6) p. 706-708
Available from: American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, VA   22209-3901
Tel: 703-907-7300
apa@psych.org
Available from: http://www.psych.org/
This article examines the use of psychotropic medications among youths in residential community based placements. Data are from a study funded by the National Institute of Mental Health of therapeutic foster care (June 1999 through May 2001) and group homes (January through June 2001). Data were collected from staff by means of in-person interviews. Many youths in both settings received psychotropic medications, and approximately one-half were
taking multiple psychotropic medications. After the authors controlled for demographic and clinical factors, the youths in group homes were nearly twice as likely as the youths in therapeutic foster care to receive medication. However, residential setting was not related to polypharmacology. Additional work is needed to study the appropriateness of use and implications of such patterns for research on intervention outcomes. (Author abstract)

**Psychotropic drug use in foster care.**

*Red Item Report*


2003

Distributed by: Florida Statewide Advocacy Council

4030 Esplanade Way Room 315-M

Tallahassee, FL  32399

Tel: (850) 488-6173


This report highlights the findings of a study conducted by the Florida Statewide Advisory Council about the utilization of psychotropic medicines among foster children. A review of case files for 1,180 children living in therapeutic foster care revealed that more than half were taking at least one psychotropic medicine. The children taking psychotropic medicines were an average of 12.7 years old and had been in care for approximately 11.5 months. Children not using psychotropic medicines were an average of 7.5 years old and had been in care about 5.5 months. Forty-four percent of the children taking psychotropic medicine had no record of a medical evaluation and many did not have an identified psychiatric diagnosis. Proper consent forms were obtained for less than half of the children using psychotropic medicine. Thirty-eight percent of the case files had no documentation of consent and 15 percent had forms signed by an unauthorized person. Very few of the children were monitored for side effects of the drugs. The Statewide Advisory Council recommends that the state initiate a quality assurance program to oversee the appropriateness of prescriptions for children after alternative interventions have been used. The state also should ensure that informed consent is obtained in writing with a review of benefits, risk, and other treatments. Finally, medical records must be kept up-to-date.


**Psychotropic medication use among children in foster care: relationship to severe psychiatric disorders.**


University of California - Los Angeles.

1999

*American journal of public health*

89 (11) p. 1732-1735

Available from: American Public Health Association

800 I Street NW

Washington, DC  20001-3710
This study sought to describe the level of psychotropic medication use and its relationship to severe psychiatric disorders among school-aged children in foster care. Home interviews with 302 foster parents and children aged 6 to 12 years and 266 follow-up clinical evaluations were conducted. Thirteen percent of the children had taken psychotropic medication in the previous year, and 52% of those whose clinical status merited a medication evaluation had not received medication in the previous year. As the efficacy of psychotropic medication treatment for severe child psychiatric disorders becomes more established, research on the appropriateness of such care can begin. (Author abstract)